Start Healthy. Start Now.

Project Evaluation Report

community-minded ENTERPRISES

INHS COMMUNITY WELLNESS

SPOKANE REGIONAL HEALTH DISTRICT

WASHINGTON STATE UNIVERSITY SPOKANE COUNTY EXTENSION

Spokane Regional Health District – Data Center
1101 W. College Ave., #356, Spokane, WA 99201
TEL 509.323.2853 | TDD 509.324.1464 | srhd.org

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Introduction

The ***Start Healthy Start Now***[1] **(SHSN)** project is an innovative collaboration based out of Spokane, Washington, to promote three specific areas of child development:

1. **healthy nutrition**
2. **physical activity**
3. **emotional well-being and mental health**

The local effort, led by Inland Northwest Health Services (INHS) in collaboration with Spokane Regional Health District (SRHD), Community-Minded Enterprises—Child Care Aware of Eastern Washington (CME), and Washington State University's Area Health Education Center (WSU AHEC), was awarded a U.S. Centers for Disease Control and Prevention (CDC) Community Transformation Grant (CTG) in the spring of 2013[2].

1 To improve readibility, authors removed "periods" from project name and opted to simply italicize.

2 CDC Award number: 1H75DP004269-01

CTG supports government and community agencies in implementing, evaluating and disseminating evidence-based community health initiatives to[3]:

- **reduce chronic disease**
- **prevent secondary conditions**
- **address health disparities**
- **further develop the evidence-base of effective prevention programming**

As funding for CTG stems from the Affordable Care Act (ACA), each grant must address one or more of these ACA targeted outcomes:

- **changes in weight**
- **changes in proper nutrition**
- **changes in physical activity**
- **changes in tobacco use and prevalence**
- **changes in emotional well-being and overall mental health**

The target audiences for the SHSN project were children attending child care and their families, and licensed child care providers and early childhood educators and their families in a six-county region of eastern Washington. These populations demonstrate a significant need for support, namely due to the influence that early childhood has on multiple outcomes later in life. Early care also plays a significant role on health and developmental outcomes.

Multiple target outcomes for these audiences were selected based on the capacity and expertise of the collaborators and built from local community planning members' input. In addition to the target outcomes related to nutrition, physical activity, and emotional well-being and mental health, a supplemental goal of CTG is to support system change and sustainability through changes in policy.

Specific to the grant application, to better receive input from community stakeholders, initial meetings were held with 18 community agencies. These agencies provided input on areas of need in the community, and on their capacity and desire to be involved in the grant. Focus was given to physical activity and nutrition, as well as emotional well-being and mental health. INHS was selected to manage the grant, due to its experience managing similar community projects, including its Step UP and Go, 85210 (Step UP) initiative – which focuses on physical activity and healthy eating. SRHD was selected to lead SHSN nutrition efforts related to improving the foods served in child care centers. This was based on SRHD's background in nutrition education and its capacity to support policy, systems and environmental change. Strong in its understanding of complex trauma, building awareness around trauma exposure, and in implementing trauma-sensitive care trainings, WSU AHEC was invited to participate in the grant and asked to take lead on meeting the emotional well-being and mental health outcomes. CME staff volunteered to take the lead in training child care staff in *Let's Move! Child Care*, a national initiative addressing physical activity and nutrition. CME served a major role in recruiting child care centers to participate, based on its subsidiary program, Child Care Aware of Eastern Washington. During the 18-month course of the grant project, these leading collaborators met monthly to touch base about the status of each project component, troubleshoot problems that arose and engage in continuous quality improvement during implementation.

During the time that SHSN took place, the state of Washington was also participating in an effort to improve the quality of child care offered across the state called Early Achievers, by Washington State Department of Early Learning. Early Achievers is a voluntary program that involves coaching and resources for licensed child care providers to support each child in their learning and development[4]. This ongoing effort provided an opportunity for SHSN to recruit participants through Early Achievers coaches, in an effort to improve centers' quality in the areas of nutrition, physical activity, and emotional well-being and mental health. To encourage Early Achievers participation in each of the SHSN trainings and trainers were approved by the MERIT/STARS systems in Washington, which helps to track early learning professionals' education training and professional development[5]. By participating in SHSN trainings, participants received training credits through this system that met their yearly requirements for licensing.

3 "CDC-RFA-DP09-9010301PPHF11 Prevention and Public Health Fund Coordinated Chronic Disease Prevention and Health Promotion Program." Www.grants.gov. U.S. Centers for Disease Control and Prevention, 8 June 2011. Web. 02 Dec. 2014.

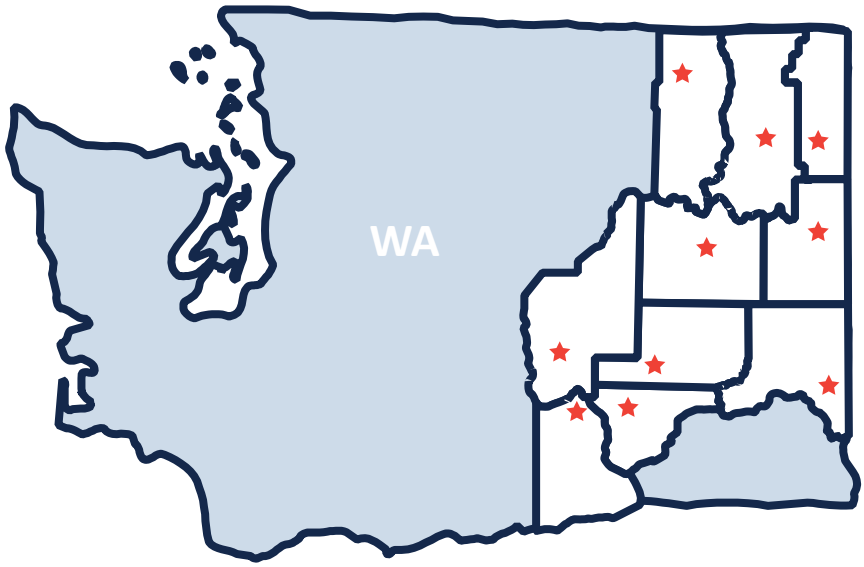
4 "Early Achievers, Washington's Quality Rating and Improvement System." Washington State Department of Early Learning. 1 Jan. 2010. Web. 11 Dec. 2014.

5 "Managed Education and Registry Information Tool (MERIT) Frequently Asked Questions." STARS on the Internet. Web. 30 Nov. 2014. <http://www.starstab.com/MeritQA.pdf>.

Project Reach and Participation

Start Healthy Start Now reached more than 157 centers from 39 cities in eastern Washington, each of which participated in at least one of the three training programs (*Let's Cook Whole Foods, Let's Move Child Care* and *Trauma-Informed Care*). It is estimated that over 5,700 children in the region were reached based on centers' participation.

The map to the right shows all of the counties in eastern Washington that participated in the *Start Healthy Start Now* trainings, including those not specifically targeted by the grant.



Evaluation Purpose

This evaluation of the *Start Healthy Start Now* project was conducted primarily to determine effectiveness in meeting targeted outcomes. Secondarily, organizers wanted to determine areas of improvement to support future project sustainability.

The intended audiences for this report include a variety of project stakeholders. One intended audience is the **participants of the project trainings**. Project participants can use this report to help them sustain changes made after participating by finding additional strategies used by other centers to overcome barriers. Additionally, they can gain new ideas for implementing training recommendations by reading about changes made by others. Finally, they will be able to see their contributions to project successes.

***Start Healthy Start Now* project leadership and staff**, another intended audience for this report, can use this document to reflect on training outcomes and understand program effectiveness in achieving targeted outcomes. Specific examples of ways participants used training recommendations are cited. Additionally, program leadership and staff can use this document in its entirety–or, each individual training section *(Let's Cook Whole Foods, Let's Move! Child Care and Trauma-Informed Care)* – to pursue funding and support of similar projects or trainings. They can also **use this report as a tool for communication with other audiences, i.e. key legislators and decision makers** who may be interested in incorporating one or more of these trainings into existing training infrastructures, or fund future training efforts.

As described previously, the primary purpose of this report is to communicate results with **public stakeholders, sustain project outcomes in participants, celebrate project successes, and provide information from lessons learned** throughout the project. Secondary to that, another intended audience is the project funder–this report will be provided to CDC, in addition to a more extensive presentation of analytic results, and other required reporting documents.

Report Organization

This document is structured in three main sections, one for each of the three trainings–*Let's Cook Whole Foods, Let's Move! Child Care, and Trauma-Informed Care*. Each section provides:

- **a description of the program,**
- **results from participant evaluations collected immediately after participating in each training,**
- **specific changes made, and**
- **examples of program impact from interview data collected after the end of the project.**

Finally, each section includes **a summary of lessons learned** and **next steps** for each individual training program. The document is summarized at the end with a selection of **key results** and **overall lessons learned** during the project. This report is intended to either be read in its entirety or broken down into individual project reports.

Evaluation Methods

Child care staff who participated in the ***Let's Cook Whole Foods*** training were **evaluated on knowledge change, meeting goals around cooking whole foods**, and **being able to apply the information in their child care practice.** This was done via survey distributed at the end of the training session. Information about policies and practices around nutrition and the feeding environment were collected from participating child care centers by having each center complete both a pre- and post-test evaluation form at the training. The center-wide evaluation used the *Let's Move! Child Care* assessment as a template. Additional questions were drawn from the Young Men's Christian Academy (YMCA) Community Healthy Living Index (CHLI) assessment.

Child care staff who participated in the ***Let's Move! Child Care*** training were **evaluated on knowledge change, meeting goals around healthy eating for children**, and **being able to apply the information in their child care practice**. Evaluations were paper surveys completed at the end of the trainings by participants. Information about policies and practices around physical activity and nutrition were collected from participating child care centers by having each center complete both a pre- and post-test evaluation form at the training. The center-wide evaluation used the *Let's Move! Child Care* assessment provided on its website.

Child care staff who participated in the ***Trauma-Informed Care*** **trainings** were **evaluated on knowledge change**, **meeting goals around trauma-informed care**, and **barriers to implementing trauma-informed practice**. Evaluations were paper surveys completed at the end of the trainings by participants. There were three trainings: a two-part basic training and an advanced training. Evaluation questions were based on training objectives for each, as identified by the trainers and collected at each of the three trainings.

To supplement survey responses and collect additional follow-up information, child care centers that participated in two or three components of the *Start Healthy Start Now* project were invited to interview with a program evaluator. A total of 17 centers were invited to interview, of which **14 centers participated** (82 percent response rate). Interviews were completed with participating **center directors** (n=14), **teachers** (n=19), and **cooks** (n=13), and took place onsite for 11 child care centers and by phone for three. Interview lengths ranged from approximately 20 to 75 minutes. Participants were asked questions related to **overall program impact**, **impact on staff and children**, and **supports and barriers to sustainability**. Interview data was coded thematically based on interview questions and concepts.

Evaluation Limitations

Though this evaluation effort had much strength in utilizing multiple sources of data, and multiple perspectives, it is not without its limitations. One limitation is in the **low response rate of child care centers for the *Let's Move! Child Care* evaluation**. Due to high levels of program staff turnover, and inconsistent implementation of surveys, a total of 15 center pre-test, and 16 center post-tests were collected making training results non-significant. There were also a small number of interviews collected relative to the total number of participants. Though interview data reached saturation in responses, eventually revealing no new information, the data presented represents the changes made only by those interviewed. Participants were invited to be interviewed if their center had participated in two or three trainings. The data presented does not reflect the changes made or impact of the program on those who only participated in one of the three trainings. There were also **several areas of program implementation and impact that were unevaluated as the evaluations were based** on other available, previously-validated questionnaires, with the exception of *Trauma-Informed Care*. Evaluation methods also relied on self-reports, and participants' perceptions of changes made rather than direct assessments of practice from other sources. Causality of these results can not directly be attributed to the *Start Healthy Start Now* trainings.

Why Focus on Nutrition?

Children and adolescents who become overweight or obese can have significant health problems[6]. Rates of obesity have doubled for preschool-age children and tripled for school-age children since 1980[7]. Nutrition and healthy diets rich in fruits and vegetables play a key role in the prevention of obesity and may reduce the risk of cancer and other chronic illnesses[8]. Lowering sodium in children's diets can help prevent chronic illnesses such as heart disease by lowering blood pressure[9].

Given the relationship between healthy eating and lowering risk for chronic illness and obesity, targeting these specific practices, in an effort to improve nutrition, is an important step. Given the high prevalence of childhood obesity, even in early childhood, intervening through food received in group child care such as the focus of *Let's Cook Whole Foods* and *Let's Move Child Care*, are promising strategies.

6 Ogden CL, Carroll, Curtin LR, et al. Prevalence of high body mass index in US children and adolescents, 2007-2008. JAMA 2010;303:242-49

7 "Overweight and Obesity." Centers for Disease Control and Prevention. 10 Sept. 2014. Web. 11 Dec. 2014. <http://www.cdc.gov/obesity/index.html>.

8 "Nutrition for Everyone: Fruits and Vegetables." Centers for Disease Control and Prevention. 8 Dec. 2014. Web. 11 Dec. 2014. <http://www.cdc.gov/nutrition/everyone/fruitsvegetables/index.html>.

9 "Vital Signs: Reducing Sodium in Children's Diets." Centers for Disease Control and Prevention. 9 Sept. 2014. Web. 10 Dec. 2014. <http://www.cdc.gov/vitalsigns/children-sodium/>.

Let's Cook Whole Foods Training

To address two of the nutrition objectives of this grant, SRHD staff set out to develop a hands-on training that could **target child care nutrition by reaching center cooks and administrators**. Cooks in early learning settings play a critical role in creating quality child care environments, teaching healthy eating habits and helping children get off to a healthy start. In spite of the significant role they play in children's nutrition, few training opportunities are available to cooks to improve their skills and continue their education.

Let's Cook Whole Foods was modeled after a similar program called *Discover. Cook. Nourish* out of Seattle. The *Discover. Cook. Nourish* training provides an opportunity for school food service providers to build their knife skills and explore opportunities for incorporating fresh natural foods into their menus. The approach of the *Discover. Cook.Nourish* was incorporated into the design of *Let's Cook Whole Foods*. To inform the *Let's Cook Whole Foods* program, focus groups with center cooks and administrators were held in March 2013 to identify challenges and opportunities for cooking whole foods in child care settings. The *Let's Cook Whole Foods* training was, therefore, designed to address challenges and opportunities, while incorporating aspects of the *Discover. Cook.Nourish* program approach. It was then piloted with stakeholders of the project and further refined to address training gaps.

The goal of the *Let's Cook Whole Foods* training was to teach child care facility cooks how to prepare child-friendly, whole foods efficiently, while keeping costs down. This hands-on training was taught by a trained chef and allowed cooks to practice such skills as using creative cooking methods, spices and presentation to enhance flavor and taste expectations, while preserving the nutrition in whole foods. The training itself had multiple components beginning with a **six-hour group** training where participating cooks had an opportunity to:

- **practice their knife skills**
- **review menus**
- **create new recipes using whole grains, legumes, fresh fruit and vegetables**
- **learn cost saving strategies to support these practices**

Center directors were invited to attend this training to learn more about training goals and to gain resources on how and where to purchase whole foods at competitive prices. As the training was further refined, previously-trained participants were sent updated resources.

Another component of the training included individual follow-up support for these newly-trained cooks. Follow-up consisted of multiple visits and discussions with a traveling chef consultant. During these visits, cooks had the opportunity to receive technical assistance based on individual areas of need. They received resources from the chef consultant, including a binder with recipes, strategies for introducing new foods to picky eaters, and additional U.S. Department of Agriculture (USDA) *Team Nutrition* and *My Plate* resources. Another component of the training involved participation in a peer network called Cook's Connection, to help with troubleshooting, share ideas and support peers in making changes. Once established, information from Cook's Connection was sent to all child care centers in the region. Cook's Connection allowed cooks from child care centers to network through monthly meetings and e-newsletters, and other electronic communication through a Cook's Connection Facebook group and associated emails.

A total of 14 *Let's Cook Whole Foods* trainings were provided as a part of *Start Healthy Start Now*, with approximately 10-12 participants at each training. *Let's Cook Whole Foods* trainings hosted 70 cooks and center administrators, while 10 centers participated in the Cook's Connection peer network. These cooks represented 57 child care facilities, reaching approximately 4,653 children in the region.

Targeted Goals of *Let's Cook Whole Foods* Training

- Increase the number of child care/early childhood education facilities implementing whole/healthy food sourcing strategies.
- Increase the number of child care/early childhood education centers implementing whole/healthy food preparation techniques.

Program Evaluation Results: *Let's Cook Whole Foods*

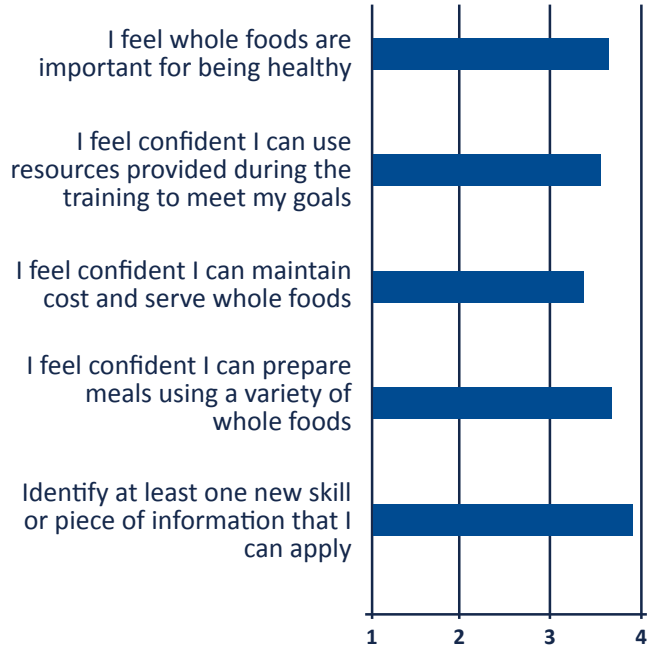
Individual and Center-Wide Post-Training Evaluation

Child care staff who participated in the *Let's Cook Whole Foods* training were evaluated at the end of the training on knowledge change, meeting goals around cooking whole foods, and ability to apply the information in their child care practices. Additionally, information about policies and practices, specific to nutrition and the feeding environment, were collected from participating child care centers at the start of the trainings and through chef visits after the training. The population samples for the results in this section are individual participants, as well as child care facilities that attended the trainings. Seventy child care staff completed a training evaluation and 57 child care facilities provided evaluation responses.

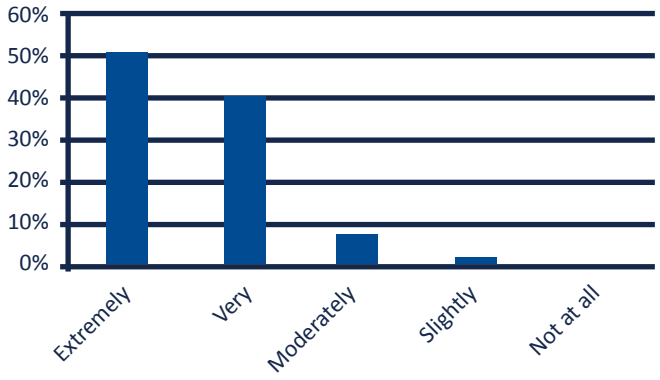
Individual participants **were asked to rate their knowledge of the training content**, on a scale of 1-10, prior to, and after, the training. Prior to the training, participants averaged 5.37 for knowledge, and after the training, they reported an average of 8.45, a significant increase of 3.1 points.

On a scale from 1-5, 1 being 'not at all' and 5 being 'extremely', ***Let's Cook Whole Foods*** **participants averaged 4.4 for how likely they were to use a new skill or information from the training**. Most participants felt they could start using the skills or information from the training very soon. Half of participants anticipated using the new skill or information in the next week; 37.7% in the next month, 4.3% in the next three months, 5.8% in the next six months, and 1.4% expected to take more than six months to use the skill or information.

Let's Cook Whole Foods training objectives



How likely are you to use the new skill or information you learned from the LCWF training?



Participants were asked to rate, on a scale of 1-4, 1 being 'strongly disagree' and 4 being 'strongly agree', on **whether they agreed that they achieved the program objectives. All training objectives were rated 3.3 or higher.**

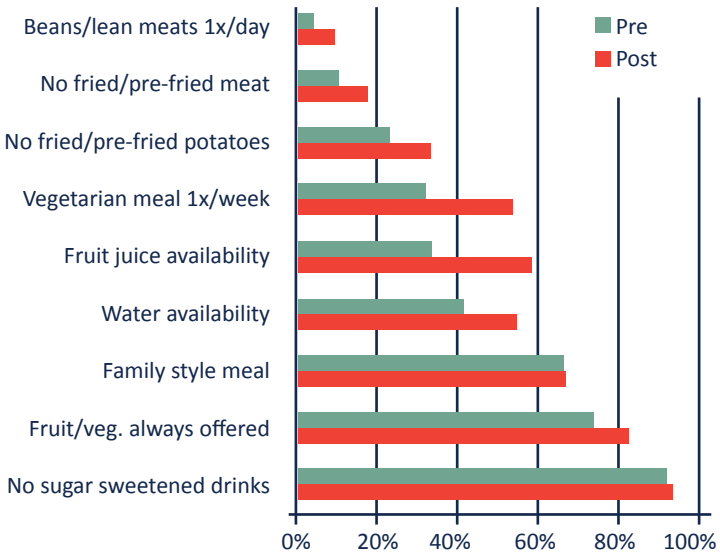
There was an **increase in child care centers reporting use of child care collaboratives**, one of the opportunities provided by the *Let's Cook Whole Foods* training, offering a way for facilities to help each other solve problems. While not a statistically-significant change[10], the results show that child care centers began to use a collaborative concept. The collaborative component of this training program, called Cook's Connection, was offered as a resource to everyone who participated in the training.

Specific to the area of policy, there was a **shift from centers that had no written policy in support of providing whole or minimally-processed foods to those having a policy in development after training completion**. *Let's Cook Whole Foods* program staff deduce this change was prompted by training efforts to help centers understand what constitutes a whole foods policy. In terms of meeting a policy, many centers initially reported having a policy in support of providing whole or minimally-processed foods, but in fact were referring only to policies around food allergies and participation in USDA Food and Nutrition Service's Child and Adult Care Food Program (CACFP) reimbursement.

Through the *Let's Cook Whole Foods* project, staff worked with facilities to help them better understand the 'how' and 'why' of serving more whole foods and how policy supports these choices. Subsequently, centers better understood what it meant to have a policy in support of providing whole or minimally-processed foods. Conversely, some centers felt that instituting a policy was not an immediate need, and that developing a policy would be disruptive to staff. To support the development of whole foods policies, *Let's Cook Whole Foods* staff provided policy templates and examples to centers to consider adopting based on best practices for child care food preparation and foods served. Staff also trained on best practices to help centers understand the policies and their utility.

The proportion of child care centers that met the desired level of offering minimally-processed foods increased for most measures. A statistically-significant difference was found for child care centers limiting fruit juice to no more than 4 to 6 ounces per day and encouraging parents to support this limit. Most centers did not offer sugar-

How likely are you to use the new skill or information you learned from the LCWF training?



sweetened drinks to children and reported offering either a fruit or vegetable at every meal after the training.

A statistically-significant difference was found for **child care centers offering one or more vegetarian meals per week after participating in the training**. The areas of food service with the least amount of change and the greatest room for future improvement (based on evaluation results) was for centers to refrain from serving fried or pre-fried potatoes or meats and instead serve beans and lean meats.

Among facilities reporting both a before- and after- cost figure, the **difference in cost to feed each child, after the program compared to before the program, was not significant**. Among centers that reported a cost for both before and after the program, the average cost per child, per month, for food was **$29 before** and **$33 after** the program. Centers reported an **increase in estimated time spent prepping food per month per child**, from **75 minutes to 88 minutes**. Though this was not statistically-significant, the increase does reflect a small increase in the amount of time needed to prepare whole foods.

Changes Made After Participating in *Let's Cook Whole Foods*

During interviews with participating center directors, classroom teachers and kitchen staff, that took place after the trainings ended in summer 2014, participants identified several specific changes made in policy or practice as a result of participating in the *Let's Cook Whole Foods* program.

10 p=0.20

Changes in Centers' Food Environments

The **most frequent changes made** after participation in the *Let's Cook Whole Foods* training **involved menu changes** to include **more whole and fresh foods**, rather than processed foods, including **increased use of whole grains and fresh fruits and vegetables**, instead of canned. Some centers **removed processed meats** (i.e. chicken nuggets and fish sticks) from menus and replaced them with fresh or frozen meats. Additional centers **dropped all other meats from menus, except turkey, chicken and fish**, and **incorporated meatless meals** utilizing alternative sources of protein including lentils. Many centers began serving foods that were never on their menus before and **adopted seasonal menus,** taking advantage of readiy-available produce. Other changes were made to menus in an effort to reduce fat, sugar, and sodium by purchasing foods that are sugar or fat-free or are made from scratch to reduce sodium. Many centers are **began serving low-fat milk** for preschool-age children, **limiting the amount of juice** served to children, and **offering more water** throughout the day. Several centers are making an effort to **repeatedly serve new foods** in spite of resistance, making new foods fun through presentation, or holding tasting activities for introducing new foods.

Policy Changes

One of the supplemental focuses of the training was to support centers in making changes to policy involving food and nutrition. Policy changes made in centers included **requiring family-style meals** and specifying that teachers must eat the same food with the children. Several centers adopted policies that **disallow outside food or drinks** being brought into the center by children and families and staff from eating or drinking outside items in front of the children. Policy changes led to **changes in parent handbooks**, informing parents of philosophies for serving whole grains, fruits and vegetable and juices, and some requiring children to try new foods. Other centers established **unwritten policies on the frequency of which new items are introduced to the menu**, including once-a-month, with repeated weekly exposures of new foods.

System Changes

Changes were made in how parents are communicated with including **educating parents** about nutrition and menu changes, and providing recommendations on **healthy options for celebration foods and treats**. Communication changes continued with children as well and included staff engaging in conversations with children about new foods, **healthy portions**, **preventing food waste**, and the importance of healthy foods. Many centers **adopted incentive programs**, like the two-bite club, where children get a stamp or sticker for taking two bites of new foods, to increase children's willingness to try new foods. Centers are **asking children for their feedback** on new menu items and reported children's reactions to the kitchen staff. Communication between staff members changed in that **staff now meet to discuss menu changes** and share ideas for getting children to eat the new foods. Some teaching staff reported that they are now involved in meal planning and recipe sharing with kitchen staff.

To support changes in nutrition, **center administrators made changes including hiring additional support for kitchen staff or designating kitchen support roles for existing staff**. Administrators reported supporting on-site gardens to supply whole-food items for serving to the children. Multi-site child care systems also made system-wide changes in food policies and menus to include more whole food items. Lastly, administrators supported healthy food philosophies by requiring healthy foods at family events and providing healthy food items for snacks to be offered for children to bring home with them.

Barriers to Implementing *Let's Cook Whole Foods* and Strategies for Mitigating Barriers

Interviews with participating center directors and classroom teachers that took place after the end of the project identified several barriers to making changes in practice and policy at various levels. The experience of encountering barriers and ways that centers mitigated these barriers can be used to assist other centers experiencing similar obstacles in implementing whole foods practices and policies.

"When the kids come back to the kitchen and say 'Oh, that smells so good!' that is nice to hear. Even though I think that I am doing a good job, they think so too."

– Center Cook

	Barriers to Implementing *Let's Cook Whole Foods*	Strategies for Mitigating Barriers to Implementing *Let's Cook Whole Foods*
KITCHEN STAFF	• Thinking that whole foods are already being served and nothing needs to be changed • Difficulty of changing routines and behavior • Reluctance to change menus or practices • Kitchen staff not buying into the importance of nutrition for children's development • Need for continued support to sustain changes • Limited continuing education opportunities • Extra time needed for meal prep • Menus set by outside source, kitchen staff not having control over menus • Turnover of kitchen staff • Being discouraged or stopping serving new items when children resist • Time required to set up and tear down between meals, balanced with prep time	• Support of administration • Requiring changes to menu to include whole foods • Administration communicating whole food philosophy and requirements with kitchen and teaching staff • Providing additional support for food preparation • Idea sharing with other cooks through Cook's Connection
TEACHING STAFF	• Eating and drinking unhealthy foods in front of children • Negative attitudes and comments about food changes • Not liking healthier foods themselves • Time required to introduce new foods to children • Unaware of food policies, and menu changes • Difficulty of introducing new foods to children including preverbal children	• Banning outside food or drinks from the classroom • Requiring family-style meals • Requiring staff to eat the same foods as the children during mealtimes • Continuing communication and sharing ideas for getting children to try new foods • Established protocols for communicating feedback about menu changes in a respectful manner

CHILDREN

Barriers to Implementing *Let's Cook Whole Foods*	Strategies for Mitigating Barriers to Implementing *Let's Cook Whole Foods*
• Not liking whole foods • Not wanting to try new foods • Going hungry instead of eating new foods • Arriving to child care after scheduled meals and snacks, being hungry during the day • Wasted food • Food allergies • Longing for old food practices	• Engaging children in activities to encourage healthy eating, introduce new foods and encourage exploration (i.e. gardening, cooking in the classroom, trips to the farmers' market or Greenbluff) • Utilizing incentives for getting children to try new foods (i.e. stamps for trying new foods, two-bite club, no-thank-you bites) • Offering food at non mealtimes for children • Talking to children about portion size and food waste • Modeling child-size portions • Encouraging children to slow down while eating and use all 5 senses to explore food • Showing children food prior to serving • Providing healthy snacks for the children to take home; sending home healthy snacks for the children each day, snack basket in the hallways outside of classrooms • Making some foods interactive for the children to participate in preparing • Talking about how children's ancestors ate long ago • Encouraging children to think about what foods are healthy, what vitamins and nutrients are in food, and the relationship between healthy food and healthy bodies • Having children be scientists and investigate new foods • Making food fun for children to explore

"To help introduce children to new foods we are showing the foods to them. When we first started using quinoa I took it around and showed the kids the raw food before I cooked it and told them that it is going to look different when we have it for lunch. I told them it will look silly and will have a little tail."

– Center Cook

	Barriers to Implementing *Let's Cook Whole Foods*	Strategies for Mitigating Barriers to Implementing *Let's Cook Whole Foods*
PARENTS	• Thinking unhealthy foods are fine • Not liking food changes • Sending unhealthy foods with children to child care center • Not serving whole foods at home	• Communicating importance of whole foods and healthy eating with parents • Sending home recipes with families • Creating policies banning outside food with exception of allergies • Providing recommendations for alternative celebration foods
ADMINISTRATION	• CACFP guidelines (described below) • Not purchasing requested food or equipment • Not wanting to get involved in the kitchen • Differential treatment of kitchen staff • Time needed to communicate changes in kitchen staff to teachers and other staff	• Involving center staff in menu planning • Utilizing software programs to generate required nutrition labels for whole food purchases or recipes • Allowing kitchen staff to make food purchase • Fostering open communication between kitchen staff and director • Providing support staff for kitchen staff • Planning for, and providing, kitchen staff absences (i.e. sick days and vacation)
FOOD OPTIONS	• Food availability • Vendor availability of food items and changes to availability • Quality of produce • Having to buy food with labels per CACFP guidelines • Food cost	• Changing menus based on seasonal availability of produce • Supplementing vendor purchases with other sources (i.e. local grocery store or deli, local farm or farmers' market) • Use Clean 15 or Dirty Dozen guidelines
KITCHEN FACILITIES & EQUIPMENT	• No kitchen • Not enough refrigeration • Additional prep equipment • Inconsistencies in child nutrition label software	• Utilizing electric cooking surfaces (i.e. crockpots, skillets, rice cookers) • Requesting additional equipment from administration • Balancing whole food purchased with other minimally-processed items in order to accommodate issues of cost and equipment

Child and Adult Care Food Program (CACFP) Guidelines

CACFP provides financial reimbursements to child and adult care facilities for providing nutritious meals and snacks to those in their care[11]. CACFP is a federally-funded program administered by individual states. CACFP reimburses centers where its meals and snacks: **1) include all CACFP required components, 2) contain servings in at least minimum quantities, and 3) are served to eligible children** (25 percent of children in care must be eligible for free and reduced-price meals or the center must be considered tax exempt).

CACFP guidelines provide 'meal pattern' charts that establish which food groups or components must be served at each meal and required portion sizes of each group[11].

CACFP guidelines then provide specific guidelines and definitions for foods that qualify in each food group or component including:

- **grains/breads**
- **fruit and vegetable**
- **meat/meat alternatives**
- **milk**

Let's Cook Whole Foods is a voluntary whole foods program for childcare agencies that references 45 widely-accepted and reputable nutrition resources including USDA dietary guidelines, healthy child care policies, healthy food, beverage, feeding and access tips and policies.

On the next page are some of the **similarities** and **differences** between the CACFP regulations and recommendations and the *Let's Cook Whole Foods* recommendations.

Some centers believed that if they were meeting CACFP guidelines they were providing whole foods, and that no changes were needed in their policies or practices. The table shows where recommendations overlap and where they are different. Meeting CACFP requirements were not considered having a whole foods policy for *Let's Cook Whole Foods*.

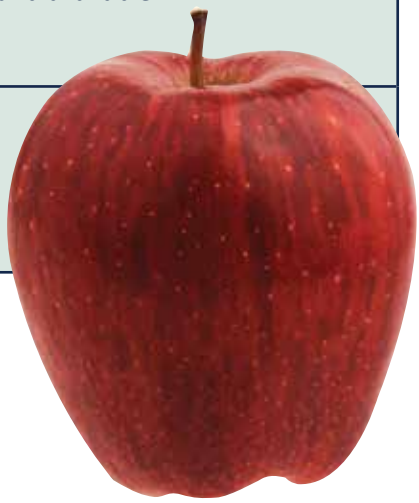
Additionally, CACFP participating institutions were notified of an update to the USDA Crediting Foods handbook in March 2014[11]. Some child care centers interpreted the changes in guidelines as a requirement to purchase processed foods with child nutrition labels. The other alternative is to have written recipes with ingredients and quantities that meet reimbursement criteria. Some child care cooks/directors identified this as a barrier for implementing whole foods cooking. This confusion is being addressed during the CACFP annual training with examples of how to standardize recipes to ensure the children are being fed adequate amounts of each component being credited. CACFP and SRHD will be working together to develop a resource on how to standardize recipes and continue to incorporate whole food ingredients.

The USDA Crediting Handbook was posted to the State of Washington, Office of Superintendent of Public Instruction (OSPI) CACFP website in March of 2014. The USDA Crediting Handbook replaces the Creditable Foods Guide for Family Day Care Homes, Child Care Centers, and Adult Day Service Centers Participating in the Child and Adult Care Food Program which was revised in March of 2007.

11 Child and Adult Care Food Program: Off to a Good Start. State of Washington Office of Superintendent of Public Instruction, Child Nutrition Services, 2012. Print.

Differences Between CACFP Guidelines[11] and LCWF Recommendations:

	CACFP Guidelines	LCWF Recommendations
GRAINS	• Serve at least one whole grain item per day • Limit sweet grain items to no more than twice per week	• 100% whole grains served at least once a day
FRUITS & VEGETABLES	• Serve at least one vegetable at lunch and supper rather than two fruits • Serve whole fruits rather than fruit juice • Fruit juice is to be limited to 3 times per week maximum (regardless of the number of meal services and days of the week)	• Vegetables are served twice daily • Dark green, orange, red, or deep yellow vegetables are served at least one time per day • Fried and pre-fried potatoes are never served
MEAT & MEAT ALTERNATIVES	• Hog dog, corn dog, bologna and processed type meat limited to 1 time per week Requirements: • CN labels are required for luncheon meats unless the product is listed in the Food Buying Guide • Spam and beef jerky are no longer creditable • Pepperoni and salami must have a CN Label or a Product Specification Sheet • Chicken nuggets must have a CN Label or a Product Specification Sheet	• Fried or pre-fried (frozen and breaded meats) (chicken nuggets) or fish (fish sticks) are never served • Highly processed meats including hot dogs, corn dogs, bologna, salami, pepperoni or bacon are never served • Legumes are served three or more times per week
MILK	• Water cannot be served in competition with milk • Water must be made available to all children throughout the day	• (Flavored milk-sugary drinks) are never served
WATER	• Water cannot be served in competition with milk • Water must be made available to all children throughout the day	• Drinking water is available inside and outside where it is visible and available for self-service
OTHER	• Children age 12 and older may be served larger portions based on their greater food needs. They may not be served less than the minimum quantities listed in this column	



Program Impact: *Let's Cook Whole Foods*

Interviews with participating center directors, classroom teachers and kitchen staff identified several areas of short and potentially long-term impact, or effects, on these target audiences based on changes made after participating in the *Let's Cook Whole Foods* training. In spite of previously- mentioned barriers to implementing training information, centers were able to make many specific changes to the foods served, kitchen, teaching and other staff practices, resulting in a substantial impact.

The focus on food preparation techniques **provided participants with knife skills** that they are using at home and in the centers to be more efficient in their preparation of whole foods. They are **more careful in regard to food safety** and preparation. Participants reported that centers are **purchasing more whole foods** and reducing processed food purchases as a result of the classes and coaching. Kitchen staff are now **more mindful about the nutritional value** of the food they serve the children such as sugar and sodium content in foods, as well as communicating these changes to families. They are more cognizant about how the food served impacts children's health and behavior. **Allergies are more prominently considered** and staff are communicating menu changes with parents in order to be prepared for, and responsive to, food allergies. Participating in the *Let's Cook Whole Foods* training also impacted staff by providing specific ideas for healthy recipes and menus. Cooks reported that learning this information enabled them to eat healthier both at the center and at home, resulting in weight loss for some. The training taught them how to use food wisely and save on budgets through purchasing differently.

Staff Impact

Many kitchen staff and center directors reported that this **training provided a rare opportunity to support kitchen staff in food preparation and a hands-on opportunity to learn about cooking for a child care center**. Many participating cooks and administrators reported that cooks had not received any training in food preparation, and were many times classroom teachers that were placed in the kitchen to fill a center need. This opportunity **helped cooks to feel more professional and more connected to other cooks in the community, as well as validated the importance of what they do**. Child care center cooks are often treated differently than teachers at the center, unable to take time off or be absent from their position, and disconnected from other center staff. Participants reported that after this training they felt valued and understood more by administration and teachers. It also helped kitchen staff and administration work together to determine what equipment is needed to make healthier foods.

These changes are impacting staff and children as well. Teaching staff reported they are eating less fast food or unhealthy foods. It has helped some teachers and cooks to lose weight by providing healthier meals for them while they are at work and encouraging them to eat healthier at home. Staff are being exposed to foods that they otherwise might not have tried and learning to like new foods. They learned about the importance of exposing children to new foods to expand food preferences. Children are learning to recognize new foods and are excited to try new foods they may not have been exposed to at home–some have asked for the new foods at home. These changes are helping children to create healthier habits. As a result of menu changes, children are eating less sugar and unhealthy foods. Some teachers reported a perceived impact on children as being less hyper and better able to focus, affecting their overall health and well-being.

Summary: Nutrition

Let's Cook Whole Foods trainings were successful in achieving both targeted outcomes in that centers reported changes in many of their food choices and in food preparation of whole foods items and meals. Many participants reported improving their cooking skills and food preparation methods, in addition to many other changes made in practices.

Throughout the process of implementing the *Let's Cook Whole Foods* trainings there were many lessons learned to help guide future evaluation efforts, as well as dissemination and sustainability of future trainings. To support changes made in child care centers and the impact made by the program, it would be helpful to include a supplemental training, or additional resources to involve teachers, parents and children in the changes made at the center. Given the separation and limited communication between cooks and center staff, parents, and children, providing cooks with strategies for communicating changes with these audiences and how others can support the changes made in the kitchen would help to ease this transition.

With changes in CACFP guidelines near the end of the *Let's Cook Whole Foods* trainings, it would have been helpful to make more of an explicit effort to address how

to modify scratch cooking recipes to meet the guidelines for reimbursement. In the future it will be important to support centers in meeting the requirements for reimbursement and to help adjust their menu planning based on anticipated future changes to these guidelines.

Another lesson learned was that few centers were interested in the idea of cooperative purchasing to help drive down costs of whole foods. The cooperative purchasing was seen as time consuming and requiring more coordination than centers wanted to engage in. Encouragingly, the price of whole foods ultimately did not keep most centers away from trying new ways to incorporate them into their menus. With cost being a barrier for a few centers, and the larger lack of interest in cooperative purchasing, it will be important to re-direct program and training efforts into helping centers balance their costs and other restraints to allow them to better integrate whole foods into their menus.

There were several areas of interest that were ultimately not evaluated based on the scope of the current project, but that would be important to explore in future implementations and evaluation of the training. These include the need for an assessment of participants' knowledge of whole foods policies and practices prior to attending the training, as well as their level of decision-making control in their job. It would also be helpful to collect menus and copies of written policies to examine before and after the training to analyze for content. This information could direct individual chef visits and technical support for each center.

Next Steps for *Let's Cook Whole Foods*

The next steps for this project are to communicate results of this evaluation with the community of child care professionals who participated in this project, as well as key decision makers involved with child care regulations and early childhood professional development training systems. It is important to spread the word about the *Let's Cook Whole Foods* training in the hopes of sustaining the training through existing training systems such as Early Achievers, STARs (a Washington Department of Early Learning MERIT-registered training organization) training, and Healthiest Next Generation trainings, where it can be adopted into existing training processes. This could generate word-of-mouth recommendation for others who would benefit from trainings. Spokane Regional Health District will also seek continued funding to sustain their work in this area.

Participating cooks and child care center directors stressed their appreciation for this training program, and their desire for continued training in this area. Several commented that this was the first training in the region offered for cooks that focused on building cooking skills. Given the limited training required to serve as a cook in child care centers, and the high levels of turnover among kitchen staff and cooks, there is a strong need and desire for continued support and additional trainings. Many child care center cooks are only required to hold a food handler's permit and often rely on cooking skills attained in their personal lives to perform their duties. Additionally, the role of cook is often filled by teachers who have been moved into the role to fill a need in their center. It is crucial that efforts continue to be made in building the skills of child care center cooks who are responsible for planning and preparing meals for young children. Child care centers have the opportunity to greatly impact the quality of the nutrition received by children, especially those at risk or exhibiting signs of obesity. It is critical that steps are taken to improve regulations for child care centers, and guidelines for meal reimbursement including CACFP, which are ultimately driving many cooks' menu planning and food choices.

"Moms are asking for the recipes because children are eating some things that they are not eating at home. This is a real example of what is working."

- Center Cook

Why Focus on Physical Activity?

According to CDC, physical activity is one of the most important things that an individual can do for improving health. Physical activity plays an important role in controlling weight; reducing risk of cardiovascular disease, type 2 diabetes and some types of cancer; strengthening bones and muscles; and on improving mental health, and mood and ability to do daily activities. Physical activity is also one of the few lifestyle choices that can increase an individual's chances of living a longer life[12].

Given the established relationship between being overweight and obese and negative health outcomes, targeting physical activity is an important aspect of reducing and preventing obesity, especially during early childhood, which is central to *Let's Move! Child Care* training.

12 "Physical Activity for Everyone: The Benefits of Physical Activity." Centers for Disease Control and Prevention. 2 Feb. 2011. Web. 9 Dec. 2014.

Let's Move! Child Care Training

To address the physical activity and nutrition goals of the *Start Healthy Start Now* project Community Minded Enterprises of Spokane–Child care Aware of Eastern Washington took the lead in implementing a training program for child care providers and staff with the goal of increasing physical activity and reducing screen time. Originally, an evidence-based intervention program called *I am Moving, I am Learning*[13] was selected to implement in the region. After the grant was funded, a train-the-trainer event was delivered by an *I am Moving, I am Learning*-approved trainer. Program directors and trainers from private child care, Headstart and ECEAP programs, and community early learning service providers who work with young children participated as a first step in bringing this program to the region.

After attending this training, multiple issues arose in attaining the *I am Moving I am Learning* copyrighted curricula, as well as concerns with the appropriateness of the content and delivery for the regional audience. In order to address these concerns, an alternative training plan was developed. Familiar with the *Let's Move! Child Care* initiative put forth by First Lady Michelle Obama, CME selected the initiative instead as its foundation for future trainings.

Let's Move! Child Care is a national initiative that aims to empower child care providers in making changes to promote five key goals in their classroom practices regarding physical activity, screen time, food, beverages, and infant feeding[14]. While *I am Moving, I am Learning* is a packaged curriculum with structured resources for in-person training, *Let's Move! Child Care* differs in that the resources and materials provided through its web site are considered open access and copy-right free. The *Let's Move! Child Care* training resources were designed for trainers to select at their own discretion and use to train child care providers in making changes in their practice that promote children's health[15].

These resources include:

- detailed slide sets for each of the program goals
- promotional materials
- additional resources for each topic area including ideas for games and activities to use in the classroom

	***Let's Move! Child Care* Key Goals**
GOAL 1 PHYSICAL ACTIVITY	• Get 1-2 hours of activity every day • Include outside play whenever possible • Fit activity into daily routines
GOAL 2 SCREEN TIME	• No screen time for kids under age 2 • 30 minutes or less weekly for ages 2 and up during child care • No more than 1-2 hours daily at home
GOAL 3 FOOD	• Serve fruits and veggies at every meal • Eat meals family-style and let kids choose • Steer clear of all fried foods
GOAL 4 BEVERAGES	• Offer water all day and during meals • Don't serve sugary drinks • Allow one serving (406 ounces) of 100% fruit juice per day • Give low-fat or non-fat milk for kids 2 and up
GOAL 5 INFANT FEEDING	Recommendations from the American Academy of Pediatrics: • Breastfeeding for at least the first 12 months • After 12 months breastfeeding continued for as long as mom & baby desire • Breast milk for toddlers to build their immune systems How to support: • Educate staff about breastfeeding & storing expressed milk • Use expressed milk carefully-be sure none is wasted • Create an inviting, private space for moms to express milk or breastfeed

13 "*I Am Moving, I Am Learning*." Head Start. An Office of the Administration for Children and Families Early Childhood Learning & Knowledge Center, 10 Oct. 2014. Web. 11 Dec. 2014.
14 "Trainers: Resources for Trainers." *Let's Move! Child Care*. The Nemours Foundation, 1 Jan. 2014. Web. 9 Dec. 2014.
15 *Let's Move! Child Care*. The Nemours Foundation, 1 Jan. 2014. Web. 9 Dec. 2014.

Let's Move! Child Care resources can be found at https://www.healthykidshealthyfuture.org/home/resources/trainers.html.

For the SHSN project, CME staff recruited approximately 26 volunteers to deliver the *Let's Move! Child Care* training. Trainers then went through the process of becoming STARS-approved trainers through the state of Washington. Due to the requirements and time commitment involved with becoming an approved trainer through the state registry, many volunteers were unable to complete the process required to become a trainer. Ultimately, six trainers completed the approval process and delivered the *Let's Move! Child Care* trainings over the course of 1.5 years.

To prepare for *Let's Move! Child Care*, a work group of facilitators met to prepare training materials based on the *Let's Move! Child Care* resources web site. Each trainer then individualized his or her own training presentations, each building on the five foundational goals related to physical activity, screen time, food, beverages, and infant feeding. Trainings resources included PowerPoint presentations based on the *Let's Move! Child Care* slide show resources. Each trainer added supplemental activities and resources to complement their presentations and get participants engaged and moving, such as breaks for yoga, dance and creating action plans for how to implement the practices discussed.

A total of 28 *Let's Move! Child Care* trainings were provided as part of the *Start Healthy Start Now* project throughout the region. Trainings were offered at various times and locations, including participating child care centers that closed their centers for the training day. Lengths of trainings ranged from two to six hours depending on the trainer and audience. A total of 349 child care center teachers and staff participated in the trainings.

Targeted Goals of *Let's Move! Child Care* Training

- Increase the number of child care/early childhood centers implementing with fidelity and sustainably *Let's Move! Child Care* active living practices.
- Increase parent awareness of the Step UP and Go, 85210 social marketing campaign focusing on healthy nutrition and active living goals.
- Increase the number of child care/early childhood education centers implementing with fidelity sustainable *Let's Move! Child Care* healthy eating and beverage practices.

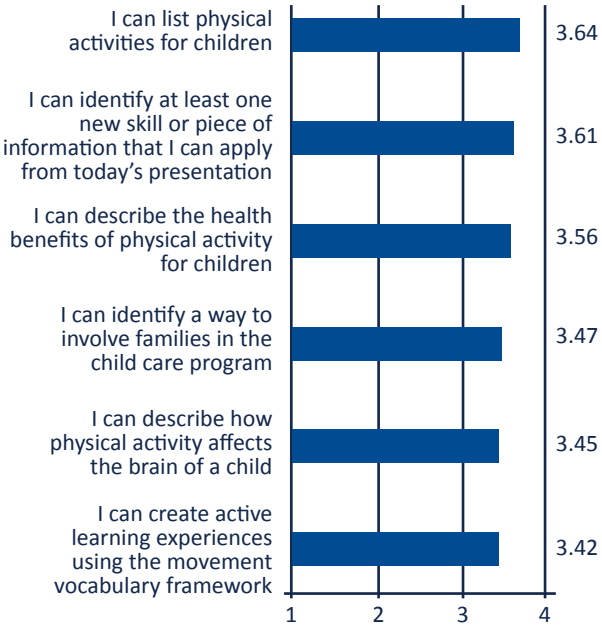
Program Results: *Let's Move! Child Care*

Individual Participant Evaluation Results

Child care staff who participated in the *Let's Move! Child Care* trainings were evaluated on knowledge change, meeting goals around physical activity for children, and being able to apply the information in their child care's practices. There were 246 child care center staff who completed an evaluation form at the end of the training.

Participants reported that prior to the training they rated their knowledge of the program content as average of 5.93, on a scale of 1-10. They reported that after the training, their knowledge of program content was 8.79, a significant increase of 2.9[16] points following the training.

After this training...



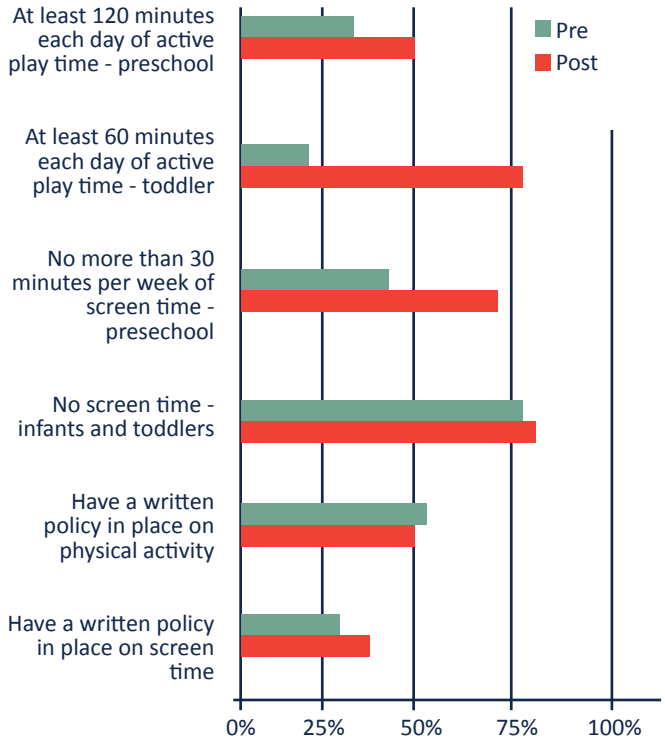
16 T-test, P<0.001

Participants were asked to rate, on a scale of 1-4, 1 being 'strongly disagree' and 4 being 'strongly agree', if they could identify at least one new skill or piece of information that they can apply in their work with children or families. Participants responded with an average of 3.61. Using the same scale, participants were asked to rate if they agree that they had met six objectives, listed on the table to the right. All training objectives were rated 3.4 or higher.

Training Results: Child Care Evaluations

Information about policies and practices around physical activity and nutrition were collected for participating child care centers prior to participating in the *Let's Move! Child Care* training. At the end of the grant, after allowing time for implementation of principles in the training, participating child care centers were again asked to complete a survey with information about current practices around physical activity. Centers were offered an electronic version of the facility practice survey and a paper survey. Evaluation questions were drawn from the *Let's Move! Child Care* checklist. Fifteen centers completed the baseline assessment and 16 completed the follow-up assessment.

Though there were no statistically-significant changes in the nutrition practices and policy among reporting child care centers due, at least in part, to the small sample size, most responses reflected expected changes after participating in the training.



Changes Made after Participating in *Let's Move! Child Care*

Interviews with participating center directors and classroom teachers identified several specific changes made in centers as a result of participating in the *Let's Move! Child Care* training. To ensure that changes were made throughout the center, several changes in policy related to physical activity and nutrition were made after participating in the training. Nutrition policy changes made included:

- **disallowing outside food or drinks from being brought to the center by families**
- **disallowing staff from consuming outside food and drinks in front of the children**
- **disallowing teachers from using candy or treats as incentives for the children**

Policies were established that require water to be available in each classroom, and outside during play. Some centers adopted policies for encouraging children to try new foods, or requiring children to take one bite of new foods when introduced.

Several policies were established related to physical activity including:

- requiring two blocks of 45 minutes of physical activity each day
- requiring physical activity each day in all weather
- requiring teacher participation in physical activity
- requiring parents to provide all-weather attire appropriate for outdoor play

Additional physical activity-related policies involve guidelines for infant physical activity to disqualify outdoor time in a stroller or buggy from being classified as physical activity. Additional changes made regarding physical activity included increasing physical activity in centers, designating more time for outside play, and supporting more physical activity with infants and toddlers. Centers provided information for parents about recommendations for screen time and physical activity with young children. Participating centers also incorporated more structured physical activities such as SoccerTots® and Zumba® classes.

In addition to its focus on physical activity, information provided in the *Let's Move! Child Care* training involving nutrition resulted in many changes in practice by participating centers. These changes included:

- disallowing coffee and other beverages aside from water in the classroom
- requiring that staff keep any outside food or beverages in designated break areas to consume away from the children
- educating parents about nutrition
- meeting with parents to plan for allergy accommodations
- providing parents with recommendations for healthy celebration foods

Changes were made in conversations between staff and with children regarding nutrition. Teachers increased communication about nutrition and about menu changes made and how to support children in trying new foods and adjusting to menu changes. Conversations with children changed to include discussions about where food comes from, and health benefits of foods. Teachers also started using incentives to encourage children to try new foods and are leading nutrition-related activities in the classroom.

Barriers to Implementing *Let's Move! Child Care* and Strategies for Mitigating Barriers

Interviews with participating center directors and classroom teachers that took place after the end of the project identified several barriers to making changes in practice and policy at various levels. The experience of encountering barriers and ways that centers mitigated these barriers can be used to assist other centers experiencing similar obstacles in implementing program recommendations.

Impact of Participating in *Let's Move! Child Care*

Physical activity impact on staff

Interviews with participating center directors and classroom teachers identified several areas short and long-term impacts, or effects, on the target audiences based on changes made after participating in the *Let's Move! Child Care* training. In spite of implementation barriers, training centers were able to make a large impact on the staff and children at the center. Participating staff have been impacted in many ways including becoming more aware of the importance of being active and getting moving throughout the day. Staff learned different ideas for physical activities with children and infants, as well as ideas for activity in extreme weather and working with space and facility restrictions. Staff have also been more active during their breaks.

	Barriers to Implementing *Let's Move! Child Care* in the classroom	Strategies for Mitigating Barriers to Implementing *Let's Move! Child Care* in the classroom
PHYSICAL ACTIVITY FACILITIES & EQUIPMENT	• Severe weather • Limited space (indoors and outdoors) • Availability of toys and equipment to promote physical activity • Children not having appropriate attire for physical activity (i.e. shoes, coats, etc.)	• Move furniture to make space for activity indoors • Taking children on walks nearby • Adding structured physical activities into schedule (i.e. Zumba, Kids Rock, rock wall, Soccer Tots, boot camp, etc.) • Using public outdoor space close to center for physical activity • Planning activities that require less space (i.e. scarf dances) • Disallowing TVs, computers or other electronic toys in the classroom to encourage physical activity

PHYSICAL ACTIVITY, *CONTINUED*

STAFF

Barriers to Implementing *Let's Move! Child Care* in the classroom	Strategies for Mitigating Barriers to Implementing *Let's Move! Child Care* in the classroom
• Getting all staff to buy into new ideas • Getting new staff who haven't had the trainings to buy into ideas • Difficulty of changing routines in the classroom • Teachers who did not want to, or who were uncomfortable participating in physical activity • Extra time needed to plan and lead physical activities • Unclear guidelines or policies for physical activity requirements at the center	• Encouraging staff to take training together to create buy-in • Continuing communication of physical activity benefits at staff meetings and in-service days to share ideas • Reminding other teachers of what was learned at the training • Trying different things, new music and activities to keep things exciting • Introducing new props to keep things exciting • Working one-on-one to engage infants in physical activity Addressing extra time needed to plan and lead physical activities: • Designating physical activity (PE) teacher to lead all classes in physical activity throughout the day providing breaks to lead teachers • Bringing in part time PE teacher to lead specific activities (i.e. boot camp, Zumba and Soccer Tots classes) Addressing unclear guidelines or policies for physical activity requirement at the center: • Creating policies requiring multiple physical activity opportunities throughout the day, in rain or shine • Requiring staff to participate in activities with the children • Requiring parents to bring suitable attire for physical activity for their children (i.e. appropriate shoes and clothing) • Communicating policies to all staff and parents • Continuing enforcement of policies and periodic checks by supervisors • Continuing communication about policies with staff during staff meetings and in-service days

IMPROVING NUTRITION	Barriers to Implementing *Let's Move! Child Care* in the classroom	Strategies for Mitigating Barriers to Implementing *Let's Move! Child Care* in the classroom
STAFF	• Eating and drinking unhealthy foods in front of children • Negative attitudes and comments about food changes • Not liking foods themselves • Time required to introduce new foods to children • Unaware of food policies, and menu changes • Difficulty of introducing new foods to children, including preverbal children	• Banning outside food or drinks from the classroom • Requiring family-style meals • Requiring staff to eat the same foods as the children during mealtimes • Continuing communication and sharing ideas for getting children to try new foods • Establishing protocols for communicating feedback about menu changes in a respectful manner
CHILDREN	• Not liking whole foods • Not wanting to try new foods • Going hungry • Children arriving to child care after scheduled meals and snacks and being hungry during the day • Wasting food • Food allergies • Children missing old food practices	• Engaging children in activities to encourage healthy eating, introduce new foods and encourage exploration (i.e. gardening, cooking in the classroom, trips to the farmers' market or Greenbluff) • Utilizing incentives for getting children to try new foods (i.e. stamps for trying new foods, two bite club, no thank you bites) • Providing snacks for children to take home • Offering food at non-mealtimes for children • Talking to children about portion size and food waste • Modeling child-size portions
PARENTS	• Thinking unhealthy foods are fine • Not liking food changes • Sending unhealthy foods with children to child care center • Not serving whole foods at home	• Communicating importance of whole foods and healthy eating with parents • Sending home recipes with families • Creating policies banning outside food with exception of allergies • Providing recommendations for alternative celebration foods

Nutrition Impact on Staff

Nutrition impacts to staff were also seen. They learned more about the impact made on children by eating or drinking things in front of them. **Participation raised awareness about what they are eating and drinking and what they are serving their own children.** There was surprise specific to how much sugar was in different drinks such as juices, and **many staff have cut out sugary drinks from their own diets.** They learned more about the importance of nutrition for children and how it affects their behavior. Participation also affected staff's approach in that they have more confidence in working with children and a better understanding of how everything works together to support the child.

Impact on Children and Families

Participating in *Let's Move! Child Care* impacted the children at participating centers in many ways. In the area of physical activity, children have been more active, hungrier, sleeping better and calmer throughout the day. Children have also been creating healthier habits of being more active. In the area of nutrition **children are learning to recognize new foods, and are excited to try new foods** that they otherwise may not have been exposed to at home. Children are **expanding their food preferences** and are asking for the foods at home. These changes are helping children to create healthier habits. As a result of menu changes, children are **eating less sugar** and fewer unhealthy foods and were described by teachers as not being as hyper and better able to focus, thought by teachers to affect their overall health and well-being.

Summary: Physical Activity

Though there were no statistically-significant changes in practices after completing the *Let's Move! Child Care* training, participant interviews show that it was successful in meeting its goal of increasing physical activity in some centers. In addition to increasing physical activity in some centers, *Let's Move! Child Care* supported menu changes made as a result of the *Let's Cook Whole Foods* training. As many centers made changes in the foods that were being served, the *Let's Move! Child Care* training provided strategies for teachers to encourage children to try new foods, and how to support these changes and children's healthy eating through modeling. Additionally, participants of the *Let's Move! Child Care* program were exposed to the *Step UP and Go, 85210* campaign, an additional training objective, which was led by Inland Northwest Health Services. Participants received information during the *Let's Move! Child Care* training, as well as supplemental follow-up materials after participation.

Though the program was successful in achieving targeted outcomes, many lessons were learned along the way that will help move future training efforts forward, and help others hoping to carry out similar projects. One of the many challenges faced in preparing for this program was the difficulty in attaining the I am Moving I am Learning training curriculum. Obtaining copyrighted curricula is a major challenge facing the field today with the emphasis placed on utilizing evidence-based or promising program curricula. In the future, to support implementation and adoption of these curricula it will be important for program developers to make their curricula available to programs more readily, and provide technical assistance and support in maintaining program fidelity.

Another challenge faced by the *Let's Move! Child Care* training program, as well as the other training programs as part of this project, was the difficulty of getting trainers, and then getting the training content approved by the STARS system. One possible solution to ease in this difficulty is to use trainers who have already been approved by the STARS system, or selecting fewer trainers to support in working through the approval process. Another possible solution would be to allow for more time in a project timeline for approval of new curricula, a challenge for projects of this nature that rely on grant funding and concise timelines.

Some of the other challenges faced included the background of participants. The *Let's Move! Child Care* training curricula targets specific practices that can be applied in an early childhood classroom setting. This was challenging given the initial desire to offer this training to a variety of audiences. While this training was useful for community services providers who work with young children in a group setting, it was less relevant for other service providers or community participants.

Due to the nature of this project and its three training components, there were challenges in scheduling trainings and competing for participants with the *Trauma-Informed Care* training that was well-known and popular with participants, especially those who had received one or more parts of the training already. In the future it will be important for projects that aim to implement multiple trainings to integrate their training efforts and content to support each other, as well as communicating scheduling as to not overlap training schedules.

Next Steps

After completing this project, an additional *Let's Move! Child Care* training, with similar content, was released by the University of Washington and Washington State Department of Early Learning. This training is provided free for service providers and is available online, therefore, efforts will be made to encourage those interested in the training to participate. CME staff will be making efforts to adapt their training to focus specifically on integrating physical activity into classroom curricula and practices. This training will be provided in person, and will focus specifically on changes related to physical activity.

Why Focus on Emotional Well-Being and Mental Health ?

Emotional well-being and mental health are impacted by many factors throughout the lifespan, including early childhood. For the *Start Healthy Start Now* project, impacting outcomes of childhood trauma and Adverse Childhood Experiences (ACEs) were the targeted outcomes for the project. ACEs include "verbal, physical or sexual abuse and family dysfunction (e.g., incarcerated, mentally ill, or substance-abusing family member; domestic violence; or absence of a parent because of divorce or separation)"[17]. ACEs are linked to many adverse health outcomes in adulthood including substance abuse, depression, cardiovascular disease, diabetes, cancer, and premature mortality.[18] ACEs were found to be very prevalent in adult populations, with 59.4 percent of respondents to the ACEs study from Arkansas, Louisiana, new Mexico, Tennessee and Washington state experiencing one or more ACES, and 15.2 percent reporting four or more ACEs[1]. In the eastern Washington region, of focus for the *Start Healthy Start Now* project, the prevalence of experiencing ACEs is even higher–one in three residents of the region (31.87 percent) report experiencing high levels of ACEs, defined as four to eight ACEs in their lifetime.[19]

Given the established relationship between ACEs and many emotional well-being and mental health outcomes, targeting these outcomes during early childhood, with the goal of mitigating the impact of these experiences through trauma-sensitive care practices, is an important opportunity for intervention.

17 "Adverse Childhood Experiences Reported by Adults." Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, 30 Dec. 2010. Web. 12 Dec. 2014. <http://www.cdc.gov/features/dsACEs/>.

18 "What Is ARC?" Department of Mental Health. 1 Jan. 2014. Web. 29 Dec. 2014. <http://mentalhealth.vermont.gov/cafu/vctc/arc>.

19 "Behavioral Risk Factor Surveillance System (BRFSS)." :: Washington State Dept. of Health. Web. 12 Dec. 2014. <http://www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/BehavioralRiskFactorSurveillanceSystemBRFSS>.

Trauma-Informed Care Training

To address the emotional well-being goals of the *Start Healthy Start Now* project, WSU AHEC was asked to partner with the project to implement *Trauma-Informed Care* training to child care providers. In addition to WSU AHEC's traditional focus as an area health education center in the community, promoting health for under-served and at-risk populations[20], WSU AHEC serves as one of the few trauma centers throughout the country. As a trauma center, it has conducted research on trauma in the community and provided trainings on trauma and adverse childhood experiences (ACEs) throughout the community. WSU AHEC staff have delivered trauma trainings to more than 8,000 professionals in the northwest, serving in K-12 education systems, early learning, juvenile justice, social work, mental and primary care providers, and other community members and service providers[21].

As part of the *Start Healthy Start Now* project, a training for early childhood educators focusing on preparing educators to provide trauma-sensitive care practices was developed based on existing trainings on ACES by WSU AHEC, adaptations of the Attachment, Self-Regulation and Competency (ARC) model[22], as well as other relevant research and information on early learning practices. The ARC model is an intervention framework that is widely implemented with "youth and families who have experienced multiple and/or prolonged traumatic stress"[23]. The ARC model is considered a promising practice by the National Child Traumatic Stress Network for the treatment of childhood trauma. Information from the ARC model training was adapted, with permission from the authors, and fidelity to the model's core concepts, for the purposes of this project. Once the training was developed it was approved by Washington State Department of Early Learning as a STARS approved training opportunity.

The training program consisted of three separate six-hour trainings that were progressive in their content. The first *Trauma-Informed Care* training focused on teaching participants about the science behind childhood experiences of trauma–the definition, prevalence and causes, as well as the impact of childhood trauma on development. It provided participants with strategies for supporting those impacted by trauma, and encourages participants to reflect on their own experiences of trauma. The second training focused on the role of care providers in supporting children and families experiencing trauma, as well as introducing evidence-based strategies for doing so. The third, and most advanced training, focused on applying strategies for supporting children and families based upon the first two trainings. Participants are also given the opportunity to work together to practice and problem solve applying strategies in their own practice.

Training participants included child care teachers, directors and staff. In order to participate in the trainings, two or more center staff were asked to participate as a group to provide a more relevant training experience for their center, problem solve, and come up with an action plan to utilize training information. A total of 25 trainings were delivered throughout the region (eleven *Trauma-Informed Care* Part One, nine *Trauma-Informed Care* Part Two, and five Advanced *Trauma-Informed Care* trainings). Participants who completed one or more portions of the *Trauma-Informed Care* trainings totaled 485, reaching 108 child care facilities.

Targeted Goals of *Trauma-Informed Care* Training

- Increase the number of child care/early childhood education centers, implementing with fidelity, sustainable *trauma-informed care* practices.
- Increase the number, from zero to one, of community colleges in the region offering trauma-informed coursework in their early childhood education curriculum.

20 "Area Health Education Center of Eastern Washington: Supporting Underserved and At-Risk Populations." Washington State University Extension. Web. 12 Dec. 2014. <http://extension.wsu.edu/ahec/Documents/AHEC_Flyer.pdf>.
21 "Area Health Education Center." Area Health Education Center. Web. 12 Dec. 2014. <http://extension.wsu.edu/ahec/Pages/default.aspx>.
22 "The Trauma Center at JRI." The Trauma Center at JRI. Web. 12 Dec. 2014. <http://www.traumacenter.org/research/ascot.php>.
23 "Department of Mental Health." What Is ARC? 1 Jan. 2014. Web. 12 Dec. 2014. <http://mentalhealth.vermont.gov/cafu/vctc/arc>.

Trauma-Informed Care Training: Program Results

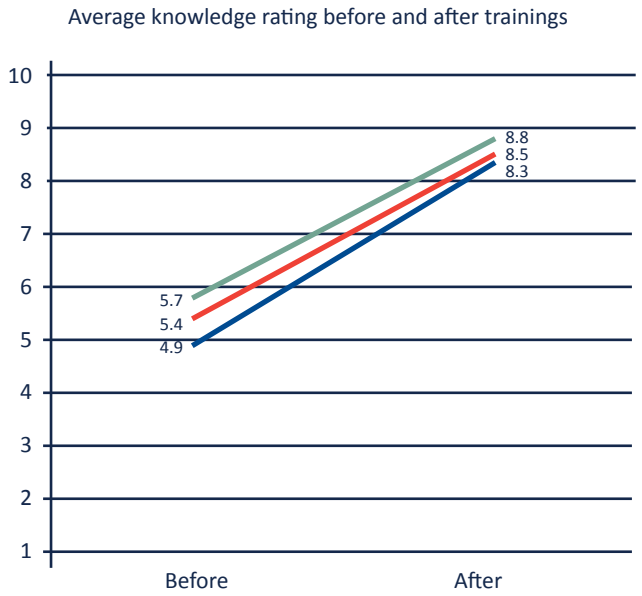
Training Results: Participant Evaluation

Child care staff who participated in a *Trauma-Informed Care* training were evaluated on knowledge change, meeting goals around trauma-informed care, and barriers to implementing trauma-informed practice. Evaluations were paper surveys completed at the end of the trainings by participants. There were three trainings: a two-part basic training and an advanced training. Evaluation questions were based on objectives identified by the trainers.

Evaluations were completed by 430 individuals in the first basic training, 242 individuals in the second basic training, and 100 individuals in the advanced training.

At each training, participants were asked to report their knowledge of the topic before and after the training. The mean rating of knowledge significantly changed[24] from before the training to after the training for participants of each training. The rating increased 3.4 points for training one, and 3.1 points for the other two trainings. As expected, the starting knowledge level increased at each consecutive training.

Average knowledge rating before and after trainings



24 T-test, P<0.001

Participants reported finding the trainings relevant and useful. Forty percent of participants reported they strongly agreed that they would think differently about some of the children and families. Fifty-five percent reported they agreed with the statement. At the second training, 51% of participants reported they had been thinking differently a lot. The number increased at the advanced training to 58% of participants.

A major theme of the *Trauma-Informed Care* training is about the practice of self-care, or individuals caring for themselves in order to better care for others. Participants were encouraged to select at least one self-care goal to work on. Participants reported they were somewhat to moderately-successful in meeting their self-care goal, averaging a score, on a scale of 1-4, of 2.72 at the second training and 2.66 at the advanced training. The most selected self-care goal selected was physical exercise.

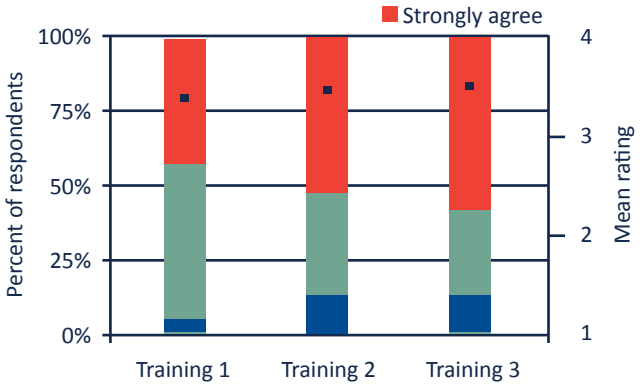
The structure of the *Trauma-Informed Care* trainings, and having multiple training sessions, provided the opportunity for participants to increase their knowledge and skills practicing and implementing trauma-sensitive care. Between training one and two, participants reported they were somewhat to moderately able to change their practice. Between training two and the advanced training, participants were able to change their practice moderately to a lot. Participants at the advanced training were significantly more likely to report having changed their practice a lot[25].

At training two, more than half of participants reported ARC building blocks as impactful or inspirational. ARC concepts with the highest proportion of participants identifying them as what they plan to focus on in their practice were attunement and routines and rituals. Generally, the proportions were similar for those ARC concepts identified for using after training two and the proportion for ARC concepts participants at the advanced training had used in their practice. The exception was affect identification, which had a statistically-lower proportion reporting use than reported planning to use it[26].

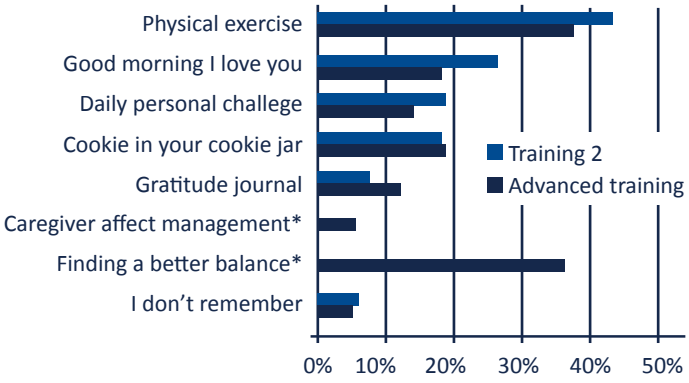
Half of child care centers reported their center had a policy regarding expulsion. The proportion did not change over the course of the project (50.8% pre, 53.3% post). Among centers that knew the last time a child had been dismissed from the child care due to behavior concerns, there was no statistically-significant change in the

25 OR=2.1, p<0.05
26 P=0.001

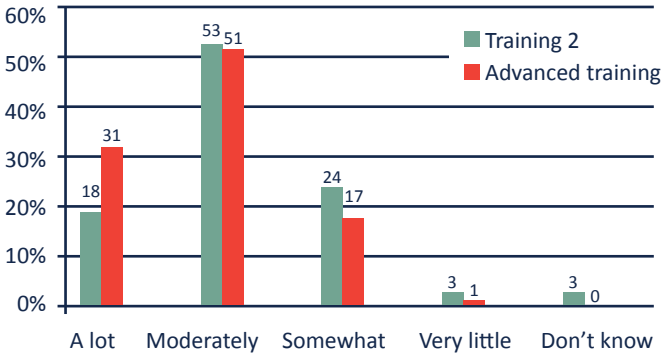
How much have you been thinking differently about children and families



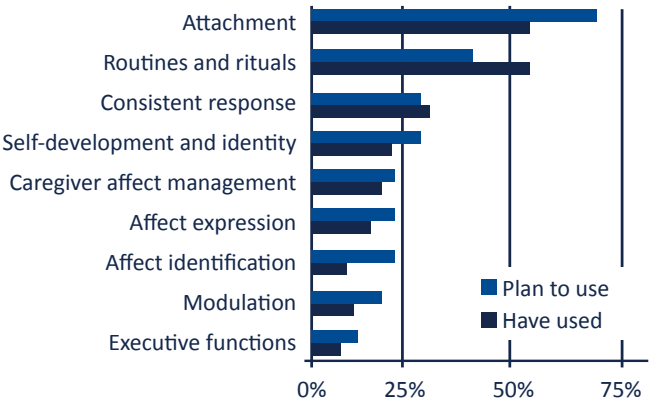
Self-care goals chosen to work on



How much have you changed your practice in some way?



ARC concepts



proportion of centers that had dismissed a child in the last year; 23% pre- and 27% post-. However, the *Start Healthy Start Now* project only ran for approximately 18 months. Longer-term effects need more time for changes to occur. Still, most respondents felt the *Trauma-Informed Care* trainings impacted the child care centers practices to varying degrees. One in 10 felt there was very little to no change in practice, while 15% felt there was a lot of change in practice.

Changes Made after Participating in *Trauma-Informed Care*

Interviews with participating center directors and classroom teachers identified several specific changes made in centers as a result of participating in the *Trauma-Informed Care* trainings. A major theme of these trainings was the development and implementation of trauma-sensitive policies in child care centers. Policy changes made in participating centers included the addition of a split/divorced family policy detailing the center's policy for becoming involved in legal disputes. Several centers adopted new policies for getting to know new families by having parents fill out informational booklets or worksheets about their family. Centers also took steps to adapt existing policy to ensure that trauma-sensitive language is used instead of the more traditional business-centered policies. Additionally, centers adopted policies for responding to children's behaviors such as revising disciplinary practices adopting a more individual, child-centered approach to working with each child.

Another major theme of the *Trauma-Informed Care* trainings dealt with staff self-care, and the impact that taking care of themselves has on their ability to provide quality care to children. Several changes have been made at the center-level to support staff in their practice of self-care. Changes included making staff break rooms more of a relaxing space, and designating specified breaks for staff. Several centers reported plans to offer sick days, and paid classroom planning time to staff to support their practice of self-care.

Changes were also made in staff's communication after participating in the *Trauma-Informed Care* trainings. In their communication with children, staff are giving more "grace" to children, finding the good in them and their actions. Staff are talking to the children at their level more frequently, observing the children's behavior before reacting, and asking children more questions about how they are feeling before reacting. They are encouraging children to think about their actions and how they make others feel instead of asking them to apologize. Additionally, staff are using the language from the brain model and other training content to help children communicate their emotion, and are individualizing strategies for responding to each child based on their individual needs.

Staff's communication changed in regard to their interactions with parents and families. They are holding more parent-teacher conferences in an effort to get to know parents and determine what might be driving children's behavior, and are asking more questions about what might be going on at home. They are also asking more specific questions during drop-offs and pick-ups about how their night was instead of just saying, "Hi, how are you?" Administrative staff are providing more support during this time to support these changes in communication. Additionally, staff are providing resources for parents about traumatic situations, as well as community resources available to them.

"It brought me back to the reason why I opened a center. You become hardened over time. It brought me back to understanding that there is a reason why people behave the way that they do. We are having more conversations with the parents and that has been very beneficial."

– Center Director

Barriers to Implementing *Trauma-Informed Care* and Strategies for Mitigating Barriers

Interviews with participating center directors and classroom teachers that took place after the end of the project identified several barriers to making changes in practice and policy at various levels. The experience of encountering barriers and ways that centers mitigated these barriers can be used to assist other centers experiencing similar obstacles in implementing program recommendations.

	Barriers to Implementing *Trauma-Informed Care*	Strategies for Mitigating Barriers to Implementing *Trauma-Informed Care*
STAFF	• Refusal to buy into ideas and practices • New staff who haven't received training • Staff burnout • Momentum fading after training • Not knowing what children's home lives are like • Difficulty of finding out what is going on in children's home lives • Recognizing how teacher or staff moods affect children • Remembering to empathize with children and parents about what they are going through • Not knowing center policies to share with parents	• Director enforcement of practices and trauma-sensitive philosophy • Continued discussion during staff meetings and in-service days on trauma sensitive practices • Self-reflection exercises of hypothetical scenarios • Taking a step back to think before reacting to child behavior • Thinking about the child's perspective • Asking the child questions about how they are feeling and what their life is like • Thinking about how the teacher's response is affecting the children's behaviors or moods • Bringing in support of director or other teachers to speak with the child who is struggling individually • Using trauma-sensitive language in their communication with parents and children • Using specific language from the program and teaching it to parents and children (i.e. upstairs, downstairs brain, flipping lid, and labeling emotions) • Individualizing developmentally-appropriate responses and strategies when working with each child and family Addressing Staff Burnout • Provide medical benefits • Paid days off and sick leave • Designated time for planning during the day • Staff appreciation efforts by administration (i.e. dinners, small gifts) • Administrative support of staff's professional growth and development

	Barriers to Implementing *Trauma-Informed Care* in the classroom	Strategies for Mitigating Barriers to Implementing *Trauma-Informed Care*
SELF-CARE	• Being too busy • Being too emotionally invested with children at the center	• Centers providing paid time off for all staff • Providing designated breaks and staff break rooms
CENTER POLICIES	• Not having a written policy involving self-care • Not having a written policy involving families experiencing trauma • Staff being unaware of policy changes or center policies involving families • Time needed to write or update policies • Time needed to introduce policy changes to staff and families	• Creating policies for traumatic family situations (split or divorced families) • Dedicating time to write policies into center handbook • Establishing policies and procedures for getting to know new families (question sheet or booklet getting to know the family, completed by the parent) • Communicating policies with staff all at once • Continued discussions around policies to keep everyone on the same page
PARENTS	• Reluctance of parents to share personal information about their life • Language barriers between staff and parents • Difficulty of working with parents in conflict • Extra time needed to speak with parents • Not having support staff in the classroom in order to step away and speak with parents	• Providing center activities to get to know families (i.e. game night, spaghetti dinners) • Setting up individual meetings with parents • Asking parents specific questions about their life or how their night was etc. • Sharing resources with parents • Establishing written policies regarding family conflict and the center's involvement • Focusing on the child during instances of conflict • Having support staff available during pick-up and drop-off times allowing time to speak with parents

Program Impact: *Trauma-Informed Care*

Interviews with participating center directors and classroom teachers identified several areas of short and long-term impact, or effects, based upon changes made after participating in the *Trauma-Informed Care* trainings. In spite of barriers to implementing the information recommended in the training, participation made a substantial impact on the staff and children at the center. Participating staff reported a profound change in their ways of thinking and relating to not only the children and families that they serve, and to people in general. Staff reported being more aware of children's personality traits, more attuned to what is happening with children and families, a better understanding of what drive's children's behavior, and better insight into what children and families are going through, more compassion and less frustration generated by their behavior.

Participating staff reported that they now have language for things that they had previously thought about children but couldn't articulate. It helped staff to feel more confident in best practices and more professional in their communications about children. It provided staff with more tools to use with children and families and helped them to understand the importance of the role that they play on children. Staff felt validated in their beliefs of what was important, and in their role in working with children. It made them realize how much they put themselves down. Staff are also better able to recognize when they need support to handle situations in the classroom too. Additionally, going through the training process helped staff to move beyond thinking that what was recommended was hard to do, growing to a place of it being doable.

The impact made on staff thinking, in-turn had a great impact on their interactions with each other, children, and in their personal lives. Participating staff reported feeling more closely knit to the other staff at the center– training helped put staff on the same page in terms of what best-practices are with other staff who participated. It provided information on best-practices to those teachers and staff who had not had as much education about child development.

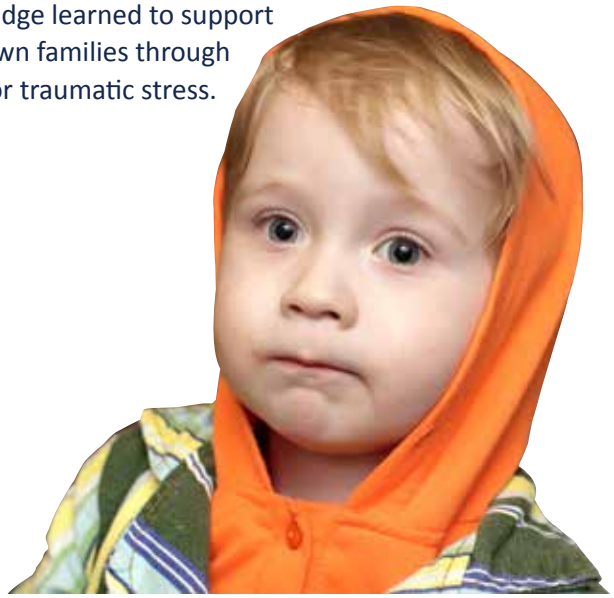
Many staff reported **more conversations with each other about:**

- **what is driving children's behavior,**
- **strategies for responding to children,**
- **their practices of self-care, and**
- **sharing information from the training with those who were unable to attend.**

Staff reported that they are making more of an effort to get to know parents and provide support during crisis. They are also more careful about what they are discussing with parents and teachers in front of the children.

In their interactions with children participating teachers felt that they are providing better care for each child based on what they need. They are not losing control of children as easily and are better able to talk children down in a positive manner after participating in the training. Instead of wanting to remove children from the center who exhibit challenging behaviors, they are more understanding and are looking for ways to help children. As young children are greatly impacted by their interactions with others, they too have been impacted by staff participation in the *Trauma-Informed Care* trainings. Staff report that children are better able to work through their feelings, communicate their feelings with staff and other children, and that there aren't as many struggles or fits because children feel more understood. They reported that children are using the brain model language in their communication such as talking about their upstairs and downstairs brain, and the concept of flipping their lids. Participating staff also feel that children are more comfortable coming to them with their problems, and feel safer and more loved at school.

The impact on participating staff's thinking was also seen in their personal lives. Many staff shared how eye-opening and shocking it was for them to look at how they themselves were impacted by trauma. It helped to put their own lives into perspective, and made them more aware of their own feelings and triggers. Staff are making an effort to engage in self-care practices by taking breaks, trying not to take work home with them, and coming in to work better rested and fresher. They are using the knowledge learned to support their own families through times or traumatic stress.



Summary: Emotional Well-being

The *Trauma-Informed Care* trainings were highly successful in achieving the primary goal of increasing the number of child care and early childhood education centers implementing, sustainable trauma-informed care practices in spite of reported barriers. In addition to program evaluation results, a community survey of child care centers reported that at the start of the grant, one in three child care centers reported none of their staff had been trained on how ACEs impacts children. Another quarter of centers did not know if their staff had been trained. At the end of the grant, three in four centers had at least a few staff trained. This shows an increase of centers attending trauma trainings. Additionally, at the start of the grant, a little more than one in three child care centers reported having at least a few staff using trauma-informed care when working with children. At the end of the grant, 65 percent of centers had at least a few using trauma-informed care practices. Training participants reported changes made at many centers in how they approach working with children, as well as specific changes to behavior.

The goal of increasing the number of community colleges in the region offering trauma-informed coursework in their early childhood education curriculum was not met because of significant challenges in reaching, and working with higher education.

Since 2008, as the *Trauma-Informed Care* trainings were implemented in the Spokane region and community, there were few challenges encountered in implementing this training. The training was adapted to meet the needs of the specific audience by a trainer familiar with early childhood development, and classroom care. The training and trainer became approved by the STARS system, which was challenging in its difficulty and the time required to move through the approval process. Additionally, the *Trauma-Informed Care* trainings were offered by one trainer, which limited the flexibility in scheduling trainings yet provided for consistency in program delivery.

Next Steps for *Trauma-Informed Care*

The next steps are to continue to implement trainings based on existing contracts held by WSU AHEC. As WSU AHEC has offered *Trauma-Informed Care* trainings for many years in the community, they will continue to do so and to seek additional funding grants and contracts to provide training in the community. Additional projects will include supplemental training that involves individual center consultation and observation of classroom teachers and practices. Due to the many barriers of adopting trauma-sensitive care practices and sustaining changes over time, WSU AHEC plans to offer consultation services to support long-term change and sustainability of training outcomes in participating centers. By adopting this consultation model, WSU AHEC plans to offer more comprehensive training options to individual centers, in addition to continuing to implement *Trauma-Informed Care* trainings throughout the community to various audiences. The *Trauma-Informed Care* trainer also plans to sustain training efforts by publishing a book supporting trauma sensitive care.

Pulling It All Together

The Start Healthy Start Now project resulted in a significant **increase in knowledge of training content** for participants in each of the three trainings (Let's *Cook Whole Foods, Let's Move! Child Care* and *Trauma-Informed Care*). Participants reported that for each of the three trainings, they **received information or skills that they anticipated using in their practices.** They reported **increased conversations in each of the three topics with other staff, parents and children.** Many participants reported **a greater understanding of the importance of nutrition, physical activity and emotional well-being,** and how they have the potential to work together and contribute to the health of children.

In addition to the shared effects of the three trainings, participants of the ***Let's Cook Whole Foods*** training reported that they 'agreed' or 'strongly agreed' that they had met the program objectives by participating in the training. Specific to the area of policy, there was a shift from centers that had no written policy in support of providing whole or minimally processed foods, to having a policy in development after training completion. A statistically-significant difference was found for child care centers limiting their serving of fruit juice to 4-6 ounces each day, and offering one or more vegetarian meals per week after participating in the training. Many centers reported changes in their food preparation practices and menus in an effort to serve more whole food items.

Participants of the ***Let's Move! Child Care*** training have reported changes made in their center including physical activity policies such as requiring more time for physical activity. Some centers made changes in nutrition policies. For example, disallowing teachers and children from bringing in outside food or drink in the center, and have also disallowed coffee or other beverages from being consumed in the classroom.

The ***Trauma-Informed Care*** training participants reported they were somewhat to moderately successful in meeting their self-care goals. Between each of the three training parts participants reported that they were able to change their practice between trainings and continued to change practices more after each advanced training. Participants reported many specific changes made in their center policies, their practice of self-care, and their interactions with staff, parents and children. These changes, and participation in Trauma-Informed Care led to many impacts on staff thinking, and staff understanding of other people and their interactions.

Overall, the SHSN project was successful in achieving many of its target objectives for each of the three training programs.

Lessons Learned

One of the biggest challenges that arose during the SHSN project was the delay in the response from the funder. The notice of award was received by INHS at the time that the grant work was planned to start. After receiving the initial notification it took three additional months for the contract and formal award notice to be sent to INHS, and three months after that for the agency to approve subcontracts to each collaborating partner. This put a significant six-month delay in the work by each partner and in preparing for the training to begin. The lesson learned from this experience that can aid in the planning of future projects is to plan for a delay in funding within the scope of work and project timeline.

Additionally, project staff encountered challenges trying to work with higher education systems including the local community college. The goal of partnering with higher education systems was considered to be a crucial aspect of sustaining training recommendations by project staff and collaborators. Incorporating these ideas into early childhood education courses, preparing child care teachers and early childhood professionals for the workforce, would help to sustain the knowledge gained and potentially reach an immeasurable number of children, families, and child care centers. One challenge involved copyright issues in implementing Trauma-Informed Care Training concepts in other curricula, such as higher education courses. There were also challenges in working with the community college and universities in the area, and establishing partnerships. Specifically, program staff were unable to make connections or establish communication with higher education institutions. The project was ultimately unsuccessful in meeting the goal of working with higher education, which is an area of focus for future training and intervention efforts. If education systems that are training early childhood educators could integrate principles of trauma sensitive care, or physical activity and nutrition, they have the potential to greatly influence the behaviors of the educators being trained in their programs, and the countless children they will encounter in a sustainable manner.

Another significant challenge in achieving project goals was in the timing of the grant. While the state effort to improve child care quality, Early Achievers, was beneficial and timely for recruiting participants for the SHSN trainings, several centers reported challenges in implementing recommendations because of their involvement with Early Achievers. Early Achievers required participants to change policies and make substantial changes to their policies or practices which proved to be time consuming. Early Achievers also offered financial incentives for participation, making it a higher priority for many centers to participate.

Finally, challenges occurred in the organization and management of such a large project. It was difficult to track the work being done by each group and the participants that attended each training. Each separate organization responsible for implementing the three trainings was responsible for tracking participation and program reach individually. This made it difficult to capture an accurate reach of the program. Due to the different methods of tracking participants it was also difficult to merge the participant lists in an attempt to capture who participated in multiple components. Some agency partners also experienced high levels of turnover in those who were working on the project resulting in confusion, and challenges in carrying out the project tasks, training and evaluation efforts. In the future more explicit efforts should be taken to plan the implementation of these trainings and in communicating aspects of implementation effectively with the project manager in order to create master participant list. Additional steps should also be taken by each partner to track the development and implementation of project efforts in an attempt to collect more comprehensive evaluation data during each phase of the project.

Next Steps

What's next for the SHSN project? The next steps will be to disseminate evaluation results, including this report with all participating center and various project stakeholders. Further dissemination will include presenting program results to various community agencies in the hopes of sustaining training efforts, and adopting relevant training components into existing training infrastructures. Agency partners will be seeking additional funding to further support the implementation of each training in the field.

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Agency partners:

Inland Northwest Health Services, Community Wellness

- Emily Fleury, SHSN Leadership Team
- Brittany Hadley, Project Coordinator
- Community-Minded Enterprises
- Kathy Thamm, SHSN Leadership Team

Spokane Regional Health District, Health Promotion

- Cindy Greene, SHSN Leadership Team
- Natalie Tauzin, Let's Cook Whole Foods Lead
- AJ Sanders, Let's Cook Whole Foods Coordinator
- William Barnes, Let's Cook Whole Foods Chef

Washington State University Area Health Education Center

- Kristin Souers, *Trauma-Informed Care* Trainer & SHSN Leadership Team

Coalition Agency partners:

Empire Health Foundation

ESD 101

Spokane County Head Start/ECEAP/ Early Head Start

Spokane County Library District

Step UP and Go

Rural Resources

YMCA of the Inland Northwest

Participating centers:

A Bright Beginning Learning Center

A Heart for the Home Childcare and Preschool

Advent Lutheran Child Center

Assumption Preschool

Beautiful Savior Early Learning Center

Bethel Christian Preschool and Daycare

Blueprints for Learning

Browne Elementary Express

Building Blocks Child Care Center, Inc.

Busy Bodies Early Learning Center

Busy Bugs Day Care

Camas Early Learning Center

Cela's Creative Learning Center

Central Valley Early Learning Center

Central YMCA Children's Center

Chapel Children's Center

Cheney School District

Chewelah Head Start/Rural Resources

Child Haven Learning Center LLC

Child's Play at Glenna's

Children's Montessori Center, Inc.

Circle of Friends Daycare

Clown Town Children's Center

Lower Columbia College – East/West ECEAP

Colville Head Start/Rural Resources

Community Building Children's Center & Main Street School

Community Child Care Center – Head Start/ ECEAP

Crayon College

Curlew School District ECEAP

Cusick ECEAP

Davenport ECEAP

Deer Park Early Learning Center

Deer Park Elementary School ECEAP

Destiny Kids Early Learning Center

Spokane Falls Community College Early Learning Center/Head Start

East Valley Enrichment Center ECEAP

Easter Seals ECEAP

Easter Seals Northeast Child Development Center

Eastern Washington University Early Head Start

Eastern Washington University Children's Center

Emmanuel Lutheran Preschool

ESD 101

Evergreen Early Learning Center ECEAP

Fairchild Child Development Center

Fantasy Farm Children's Center

Farwell Early Learning Center ECEAP

Flamingo Daycare

Garfield and Friends Childcare

Giggling Guest Again

Giggling Guest Too Childcare

Greenacres Child Care

Guardian Angel Academy

Harvard Park Children's Learning Center

Heart & Home

Herzog Family Center

Hutton Elementary Express

Inspire Development Center – Basin City

Inspire Development Center – George

Inspire Development Center – Othello

Inspire Development Center – Warden

Inspire Development Center – Royal City

Jefferson Elementary Express

Journey Discovery Center

June's Home Child Care

Kids First Children's Center

Kettle Falls Head Start Program

Kid Central Early Learning Center

Kids Zone Daycare

Participating centers, continued:

Mullan KinderCare

Sullivan KinderCare

Liberty Park Child Development Center

Lil' Hawks Child Development Center

Lilac City Early Learning Center

Lind Elementary ECEAP

Little Blessings Christian School and Daycare

Little Dickens Learning Center

Little Hands Childcare

Little Learner Child Development Center

Little Rascals Children's Center

Little Scholars Early Learning Center

Lolita's Daycare

Martin Luther King Jr. Family Outreach Center

Mary Walker School District

Mead School District

Meadow Wood Children's Center

Melissa's Daycare

Moran Prairie Elementary Express

Newport Head Start/Rural Resources

Noah's Ark Early Learning Academy

North Monroe Learning Center Inc.

North Wall Schools

Northeast ECEAP

Northport ECEAP

Odessa ECEAP

Orient ECEAP

Palouse Early Learning Center

Panda Bear Child Care Center

Parkview Early Learning Center

Parveen's Playhouse Child Care Center

Pauline Stearns Early Learning Center, Spokane Tribe

Planet Kids Inc.

Precious Angels Children's Center

Precious Child Care

Pullman Christian Childcare Center

Raggedy Ann and Andy Childcare

Rainbow Connection

Rainbow Connection Too

Rainbow's End Children's Center

Reach 4 The Stars TLC

Reardan ECEAP

Republic ECEAP

Ridgeview Elementary Express

Ritzville ECEAP

Riverside School District ECEAP

Riverwood Community School

Robyn's Nest Preschool and Playcare Center

Roosevelt Elementary Express

Selkirk School District ECEAP

Shiloh Hills Early Learning Center/ECEAP

YMCA Shiloh Hills Elementary

Small Wonders Childcare

SonShine Early Childhood Center

South Hill Children's Center

Southeast Daycare Center

Spokane Child Development Center

Spokane Community College Head Start/ Early Head Start Child Care Center

Spokane County Head Start/Adult Ed Center

Spokane County Library District

Spokane Guilds School

Spokane Public Schools – Express Program

Spokane Tribal TANF Children's

St. Aloysius Early Learning Center

St. Anne's Children and Family Center

St. Pascal's School

St. Thomas More Parish & School

Summit Valley School

District ECEAP

Sunny Dawn Children's Center

Sunshine Daycare

Tender Care Day Care & Preschool

The Children's Garden Learning Community

The Learning Center

The Montessori School of Pullman

Tiny Toes Childcare

Transitional LIV CT Educare MTCC

Trinity Educare Center

Valley Early Learning Center

Valley Montessori School

Valleypoint Learning Center

West Central Community Center Head Start

Westview Elementary Express

WP ECEAP

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Young Years

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