Marin Community Foundation

Evaluation of the Access to Quality Child Care (AQC) and the Healthy Eating Active Living (HEAL) Initiatives

Preliminary Insights and Recommendations to Inform Program Development

Prepared for:
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ABOUT THE SAMUELS CENTER

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EXECUTIVE SUMMARY

INTRODUCTION

The Access to Quality Child Care (AQC) and Healthy Eating and Active Living (HEAL) Initiatives are being implemented by the Marin Child Care Council (MC3) to address inequities in access to child care, improve quality in early care and education, strengthen healthy food and physical activity environments, and support social and economic self-sufficiency among underserved families in Marin County. MC3 works in partnership with the Buck Family Fund of Marin Community Foundation (MCF), which has provided funding support since July 2015. The goal of AQC is to provide eligible families with high-quality child care that includes support services and resources to help them reach social and economic self-sufficiency. AQC supports eligible child care providers by assessing their baseline quality rating assessments, supporting the development and implementation of quality improvement plans, and providing technical assistance, coaching, workshops and trainings, professional development, capacity building, and reassessments to track progress. The goal of HEAL is to improve the nutrition and physical activity environment of child care settings through a multi-component approach focusing on improving policies and practices by providing training, one-on-one coaching, and resources to providers and engaging and educating children and parents in HEAL activities.

As of June 2017, a total of 56 families and 311 children 0 - 3 years of age are enrolled in AQC. The greatest proportion of participating families resides in the Canal Area, Novato, and San Rafael. Most families are of Hispanic/Latino ethnicity and reported Spanish as the primary household language. While just over half are from two-parent families, 42% constitute single parent female-headed household.

EVALUATION

An evaluation was conducted by the Sarah Samuels Center for Public Health Research & Evaluation to understand the ways in which participating child care sites, parents, and children have benefited from both initiatives, the strengths and challenges in implementing both programs, and the lessons learned thus far that can inform recommendations for strengthening and sustaining this work. To this end, a multi-method evaluation approach including in-depth key informant interviews with the implementing agency (MC3) and the initiative funders (MCF), focus groups with parents and child care providers, and a review of relevant initiative documents was conducted in the early Spring of 2018. In addition, analysis of individual-level program data collected by MC3 was also conducted. Data from the interviews, focus groups, document review, and quantitative data were analyzed and triangulated to answer the following evaluation questions:

1. In what ways is AQC continuing to meet its goals and improving quality of care?
2. Did parents move towards social and economic self-sufficiency?
3. How has the nutrition and physical activity environment improved?
4. How has HEAL contributed to broader quality improvement efforts?
5. What are strengths and challenges of the partnerships created for implementing HEAL?
6. Influence of AQC and HEAL on providers, families and children, families: How were they involved and have benefited?
7. What other activities helped to facilitate progress toward the goals of both initiatives?
8. What are the strengths and challenges of the two initiatives?

9. How have assumptions and contextual factors changed?
10. How has MC3's organizational capacity improved over time?
11. What are the lessons learned from the implementation?

FINDINGS

Across all AQC and HEAL stakeholders, there is evidence that both initiatives are progressing towards their respective goals and are having a positive impact on moving parents towards self-sufficiency, building the capacity of providers to implement HEAL practices and policies as part of their quality improvement work, and creating child care environments that engage children and families in healthy eating and increased physical activity.

Ways Child Care Providers Benefit

- **Providers are building their knowledge and capacity for quality improvement, healthy eating, and physical activity** and leveraging these new skills on behalf of their child care environment and programming.
- **Providers are becoming more adept at using well-established child care assessment tools** (ASQ, DRDP, and CHOICE) and integrating these tools and the results into their learning about early childhood education.
- **HEAL changes are observed in child care sites:**
    - **Nutrition practices and policies are being implemented.** Healthier foods are being served at child care sites and staff are modeling healthy eating practices.
    - **Physical activity practices are being implemented**. Most noted was an increase in activity space and outdoor learning activities.
- **Parents are more engaged in their child's development and in their child care programs.** More engaged parents will support and elevate the work of the child care provider.

Ways Parents and Children Benefit

- **Children have greater access to healthy foods and healthier eating practices**. More fruits and vegetables are being offered to children and some children are asking for healthy food at home.
- **Parents are more knowledgeable about social service resources**, such as housing, immigration services, financial planning, and educational opportunities for their children.
- **Parents benefit from the subsidy for child care**, which provides the opportunity to engage in employment opportunities that may augment their family finances.
- **Parents gained advocacy skills through Parent Voices**. Building advocacy skills will be key to broader equity efforts for Marin families. This has also strengthened their social support system.
- **Parents are more engaged and knowledgeable about the value of child development.** The assessment tools also facilitated communication between the parent and provider.

Successes Across Both AQC and HEAL Initiatives

- **HEAL integrates well with the AQC work and enhances child development**. Maintaining strong communication between the HEAL and AQC staff will strengthen the collaboration between the two initiatives.

- **Dedication and passion from key leadership** as well as strong partnership and collaboration among implementing staff is essential to the success of this work.
- **Provider stipends and mini grants were influential** in making improvements at child care providers' site.
- **AQC and HEAL are increasing the quality of child care**, which may reduce inequity in quality among child care sites in Marin County.

KEY RECOMMENDATIONS

Based on the evaluation findings, recommendations have emerged for the AQC and HEAL Initiatives which are intended to advance the work of both programs:

Implementation and Operations of the AQC/HEAL Initiative

- Present AQC and HEAL to new providers as one program
- Meet the cultural and social needs of parents
- Provide more support for parents economic and educational development
- Further examine the environmental rating score improvement discrepancy between centers and family child care homes

Child Care Providers

- Tailor strategies to support providers to make nutrition and physical activity changes
- Continue to work with providers to build their capacity to administer the assessment tools
- Continue to invest in the time needed to gain trust from providers

Sustainability

- Continue to engage parents and develop their leadership for social and health equity
- Strengthen key partnerships
- Engage in continuous quality improvement to ensure program fidelity
- Seek continued funding
- Share the AQC/HEAL model and learnings with the broader field

CONCLUSION

Evaluations of AQC and HEAL that have been conducted separately over the last two years have demonstrated strengths in both program fidelity as well as impact. This current evaluation showed that HEAL enhances and integrates well with the quality improvement work of AQC. Findings from this evaluation demonstrates that children are benefiting from environments that support healthy eating and physical activity as well as educational opportunities that is enhancing their developmental growth. The evaluation also finds that providers are building their knowledge and capacity for quality improvement, healthy eating, and physical activity and that parents are gaining knowledge about child development and applying new practices at home. Findings also show that there is room for improvement, as outlined in the recommendations section. From a health equity standpoint, the positive impact that AQC and HEAL is having on families living in poverty cannot be understated. Children living in poverty deserve to be nurtured in child care environments that support their developmental growth and health, which can help them break the cycle of poverty.

INTRODUCTION

OVERVIEW of the ACCESS TO QUALITY CHILD CARE INITIATIVE

The Access to Quality Child Care (AQC) Initiative was launched in July 2015 to address inequities in access to child care, improve quality in early care and education, and support social and economic self-sufficiency among underserved families in Marin County. AQC is implemented by the Marin Child Care Council (MC3) with funding support from the Buck Family Fund of the Marin Community Foundation (MCF). Grounded in the socio-ecological systems perspective[1], AQC strategies address child care equity, access, and quality, while considering the complex interplay between individual, community, and societal factors in seeking to positively change the lives of low-income/low-wage families. Building on the wisdom of these multi-level and interactive models, AQC provides and leverages technical assistance and coaching to support child development, family self-sufficiency, and child care quality improvement through focused efforts in three key areas: child care environments, teacher-child interactions and relationships, and family engagement. The overall goal of AQC is to provide eligible families with high-quality child care that includes support services and resources to help them reach self-sufficiency. The AQC Initiative also aims to bring about system change with the development and implementation of a Quality Rating and Improvement System (QRIS) in Marin County that is inclusive of infant and toddler care. The AQC data presented in this report are cumulative (July 1, 2015 – June 30, 2017).

AQC and HEAL Initiatives At-a-Glance

Access to Quality Child Care (AQC)

Children 0 – 3 years of age ≤200% of Federal Poverty Level selected from Centralized Eligibility List

Families provided subsidized child care, workshops, coaching and referrals to increase their social and economic self-sufficiency.

Participating child care sites receive ~$1K/child and receive coaching and participate in quality improvement plan.

Healthy Eating, Active Living (HEAL)

Participating AQC sites invited to join HEAL.

HEAL providers receive healthy eating and active living coaching and resources to strengthen HEAL practices and policies.

Stipends and mini-grants are provided to support the implementation of changes to the food and physical activity environments.

OVERVIEW of the HEALTHY EATING ACTIVE LIVING INITIATIVE

The Healthy Eating and Active Living (HEAL) Initiative was launched in May 2016, following the implementation of AQC as a complementary component to strengthen child care settings by instituting policies and practices that improve the food and physical activity environment. The HEAL Initiative is a voluntary program that is offered to child care sites currently participating in AQC. Eligible child care sites (based on levels of engagement in AQC[2]), agree to adopt a policy, systems and environmental approach to improving the food and physical activity environment of their child care setting. The design of the HEAL Initiative was informed by the Marin County Early Childhood Obesity Prevention Plan[3], best practices from the Healthy Kids from Day One Collaborative work, and other local and national interventions that have been successfully implemented in early care and education settings[4]. The goal of HEAL is to improve the nutrition and physical activity environment of child care settings through a multi-component approach focusing on improving policies

[1]Bronfenbrener, 1986; McLeroy, Bibeau, Steckler, & Glanz, 1988; Britto, Yoshikawa, & Boller 2011; Chase-Lansdale and Brooks-Gunn, 2014.
[2]HEAL levels of participation are based on the degree of site engagement, from Level 1 (highest level of engagement) to Level 4 (lowest level of engagement).
[3]Created by the First 5 Marin Children & Families Commission in 2012.
[4]Clifton Zarate, B. First 5 Marin Children & Families Commission 2012: Marin County Early Childhood Obesity Prevention Plan.

and practices by providing training, one-on-one coaching, and resources to providers and engaging and educating children and parents in HEAL activities. Unless specified otherwise, the HEAL data presented in this report represent the reporting period of July 1, 2017 – December 31, 2017[5].

Description of AQC/HEAL Key Program Components

In-depth descriptions of the AQC and HEAL Initiatives are described in two previous evaluation reports[6] developed for MCF by the evaluation team. To provide context for the findings presented in this report, a brief description of the key program components for both initiatives is described here. While each program has distinct goals and strategies, the AQC and HEAL programs collaborate and work together as an interconnected model. Figure 1 illustrates the key components of the AQC and HEAL Initiatives.

Figure 1: Key Components of the AQC/HEAL Initiatives Model

Access to Quality Child Care Initiative Strategies

The AQC Initiative employs multiple complementary strategies to provide low-income/low-wage families with subsidized child care, support services, and resources to help them reach self-sufficiency. Self-sufficiency is defined by the California Family Economic Self-Sufficiency Standard (Self-Sufficiency Standard)[7], which determines the amount of income required for working families to meet basic needs at a minimally adequate level, considering family composition, ages of children, and geographic differences in costs. In the context of the AQC/HEAL Initiatives, reaching self-sufficiency is understood as the provision of resources and support, including access to subsidized child-care, to increase parents' ability to work and attend educational programs to meet the needs of their families.

[5]HEAL findings from July 2016 – July 2017 can be found Healthy Eating Active Living Initiative: Stakeholder Insights on Year One Implementation (2017). The Sarah Samuels Center for Public Health Research & Evaluation.
[6]Access to Quality Child Care Strategic Initiative in Marin County: Findings from a Mixed-Methods Evaluation (2016) and Healthy Eating Active Living Initiative: Stakeholder Insights on Year One Implementation (2017). The Sarah Samuels Center for Public Health Research & Evaluation.
[7]The California Family Economic Self-Sufficiency Standard (Self-Sufficiency Standard), quantifies the costs of basic needs for California's working families. https://insightcced.org/tools-metrics/self-sufficiency-standard-tool-for-california.

AQC Child Care Provider Support and Resources

To implement this work, an AQC Quality Improvement Specialist works with child care programs to understand and comply with AQC participation requirements, manage site visits, and conduct baseline assessments using tools such as the Environmental Rating scales and Ages and Stages Questionnaire (ASQ)[8]. The specialist also works with providers to develop, track and reassess progress on their individualized quality improvement plans and track progress and reassessment. AQC supports quality improvement for eligible child care sites by providing them with baseline quality rating assessments, support to develop and implement quality improvement plans, technical assistance, coaching, workshops and trainings, professional development, capacity building, and reassessments to track progress:

- Providers and child care site staff work together on two Environmental Rating Scales of child care quality: The Family Child Care Environment Rating Scale-Revised [FCCERS-R][9] and The Infant/Toddler Environment Rating Scale-Revised [ITERS-R][10].
- Providers participate in continuous quality improvement data collection, program assessments, site visits, coaching, technical assistance, and monitoring.
- Providers receive facilities and learning material enhancement mini-grants to support adaptations of the instructional space and purchase of developmentally-appropriate features/materials, such as updated libraries and enhanced indoor and outdoor learning stations.

AQC Family Support and Resources

In addition to offering subsidized child care, AQC's support strategies are designed to help parents set goals for their families, move them towards social and economic self-sufficiency, and engage them in their children's development:

- Parents and MC3 staff work together on the ASQ to better understand their children's developmental stage and identify areas for support.
- Parents participate in evidence-based parenting classes and workshops. The AQC educational workshops have been geared toward increasing families' understanding of child development, financial literacy, local support services and resources, and learning how to identify and advocate for high quality child care.
- On-going one-on-one case management support includes referrals for social services and public benefits.

Examples of AQC Provider and Parent Workshops and Trainings

Workshops and trainings are offered to parents and providers, based on need and interest. Examples include:

[8]Ages and Stages Questionnaire (ASQ) is a tool designed to help parents understand their child's development and whether the child should be referred to a developmental professional.

[9]The Family Child Care Environment Rating Scale-Revised [FCCERS-R]. Website: https://ers.fpg.unc.edu/family-child-care-environment-rating-scale-revised-edition-fccers-r.

[10]The Infant/Toddler Environment Rating Scale-Revised [ITERS-R]. Website: https://ers.fpg.unc.edu/infanttoddler-environment-rating-scale-iters-r.

- Eco-Healthy Child Care
- Using the Ages and Stages Questionnaire (ASQ)
- Breaking Down the Scales- Block Play
- Breaking Down the Scales: Diapering and Toileting
- Breaking Down the Scales: ART
- Breaking Down the Scales: Dramatic Play

Healthy Eating Active Living Initiative Strategies

In coordination with the AQC Initiative, MC3 implements the HEAL Initiative which focuses on policy, systems and environmental approaches (PSE) to strengthen organizational policies, practices and environments related to nutrition and physical activity outcomes for children in child care settings. HEAL is offered to qualified AQC sites that are interested in addressing nutrition and physical activity policies and practices as part of a broader effort to improve the quality of these early childhood settings. In addition to managing the daily operations of the HEAL program and aligning the work with AQC, a HEAL Coordinator works with providers and parents to help them understand HEAL's goals. The HEAL Coordinator conducts a baseline assessment to identify areas of need and develops a site action plan. The coordinator also conducts site visits, coordinates trainings, and provides ongoing technical assistance to help implement the action plan.

HEAL Policy, Systems and Environmental Changes

With support from the Parent Engagement and HEAL Coordinators, participating sites assess their current policies and practices using the CHOICE[11] tool and develop an action plan for improvement. Potential areas for improvement may include adopting new curricula to educate parents about early childhood nutrition and its connection to child development; changing feeding practices such as the use of family style meals where staff and children eat together; instituting policies and practices that support breastfeeding mothers; improving the nutritional quality of food served with a focus on fruits and vegetables; or creating opportunities for children to engage in more physical activity while in child care by revising schedules or daily routines.

Examples of HEAL Provider and Parent Workshops and Trainings

The implementation of action plans is supported through on-site technical assistance, training, educational workshops, and peer to peer learning to assist sites in developing new policies or more effectively implementing existing policies. Examples of MC3's workshop topics include:

- Nutrition Fundamentals
- Family Style Eating
- Child and Adult Care Food Program (CACFP) New Guidelines and Recipe Tasting and Exchange
- Farm to ECE
- Food for Thought
- Nutrition Activity/Make and Take
- Meals for CACFP change

[11]Creating Healthy Opportunities in Child Care Environments. Contra Costa Child Care Council. Website: Https://www.cocokids.org/child-health-nutrition/c-h-o-i-c-e-toolkit-self-assessment-questionnnaire.

- Breaking Down the Scales: Meals and Snacks
- Early and Active

Several child care providers participate in a Garden-based Learning Cohort where they learn to incorporate nutritional concepts into the daily routines at a child care site such as meal and story times. They are also being trained to develop a garden program as a source of fruits and vegetables for meals and snacks as well as a vehicle for creating a learning environment that connects young children with nutritious foods.

AQC and HEAL Partnerships

Key partnerships are essential in advancing the goals of both AQC and HEAL Initiatives. Through the AQC Initiative, MC3 has fostered a strong and evolving partnership with the Marin County Office of Education to mutually align resources and sustain quality improvement efforts in Marin County beyond AQC funding.

A complete list of organizations, which are detailed in a previous evaluation report[12], describes the wide range partnership that have been instrumental in the implementation of both initiatives.

AQC and HEAL Parent Engagement

An important program component of both the AQC and HEAL Initiatives is engaging parents in this work. MC3 supports these efforts through their child care case manager, who serves as the Parent Engagement Coordinator. In addition to maintaining daily operations of the program, the Parent Engagement Coordinator provides parent support services such as monitoring eligibility, identifying child care options, accessing community resources, and assessing family needs.

Parents are engaged in a variety of ways, from receiving information from child care providers, attending workshops and meetings, and volunteering at the child care site. Since a formal description of parent engagement has not been defined, the Initiative Stakeholders (MCF and MC3) agreed that a comprehensive definition of parent engagement will help to identify strategies to strengthen this component of the program.

One notable success of MC3's parent engagement efforts is the increased interest and participation in MC3's Parent Voices group[13]. As one of the 18 chapters across California, the local Parent Voices chapter provides grassroots leadership and advocacy opportunities for parents to voice their unique child care needs and experiences as part of the policy making process. MC3 reports that 75% of AQC parents have participated in at least one Parent Voices activity.

Modifications to Initial Program Implementation Strategies

An important aspect to the success of any community-based intervention is the willingness to modify program strategies and course correct as needed to meet the evolving needs of program participants. Lessons learned over the past two years have resulted in several modifications to the original strategies for both initiatives:

[12]Healthy Eating Active Living Initiative: Stakeholder Insights on Year One Implementation (2017). The Sarah Samuels Center for Public Health Research & Evaluation.
[13]Marin Child Care Council Parent Voices. For information, go to http://www.mc3web.org/parent-voices.

- **A HEAL Coordinator with nutrition and physical activity expertise was hired** to support providers' HEAL work. This ended the formal partnership with a subcontractor, who previously provided HEAL support, in order to reduce duplication and maximize resources.
- **A bilingual Child Care Provider Support Specialist with expertise in both early childhood education and healthy eating active living was hired to expand Spanish language capacity**. In collaboration with the AQC, HEAL, and Parent Engagement Coordinators, this specialist provides ongoing support, coaching, and technical assistance to participating child care providers and parents.
- **The CHOICE Assessment Tool was revised** in the fall of 2017 to include additional HEAL strategies implemented by MC3, including gardening, outdoor classroom, and Eco Child Care.
- **More enhanced tailoring of one-on-one coaching for providers.** Coaching is tailored to match the providers' needs, for example, by visiting a site once per day or visiting one site twice a day. A 2 to 3-hour visit/observation of a site in the morning may be followed by a 1 to 1.5-hour visit in the afternoon for an in-depth conversation which benefits both coach and teachers by having timely discussions.
- **Coaching staff utilize more video recording** during the site visit observations to target specific areas of strength, as well as areas for growth with the teachers.

Contextual Factors in the Design of the AQC and HEAL Initiatives

The AQC and HEAL Initiatives were both conceptualized and designed amid several contextual factors. The first is MCF's deep commitment and experience in designing and implementing early childhood and education initiatives. This work has been bolstered by engagement with other local partners and the relationships that were cultivated and nurtured throughout the process of implementing these initiatives. MCF's key partner in this work is MC3, which serves as the county's Child Care Resource and Referral Program. MC3 provides referral information for parents, resources to child care providers, and is a key trusted provider of professional development for the child care community with over 40 years of experience. MCF and MC3 have worked in partnership over the last 3 years to design and implement these efforts.

Second, the decision to prioritize low-income children in the 0 – 3-year age group was based on best practices as evidenced in the literature and to expand MCF's early childhood focus under the Education Programs Pre-K-3 initiative that focused on children ages 4 through 3rd grade. It was also influenced by the campaign for Marin Strong Start, a ballot initiative that was anticipated to provide sustainable funding to AQC/HEAL related activities and serve children 4 years to Kindergarten age. While this ballot measure was defeated in November 2016, it broadened awareness about the critical need for affordable child care in the county and built support among advocates for these programs.

Third, the policy, systems, and environmental approach to improving quality, healthy eating, and physical activity opportunities in early child care settings is consistent with recommended approaches to address the myriad and complex factors which influence child healthy weight status and health[14]. The initiative's relationship-based supports in the form of on-site coaching, modeling, and reflective

[14]The State of Obesity: Better Policies for a Healthier America 2016. Trust for America's Health.

consultations, collaborative efforts to help child care teachers engage in formal education or credentialing systems, and provision of facilities and learning material enhancement grants have been shown to be effective in improving quality[15]. The importance of parent engagement in the AQC and HEAL Initiatives is in keeping with recent evidence that multi-component, multi-level early child care education obesity prevention interventions with parental engagement are most likely to be effective[16].

AQC and HEAL's efforts to increase families' understanding of child development and the importance of child care quality is having an impact on their engagement in their child's development and in their enrollment of their children in development-enhancing programs. The development of the Quality Rating Improvement System (QRIS) in Marin County provides an additional opportunity for MC3 to translate and disseminate QRIS rating information broadly, to maximize families' access to information about the quality of individual programs, thereby elevating the overall quality of early care education in the community. Between July 2015 to June 2017, 21 of the 35 providers serving AQC children participated in Marin Quality Counts (MQC), the countywide QRIS system operated by the Marin County Office of Education (MCOE). Because of MC3's early work with infants and toddlers, MCOE partnered with MC3 to provide quality coaching, professional development and support to infant/toddler and family child care providers. This was a fortuitous partnership, as it ultimately brought in the California Infant/Toddler QRIS Block grant of $112,955 (for the grant period 7/1/16-12/31/17), a second Infant/Toddler QRIS grant for $65,450 (FY 17-18) and a First Five Marin IMPACT grant match of $75,000/year for 5 years.

[15]Buysse V, et al. 2013. Recognition & response: A model of response to intervention to promote academic learning in early education & Joyce B & Showers B. (2002). Student achievement through staff development. 3rd ed. Alexandria, VA: Association for Supervision and Curriculum Development.

[16]Ward DS, et al. 2016. Strength of obesity prevention interventions in early care and education settings: A systematic review. Preventive Medicine.

AQC/HEAL EVALUATION DESCRIPTION

With the introduction of the HEAL Initiative and its integration into existing AQC sites, an evaluation was conducted by the Sarah Samuels Center for Public Health Research & Evaluation to understand the ways in which participating child care sites, parents, and children have benefited from both initiatives, the strengths and challenges in implementing both programs, and the lessons learned thus far that can inform recommendations for strengthening and sustaining this work. To this end, a multi-method evaluation approach including in-depth key informant interviews with the implementing agency (MC3) and the initiative funder (MCF), focus groups with parents and child care providers, and a review of relevant initiative documents was conducted in the early Spring of 2018. In addition, analysis of individual-level program data collected by MC3 was also conducted. Data from the interviews, focus groups, document review, and quantitative data were analyzed and triangulated to answer several evaluation questions.

EVALUATION QUESTIONS

Access to Quality Child Care

12. In what ways is AQC continuing to meet its goals and improving quality of care?
13. Did parents move towards social and economic self-sufficiency?

Health Eating Active Living

1. How has the nutrition and physical activity environment improved?
2. How has HEAL contributed to broader quality improvement efforts?
3. What are strengths and challenges of the partnerships created for implementing HEAL?

AQC and HEAL

1. Influence of AQC and HEAL on providers, families and children, families: How were they involved and have benefited?
2. What other activities helped to facilitate progress toward the goals of both initiatives?
3. What are the strengths and challenges of the two initiatives?

Sustainability

1. How have assumptions and contextual factors changed?
2. How has MC3's organizational capacity improved over time?
3. What are the lessons learned from the implementation?

EVALUATION METHODS

In-Depth Key Informant Interviews

Samuels Center conducted in-depth interviews with five MC3 staff and two MCF staff in March 2018 (Table 1). Two semi-structured interview guides were developed, one for each MC3 and MCF staff. Interview questions were open-ended with probing questions to ensure specific aspects of the program were addressed (See Appendix B for Key Informant Interview Guides).

Informed consent was obtained from interviewees verbally before each interview. Interviews were conducted by telephone and took 60 minutes to complete. Audio recordings of the interviews were

professionally transcribed. Data from the interviews were analyzed using conceptual analysis. Conceptual analysis, a process used to determine the presence of certain concepts within sets of texts known as codes or themes, was applied to examine responses for each open-ended question. Data were analyzed by integrating both inductive (i.e. interviewee-generated categories) and deductive (i.e. interviewer-generated categories) analyses. Data were coded using NVivo version 10 analysis software. Relevant themes that emerged from the data were used to answer the evaluation questions.

Table 1. AQC/HEAL Evaluation Key Informant Interviewees, by Name, Organization, and Role/Title, N=7

Number of Interviews	Name of Interviewee	Organization	Role/Title	Number of Interviewees
1	Shirin Vakharia	MCF	Director Health and Aging	1
	Barbara Clifton Zarate		Director for Economic Opportunity	1
2	Madelene McCann	MC3	HEAL Coordinator	1
3	Michele Tyler		AQC Coordinator	1
4	Dennise Enriquez		Parent Engagement Coordinator	1
5	Aideen Gaidmore		Executive Director	2
	Jody W. Stamps		Program Director	
Total Number of Interviewees				**7**

Focus Groups

A total of three focus groups were conducted: two focus groups with parents (one each in English and Spanish) in March 2018 and one focus group in English with child care providers in April 2018. All focus groups were conducted at the MC3 office, lasted 90 minutes and were conducted by trained moderators using a semi-structured questioning guide with open-ended and probing questions that were developed and tailored for each group (See Appendix C for Focus Group Guides). Purposeful sampling was used to identify a cross section of parents and child care directors, staff, and teachers to participate in the discussions. MC3 recruited participants using a set of eligibility criteria:

1) Participants from a family child care home or child care center accepting vouchers through the AQC Initiative;
2) Participation in both AQC and HEAL Initiatives for at least 6 months;
3) Have decision-making authority to implement AQC and HEAL-inspired changes at the site; and
4) Over the age of 18 years.

An effort was made to have balanced representation from site leadership (family child care home owner/operator and child care center director/senior leader) and teachers/staff. In addition, eligible providers may or may not have participated in the AQC focus group conducted in 2016.

At each focus group, participants were asked to read and sign an informed consent form and to complete a short demographic questionnaire. As an incentive to participate, a drawing for three $25 gift cards was conducted at the end of each focus group and healthy snacks were provided. Focus groups

were audio recorded and data analyzed using the same process as the in-depth interviews, as described above. Descriptive analyses and frequencies from the demographic questionnaires were calculated using SPSS v. 21 (IBM Corp, Armonk, NY, USA) and Stata v.13.1 (StataCorp, College Station, TX, USA).

Characteristics of Focus Group Participants

A total of 21 parents participated in the focus groups; 11 participated in the Spanish language focus group and 10 in the English language focus group (See Appendix A, Table I for parent demographics). Across all 21 parents, most were female (86%) and employed full-time (86%), with over half identifying as Latino/Hispanic (62%). Most participants were mothers of children in the program (86%) and reported some college credit or less as their highest level of education (86%). Participants reported having their child in child care for an average of 34.4 hours per week. Most reported being involved in the AQC Initiative for 13 or more months (76%), while less than half reported being involved in the HEAL Initiative for 13 or more months (40%).

Eight female providers participated in a focus group (See Appendix A, Table II for provider demographics). Most received some college credit or higher (87%). Most participants identified as Latina/Hispanic (63%). Half of the participants worked at a child care center (n=4) and the other half worked at a family child care site (n=4). Participants reported working in child care for an average of 12.5 years. Most reported spending 13 or more months in the AQC (88%) and HEAL (75%) Initiatives.

Document Review

Samuels Center gathered and reviewed all existing materials and reports produced by MC3 and MCF on the two initiatives, including periodic grantee progress reports from MC3. The evaluation team also reviewed the most recent academic and implementation literature related to quality improvement and healthy eating and active living interventions in child care settings. This review informed the development of data collection tools and supported the interpretation of evaluation results that are incorporated in this report.

AQC Program Data

As part of their role as lead agency for the AQC Initiative, MC3 collected, maintained, and reported AQC data consisting of programmatic and individual-level participant data (e.g., socio-demographics). This quantitative data was collected at intake (upon enrollment into the Initiative) and at follow-up[17] with the following key indicators analyzed and summarized in this report:

- Basic characteristics of parent participants
- The number of children enrolled in slots
- Parent engagement, education, and social support
- Quality improvement at targeted child care sites
- Sustainability efforts

[17]AQC follow-up time point one was from July 1, 2015 to June 30, 2016 and follow-up time point two was from July 1, 2015 to June 30, 2017. HEAL data includes the reporting period from July 1, 2017 to December 31, 2017.

Descriptive statistics were calculated to describe the sample. Where appropriate, baseline and follow-up data were compared using Wilcoxon signed rank tests. Due to the small number of variables with complete data from the second follow-up time period, changes were measured between baseline and follow-up, based on data constituting the greatest length of program participation from July 1, 2015 to June 30, 2017. This maximizes the available sample size to best determine program impact. All analyses were performed using Stata v.13.1 (StataCorp, College Station, TX, USA) and SPSS v. 21 (IBM Corp, Armonk, NY, USA). P-values less than 0.05 were considered significant.

HEAL Program Data

MC3 also managed and reported HEAL data consisting of programmatic-level data collected during the July 1, 2017 – December 31, 2017 reporting period. This quantitative data includes child care provider type, location, and ages served, as well as site goals, provider education, and level of engagement efforts. Parent education efforts as well as the number and type of site-level nutrition and physical activity policy, system, and environmental changes are also noted.

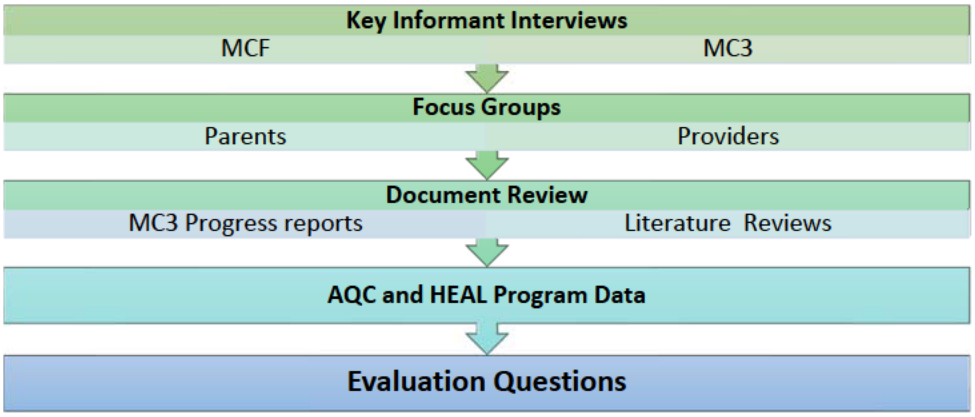
Institutional Review Board Approval

All evaluation methods and protocols were approved by Solutions IRB's institutional review board for the protection of human subjects.

Synthesis of Findings

Findings from the in-depth interviews with MC3 and MCF (herein referred to as "Initiative Stakeholders"), parent and provider focus groups, document review and quantitative program data were analyzed and triangulated to answer the following evaluation questions (Figure 2). Qualitative quotes are added to provide emphasis on the findings. Quotes have been edited for clarity while maintaining the integrity and intent of the participants' comments

Figure 2: Triangulation of Evaluation Methods to Answer Evaluation Questions



FINDINGS

ACCESS TO QUALITY CHILD CARE

Total Number of Children Served

As of June 2017, a total of 56 families and 311 children have enrolled in AQC (Table 2). Of this total, 165 children have received vouchers, 91 are have received Title V retention funds[18], 42 are 4-year old children who have continued in the program past 3 years of age, and 13 received home visiting services. Most of the families enrolled in year one of the program continued services into the second year of AQC. The greatest proportion of AQC participating families resides in the Canal Area (25%), Novato (24%), and San Rafael (20%) (See Appendix A, Table III for AQC participant characteristics). Most families are of Hispanic/Latino ethnicity (79%) and reported Spanish as the primary household language (69%). While most (52%) are from two-parent families, 42% constitute single parent female-headed household.

Table 2. Access to Quality Child Care Strategic Initiative: Number of Number of Children Enrolled in AQC, by Implementation Year, N=311

Program	Year 1 July 1, 2015 – June 30, 2016	Year 2 July 1, 2016 – June 30, 2017	Year 3 July 1, 2017 to Date	Total
All Children (0 – 4y)	**88**	**105**	**118**	**311**
Receive Vouchers (0 – 3y)	48	63	54	165
Title V Retention (0 – 3y)	40	20	31	91
4-Year-old Children	0	13	29	42
Home Visiting	0	9	4	13

Title V Infant/Toddler Retention

The AQC Initiative has leveraged and supported the retention of Title V Infant/Toddler dollars in Marin at three state-subsidized child care sites serving infant and toddlers. This is important because in the more strictly regulated state-administered child development programs, the standard reimbursement rate to providers for each child enrolled is a set dollar amount. Since the amount does not vary in response to geographic variation in the cost of providing care, with Marin County being a high cost county, state-subsidized child care sites struggle to retain state dollars and slots in Marin, often returning dollars to the state, or shifting resources to preschool age, thereby reducing the number of subsidized infant/toddler slots in the county. Often state dollars are returned to the state, as organizations cannot take on increased deficits caused by the low reimbursement rates. AQC addresses the reimbursement gap by subsidizing Title V sites serving infant and toddlers in the county to leverage state dollars and thereby retain the infant/toddler slots in Marin (Table 3).

[18]Title V Retention Fund. Website: https://www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/Title-V-Block-Grant-Program.aspx

Table 3. Access to Quality Child Care Strategic Initiative: Title V Infant/Toddler Slots Retained in Marin County, CA by Implementation Year, N=91

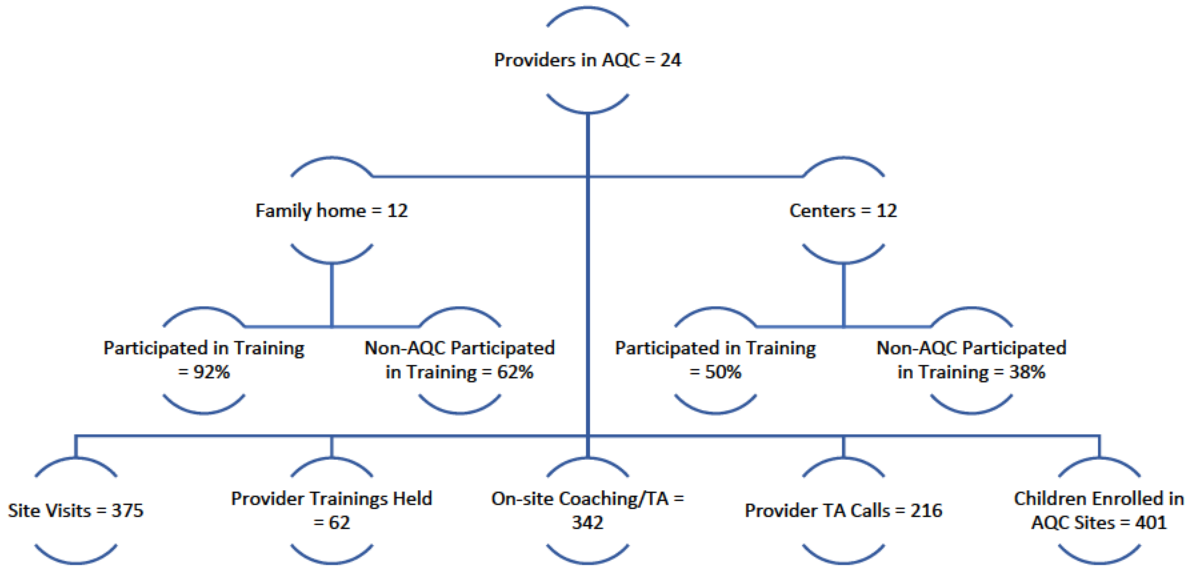
Year	Time Frame	Title V Dollars Retained	Number of Children
Year 1	July 1, 2015 – June 30, 2016	$ 485,658	40
Year 2	July 1, 2016 – June 30, 2017	$ 330,607	20
Year 3	July 1, 2017 to date	$ 270,779*	31
		Total	**91**

*Estimated to reach similar amount as in Year 2

Participating Child Care Providers

Of the 24 providers participating in AQC (12 family home-based and 12 center-based), all are working with AQC coaches. Some providers have multiple classrooms participating in quality improvement efforts. AQC sites are receiving bi-monthly site visits that integrate activities, coaching, and support based on individual goals and needs (Figure 3). Site visits span an hour or more in length of time, often have a hands-on component, and time dedicated for provider-coach reflection. The majority of AQC providers have joined the local Quality Rating and Improvement System (QRIS)[19] and Marin Quality Counts[20], which are distinct but connected efforts.

Figure 3: Child Care Providers Participating in Access to Quality Child Care Strategic Initiative Quality Improvement Activities, July 1, 2015 to June 30, 2017



[19]Quality Rating and Improvement System (QRIS). Website: https://qrisguide.acf.hhs.gov.
[20]Marin Quality Counts. Marin County Office of Education. Website: http://www.marinschools.org/ECE/Pages/Marin-Quality-Counts---QRIS.aspx.

Changes in Quality of Child Care Environments

Focusing on baseline and follow-up data representing the greatest length of time providers have participated in AQC[21], results from the analysis of AQC program data on environmental rating scores in part support the finding that AQC is making a difference in improving early childhood and child care program quality. At follow-up, there were significant improvements in environmental rating scores as measured by the Infant/Toddler Environment Rating Scale (ITERS-R) and Family Child Care Environment Rating Scale (FCCERS-R) scores at participating centers (N=12) and family child care homes (N=12), respectively. Scores on the ITERS-R and FCCERS-R items range from one to seven, with one indicating inadequate quality care and a seven indicating excellent care. According to results from 11 baseline and follow-up matched assessments conducted at AQC-participating centers (11 of 12 currently-enrolled centers had at least one follow-up environmental rating score), quality improvement efforts may have contributed to a statistically significant change in Infant/Toddler Environment Rating Scale scores. The median ITERS-R score was 0.29 higher post-AQC quality improvement intervention compared to baseline (Table 4).

Table 4. Access to Quality Child Care Strategic Initiative: Infant/Toddler Environment Rating Scale Scores Among Participating Centers, July 1, 2015 – June 30, 2017*

N=11	Median (IQR) Before	Median (IQR) After	Change	P-value**
AQC Centers	3.41 (2.85-4.53)	3.70 (3.00-4.89)	+0.29	0.003

*Baseline and Follow-up ITERS-R scores constitute the greatest length of time center providers have participated in AQC.
**A Wilcoxon Signed Rank test showed that quality improvement efforts at AQC participating centers elicited a statistically significant change in Infant/Toddler Environment Rating Scale, Revised Edition (ITERS-R) Scores (Z = -2.936, p = 0.003). The median ITERS-R score was 0.29 higher post-AQC quality improvement intervention compared to baseline.

Similarly, results from 11 baseline and follow-up matched assessments conducted at AQC-participating homes (11 of 12 currently-enrolled homes had at least one follow-up environmental rating score) show that quality improvement efforts may have contributed to a statistically significant change in Family Child Care Environment Rating Scale scores. The median FCCERS-R score was 0.19 higher post AQC-quality improvement intervention compared to baseline (Table 5).

Table 5. Access to Quality Child Care Strategic Initiative: Family Child Care Environment Rating Scale, Scores Among Participating Homes, July 1, 2015 – June 30, 2017*

N=11	Median (IQR) Before	Median (IQR) After	Change	P-value**
AQC Homes	3.10 (2.70-4.32)	3.29 (3.00-4.31)	+0.19	0.003

*Baseline and Follow-up FCCERS-R scores constitute the greatest length of time family child care providers have participated in AQC.

**A Wilcoxon Signed Rank test showed that quality improvement efforts at AQC participating homes elicited a statistically significant change in Family Child Care Environment Rating Scale, Revised Edition (FCCERS-R) Scores (Z = -2.934, p = 0.003). The median FCCERS-R score was 0.19 higher post-AQC quality improvement intervention compared to baseline.

[21]For those providers with three reported environmental rating scores, the two scores representing their greatest length of time participating in AQC was selected to assess potential program impact.

While the available data from centers and homes reporting three quality rating scores is limited, preliminary trend evidence suggests that observed increases in quality assessment scores are sustained over time (Table 6). For example, among the 8 family child care homes with 3 quality rating scores, from baseline to follow up time one (after an average of 7 months) and time two (after an average of 18 months from baseline), analysis indicates that the average reported scores differed significantly between time points. The increase in average quality rating scores over time is illustrated in Figure 4.

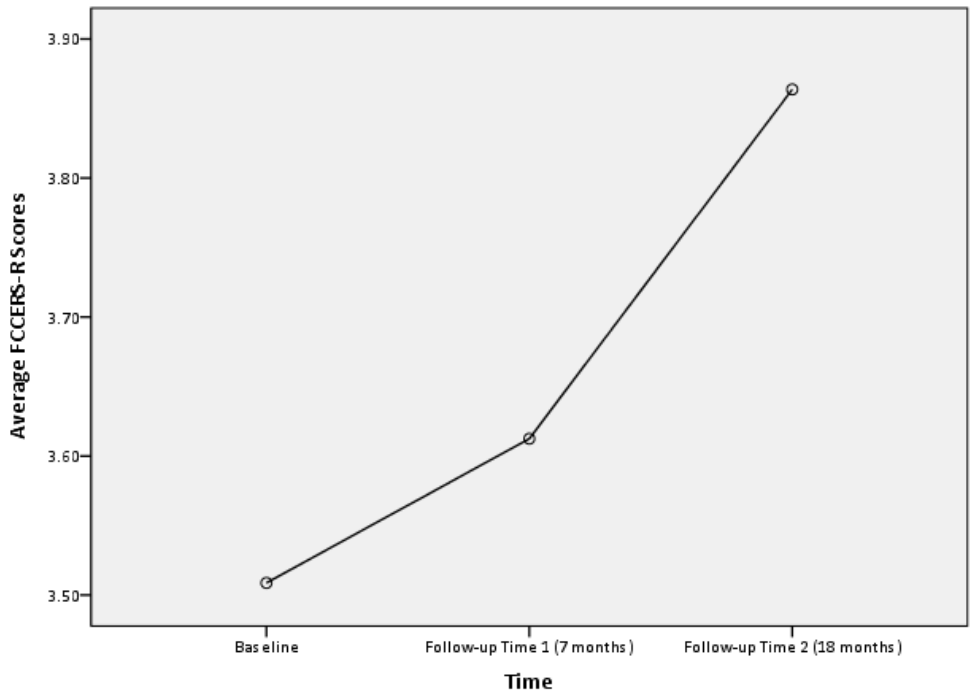
Table 6. Access to Quality Child Care Strategic Initiative: Descriptive Statistics for Family Child Care Environment Rating Scale Scores Over Time, July 1, 2015 – June 30, 2017*

Time	Mean	SD**	N
Baseline	3.51	0.96	8
Follow-up Time 1	3.61	1.00	8
Follow-up Time 2	3.86	0.94	8

*A one-way repeated measures analysis of variance with a Greenhouse-Geisser correction; [$F(1.127, 7.887) = 17.480$, $p < 0.001$]. Post hoc tests using the Bonferroni correction revealed that reported FCCERS-R scores increased by an average of 0.104 after about seven months ($p = 0.008$) and then increased by an additional 0.251 between seven months and 18 months ($p = 0.008$).

**SD = Standard deviation

Figure 4. Average Reported Family Child Care Environment Rating Scale, Revised Edition (FCCERS-R) Scores Over Time, July 1, 2015 - June 30, 2017, N = 8 Longitudinal



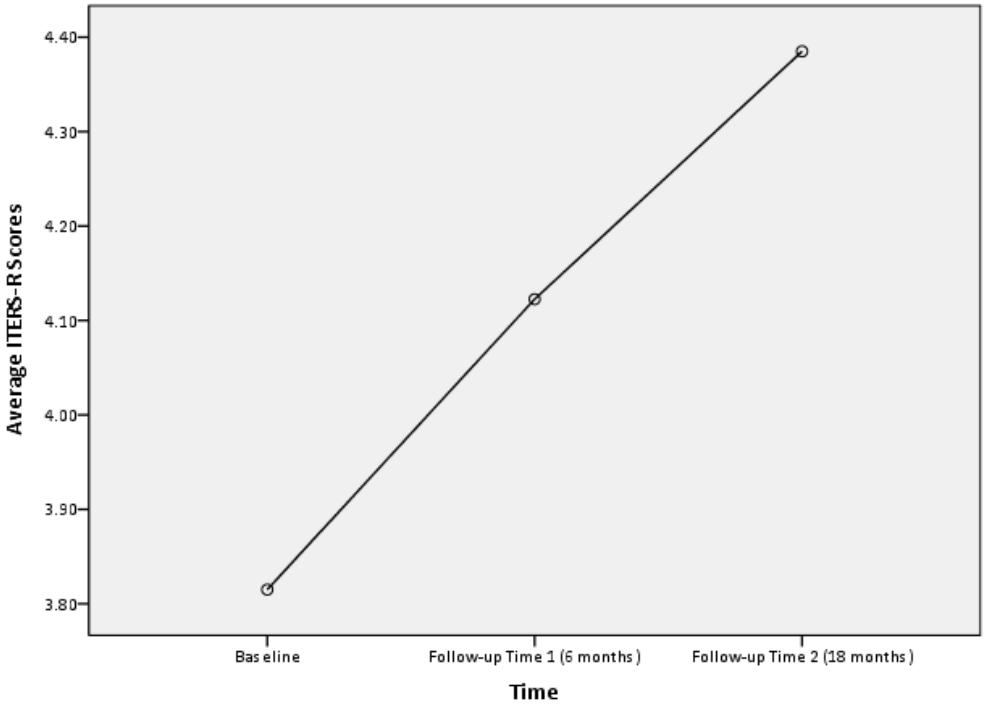
The small number of centers (N=4) with quality rating scores reported over 3 time periods and the non-normally distributed data among these centers precluded running a similar analytic method assessing changes to infant/toddler quality rating scores over time. However, this longitudinal data similarly provides preliminary trend evidence of sustained quality improvement over time (Table 7 and Figure 5 below).

Table 7. Access to Quality Child Care Strategic Initiative: Descriptive Statistics for Center Infant/Toddler Environment Rating Scale Scores Over Time, July 1, 2015 – June 30, 2017

Time	Mean	SD*	N
Baseline	3.82	1.71	4
Follow-up Time 1	4.12	1.84	4
Follow-up Time 2	4.39	1.66	4

*SD = Standard deviation

Figure 5. Average Reported Center Infant/Toddler Environment Rating Scale, Revised Edition (ITERS-R) Scores Over Time, July 1, 2015 - June 30, 2017, N = 4 Longitudinal



Parents' Movement Towards Social and Economic Self-sufficiency

As mentioned earlier, a key component of AQC is the provision of resources and support, including access to subsidized child care to increase parents' ability to work and attend educational programs to reach self-sufficiency. To this end, parents have been involved in several activities (Table 8), including involvement in family needs and ASQ assessments, as well as participating in technical assistance calls and MC3 workshops.

Table 8. Access to Quality Child Care Strategic Initiative: Parent Engagement, Education, and Social Supports, July 1, 2015 – June 30, 2017

Category	N
Parent technical assistance calls	220
Family needs assessments completed	69
AQC parents participating in MC3 workshops	61
Ages and Stages Questionnaire assessments completed	54
Parent workshops provided by MC3	21
Referrals to Golden Gate Regional Centers based on ASQ	15
Non-AQC parents participating in MC3 workshops	5
AQC providers providing parent activities and support	2

Analysis of participant socioeconomic data constituting their greatest length of time participating in AQC[22] provides additional evidence in support of families moving toward self-sufficiency. While little change is observed in reported workforce training, employment status, and educational status, there is a noted increase in family income (Table 9). Analysis indicates a statistically significant change in parental-reported income. The median reported income was $13,278 greater post AQC-quality improvement intervention compared to baseline. A demonstrable increase in the proportion of families living at or above the 201-300% Federal Poverty Level was also observed from baseline (9%) to follow-up (49%), suggesting a positive movement in the direction away from poverty.

Findings demonstrate positive direction away from poverty, for families living ≥200% of the Federal Poverty Level

[22]For those parents with reported incomes at three time periods, the two reported incomes representing their greatest length of participation in AQC was selected to assess potential program impact over time.

Table 9. Access to Quality Child Care Strategic Initiative: Parent Movement Toward Self-Sufficiency, from baseline to follow up, July 1, 2015 – June 30, 2017

	Baseline		Follow-up*	
Category	**N**	**Median %****	**N**	**Median %****
English as a second language training among parents				
Yes	3	4%	5	8%
No	76	96%	59	92%
Workforce training among parents				
Yes	0	0%	1	2%
No	79	100%	64	98%
AQC parent employment status				
Yes	70	89%	63	94%
No	4	5%	3	4%
Not in labor force (Student)	5	6%	1	2%
Annual parent income ($; SD)***	72	$20,334 ($14,989)	62	$33,612 ($20,831)
Family Federal Poverty Level				
Living below 100% FPL	14	25%	4	9%
Living between 100-200% FPL	36	66%	19	42%
Living between 201-300% FPL	5	9%	19	42%
Living over 300% FPL	0	0%	3	7%
Parent education level				
No high school diploma	24	31%	24	35%
High school graduate	27	35%	26	38%
Some college	15	19%	9	13%
Associate degree	2	3%	2	3%
Bachelor's degree	10	13%	7	10%
Graduate degree	0	0%	0	0%

*Follow-up data calculated by greatest length of participation for any one participant.
**Percentages may not add up to 100 due to rounding.
***A Wilcoxon signed-rank test indicates a statistically significant change in parental-reported annual income ($Z = -5.536$, $p < 0.001$). The median annual income was $13,278 greater post-AQC quality improvement intervention compared to baseline. SD = Standard deviation.

Trend Analysis Provides Tentative Evidence for Sustained Increases in Parent-Reported Income

There is also tentative evidence suggesting that the increase in reported parent income over time is sustained. Among the 29 parents who reported incomes on three separate occasions (i.e., baseline, follow-up time one (9 months post baseline), and follow-up time two (20 months post baseline), analysis indicates that average reported income differed significantly between time points (Table 10). The reported income increased by an average of $6,060 from baseline to follow-up time one and then

increased by an additional $16,968 between follow-up time two and follow-up time three. The increase in average income over time is illustrated in Figure 6.

There are important limitations that should be considered when interpreting these income results. First, the results are based on observational data that can only conclude that program participation is associated with an increase in income; causal inferences cannot be made. Second, analysis do not control for other factors (e.g., family size and number of children) which can temper or help explain the observed outcome. The positive increase in income may be due to other events or experiences outside of program participation occurring between baseline and follow-up. Third, a focus on reported income alone omits consideration of more sensitive and responsive measures of perceptions of adequacy of one's standard of living as well as experiences of material deprivation and hardship which arguably can more fully capture genuine movement toward economic self-sufficiency. Finally, these results are based on specific populations (those participating in the AQC program) and may not translate to other high-need populations in the United States. Including additional observations of socioeconomic status before program participation and adjusting for relevant covariates can help to rule out alternative explanations. A focus on income-to-needs ratio as well as an examination of the more affective and psychological experience and economic hardship can provide a more complete and sensitive measure of movement toward self-sufficiency among individuals living on the edge. Qualitative exploration can help assess program influence (e.g., did the child care subsidy translate to more work hours and less absences and tardiness due to child care problems) and provide a more complete accounting of child care subsidy benefits connected to economic self-sufficiency (e.g., health insurance, wage increases, and career advancement).

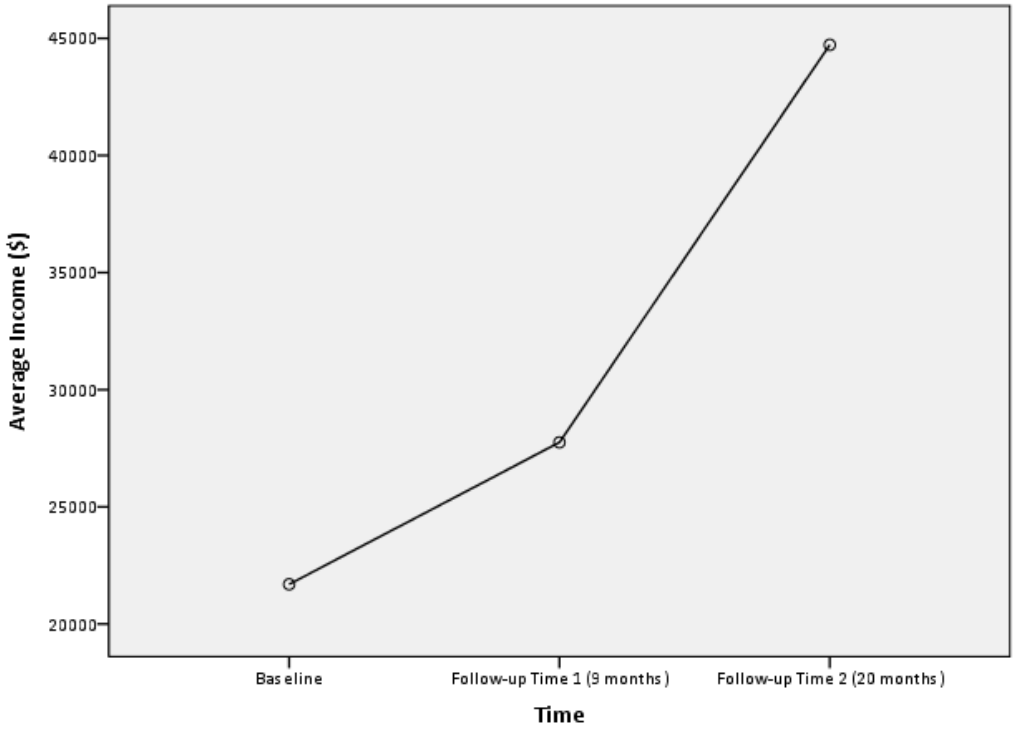
Table 10. Access to Quality Child Care Strategic Initiative: Descriptive Statistics for Parent Annual Income ($), July 1, 2015 – June 30, 2017, N = 29 Longitudinal*

Time	Mean	Median** (IQR)	Minimum	Maximum
Baseline	$21,694	$19,767 ($16,097, $25,044)	$8,275	$43,867
Follow-up Time 1 (9 months)	$27,754	$23,400 ($19,500, $33,528)	$11,712	$55,770
Follow-up Time 2 (20 months)	$44,722	$44,445 ($23,496, $57,478)	$15,258	$85,221

*Post hoc analysis with Wilcoxon Signed Rank test was used with a Bonferroni correction applied, resulting in a significance level of $p < 0.05$. There are significant differences between the baseline and follow-up time 1 median reported incomes ($Z = -2.876$, $p < 0.01$), between the follow-up time 1 and follow-up time 2 reported median incomes ($Z = -3.763$, $p < 0.01$), and between the baseline and follow-up time 2 reported median incomes ($Z = -4.422$, $p < 0.01$).

**A Friedman Test indicated a statistically significant difference in reported income over time among parents who reported income during three consecutive reporting periods, $X^2(2) = 23.211$, $p = <0.01$.

Figure 6. Average Reported Income Among Parents Enrolled in Access to Quality Child Care Strategic Initiative, Marin County, California, July 1, 2015 – June 30, 2017, N = 29 Longitudinal



Perspectives on AQC Progress Towards Goals

Initiative Stakeholders (MCF and MC3) were asked for their perspective about the extent to which they felt AQC was moving parents towards social and economic self-sufficiency, creating quality improvement in child care, and meeting program enrollment targets.

Overall, all Initiative Stakeholders felt that AQC was meeting its goals, including those for enrollment:

> "I'm amazed by what's been accomplished in the period of time that it has been accomplished."

Successful strategies in implementing AQC include having flexibility in allocating voucher funds, being flexible with time when meeting with providers, and the one-on-one, tailored support offered to providers:

> "Training is always successful because it introduces topics. Then having follow up site visits when I can take it more in depth with them. That's probably been the most effective strategy is following up and going deeper."

Another key factor to success in implementing this work is the dedication and commitment of the Initiative Stakeholders:

> "There's a strong belief in what we're doing. People believe in the difference we're making and want to make a difference. That is definitely part of the successes in my eyes."

Parents are More Knowledgeable about Social Service Resources

Parents reported benefitting from AQC's work by being more knowledgeable about social service resources, and through the one-on-one support they received.

Parents provided positive feedback about the referrals and resources provided by MC3:

> "This is the first time I applied for community help, and I am so thankful for this program because no one had ever paid a single dollar for my child care or for my son's medical bills or for my own medical bills. This year, I received that help."

Specifically, many parents spoke about using referrals to housing and immigration services and other programs such as 10,000 Degrees and Golden Gate Regional Center. Even if parents were not ready or able to take advantage of these resources, they expressed confidence in having greater awareness about where to look for assistance in the future:

> "We thought we'd never be able to buy a house in Marin County. It's just a dream. Then I realized, 'yes, there are programs out there, there is help,' which I had never heard of before. I know the agencies that I can get help from, thanks to that workshop."

Several parents also said that they found workshops on child development, financial planning, and affording college tuition to be useful:

> "There are so many scholarships out there. Before, I was just like, 'I guess we're not going to afford college.' Now, I know that we can start writing essays together. I'll help her when she gets into eighth grade. That really helped a lot."

For parents who are immigrants or come from different cultural backgrounds, these resources proved especially helpful:

> "The best part is knowing that all those resources are available. I didn't even know I could access them, because many people think that American NGOs don't give resources to Latin people. As she says, there aren't enough resources for everyone but at least we can know where to look, where to call."

Several parents commented specifically about the high degree of one-on-one support and coaching they had experienced from the Parent Engagement Coordinator:

> "If you have a question she'll answer, or if she doesn't, she'll find it. Or she'll provide information, resources and that's something that's helpful for us because we're going to school, both of us and it's easy to forget those things, or push them aside, and she helps fairly quickly."

Several parents, including a few mono-lingual Spanish speaking parents, also provided examples of the ways in which the Parent Engagement Coordinator intervened to help parents access resources from community agencies who were unhelpful or unresponsive.

In addition to what parents reported, Initiative Stakeholders felt that parents benefited by having financial support for child care, which is intended to allow them to pursue educational opportunities. They also said that parents learned about other information on housing, including the importance of keeping a good credit score, and have gained advocacy skills through Parent Voices, which has positive implications beyond AQC:

> "AQC is going to be here for a few years. Then they are going to have their families and their children for the rest of their lives. We need them to go with those tools of advocacy."

Suggestions for Additional Resources

Parents identified a variety of additional resources that would be supportive to their economic and social self-sufficiency, such as a workshop on self-care for parents, perhaps inclusive of yoga and art. Another recommended a CPR class while another parent suggested including a psychologist for children on the program team to assist with developmental and behavioral questions. Another parent was concerned that MC3 resources were only available to children from 0 to 3:

> “They cut them off when they turned three. Even if your child was doing super good in the program, after cutting the program off that child went to a daycare at home, and everything that was done here was lost.”

HEALTHY EATING ACTIVE LIVING

Summary of HEAL Activities

Of the participating 24 AQC sites, MC3 is implementing HEAL in 14 child care sites. Participants have implemented new nutrition and activity policies and practices through one-on-one support with site visits from MC3 staff. The HEAL lending library was reported as being well received and used frequently as well as the learning opportunities from the MC3 workshops[23]. As part of the lending library, HEAL has acquired new resources to share with the child care community, such as The Outdoor Classroom Project and Eco Child Care, movements that are dedicated to early childcare education and wellness.

During the July 1, 2017 - December 31, 2017 reporting period, MC3 spearheaded various activities designed to support improvements in healthy eating and physical activity in child care and home settings via policy, system, and environmental changes (Table 11). MC3 continued to facilitate action plan development to support providers in developing policies and plan practices that could make their program healthier for children. MC3 administered self-assessments to child care providers to help review existing nutrition and physical activity practices and identify opportunities for policy development, changes to practices or modifications to the built environment. MC3 continued to implement peer-to-peer leadership sessions with family child care providers which allowed for directors and staff to share information on what works in improving nutrition and physical activity policies and practices in family child care settings. Child care providers also continued to receive intensive on-site training and small group coaching sessions in support of their nutrition and physical activity efforts.

Collectively, these resources and supports allowed child care sites to make a variety of changes. System-level and environmental changes included the adoption and implementation of outdoor play space and activities, garden-based education, enhanced indoor learning areas, and Harvest of the Month[24]. Examples of the types of policies adopted at AQC/HEAL sites included garden-based learning, breastfeeding, healthy celebration meals, and outside play. Workshops were coordinated to engage child care providers and parents in the implementation of these nutrition and physical activity enhancement strategies. Workshop topics included food demonstrations, healthy recipe and shopping lists, gardening, and ideas for incorporating physical activity into every day. Materials related to these topics were distributed during the workshops.

[23]MC3 Progress Report, dated February 8, 2018.

[24]Coordinated by the California Department of Public Health, Harvest of the Month features ready-to-go tools and resources for students, families, and the community to engage in hands-on opportunities to explore, taste, and learn about the importance of eating fruits and vegetables and being active every day.

Table 11. Healthy Eating, Active Living Activities, July 1, 2017 – December 31, 2017	
Activity	**N**
Assessment and Planning	
Provider action plans developed	8
CHOICE provider self-assessment questionnaires completed	5
Parent Education and Engagement	
Parents attending workshops	67
Parent workshops held	3
Provider Education	
Providers attending workshops	48
Provider workshops held	4
Technical Assistance	
Technical assistance sessions held for AQC/HEAL sites	23
AQC/HEAL staff participating in North Bay Children's Center Garden training	6
AQC/HEAL sites participating in North Bay Children's Center Garden training	5
Policy	
Policies adopted by AQC/HEAL providers	5
Policies implemented at AQC/HEAL sites	2
Systems	
System changes implemented by AQC/HEAL providers	11
System changes implemented by MC3*	9
Environment	
Environments modified at AQC/HEAL sites	5
Provider Leadership	
Family Child Care Homes participating in leadership group	8
Collaboration	
Partners supporting MC3 HEAL Initiative**	4
*Harvest of the Month, Cooking classes, garden education	
**North Bay Children's Center, Marin Breastfeeding Coalition, Marin HEAL, Marin Food Policy Council	

Initiative Stakeholder Perspectives on the Integration of HEAL into AQC sites

The HEAL Initiative was introduced to the AQC providers as a voluntary addition to their quality improvement work. From the perspective of the Initiative Stakeholders, integrating healthy eating active living policies and practices in child care settings is a key element of quality improvement as opposed to a separate entity:

> "We launched AQC with this visual of a three-legged stool in having slots, quality improvement, and parenting engagement. HEAL runs through the quality improvement as an element of quality improvement and not a standalone."

The introduction of HEAL was made a year after AQC was initiated, a result of programmatic logistics related to the start-up of grantmaking activities. Initiative Stakeholders had mixed views on whether the timing of HEAL made it easy or difficult to integrate it into the AQC work. While some felt the timing was advantageous as the delay allowed providers to learn and operationalize AQC principles before

introducing HEAL, most of the Initiative Stakeholders implementing the work felt it would have been best if both initiatives had started together. From their perspective, one reason is that providers see HEAL as a separate program with a lower priority:

> "There is a different weight to it. The first-year people thought this was a completely separate thing."

Regardless of timing, there is overall agreement among the implementing staff that HEAL is a good complement to the AQC work:

> "I think HEAL works really well with AQC. If a coach is talking about language development, we can weave in the language around fruits and vegetables or gardening, vocabulary into that language development. If it's gross motor skills, let's do that with soil. It really blends well together."

Provider Perspective on the Integration of HEAL and AQC Initiatives

Providers had different opinions about the level of integration between the HEAL and AQC Initiatives. Some providers, especially those who had been in the program for a longer amount of time, said they felt that the initiatives reinforced each other:

> "Being able to utilize the HEAL program with those resources that have been given to us to implement in that AQC program has been great. There's a lot of other things in the AQC part that HEAL has helped to bring. The healthy eating, active living piece that we weren't sure how to implement. Now, we see more of how it all goes together."

However, several other providers discussed challenges related to integration between the HEAL and AQC initiatives. Some providers said it was difficult to understand the relationship between the two initiatives:

> "I just feel like I'm working in two different programs. I don't know if there's integration and I think if there is integration that is more visible, I might have a different feeling about the program."

According to one provider, this lack of integration could be mitigated by introducing MC3, AQC and HEAL staff as a team:

> "The only thing I would ask to be done different is if they introduced themselves as a team. Like we're all here to improve your program on a whole deeper level and on all aspects in the classroom and healthy and the active and how to bring that home with your families."

Suggestions on Integrating HEAL into the AQC Program

An Initiative Stakeholder offered suggestions on ways HEAL and AQC could work more collaboratively. One idea was to foster strong communication between the HEAL and AQC staff so they have an opportunity to identify areas that overlap as well as possible gaps in services. This is particularly important since some staff have a more comprehensive view of quality improvement efforts while others have more targeted expertise in healthy eating and active living. Another suggestion was the

importance for all staff to understand early childhood education principles, thus building capacity in this area to help the initiatives work better together.

Implementation of HEAL Changes may be Dependent on Type of Child Care

Several providers from family child care homes said they found it easy to implement changes. Some of these providers also talked about the ways in which their work with HEAL built on the current work with other nutrition programs, such as the 4Cs Child Heal and Nutrition Program, administered by Community Child Care Council of Sonoma County:

> "Honestly, we have not faced challenges and I think it is because we are smaller. We have been working with the food program which is already strict in nutrition."

Conversely, one provider from a child care site embedded within a larger center said that she faced hurdles unique to her site, particularly in terms of building buy-in with senior leadership. She said the process was especially difficult in the years before the HEAL initiative was implemented:

> "I'm a center and a corporation, so if I want any changes, you have to go through your executive director. You have to go through the facility managers, it's a whole process. I would have these ideas, but I wouldn't have anyone supporting me."

Interest in HEAL Among Non-Participants

There is growing interest in HEAL among providers not participating in the initiative, as described by an Initiative Stakeholder:

> "Providers that are not with the grant are now asking, "Can I be involved? Can I come to classes or could you come out to my site?" There's a lot of great feedback coming around HEAL."

HEALTHY EATING - CHANGES TO FOOD PRACTICES

Healthier Foods Served at Child Care Sites

Many parents and providers agreed that their child care sites were serving healthier foods. A few providers spoke about including more fruits and vegetables in their menus. They also said that the cooking and healthy eating workshops offered on site by the HEAL Coordinator helped to increase children's exposure to fruits and vegetables:

> "Before, we were cooking once in a while with the kids, doing recipes and smoothies in our preschool room. Now we do it in all of our rooms."

Multiple parents offered examples of the ways in which the food at their child care site had changed since the inception of HEAL. Specifically, parents have observed increases in the number of fruits and vegetables that their children were now eating at child care sites:

> "I've noticed that their snacks have gone from Goldfish and that kind of thing and it is more fruits and fresh veggies now."

Although most parents attributed changes in nutrition offerings at child care sites to the support and presence of MC3 staff, a couple of parents also described increased awareness among providers about nutrition and healthy eating:

> "[The providers] are more aware. They're talking more about it when they have meetings, like the importance of healthy snacks. My child has been there for about three years and I've noticed that they're talking more about it."

Parents Valued Nutrition Workshops and MC3 Support

Many parents agreed that the nutrition workshops and classes offered by the HEAL Coordinator were also very useful. According to one parent, the workshops provided ideas on how to make healthy snacks on a budget. Several parents were disappointed that cooking classes for families with Cooking Matters was cancelled without explanation. Another parent described how the workshops had exposed her to foods that she was not familiar with given her cultural background, and wished that the classes were offered more frequently:

> "I remember [the instructor] gave us her salad recipe, we tried to cook an avocado, olive oil, lettuce, cucumber and jicama salad, something weird to us as Latinos because we as Mexicans don't eat avocado with olive oil. At least it's weird to me, but it was good."

Multiple parents reported that the HEAL Coordinator visited their child care sites and prepared food with the children. They attributed many of the positive changes in their children's attitudes about healthy eating to the addition of this HEAL programming:

> "At my child care center, there's a lady who teaches them how to make food; my daughters come back home excited about it and tell me that they cooked salad with her."

Another parent observed that a consideration to their daughter's food preferences encouraged her to eat more vegetables:

> "The first time they cooked salad, my daughter didn't like the experience. The HEAL Coordinator told her that next time she was going to cook something she liked. When I got home, my daughter told me to cook certain veggies for her and she has eaten veggies since."

A Few Parents Reported Limited Changes

While many parents described examples of changes in the way food is prepared and served at their child's site, not all participants shared the same perspective. One parent reported that the food had changed only a little and another didn't observe any changes at their child care center. This may be explained by the fact that providers from a few family child care homes reported that HEAL built on work already being implemented in the county through other nutrition programs, administered by Community Child Care Council of Sonoma County. As one provider explained:

> "Honestly, we have not faced challenges and I think it is because we are smaller. We have been working with the food program which is already strict in nutrition. Probably in the early years [we] probably offered juice, but now we do not offer it. It is just water and milk. Even though the food program says it is okay, we do not. We limit ourselves to what we give to the kids like our menu and stuff."

HEALTHY EATING - CHANGES TO THE NUTRITION ENVIRONMENT

CHOICE Assessment Tool Helpful to Providers in Making Changes

Most providers reported that they implemented changes in the nutrition environment at their child care site. A few providers described changes that had been implemented as a direct result of conducting the CHOICE assessment. For example, one center director said that she created a new designated breastfeeding area after conducting the assessment and another said her staff started modeling healthy eating behavior by sitting with the children and eating the same foods:

> "One small change we made is sitting down and eating with the kids, family style. The teachers were having their own lunch and we were asking the children to 'come on, try it, try it.' We weren't modeling that. As a result, now we eat what the children are eating."

One Initiative Stakeholder reported that changes to the nutrition environment have been positive and made in child care sites in various ways including incorporating fruits and vegetables in counting or learning the alphabet, serving healthier snacks, having books on gardening, and healthy imagery on the walls:

> "When you walk into some of these sites, you can visually see that the environment has changed, regarding food and nutrition."

HEAL Provides Opportunities to Enhance Child Development

One provider said that outdoor learning, specifically garden-based learning, provided her children the opportunity to learn about nature and to refine their motor skills by using tools:

> "My God, it is amazing because they are learning to work with the little tools. They are excited when we have tomatoes. The last year, we plant tomatoes, we plant lettuce, radishes, many kinds of vegetables."

Another provider agreed and said that for children at her site, the garden offered a way to explore sensory experiences around taste and touch even among very young children:

> "We have an herb garden - we call it our edible garden. They can go and taste whatever they want, free to put it in their mouth and we can talk about the texture and the taste and still let them be a part of the gardening process."

The same provider went on to say that she and other teachers use taste tests to teach children new vocabulary related to colors and senses:

> "We talk about the colors, we let them smell them and taste them. We cut everything in front of them. We talk about the seeds. We are constantly using vocabulary about the process, is it sweet, is it tart, is it crunchy?"

A different provider echoed these comments and described how she now purchases a box of fruits and vegetables from a CSA company, which she learned about in a workshop, which she incorporates into her teaching:

> "Getting that box once a week - we open it up and the kids see what is in it. For example, we got green cauliflower. It was real fun for the kids to get it, to see it and to be able to touch it and play with it and then to eat it."

HEALTHY EATING - CHANGES IN NUTRITION POLICIES

Implementation of No-Sweets and Healthy Celebrations Policy

Most providers spoke at length about the new policies they established at their child care sites to improve the nutrition environment. Several providers reported that they had established "no candy" policies to restrict the consumption of sweets:

> "We established a no candy policy. Families always want to share, and we always get a lot of candy. As a result, we implemented a no candy policy and low sugar treats."

Other providers reported establishing additional policies, such as a healthy celebration policy and an edible garden policy. Another provider developed a food policy for her staff to reinforce healthy food behaviors and modeling for children:

> "We are creating a policy – not to discriminate what they eat or what they bring to eat at our

> program - but ways that they can avoid having that exposed to the children. Like Coca-Cola or something like that."

Parents Perspective on Nutrition Policies

Several parents also said that their child care site had established new food policies. They reported that these policies limit the consumption of certain food items at the site while also asking parents to comply with guidelines about which foods children can bring from home. All of the new policies that parents described focused on the consumption of sweets, particularly during holiday and birthday celebrations:

> "For their birthday, they say 'don't bring cakes or anything sweet.' We can provide fruit for them and they can sing Happy Birthday with the fruits, which I think is awesome."

Several other parents noted having a "no sweets" policy at their site but clarified that these were existing nutrition policies. Regardless of whether the policies were new or existing, parents indicated that they were supportive of these policies:

> "I think it's great if they don't give candy, cookies or sweet foods to the children."

ACTIVE LIVING - CHANGES IN PHYSICAL ACTIVITY PRACTICES

New Activities and Equipment Supports Physical Activity

While most providers reported changes in nutrition practices and policies, some providers also reported changes they had implemented to support physical activity at their sites. Several providers said they received supplies from the HEAL Coordinator to enrich physical activity offerings. One person said that the HEAL Coordinator had brought a rope, bean bags, and games to her site, which encouraged the children to be more active. This observation was also supported by an Initiative Stakeholder:

> "They know how to use them, and they have the activities in mind, so they can now grab it from their outdoor storage bin or pull it off a shelf and be able to do the activity. They have the materials available."

Another provider explained that she had implemented new activities such as letter yoga and Happy Feet at her center. This provider said that this change permitted children to move from high-energy active activities into slower, quieter ones like circle time:

> "One of the other things that was an inspiration was to do Happy Feet. We turn the music on and we run laps around our playground. Then we ease the transition with turning to a very soft song, so kids stretch, and they walk into circle right after that."

A few parents commented that they had noticed changes in the types of physical activities offered at their child care center by providers. These included new yoga classes and physical activity exercises, such as running and jumping:

> "They play music and they make [the children] jump, lay down, stand up. They're exercising with music; I like that because I've seen them keep the children more active like that."

Children Engaged in More Outdoor Play

Some providers also said that they were spending more time outdoors as part of their physical activity programming. One provider said that sometimes the physical activity changes required explanation to parents, who might be otherwise unfamiliar with or even concerned about these sorts of outdoor activities:

> "We're outside until dark, we're involved, we're moving, we're playing. If it's cold, we do extra moving, and dancing and it's been a whole change for our parents, especially different cultures. They don't want you in the cold. They think you get sick."

Several parents also said that their children were spending more time outside as part of the daily schedule:

> "I know recently I've been hearing my daughter talk about how they went outside, or the provider has said, 'today we went outside, today we went to the garden'; probably within the last month, I've been hearing it more often."

This change was echoed by other parents who observed that their child was more active because of having access to a garden at the child care site. One parent said that her child care provider integrated outdoor exercise into the daily schedule by walking children two blocks to the community garden site.

A Few Parents Reported Lack of Free Access to Physical Activity Programs

Some parents commented on the lack of free physical activity programs as a concern, explaining that these sorts of activities required additional fees at their child care site. Another parent commented that there seemed to be differences in physical activity programming based on the type of child care site, noting that child care centers typically have more resources and therefore more programs than family child care homes.

ACTIVE LIVING - CHANGES IN PHYSICAL ACTIVITY ENVIRONMENT

Improvements in Physical Infrastructure

For several parents, the most notable changes at their child care site were improvements in the physical infrastructure of physical activity spaces. These parents commented that their providers made the site more engaging and more conducive to physical activity:

> "They also redesigned the inside to make it more open or welcoming and more interesting. They added new play areas. I remember three years ago, it was pretty crowded."

Another parent agreed, saying that her child now has more room to play:

> "They've been making a lot of changes recently. They've restructured part of their rooms, so they have more areas for the kids to play in. Before, it was mostly outside and smaller areas. They stretched everything out, so they could have more room."

Several parents said that their child care sites added sandboxes. Another parent said that the playground had been upgraded and new outdoor wooden kitchen was built for children to play in.

Overall, while the changes to the physical activity environment were noted by providers of all types, there were more examples of changes noted by family child care home providers. This may be because they traditionally have had less access to services and resources than providers at larger centers. From the parents' perspective, however, changes were noted at both centers and family child care homes.

Outdoor Learning Enhances HEAL and AQC Activities

An Initiative Stakeholder said they help promote physical activity through outdoor classroom training, so providers learn to look at the layout of their physical environment and placements for high energy activities and slower energy movement areas.

Most providers cited ways in which they integrated new outdoor learning opportunities into their child care site. Several providers talked about the support they had received from the North Bay Children's Center, including a packet of information showing the linkages between seasonal fruits and the domains

of the Desired Results Developmental Profile (DRDP)[25]. This support allowed providers to integrate these lessons more easily into their curricula.

Some providers observed that garden-based activities allowed children and staff alike to explore life cycles and the connections between growing, harvesting, and cooking food:

> "Growing our own food - looking at the seeds then planting them with the kids. Having that seed germinate and grow, harvesting them, bring them to the table and cook them. It has been amazing, the kids really got to see the whole process and not only that, the teachers were learning from that experience, so they can do it again."

Numerous parents described the addition of outdoor learning spaces and activities at child care sites as a recent change they had noticed. Gardens were the most often cited example of outdoor learning spaces that had been integrated into child care site programing; one parent also said that the provider had initiated nature hikes at the site.

Some parents noticed the construction of new gardens at the child care site while a few others reported that the HEAL Coordinator had helped secure garden plots at nearby community gardens:

> "This is where they teach children how to plant vegetables and what vegetables are. After that, she prepares them the same thing they planted so they eat it and know what they're planting and eating."

Of the parents who talked about outdoor learning, they were largely enthusiastic about their child learning about growing food:

> "The teacher told me that now they have access to part of a garden to plant vegetables. I think the fact that they're learning how to plant is a very good thing."

A Focus on Active Living Provides Opportunities to Enhance Child Development

Several providers said they were increasingly looking for ways to incorporate physical activity into specific learning objectives. One provider said she learned to use her whole body to teach math to get the children active.

When describing changes in the nutrition and physical activity environments at their child care sites, several parents also commented on how these changes had increased learning opportunities for their children. For example, parents said the cooking lessons enhanced child learning through sensory, observation and motor skill development:

> "My provider started mixing Maseca with water and the kids were making tortillas. She cooked them, and they ate them. The kids started playing with the dough and they saw it was watery, powder at first and it becomes wet. They learn by exploring all that."

[25]Desired Results Developmental Profile (DRDP). California Department of Education. Website: https://www.desiredresults.us.

Several parents agreed that changes to the physical infrastructure at the child care site, such as increased access to play areas, had also contributed to overall improvements in the learning environment at the site:

> "Each area has a purpose. Before it used to be just play everywhere, but now it seems to have a purpose."

Another parent said the changes improved access to quiet areas for reading:

> "Before, it was really claustrophobic in a couple areas where the kids sit and read and now it's wider. She's pulled out the furniture, so they could actually have an area where they can sit and read. She's got a quiet room for the kids."

A couple of parents said that their providers were integrating new teaching tools into the child care environment, such as games and puzzles. One of these parents said that while the toys were unfamiliar to her, she was able to observe the children using them during their group play at the site:

> "My child care center started to buy new toys such as puzzles, blocks and other didactic toys kind of weird to me, but normal to them; she puts the toys on the table and several kids come together to build things."

In general, parents expressed satisfaction with and appreciation for these efforts by their providers.

ACTIVE LIVING - CHANGES IN PHYSICAL ACTIVITY POLICIES

Lack of Formal Physical Activity Policies Adopted

Adoption of physical activity policies was not described by the Initiative Stakeholders, parents, and child care providers, and was not reflected in the MC3 HEAL data matrix.

PROVIDERS - WAYS THEY ARE INVOLVED AND HAVE BENEFITED

Providers Gained Increased Knowledge about Healthy Eating, Active Living and Child Development
In general, providers felt that their participation and coaching in the AQC and HEAL programs offered them access to knowledge and skill development to which they would not otherwise have been exposed:

> "It has helped me a lot with the workshops, programs, the coaching and all of that, to change my environment completely. I have many more tools in my toolbox now to help children develop properly in the stages that they need to be in. It has mostly come from individual coaching as well as all the workshops that I've attended and all of the programs that are offered to us."

This was supported by Initiative Stakeholders who reported working with providers in various ways which is largely dependent on their individual site goals. An Initiative Stakeholder said providers benefit overall and become better teachers by gaining knowledge of child health and wellness, and being more skilled at conducting assessments:

> "Teachers are getting more adept at doing their assessments and seeing where children are on the developmental scale, they're able to better plan their activities and curriculum around what benefits the child."

For HEAL, providers attend various classes at MC3, learn about garden education, receive site visits for tailored coaching, have access to a lending library of resources, and have an option of participating in a HEAL Champions program:

> "We have a HEAL Champions program, which individual teachers get enrolled. They get coaching in a group. The HEAL Champions program is another way that providers are participating in HEAL."

Providers spoke about feeling better equipped to support children's development not only from a learning perspective, but also from the vantage point of nutritional and physical well-being:

> "Now especially that the HEAL coordinator is with me, I feel free to say to the parents, 'we have a teacher in my daycare, to teach me how to eat more healthy.' She taught me how much we need to exercise with the kids."

Supported by MC3 staff, providers also said that they felt more able to discern which learning and physical investments to make in their sites, thereby saving money and improving the learning environment at their site. One provider described her experience working alongside the AQC and HEAL Coordinators:

> "It has helped because they clarified what material is worth having and what material is appropriate for children and is successful for children. They can learn and have fun and not be bored."

Providers Gained Increased Confidence in their Ability to Make Changes at their Child Care Sites
Most providers reported that they felt more confident because of their participation in the two initiatives. Providers attributed their increase in confidence to strong relationships with dedicated MC3 staff members and their one-on-one coaching. Multiple providers commented on the support they received from MC3 staff, especially the AQC and HEAL Coordinator, and the trust that these relationships engendered.

They have increased confidence to identify and implement changes to the nutrition, physical activity, and learning environments as well as to articulate the rationale for these changes to their colleagues:

> "I was so comfortable to open up and utilize my own voice and staff's voice. It was just real confidence [MC3] gave us."

One provider said that after participating in the HEAL program, she was incorporating more healthy foods in her own home:

> "It also inspired me, as a mom. Now we grow our own fruits and now we are at the store and we try to do the seasonal vegetables which I had no clue about."

Providers Participate in Varying Ways
One Initiative Stakeholder talked about a monthly family child care home provider group that has met consistently over the last two years which also served as a support group. They discuss different policies, gather ideas about future trainings, ways to complete the observations of children and the DRDP, and bring in speakers:

> "We actually brought in a national speaker to talk about policies and handbooks and business practices for providers to give them that support, encouragement and confidence."

Another Initiative Stakeholder talked about supporting providers' participation in PITC - Program for Infant and Toddler Care, where providers get in-depth training on early childhood education and receive college credit.

Initiative Stakeholders recommended that future support for providers could include training on administering the DRDP and learning about strategic ways to engage and outreach to parents.

The CHOICE Assessment Tool Helps Providers Identify Opportunities to Make Improvements
Most providers reported that the CHOICE assessment tool helped them assess and improve the nutrition and physical activity environment at their child care sites; they did not note challenges or limitations with the tool. Providers spoke about the usefulness of the CHOICE tool, saying it created a structured opportunity for providers and staff to accurately assess current activities and develop an action plan to guide future work. The CHOICE tool also helped foster a shared understanding about future goals for improvement among child care center leadership and staff:

> "We did the assessment together and we all got on the same page with the same support and the same goals. Once we all had the same expectations, it just improved our center throughout with this assessment."

The same provider went on to say that the tool helped her communicate with parents because she was able to refer back to the assessment and demonstrate to parents the changes that the center had made. Another provider echoed this comment, saying that the CHOICE tool helped her understand how to better communicate with parents:

> "For me, it has helped because there were some things that we were not doing right yet with the parents. For instance, sharing information with them more than just posting the menu. Now we are providing a harvest of the month newsletter and we are learning. We are educating our parents as well. That has really helped us to plan and educate."

Another provider said she appreciated the tool because it helped her recognize her existing competencies while simultaneously identifying potential areas for future improvement:

> "It also helped me to look at the things that I was already doing. I did not even realize here is where I am at, and those are the next steps that I want to go forward and accomplish."

These findings were supported by an Initiative Stakeholder who also reported that the CHOICE assessment tool was a good way to create a conversation for providers in setting goals for their site.

MC3's Coaching and Technical Assistance is Critical to Provider's Success

Providers attributed their increased knowledge and confidence in large part to the support and resources from MC3's AQC and HEAL Coordinator. One provider said that the individualized coaching inspired her to set aside time to think creatively about what she could do to strengthen her program:

> "There's always so much out there and we end up caught up in our days with our kids. It made a big impact and difference for me and 'what else can I do? What else can I be involved in? What else can I bring into my center, my kids and my families?'"

Another provider, speaking about the difficulty she encountered in making changes at a childcare site embedded within a larger organization, said that she felt supported by the HEAL Coordinator in proposing new ideas to the center's leadership:

> "When she came in, I had all these ideas on the back burner, and she just inspired me, gave me the confidence, gave me the resources. She was my backbone to present it all."

Other providers reported specific resources that they had received for HEAL activities, which allowed them to implement changes in nutrition and physical activity programs at their site:

> "It was wonderful to have her because she will suggest an activity and she'll bring everything that you need to foresee that activity, which is great."

Two providers reported using or planned to use the lending library and mini-grants to continue implementing improvements at their child care sites.

Providers are Grateful for the Stipends and Welcome Continued Support

All providers expressed gratitude for the stipends they received from MC3 and several described how they had used the stipend to make improvements at their child care site. They reported making physical improvements to their child care space so that it was better suited to children's learning, including repainting and buying furniture:

> "The stipend helped me change my environment to better fit the quality of care that we should be giving the children. I used my stipend money to paint the entire interior and change things around to where instead of it being an open floor plan, it's more of an intentional learning space. Being able to buy bookshelves and paint the walls and things like that, to help improve the quality of the care that I'm giving the children."

The same provider said that the stipend was not the main reason for joining the program. Rather, it was about the education that she received:

> "The reason why I took it was because I wanted to give a higher quality of care. I needed the education and the support that the programs offered. The stipends were just a benefit, were just a plus."

There was broad agreement within the group for this sentiment. One family child care home provider said that with this support, she finally felt like a teacher. Another observed that the stipend represented her investment in her center:

> "I think the stipends for me was something that I could use to reflect what I've been learning."

Providers were concerned that at the program's completion, they would no longer have access to stipends and other resources from MC3. One provider said she was looking for a long-term investment in her site because in her opinion, that's what this type of work requires:

> "Continued support is what we are looking for. We are looking for programs that are going to be long and sustainable. That's what personally I'm looking for - a program that will sustain and help me improve my place to a comfortable level to give better quality care."

FAMILIES AND CHILDREN - WAYS THEY ARE INVOLVED AND HAVE BENEFITED

Parents are Involved in HEAL and AQC in a Variety of Ways

There was wide variation in the degree to which parents were involved in HEAL and AQC activities at child care sites. Several parents reported that they attend special events and volunteered at the child care. For example, they assisted with cleaning at the site and cutting the grass.

Other parents felt their providers engaged them in their HEAL work informally through ongoing communication:

> "Maybe we're not sitting down and making policy changes, but through talking and communicating. She's always trying to improve things. I feel that she listens. Not directly, but indirectly I feel that we do participate in changes."

A few others said they were often too busy to help at the child care site directly beyond normal pick up and drop off times, given their job obligations.

However, numerous parents emphasized working closely with their provider on issues related to child development as identified by the Ages and Stages Questionnaire.

Providers are Engaging Parents in HEAL Activities at Child Care Sites

Most providers explained that the HEAL program had given them new tools for increasing parent engagement overall. One provider from a family child care center said that parent engagement had improved since her site's participation in the HEAL program because she used visits from the HEAL Coordinator as an occasion to invite parents into the classroom:

> "Our parents were never involved until HEAL came. What actually opened that window for parents to participate and come into the classroom and work with the children."

Another provider from a child care center said that she was collaborating with the HEAL Coordinator to increase parent awareness about the HEAL program:

> "We scheduled a day in the garden - an hour that the parents will be involved in cooking activities and physical activity games with the kids. I think this is going to be a huge part of involving parents and getting them to know more about the program."

In addition to hosting special events like the one described above, the same provider reported that she was also now encouraging parents to bring recipes from home and come in to cook with their child at the center.

Recognizing that some parents have limited time, another provider said she was scheduling introductions to MC3 staff during pick up and drop off times:

> "When the children are picked up at pick up time, the AQC or HEAL Coordinator would be there to just talk to the parents. It's not a formal meeting, just to catch the parents and to introduce themselves."

A provider said that she was more intentional about designing workshops in response to parents' questions and requests. For example, upon hearing that parents were taking their children to McDonalds because they were picky eaters, she organized a workshop with the HEAL Coordinator about cooking for children with strong food preferences:

> "Our parents are saying 'we go to McDonald's because our children are picky eaters.' We did a healthy eating workshop, we did healthy eating on a budget, we had a healthy eating potluck with her."

The same provider also described sharing updates with parents by sending materials home and including pictures and recipes so that parents could continue implementing healthy eating practices at home:

> "Since HEAL, we created a resource center with information that we send home to the parents. We're sending pictures or recipes and the Smoothie of the Week. "

From providers' perspectives, parents also benefit by having increased knowledge about child health and wellness:

> "I think that they've gained more knowledge around the importance of health and nutrition, especially when it comes to their children, understanding that child nutrition is really pivotal, not only in brain growth and development, but also the child's long-term health."

Children are More Willing to Try and Accept New Foods

Providers noted changes in children's attitudes towards healthy foods. One provider observed that after tasting and cooking workshops, she noticed that children were more curious and willing to try new vegetables:

> "It just opened curiosity for the kids into trying things. Now our children are eating more vegetables, cooked or uncooked. It is really amazing. They even tell the parents, 'we are not going to eat that, this is better, healthier.' They are using vocabulary too with the parents."

Many parents corroborated this observation, noting positive changes in their child's willingness to try new foods. Most also observed an increased acceptance of healthy foods. For example, numerous parents reported that their child was more willing to ask for fruits and vegetables.

Another parent said their child uses vocabulary that he learned at the child care site when they go grocery shopping, such as "Go Food" and "Slow Food" to signal which foods are healthy and which foods should be avoided.

Several parents credited these changes to the healthy eating and cooking lessons offered by the HEAL Coordinator, which encouraged children to try new foods in a group setting:

> "On Fridays, they cook foods. [My son] has to eat with the kids at the daycare and that's the only way he'll try things. If he likes it and sees it with us, he'll try it again, but trying new foods with us, he doesn't do it. Having other kids, seeing it, trying it and then he'll try it."

Parents also commented on their child's increased enthusiasm for and pride in contributing to the cooking process at home:

> "A sense of pride, like, "Mom, we cooked this together and it tastes good. What are we going to do next time?"

Changes at Child Care Sites Influence Parent Attitudes and Behaviors about Nutrition at Home

Overall, parents reported numerous examples of changes in their own attitudes and behaviors related to nutrition and healthy eating at home. Several parents said they had received support from child care providers with ideas for trying new healthy foods at home, especially for children who are picky eaters:

> "[My provider] tells me, 'today, she ate cauliflower,' and I'm like, 'I didn't know she liked that.' She'll cook it differently and she'll let me know. It gives me ideas."

Multiple parents also described changes in their food purchasing choices in response to changes in their child's eating preferences. They agreed that they were trying to incorporate more vegetables in their family's diet:

> "My children didn't like broccoli before and now they love it. Now I have to cook it every day. I always have to keep a bag of broccoli at home because they love it. The youngest one loves it the most."

Several parents said that they now involve their child in cooking at home. This change was attributed to a combination of new knowledge and tools from MC3 and their child's own desire to be more involved. Parents specifically appreciated the child-safe knives provided by MC3, which allowed them to more easily integrate their child into the cooking process:

> "I used to say, 'don't even let him get close to the kitchen because apart from making a mess, he's going to get burned or cut.' But I thought that once a week I would try to be patient and give him space, so he can do what he can. I try to let him cut, mix the foods, see how they're prepared. Now he tells me, 'Mami, thank you for cooking with me.' He likes it."

Another parent said that the child-safe knives allowed her to work on mobility and dexterity skills with her child at home which created additional opportunities to enhance child development and learning:

> "We got these safety knives from here. We had him practicing controlling a knife, and sizing and going over the different sizes and the colors and the shapes."

Initiative Stakeholders also reported parents are positively changing practices in the home where they are prioritizing cooking together with their children. As described by one parent:

> "My husband went to the class and now, he's cooking with my daughter on weekends. It's so great to have your dad cooking with you and build upon your vocabulary and your gross motor skills and social development, all these things he learned. Now, he sees the importance around that. He's actually making time on the weekends, not to just let her watch TV as he makes breakfast."

Changes Related to Physical Activity

In general, there were fewer comments about changes in children's level of physical activity than nutrition, but among those that were made, parents generally reported that children were more active:

> "My son wouldn't really move. Once he started at the new center he improved so much. He's all over the place. He likes being outside."

Another parent observed that her provider was encouraging children to run, do sit-ups and jump more and that her provider added music as part of these physical activity sessions. Another parent, however, said that most of the physical activity opportunities were tailored towards older children and that there needed to be more options for younger, toddler-aged children.

One parent said she had shifted their attitudes and behaviors related to physical activity, reporting that she no longer allowed as much tablet time at home in the evenings.

ASQ Increases Parent Knowledge of and Engagement in Child Development

As previously noted, MC3 staff provided 69 family needs assessments, guided parents through 54 self-administered child development assessments (ASQ) and conducted 21 workshops to help parents create specific goals for their family (Table 8).

Parents generally appreciated the ASQ, especially because it fostered collaboration with providers:

> "I was talking to his teacher and she offered to help fill it out with me. That was really supportive."

Multiple parents reported that the ASQ tool helped them both engage with their child's learning at the child care site as well as identify opportunities to continue these activities at home:

> "It just puts a note in your mind that, "yes, I need more feedback from the child care. Are they doing these things and how is my daughter participating? Maybe I should do the same thing at home whenever I have time." Yes, it just opens up more ideas."

Several parents also said that the ASQ helped them identify developmental delays in their children:

> "After doing this, that's when I realized I have to accept it, my daughter has a delay. Then I went and talked to her doctor and she started receiving therapy. I think if you understand what it's meant for, it's very helpful."

Other parents felt that the tool was not accurate or detailed enough to be useful. They thought it sometimes contributed to unnecessary worry about the child's development trajectory:

> "My experience with the Ages and Stages is, I kind of like it, but I think the missing component is to let us know it's not meant to diagnose anything. It's literally a screening tool and it's not the end all be all kind of thing."

An Initiative Stakeholder supported these comments, saying that parents now appreciate the value of the ASQ appear less concerned about their children being labeled once they are able to complete the assessment and get the services their child needs.

Parents Gained Knowledge about Quality Child Care

Initiative Stakeholders reported their perception that parents benefit by knowing how to select a high-quality child care setting and having peace of mind by knowing that their child is in a safe and nurturing environment:

> "Parents are leaving more confident that they've chosen the right place. They feel comfortable leaving their child. They know that their child is getting the best care possible."

Parents echoed these comments, saying they felt more informed and had learned more about what developmental activities their children should be engaged in both at child care and at home. Several parents expressed appreciation for the support and oversight of the AQC Coordinator who had helped to make improvements at their child care sites. Another parent said that the emphasis on access to quality care had encouraged him to pay more attention as a parent.

KEY FACTORS IN THE IMPLEMENTATION OF BOTH INITIATIVES

MC3's Organizational Capacity and Effectiveness

MC3 has led both AQC and HEAL Initiatives upon their inception, working closely with its partners and MCF. Over time, MC3 has strengthened their capacity to do this work. A foundational change described by Initiative Stakeholders was the adoption of MC3's internal board-approved health and wellness policy that demonstrated to the community that they were embracing a culture of health:

> "It was a priority - we had to be doing it internally. When we're out in the community we have a different attitude towards it. It's not just, "Whatever, HEAL." It's, 'Yes, we've implemented these changes within our own agency to support this work.'"

Initiative Stakeholders also reported a noticeable shift in the perspective of MC3 regarding the alignment of HEAL with AQC as "two sides of the same coin." It was felt that the likelihood of the initiatives' success and continuity is dependent on the level in which it is embedded and integrated into the ongoing operations of MC3. In this regard, staffing decisions are more likely to be made in consideration of the skills sets needed to carry out this work. The addition of a new staff member with Spanish language capacity who is also versed in both early childhood education and healthy eating active living principles demonstrates the commitment and prioritization from MC3 to successfully carry out this work.

Two areas that were recognized as areas that need to be elevated and further developed in the coming year were fundraising and communication.

Buy-In and Trust from Providers is Important in Making Changes

An Initiative Stakeholder reported that changes have been based largely on the amount of buy-in they develop with the provider, rather than by provider type:

> "They're all very different, and it really is based on those providers that I'm working with and how much buy-in I've been able to get from them from our work together."

Building trust with the provider is key in being successful in working with them to make changes to the nutrition and physical activity environment, since it can take time for them to "see the value and they see that it's doable for them," as one Initiative Stakeholder observed.

An Initiative Stakeholder described the foundation and model in which the two initiatives were designed as a key strength of this work, which combines subsidized child care with partnerships with providers and parents to engage in quality improvement:

> "What is successful in my mind is having the slots be an incentive and there is also a directive participating in parent engagement and education. For a provider, if a child is being enrolled at their site, the agreement is to participate in the quality improvement effort. In that aspect, it's been really successful."

Several other strengths of the two initiatives were described by the Initiative Stakeholders. One noted

earlier was the dedication and passion from key leadership as well as strong partnership and collaboration among staff that are implementing the work. Other noted strengths include:

- Training for providers is important, but the one-on-one coaching has been key.
- AQC and HEAL are increasing the quality of child care, which may promote equity among sites.
- The initiatives are bringing parents together and strengthening their social support system.

There is overall agreement that the initiatives are making an impact on families and children:

> "… our community, our people, are doing better because of these initiatives."

Lessons Learned from the Implementation

When asked about ways in which Initiative Stakeholders would implement the two initiatives differently, one stakeholder talked about the need to identify and formalize partnerships with key partners, i.e., workforce development partners at the start of the roll out.

Other lessons learned include the need to be clearer about the types of program and participant data to collect, and to hire Spanish language staff sooner. Also due to challenges in implementing the initiatives in multi-service sites, Initiative Stakeholders noted that it may have been better to focus on sites that only provided child care.

In hindsight, one Initiative Stakeholder talked about the inclusion of children 4 - 5 years of age:

> "I was far too optimistic in Strong Start passing. Because it didn't pass and there wasn't preschool for all, there were four-year-olds that would go off a cliff once aging out of AQC. I would have intentionally built in the four-year-olds for transition from AQC to either pre-K or other opportunities at four and five years old."

CHALLENGES

Degree of Parent Engagement Is Varied and Requires Greater Definitional Clarity

Parent engagement is an important component of the AQC and HEAL work. While parents, providers, and Initiative Stakeholders alike offered a variety of examples of ways parent are engaged, findings suggest the need for further clarity among the different stakeholders about what parent engagement means and how it can be measured.

Defining parent engagement is particularly important, given the fact that for many low-income families and particularly, single head of households, time is a valuable resource and engagement at the child care site may be outweighed by other competing demands, such as work. Indeed, several parents, when asked to provide examples of their involvement at child care sites, said they have to quickly drop off their child before work which limits their ability to observe, volunteer, or otherwise work with the provider at the child care site. Furthermore, their time is often also limited during pick up when they need to get home to attend to personal commitments. Despite these constraints, parents spoke about their desire to integrate learnings from the ASQ and implementing nutrition changes at home, signaling their interest and ability to stay engaged at home.

Thus, it may be useful to continue providing parents with similar learning tools and equipment as those shared with providers, so they can use the same resources with their children at home. Another suggestion from an Initiative Stakeholder was the need to work more intently with the providers in teaching them both the value of and techniques to engage parents:

> "It is going to take the provider's understanding about why it's important to involve parents in the HEAL effort. Are they going to tell the parents about what's going on with HEAL? Are they going to send out those nutrition recipes that I give them? I'm really seeing that it's going to take the engagement of the providers to help engage the parents more."

Another Initiative Stakeholder said that as providers grow more skilled and confident in conducting the DRDP, providers will be initiating parent/teacher conferences, which may be a good strategy for engaging the parents in their child's development.

Parent Communication about HEAL Changes Varies by Provider

Parents reported learning about changes at their child care site in varying ways. Multiple parents said they often observed changes at the child care site themselves or were notified informally by providers during pick up and drop off times. Other parents said they learned about changes through newsletters, emails, posted menus, and parent meetings:

> "You could see the schedule on the board when you walk in. She has everything, like, 'playtime is at this time, sleep time, what they're going to eat that day.' It's always different because she's part of the HEAL program, I think."

However, other parents expressed concern about not being in closer communication with their provider about the type of snacks being served and other changes, including visits by MC3 staff:

> "Regarding children's food and nutrition, can providers let us know when the HEAL Coordinator is coming? Because the truth is they're not giving us information."

Providers Expressed the Need for More Spanish Language Support

While providers were grateful for MC3 support and resources, many of them voiced concern that providers who did not understand English were not able to adequately access and comprehend MC3 coaching and resources, especially in a workshop or individualized coaching session:

> "My teacher's primary language is Spanish. Not all of them have the ability, they understand some English but having coaching or support in their home language would make a huge difference."

Furthermore, several providers were concerned that poor translation of MC3 written materials might impede successful outreach and education to non-English speaking parents.

One provider offered another perspective and found that translation services at parent workshops often slowed the process down, frustrating parents:

> "When some people go to workshops, we lose them because the process gets slowed down because they have to stop and re-explain and answer questions and try to understand."

She suggested offering English-speaking and Spanish-speaking parent workshops for ease of communication between MC3 workshop presenters and parent participants.

Providers Desire More Communication Regarding Program Changes

Some providers said that staffing changes at MC3 were not always communicated with them. In particular, they described confusion about the addition of the newest member to the HEAL team. One provider felt that her program lost momentum and focus due to this staff change. Providers and their staff had to adjust to a new MC3 staff person's orientation and work style:

> "If you're going to swap out, you need to catch them up where we are, so it's continued, to not lose it. It lost some of our staff's interest and respect a little bit for the program when all our work, our goals all of a sudden shifted. It just went. The new staff person has a whole different perspective and a different opinion on things."

Providers Suggest More Collaboration with other Agencies for Workshops and Trainings

Many providers said they found it challenging to attend all the workshops and trainings at MC3 given both their personal obligations as well as competing demands from other agencies they work with in the county:

> "That's my main issue right now. I'm a full-time student at college. I've been missing a lot of the workshops."

This provider suggested that agencies work together to avoid scheduling conflicts, but also recommended offering more dates for workshops and trainings. There was general agreement among

providers that this would improve a sense of integration, especially between MC3 and Marin Quality Counts/MCOE.

Continued Need to Strengthen Key Partnerships

The need to deepen and streamline partnerships with safety net organizations and workforce training as well as health anchor institutions[26] was described as important, given the social and economic self-sufficiency goals of AQC and health-related goals of HEAL. It was recommended that other important strategic partners such as the College of Marin and Health and Human Services needs to be engaged in this work.

[26]Health anchor institutions refer to local public entities with a mandate to protect and promote the public's health (e.g., local health department). The work and focus of these institutions is on broad social determinants of health that align with the initiative's goals.

SUMMARY OF FINDINGS

Across all AQC and HEAL stakeholders - initiative funders (MCF) and implementing agency (MC3), providers, and parents - there is evidence that both initiatives are progressing towards their respective goals and are having a positive impact on moving parents towards social and economic self-sufficiency, building the capacity of providers to implement HEAL practices and policies as part of their quality improvement work, and creating child care environments that engage children and families in healthy eating and increased physical activity. Based on the findings, there are also particular areas that warrant more attention to help strengthen and advance the work of AQC and HEAL. The findings are summarized by the ways in which child care providers, parents, and children benefit from the initiatives, and identified successes across both initiatives.

Ways Child Care Providers Benefit

- **Providers are building their knowledge and capacity for quality improvement, healthy eating, and physical activity** and leveraging these new skills on behalf of their child care environment and programming. Providers are receiving easily accessible tools and much needed resources to support improvements. Individualized and tailored coaching is key in supporting providers to operationalize changes.
- **Providers are becoming more adept at using well-established child care assessment tools** (ASQ, DRDP, and CHOICE) and integrating these tools and the results into their learning about early childhood education. In particular, the CHOICE assessment tool helps providers to identify opportunities to make improvements in nutrition and physical activity practices and policies at their child care site and provides a starting point for staff training and parent education.
- **HEAL changes are observed in child care sites:**
    - **Nutrition practices and policies are being implemented.** Healthier foods are being served at child care sites and staff are modeling healthy eating practices.
    - **Physical activity practices are being implemented**. While most reported changes were in nutrition practices and policies, physical activity has also changed in some sites. Most noted increases in activity space and outdoor learning activities.
- **Parents are more engaged in their child's development and in their child care programs.** It is anticipated that more engaged parents will support and elevate the work of the child care provider and help to ensure that household practices complement and reinforce the quality and healthy eating and physical activity improvements in the child care setting.

Ways Parents and Children Benefit

- **Children have greater access to healthy foods and healthier eating practices**. More fruits and vegetables are being offered to children and some children are asking for healthy food at home.
- **Parents are more knowledgeable about social service resources**, such as housing, immigration services, financial planning, and educational opportunities for their children. Coaching and one-on-one support for families have been key in navigating community agencies.

- **Parents benefit from the subsidy for child care**, which provides the opportunity to engage in employment opportunities that may augment their family finances. While preliminary, the observed increase in reported income provides promising evidence of AQC's impact.
- **Parents gained advocacy skills through Parent Voices**. Building advocacy skills is key to the broader equity efforts and sustained action for Marin families. Their participation in this group has also strengthened their social support system.
- **Parents are more engaged and knowledgeable about the value of child development.** The ASQ and DRDP tools were instrumental in helping parents understand the value of assessing their child's development and seeking out resources for their child depending on the child's unique needs. As a result of the ASQ, children have been appropriately identified and referred to the Golden Gate Regional Center for further developmental evaluation. These tools also facilitated communication between the parent and provider.

Successes Across Both AQC and HEAL Initiatives

- **HEAL integrates well with the AQC work and enhances child development**. Maintaining strong communication between the HEAL and AQC staff will strengthen the collaboration between the two initiatives.
- **Dedication and passion from key leadership** as well as strong partnership and collaboration among implementing staff is essential to the success of this work.
- **Provider stipends and mini grants were influential** in making improvements at child care providers' site.
- **AQC and HEAL are increasing the quality of child care**, which may reduce inequity in quality among child care sites in Marin County.

KEY RECOMMENDATIONS

Based on the evaluation findings, several recommendations have emerged, which focus on three broad areas: 1) the implementation and/or operations of the AQC/HEAL program, 2) child care providers, and 3) program sustainability. These recommendations are intended to provide MCF and MC3 with constructive information to advance the work of both programs.

Implementation and Operations of the AQC/HEAL Initiative

Present AQC and HEAL to New Participants as One Program

- While integration of HEAL into the AQC sites was successful and contributed to quality improvement, it may be advantageous to present AQC and HEAL as one program to the next cohort of providers. Continuing to refer to AQC and HEAL as two separate initiatives or HEAL as a voluntary program may prevent seamless alignment and true integration.
- Ensure all implementing staff have knowledge of early care and education principles to strengthen the collaboration between both initiatives. As each staff holds specific skills and

expertise within their respective roles, meeting often to collaborate and strategize will reinforce the coordinated efforts of both initiatives.

Meet the Cultural and Social Needs of Parents

- Given the high proportion of AQC parents that are Latino and primarily use Spanish language in the home, consider future staffing to increase not only Spanish language capacity, but also cultural humility. Since building a trusting relationship and buy-in with providers and parents is key to this work, having a strong cultural connection is important.
- Since a good proportion of AQC parents are single female-headed households, consider additional targeted resources for these parents who often face more challenges compared to two-parent homes. Suggestions include self-care type workshops and creating or building upon a social support network, as well as considering their specific needs particularly related to scheduling workshops and expectations regarding parent engagement.

Provide More Support for Parents Economic and Educational Development

- Findings indicate a low proportion of parents are participating in ESL and workforce training and over a third of parents do not have a high school diploma. Offer more workshops and support to help parents identify and utilize social support resources in these areas.

Further Examine the Environmental Rating Score Improvement Discrepancy Between Centers and Family Child Care Homes

- While both settings show improvement, greater improvement in environmental rating scores were observed in centers compared to family child care homes. Further examination of the two subscale scores is recommended to identify which component of quality care (variation in physical environment, basic care, curriculum, interaction, schedule and program structure, and/or parent and staff education) contributed to the observed difference. This analysis will help to identify which of these components of quality care may require additional support to address the improvement discrepancy observed between centers and homes.

Child Care Providers

Tailor Strategies to Support Providers to Make Nutrition and Physical Activity Changes

- Since implementing changes may differ for family home and center providers, develop strategies that are unique to each provider's situation. For example, more effort may be needed to gain center leadership buy-in early on while less is needed to engage family home providers.
- More work is needed to help providers implement and monitor formal physical activity policies in their child care programs. The use of physical activity subscales scores from Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC)[27] and a modified version of the Environment Policy Assessment and Observation (EPAO)[28] tool to assess changes before and after program intervention for participating centers and homes can help monitor changes in

[27]Ammerman A, Ward DS, Benjamin SE, Ball SC, Sommers J, Malloy M, Dodds J. An intervention to promote healthy weight: Nutrition and Physical Activity Self-assessment for Child Care (NAP SACC) theory and design. Prev Chronic Dis (serial online). 2007;4(3). For tool, go to https://gonapsacc.org.

[28]Ward D, Hales D, Haverly K, Marks J, Benjamin S, Ball S, et al. An instrument to assess the obesogenic environment of child care centers. Am J Health Behav. 2008;32(4):380–6. For tool, go to: http://chwr.web.unc.edu/resources.

elements of the physical environment and child-provider interactions that would be relevant for this age group (e.g., portable play equipment is varied and accommodate all children, minutes of tummy time, providers encourage toddlers to be active).

- Help and encourage providers to strengthen their communication with parents about changes at child care sites, with specific attention to physical activity changes which may be harder for parents to observe first-hand.

Continue to Work with Providers to Build Their Capacity to Administer the Assessment Tools

- The ASQ, DRDP and CHOICE tools are key to supporting the AQC and HEAL work and have been instrumental in building alliance between providers and parents on ways to support their child's development and improve their child care environments. Continue to work with providers to build their competency in administering these tools and strategizing with parents to operationalize the results.

Continue to Invest in the Time Needed to Gain Trust from Providers

- Building trust with the provider was identified as being key to successfully work with them to make changes to the nutrition and physical activity environment. Invest in the time and resources needed to develop trusting partnerships with providers.

Program Sustainability

Continue to Engage Parents and Develop their Leadership for Social and Health Equity

- There is a need to develop a comprehensive and clear definition of parent engagement in partnership with the funding partners and implementation staff. Defining parent engagement will then help to identify and strengthen strategies to engage parents in this work. It will also help to understand ways to measure and monitor this component of the program which is important for sustainability.
- The success of Parent Voices demonstrates the value and viability of building advocacy skills for parents. Consider continuing to build parent leadership to advocate for social and health equity that will impact the lives of families beyond AQC.

Strengthen Key Partnerships

- Develop and foster partnerships with organizations that are aligned with the AQC/HEAL work, such as safety net organizations, workforce development agencies, College of Marin and the Marin County Department of Health and Human Services.
- Given the complex nature of poverty and workforce development, consider partners from these fields and other social service networks.

Engage in Continuous Quality Improvement to Ensure Program Fidelity

- While the current evaluation helped to assess progress towards the goals of AQC/HEAL, future evaluation can examine other fidelity components in greater depth, such as adherence to the planned intervention, dosage of intervention received by participants, quality of delivery, participant responsiveness, and/or program differentiation.

- Revisit logic model periodically and update as needed (since strategies may change overtime) to ensure that program strategies are being implemented as planned and continuing to serve the target populations' needs, particularly in underserved geographies in Marin County.

Seek Continued Funding

- Providers expressed concern for continued access to stipends and other resources from MC3 which were instrumental in making positive changes. Increased financial investment in the AQC/HEAL Initiatives is key to supporting increased quality child care slots, continued quality improvement and parent engagement efforts.
- Continue to align efforts with the County of Marin, funders, Marin Strong Start ballot initiative, and build grassroots support through Parent Voices for future funding.

Share the AQC/HEAL Model and Learnings with the Broader Field

- Share the quality improvement and HEAL learnings with the broader early child care and education field, both researchers and practitioners, to keep the field moving in the right direction. The findings and recommendations may also be useful to other jurisdictions seeking to implement similar quality improvement strategies and HEAL work in early care and education settings.

LIMITATIONS

This evaluation is not without limitations. First, the design, while multi-method, is pre-experimental, and thus the ability to make accurate causal inferences about the Initiatives' impacts are limited. A quasi-experimental or experimental design with a comparison group examining the evaluation questions could lead to stronger causal conclusions. Second, though the Initiatives have reached a good number of their target audience, the number of participants with reported quantitative program data limits the ability to use sophisticated statistical methodologies and thus examine complex relationships between areas of interest. Future evaluation will benefit from the use of a larger sample of Initiative participants. Finally, the report findings are limited to the Marin County community and may not be generalizable to other settings.

CONCLUSION

The evaluation findings demonstrate that both the AQC and HEAL Initiatives are being implemented as planned and are making an impact on providers, families, and children. AQC/HEAL is well positioned for success as demonstrated by the deep dedication of key leadership and their partners, as well as strong commitment by implementing staff.

Findings also show that there is room for improvement, as described in the recommendations section. While there is evidence and best-practice guidelines for implementing interventions such as AQC and HEAL in child care settings, it is important to note that children and families will not benefit from these initiatives if they do not continue to be implemented with high fidelity. Therefore, revisiting the logic model from time to time will be important to ensure implementation goals, strategies, and outcomes are in alignment.

While there are only a handful of interventions that combine quality and healthy eating and physical activity improvement in early child care settings, there are notable exceptions, such as YoungStar[29], which offer several similarities from which AQC/HEAL could glean insights.

Supporting families to increase their social and economic self-sufficiency is complex and requires a long-term solution. Future evaluation could include other important measures of social and psychological experiences of economic hardship such as short and long-term stress which may provide a clearer picture of movement towards self-sufficiency. Focusing on absolute economic measures alone may not fully capture program effects nor change as readily as daily stressors associated with living in poverty. The notable increase in parental income is in line with studies that show that providing better access to and lowering the cost of high-quality child care can significantly increase incomes[30]. As the relationship between English language proficiency and economic mobility may be related to income, AQC/HEAL is uniquely positioned to provide parents with tailored support in accessing ESL and workforce training as well as support parents in obtaining their GED, which are all key components in economic mobility.

The lack of emphasis on physical activity policies was a notable finding, which may be challenging for this particular age group. There is a paucity of intervention studies in centers and family child care homes that have examined changes in physical activity policies, practices, and environments among infants and toddlers; however, one center-based study[31] among infants and toddlers showed improvement in physical activity over time which can be a useful reference for future work to strengthen programmatic efforts in this area.

Funding is a vital element when it comes to sustainability. Funding for staff and programs to implement this work is important, and now more than ever, there is a need to cultivate broad-based policy and advocacy in support of sustained funding for quality child care. The willingness to continue to fund these initiatives will need to come from multiple sources, including the private sector and government. The justification for such funding often arises when parents and the community demand higher quality and the private sector and politicians understand and accept that quality care makes a difference in child outcomes. In this regard, the value of the policy and advocacy efforts via Parent Voices to advocate for continued funding is underscored. Accurate and on-going initiative monitoring and assessment and QRIS data-driven decision making will provide needed information for policymakers and funders to support the work.

From a health equity standpoint, the positive impact that AQC and HEAL is having on families living in poverty cannot be understated. Children living in poverty deserve to be nurtured in child care environments that support their developmental growth and health, which can help them break the cycle of poverty

Evaluations of AQC and HEAL have been conducted separately over the last two years that have demonstrated strengths in both program fidelity as well as impact. This current evaluation showed that HEAL enhances and

[29]YoungStar is a quality rating and improvement system of Wisconsin's Department of Children and Families. http://dcf.wisconsin.gov/youngstar/program.htm.
[30]Karoly LA, et al. 1998. Investing in Our Children: What we Know and Don't Know About the Costs and Benefits of Early Childhood Interventions. Rand Corporation.
[31]Preventing obesity in infants and toddlers in child care: Results from a pilot randomized controlled trial. Sara E Benjamin Neelon, Elsie M Taveras, Truls Ostbye, and Matthew W Gillman. Matern Child Health J. 2014 Jul; 18(5): 1246-1257.

integrates well with the quality improvement work of AQC. Findings from this evaluation demonstrates that children are benefiting from environments that support healthy eating and physical activity as well as educational opportunities that is enhancing their developmental growth. The evaluation also finds that parents are gaining new knowledge and applying new practices at home. From a health equity standpoint, the positive impact that AQC and HEAL is having on families living in poverty cannot be understated. Children living in poverty deserve to be nurtured in child care environments that support their developmental growth and health, which can help them break the cycle of poverty.

APPENDIX A

Table I. Demographics of Access to Quality Child Care Focus Group Parents (N=21) in Marin County, CA, 2018

Characteristic	N	Mean %*
Focus Group Language		
Spanish	11	52%
English	10	48%
Age		
18 to 30 years	9	43%
31 to 50 years	12	57%
Gender		
Male	3	14%
Female	18	86%
Race		
American Indian or Alaska Native	2	10%
Other Pacific Islander	1	5%
White/Caucasian	10	48%
Latino/Hispanic	7	33%
North African	1	5%
Hispanic Ethnicity		
No	8	38%
Yes, Mexican, Mexican American or Chicano	7	33%
Yes, another Hispanic Latino or Spanish origin	6	29%
Education		
8th grade or less	4	19%
9^{th} to 12^{th} grade, no diploma	4	19%
High school graduate/GED certificate	2	10%
Some college credits, but no degree	8	38%
Associate degree (AA, AS) or technical training	0	0%
Bachelor's degree (BA, BS, AB)	2	10%
Graduate or Professional degree	1	5%
Current Employment Status		
Full-time	18	86%
Part-time	2	10%
Unemployed, currently looking for a job	1	5%
Relationship with child		
Child's Mother	18	86%
Child's Father	3	14%
Hours per week child in child care (total, range; SD**)	20	34.4; (7 - 50); (12.8)

Table I. Demographics of Access to Quality Child Care Focus Group Parents (N=21) in Marin County, CA, 2018

Characteristic	N	Mean %*
Length of time working with Dennise in AQC		
2 to 3 months	1	5%
6 to 12 months	3	14%
13 or more months	16	76%
Not sure	1	5%
Length of time working with Madelene in HEAL		
Once	1	5%
6 to 12 months	7	35%
13 or more months	8	40%
Have not worked with her	2	10%
Not sure	2	10%

*Percentages may not add up to 100 due to rounding

**SD = standard deviation

Table II. Demographics of Access to Quality Child Care Focus Group Providers (N=8) in Marin County, CA, 2018

Characteristic	N	Mean %*
Age		
18 to 30 years	1	13%
31 to 50 years	5	63%
51 to 65 years	2	25%
Gender		
Female	8	100%
Race**		
American Indian or Alaska Native	1	14%
Asian	1	14%
Black/African American	1	14%
White/Caucasian	4	57%
Hispanic Ethnicity		
No	3	38%
Yes, Mexican, Mexican American or Chicano	4	50%
Yes, another Hispanic Latino or Spanish origin	1	13%
Education		
Less than high school diploma	1	13%
Some college credits, but no degree	3	38%
Two-year Associate degree	1	13%
Bachelor's degree	2	25%
Master's degree	1	13%
Child Care Program		
Licensed Child Care Center	4	50%
Licensed Family Child Care Home	4	50%
Years worked in child care (total, range; SD***)	8	12.5: 3.5-24.0 (7.7)
Length of time working with Michele in AQC		
6 to 12 months	1	12%
13 or more months	7	88%
Length of time working with Madelene in HEAL		
6 to 12 months	2	25%
13 or more months	6	75%

*Percentages may not add up to 100 due to rounding
**One participant did not select a race category
***SD = Standard deviation

Table III. Characteristics of Participants in Access to Quality Child Care Strategic Initiative (Families N = 56, Parents N = 84)*, Marin County, CA, July 1, 2015 – June 30, 2017

Characteristic	N	Mean %**
Family-Reported Household Composition		
Two-parent household	30	54%
Single parent male-headed household	2	4%
Single parent female-headed household	23	42%
Family-Reported Residence		
Marin City	5	9%
San Rafael	11	20%
Canal Area	14	25%
Novato	13	24%
West Marin	7	13%
Mill Valley	2	4%
Tiburon	1	2%
San Anselmo	2	4%
Family-Reported Mean Children in House (total, range; SD***)	102	1.89: 1-4 (.79)
Parent-Reported Race/Ethnicity		
American Indian/Alaskan	0	0%
Asian	4	5%
Black or African American	6	7%
Hawaiian/Pacific Islander	0	0%
Hispanic/Latino	65	79%
White	7	9%
Family-Reported Primary Household Language		
English	15	27%
Spanish	38	69%
Vietnamese	0	0%
Other (Arabic)	2	4%

*Category response totals may not equal parent or family total due to missing data.
**Percentages may not add up to 100 due to rounding
***SD = Standard deviation

APPENDIX B: KEY INFORMANT INTERVIEW GUIDES

Marin Community Foundation

Introduction and Consent

Thank you for participating in this interview. My name is [**Researcher Name**] and I am with the Sarah Samuels Center for Public Health Research & Evaluation.

You are here today because of your involvement in the Access to Quality Childcare and Healthy Eating Active Living Initiatives as Marin Community Foundation [POSITION]. I will be asking you a series of questions about the Initiatives, including the connection between AQC and HEAL, the ways in which children, families, and providers have benefited from participating In the Initiatives, AQC's progress to goals, the way in which MC3's capacity has been strengthened, strengths and challenges to the Initiatives' partnerships, and other programs that may contribute to nutrition and physical activity improvements in child care settings.

If there are questions to which you do not know the answer, or you wish to not answer, feel free to say you would like to skip the question. Please know that your participation in this interview is voluntary and you may choose to end the interview at any time.

Your responses will be synthesized with that of [EIGHT] other interviewees and in some instances, we may use direct quotes from this interview. There is a small risk of loss of confidentiality, including the possibility that someone might identify your information in the report, given the small number of interviewees. However, there are procedures in place to reduce this risk. For instance, your name or any identifying information will not be linked to these quotes in any reports that we will provide to you or MCF. The interview should take approximately one hour. We would like to audio record this interview for data collection purposes only; the audio recordings will only be used to transcribe the data and only the research staff will have access to the audio recordings and transcript.

Do we have your permission to record this conversation? Do you have any questions before we begin?

A. How has the nutrition and physical activity focus contributed to broader quality improvement efforts?

1) What has been your experience in launching the HEAL program following the AQC initiative?

B. In what ways is the AQC continuing to meet its goals?

1) Is the AQC program having the impact you had hoped for? How so?
2) How is the AQC program helping to bring about quality improvement system change in Marin County?

C. How has MC3's organizational capacity improved over time?

1) In what ways have you observed MC3 strengthen their ability to implement the AQC and HEAL initiatives?

D. What are strengths/challenges of the partnerships created for implementing AQC and HEAL?

1) What local, state, and national partnerships have MCF facilitated/leveraged to advance the goals of these initiatives?

2) Which key local, state, and national partnerships to improve the work of the initiatives are missing?
3) Which executed partnerships have not worked well? Why?
4) What contextual factors do you think are influencing the implementation and success of AQC and HEAL?
    a. PROBE: Political climate and funding

E. What other activities helped to facilitate progress toward the goals of both initiatives?

1) Aside from MC3's work in implementing the two initiatives, has MCF provided other support that was not originally anticipated to facilitate progress toward the goals of both initiatives?
        a. Probe: How has MCF supported MC3's efforts beyond grantmaking?

F. Ending Questions

1) Have there been any unexpected outcomes (positive and/or negative) of the initiatives?
    a. PROBE for both AQC/HEAL
2) From what you know now, is there anything you would do differently with these two initiatives?
3) Is there anything else you would like to share with us regarding the AQC and HEAL Initiatives?

[STOP RECORDING]

APPENDIX B: KEY INFORMANT INTERVIEW GUIDES

Marin Child Care Council

INTRODUCTION AND CONSENT

Thank you for participating in this interview. My name is [**Researcher Name**] and I am with the Sarah Samuels Center for Public Health Research & Evaluation.

You are here today because of your involvement in the Access to Quality Childcare and Healthy Eating Active Living Initiatives as Marin Child Care Council's **[name of interviewee's role**]. I will be asking you a series of questions about the Initiative, including the ways in which the food, nutrition and physical activity environments have changed, the connection between AQC and HEAL, the ways in which children, families, and providers have been involved and have benefited from participating In the Initiatives, AQC's progress to goals, the way in which MC3's capacity has been strengthened, strengths and challenges to the Initiatives' partnerships, and other programs that may contribute to nutrition and physical activity improvements in child care settings.

If there are questions to which you do not know the answer, or you wish to not answer, feel free to say you would like to skip the question. Please know that your participation in this interview is voluntary and you may choose to end the interview at any time.

Your responses will be synthesized with that of [EIGHT] other interviewees and in some instances, we may use direct quotes from this interview. There is a small risk of loss of confidentiality, including the possibility that someone might identify your information in the report, given the small number of interviewees. However, there are procedures in place to reduce this risk. For instance, your name or any identifying information will not be linked to these quotes in any reports that we will provide to MC3 or MCF. Because we will anonymize your responses, your responses will not affect your relationship with MCF or the status of your grant. The interview should take approximately one hour. We would like to audio record this interview for data collection purposes only; the audio recordings will only be used to transcribe the data and only the research staff will have access to the audio recordings and transcripts.

Do we have your permission to record this conversation? Do you have any questions before we begin?

[START RECORDING]

B. How has the nutrition and physical activity environment improved at participating sites?

1) As a result of the HEAL activities, in what ways has the food and nutrition environment changed in the participating childcare sites?
    a. PROBE: In what ways have food and nutrition environment changes varied by whether the child care provider is a stand-alone Center, a Center embedded within a larger organization or network of child care providers, or a Family Child Care Home?

2) As a result of HEAL, in what ways has the physical activity environment changed at participating sites?

a. PROBE: In what ways have physical activity environment changes varied by whether the child care provider is a stand-alone Center, a Center embedded within a larger organization or network of child care providers, or a Family Child Care Home?

3) Please describe your experience working with child care providers to make changes to the nutrition and physical activity environment at their sites.
    a. PROBE: Positive and negative experiences.

C. How has the nutrition and physical activity focus contributed to broader quality improvement efforts?

1) In what ways do/have the HEAL and AQC work compliment/ed each other?
2) In what ways do/have the HEAL and AQC work not compliment/ed each other?
3) In what ways could HEAL and AQC initiatives work more collaboratively?

D. How has AQC and HEAL influenced children and families, how have they been involved and how have they benefited?

1) Overall, in what ways do you think parents have benefited from participating in the AQC Initiative?
    a. PROBE: Increased parents' understanding of child development and what they can do to support their child's development at home.
    b. PROBE: Increased parents' understanding of ways the child care setting can support their child's development.

MC3 provides different types of support and resources to help parents increase their knowledge in child development, in the effort to support their social and economic self-sufficiency (i.e., workshops and training, case management, opportunities for community building/peer learning).

2) What have been useful ways to help parents increase their understanding of child development?
    a. What other types of support and resources do parents need?

3) What have been useful ways to help parents move toward social and economic self-sufficiency?
    a. What other types of support and resources would help parents?

4) How have parents been involved in the HEAL Initiative? (PROBE participation in workshops/trainings; making changes at childcare sites and/or at home)

5) In what ways do you think parents have benefited from participating in the HEAL initiative? (PROBE changes in knowledge, attitude, behavior)

6) What do you think will help parents to become more involved and engaged in HEAL efforts at the childcare sites? At home?

7) In what ways do you think children have benefited from participating in the AQC initiative?

8) How have children benefited from participating in the HEAL initiative?

E. In what ways is the AQC initiative continuing to meet its goals?

1) To what extent has AQC met its enrollment goals? (vouchers and Title V)
    a. What strategies were most successful?
    b. What, if any, challenges were experienced in getting sites enrolled?

2) In what ways is AQC meeting its goals to support parents in moving toward social and economic self-sufficiency?
    a. What strategies were most successful?
    b. What, if any, challenges were experienced in supporting parents?

3) In what ways is AQC meeting its goals to support quality improvement in child care?
    a. What strategies were most successful?
    b. What, if any, challenges were experienced in working toward this goal?

F. How has AQC and HEAL influenced child care providers, how have they been involved and how have they benefited?

1) Overall, in what ways have child care providers participated in AQC?
    a. In what ways do you think providers have benefited from participating in AQC?
    b. What else is needed to help providers provide quality child care?

2) In what ways have child care providers participated in HEAL?
    a. In what ways do you think providers have benefited from participating in HEAL?
    b. What else is needed to help providers make changes to their nutrition and physical activity policies, practices, and environments?
    c. How has the integration of HEAL and AQC played out for providers?

3) To what extent have child care sites facilitated parent engagement? (PROBE both HEAL and AQC)

4) What do providers need to increase their parent engagement efforts? (PROBE for specific skills, resources)

G. How has MC3's organizational capacity improved over time?

2) In what ways has MC3 increased their capacity to implement the work of the AQC and HEAL initiatives?
    a. How important has relationship-building been in meeting the goals of the initiatives?
    b. How have the initiatives influenced MC3's own policies and early child care strategy?

3) In what ways is the work of the AQC and HEAL initiatives sustainable should funding decrease?

H. What are strengths/challenges of the partnerships created for implementing HEAL?

1) What partnerships have been critical to advancing the goals of these initiatives? (PROBE for AQC and HEAL)
2) How can these partnerships be strengthened? (PROBE for each partnership described)
4) Aside from the partners described, who else do you think should be involved, either formally or informally, in AQC/HEAL work?

I. What other activities helped to facilitate progress toward the goals of both initiatives?

1) What other activities helped to support the implementation of both AQC and HEAL?
    a. PROBE: Activities within MC3
    b. PROBE: Other initiatives, programs, organizations, agencies, or collaboratives within the State, County, or site level (QRIS, College of Marin)

J. Ending Questions

1) Have there been any unexpected outcomes of the initiatives? (PROBE for both AQC and HEAL; positive and negative outcomes)
2) From what you know now, is there any implementation strategy you would do differently with these two initiatives?
3) Is there anything else you feel is important for us to know about your experience with the AQC and HEAL Initiatives?

[STOP RECORDING]

APPENDIX C: FOCUS GROUPS GUIDES
CHILD CARE PROVIDERS

OVERALL EVALUATION QUESTIONS

A. How has the nutrition and physical activity environment improved?
B. How has the nutrition and physical activity focus contributed to broader quality improvement efforts?
C. How has AQC and HEAL influenced children and families, how have they been involved and how have they benefited?
D. How has AQC and HEAL influenced child care providers, how have they been involved and how have they benefited?
E. What are the strengths/challenges of the two initiatives?
F. What is the perception of resources and services provided by MC3?

PARTICIPANTS

8-10 Child care providers from a family child care home or child care center accepting vouchers through the AQC initiative that have ideally participated for at least 6 months in the full AQC and HEAL initiatives*, have decision-making authority to implement AQC and HEAL-inspired changes at the site with a preference for balanced representation from site leadership (family child care home owner/operator and child care center director/senior leader) and teachers/staff, are over the age of 18, and English speaking. Providers may or may not have participated in the AQC focus group conducted in 2016.

*Providers from child care settings which had participated as a Level I site but are no longer accepting vouchers, are eligible to participate in the focus group/s, as long as the child care site was involved in the full AQC and HEAL initiatives in the last 6 months.

INTRODUCTION

Hi everyone, thank you for joining our discussion today. My name is _____and my assistant's name is _____. She/He will not be part of the discussion but will be taking notes. We work in Oakland with the Sarah Samuels Center for PH Research and Evaluation.

We are working with the Access to Quality Child Care and Healthy Eating Active Living (HEAL) Initiatives, programs that provide families with childcare that includes support services and resources for families and providers. The Access to Quality Child Care and Healthy Eating Active Living Initiatives are funded by the Marin Community Foundation (MCF) and managed by the Marin Child Care Council (MC3).

The reason we asked you to join this discussion is because we want to hear your thoughts and opinions on the ways you and your site have been involved and benefitted from participating in the AQC and HEAL initiatives, changes related to nutrition and physical activity that have been made at your site, how MC3 can better support your quality improvement and HEAL efforts, and your perceptions about the ways in which families have been involved and benefited in the initiatives. We will be here for about 90 minutes and as our thank you for participating we will have a drawing for two $25 gift cards at the end of our discussion.

GROUND RULES AND CONSENT FORM DEBRIEF

Your participation in this discussion today is completely voluntary. You have the right to refuse to answer any question(s) for any reason or to withdraw from this discussion group at any time without penalty, though only those here at the end of the focus group are eligible for the gift card drawings.

- That said, a benefit of participating today is your opportunity to provide your opinion that can help the AQC and HEAL initiatives improve.

It's always a good idea for a group like ours to have some guidelines that we all agree to follow. The first one is:

1) All opinions are welcome:
   - There are no right or wrong answers.
   - In fact, we welcome different points of view.
   - Please feel free to share your opinion even though it's not what others have said.
   - Please remember that we are interested in both positive and negative comments. Negative comments can be as helpful as the positive comments.

2) Only one person to talk at a time, so please, no side conversations.

3) Please speak loudly and clearly.
   - This is important since we are tape recording and we don't want to miss any of your important comments.
   - Let's also remember to turn off or silence our cell phones.

4) Your Privacy.
   - I want to assure you that whatever you say here will be used only for program purposes. Let's also agree that what is said in this room stays in this room.
   - While we will be recording this discussion and taking notes, your name and identity will remain private.
   - The purpose of the recording is so that if we miss something important as we take notes, we can go back to hear exactly what was said. Only the co-moderator [NAME] and I will have access to the recording and it will be destroyed upon completion of this project.
   - During the discussion, you may ask for the tape recorder to be turned off if you do not want to be recorded for a specific comment.
   - Before we start, if you have not done so already, please review and sign this document [MODERATOR HOLDS UP CONSENT FORM]. Also, please be sure to complete this demographic questionnaire [MODERATOR HOLDS UP QUESTIONNAIRE] before we begin.

Do you have any questions? There will be time at the end to ask questions as well.

I'm going to start the recording now if that's okay with you.

[START RECORDING]

INTERVIEW INSTRUCTION: Please read the questions below as written.

ICE BREAKER

1. First we'd like to get to know a little about you. Let's start by going around the circle; tell us your name, whether you are from a stand-alone Center, Center embedded within a larger organization or network of child care providers, or a Family Child Care Home, your role (e.g. owner, director, teacher) and ONE favorite dish/meal you like to make for yourself or your family. I will start.

KEY QUESTIONS

B. How has the nutrition and physical activity environment improved?

Madelene, from Marin Child Care Council (also known as MC3), has been working with you to make improvements to food, beverages, and physical activity policies and practices at your site. You may have also worked with staff from North Bay Children's Center (otherwise known as NBCC).

1) Thinking about the CHOICE assessment tool that is used to develop your action plan to improve nutrition or physical activity opportunities at your child care site:
    a) What do you think about that process? (Probe for opposing views)
    b) How did that process help you?
    c) How can the CHOICE assessment and action plan process be improved?

2) In what ways have the food and beverages changed at your site?

3) What challenges (if any) have you faced in improving food and beverages at your site?
    PROBE: Food and beverage cost, donations of unhealthy food and beverages from organizations
    PROBE: Differences in challenges faced in improving food and beverages between Centers embedded in larger organizations, Centers, and Family Child Care Homes

4) In what ways have physical activity opportunities changed at your site?

5) What challenges (if any) have you faced in improving physical activity opportunities at your site?
    PROBE: Differences in challenges faced in improving physical activity opportunities between Centers embedded in larger organizations, Centers, and Family Child Care Homes

C. How has HEAL influenced child care providers, how have they been involved and how have they benefited?

1) Now, thinking about how Madelene helped you to make changes related to food, beverages, and physical activity in your child care site:
    a) In what ways have MC3 trainings and workshops helped you to make these changes?
    b) In what ways has support from Madelene helped you to make these changes?

c) Are there resources provided by MC3 that have been particularly helpful?
PROBE: mini-grants, lending library
d) What can Madelene and MC3 do differently to improve their resources, training, and workshops to better help you make healthy eating and physical activity changes at your child care site?

2) For those who have worked with the North Bay Children's Center (also known as NBCC) in the Garden of Eatin', in what ways has NBCC helped you to add garden/outdoor learning into your program?

3) Overall, what other support do you need to improve how you offer food, beverages and physical activity at your site?

D. How has the nutrition and physical activity focus contributed to broader quality improvement efforts?

1) How has participating in the Healthy Eating Active Living initiative (HEAL) supported your Access to Quality Child Care (AQC) quality improvement efforts?
PROBE: Differences between Centers embedded in larger organizations, Centers, and Family Child Care Homes
2) How has participating in the Access to Quality Child Care (AQC) initiative supported your Healthy Eating Active Living (HEAL) improvement efforts?
a) In what ways do you think the HEAL and AQC initiatives and activities can work better together?
b) What have been your biggest challenges in participating in HEAL and AQC?

E. How have AQC and HEAL influenced children and families, how have they been involved and how have they benefited?

1) Overall, in what ways are parents involved in your child care site?
a) How do you invite parents to get involved in quality improvement activities at your child care site?
b) In what ways have you engaged parents in quality improvement activities at your child care site? At THEIR home?
1. In what ways have parents taken a leadership role in these efforts?
2. In what ways have they not been involved in these efforts? Why have they not been involved in these efforts?

2) Overall, what is needed to increase parent involvement in quality improvement efforts at your child care site?
a) How would you like parents to be involved?
b) What suggestions do you have to get them involved?

3) What would help to get parents more involved in nutrition and physical activities at your child care site?
4) Do you notice differences in parent's involvement in your child care program, for those who are in AQC compared to those not in AQC? Please tell me more.

5) How do you feel that parents in your program have benefited from your participation in both the AQC and HEAL initiatives?

6) Regarding HEAL, specifically, in what ways do you think parents have benefited from the changes you have made to the nutrition and physical activities at your child care site?

F. How has AQC influenced child care providers, how have they been involved and how have they benefited?

Earlier we discussed how Madelene from MC3 has provided support to you for improving healthy eating and physical activity opportunities at your site. We'd now like to talk about Michele, also from MC3, who has worked with you on quality improvement as part of the AQC initiative. We'd like to hear more about your experience with this quality improvement work.

1) Overall, by participating in AQC, what has been most helpful?
    a) PROBE for specific examples on: MC3's coaching and technical assistance
    b) PROBE for specific examples on: MC3's training and workshops
    c) To help meet your quality improvement goals, some of you have or will be receiving stipends to purchase items.
        i. How do you think that this has or will help you?
        ii. Was or is it enough for you to make the changes or improvements you want to make?

2) What other resources or support would be helpful to your quality improvement work?

3) What (if any) are the biggest challenges you have faced in putting AQC quality improvement policies and/or practices into place?

    a) What suggestions do you have for solutions to overcoming these challenges?

Thank you so much for your time. Before we wrap up, I just want to check-in with [co-moderator] to see if there are any remaining questions.

[STOP RECORDING]

APPENDIX C: FOCUS GROUPS GUIDES
PARENTS

OVERALL EVALUATION QUESTIONS

A. How has the nutrition and physical activity environment improved?
B. How has AQC and HEAL influenced children and families, how have they been involved and how have they benefited?
C. Did parents move towards self-sufficiency?

PARTICIPANTS

Parents/guardians over the age of 18 who have had at least one child enrolled in a child care home or center that has ideally participated for at least 6 months in the full AQC and HEAL initiatives*, are English or Spanish speaking, and a Marin County resident. Parents may or may not have participated in focus groups that were conducted in the AQC parent focus groups in 2016. Note, we are to recruit 8-10 English speakers for the English focus group and 8-10 Spanish speakers for the Spanish focus group.

*Parents from child care settings which had participated as a Level I site but are no longer accepting vouchers, are eligible to participate in the focus group/s, as long as the child care site was involved in the full AQC and HEAL initiatives in the last 6 months.

INTRODUCTION

Hi everyone, thank you for joining our discussion today. My name is _____and my assistant's name is _____. She/He will not be part of the discussion but will be taking notes. We work in Oakland with the Sarah Samuels Center for PH Research and Evaluation.

We are working with the Access to Quality Child Care and Healthy Eating and Active Living Initiatives, programs that provide families with childcare that includes support services and resources, while also helping child care sites to improve quality, with a focus on promoting healthy eating and physical activity. The Access to Quality Child Care and Healthy Eating and Active Living Initiatives are funded by the Marin Community Foundation (MCF) and managed by the Marin Child Care Council (MC3).

The reason we asked you to join this discussion is because we want to hear your thoughts and opinions on the ways your family has benefitted from the initiatives, your suggestions on ways the initiative or child care providers can provide more support, your perspective on the ways that your child care sites have made changes related to food and physical activity, what facilitators have enabled you to be involved in the Initiatives and in moving towards or reaching self-sufficiency, and the barriers that may prevent it. We will be here for about 90 minutes and as our thank you for participating we will have a drawing for two $25 gift cards at the end of our discussion.

GROUND RULES AND CONSENT FORM DEBRIEF

It's always a good idea for a group like ours to have some guidelines that we all agree to follow.

Your participation in this discussion today is completely voluntary. This means that you can stop being part of it at any time. You do not have to answer any questions for any reason. There will not be any kind of penalty, though only those here at the end of the group interview are eligible for the gift card drawings.

- That said, a benefit of participating today is your opportunity to provide your opinion that can help these programs improve.

1) All opinions are welcomed.
   a. There are no right or wrong answers; in fact, we welcome different points of view.
   - Please feel free to share your opinion even though it's not what others have said.
   - Please remember that we are interested in both positive and negative comments. Negative comments can be as helpful as the positive comments.

2) Only one person to talk at a time, so please, no side conversations.

3) Please speak loudly and clearly.
   - This is important since we are audio recording and we don't want to miss any of your important comments.
   - Let's also take a minute to turn off or silence our cell phones.

5) Your privacy.
   - I want to assure you that whatever you say here will be used only for program purposes. Let's also agree that what is said in this room stays in this room.
   - While we will be recording this discussion and taking notes, your name and identity will remain private.
   - During the discussion, you may ask for the tape recorder to be turned off if you do not want to be recorded for a specific comment.

Do you have any questions? There will be time at the end to ask questions as well.

[START RECORDING]

INTERVIEW INSTRUCTION: Please read the questions below as written.

ICE BREAKER

First, we'd like to get to know a little about you. Let's start by going around the room, please tell us your name and how many children you have and ONE favorite activity you like to do as a family.

KEY QUESTIONS

A. How has the nutrition and physical activity environment improved?

1. Thinking about nutrition and physical activity, what changes have you noticed in your child's child care site?
   a. PROBE: Changes related to healthy eating (IF MINIMAL RESPONSE: e.g., new written policies, daily snack and lunch menu provided, types of food and beverages served, staff model healthy eating, new garden, posters of healthy foods and beverages, nutrition education)
   b. PROBE: Changes related to physical activity (IF MINIMAL RESPONSE: e.g., new written policies, daily physical activity schedule provided, variety and frequency of activity, quality of activities offered, staff participate in class physical activity, etc.)
   c. In what ways have these changes affected you and your family?

2. Have you noticed any new spaces children can play, inside or outside your child care site? Please tell me more.

3. In what ways did your child care site tell you about these changes?

4. Were you provided tips or support in implementing changes related to healthy eating and/or physical activity at home?

5. What, if any, other changes are needed to help your child(ren) eat healthier and be more active in child care?

B. How have AQC and HEAL influenced children and families, how have they been involved and how have they benefited?

We understand that Michelle and Madelene from MC3 have been working with your child's child care provider to improve overall quality and healthy eating and physical activity opportunities at the child care site. We'd like to hear about your experience with these efforts.

1. In what ways have you been involved in changes for healthier eating and more physical activity at your child's site?

2. In what ways have your child's attitudes and behaviors about healthy eating or physical activity changed? (Probe for both healthy eating and physical activity)

3. In what ways has your child's child care site helped change **your** knowledge about healthy eating or physical activity?

4. What changes have you made (or do you plan to make) around healthy eating and physical activity for your family?

5. What child care site activities have you participated in to help your family eat healthier and be more physically active?
    a. PROBE: Attendance at MC3 educational workshops or events
    b. How did you become involved in these activities?

6. In what ways have you been involved in helping to make changes at your child's child care site?
    a. PROBE: Assisting in a classroom activity (e.g., reading to children)
    b. PROBE: Helping with improvement projects inside or outside the classroom to help children learn (e.g., gardening)
    c. PROBE: Visiting the classroom to help with special occasions (e.g., festivals, clean-up days, cultural events)

Dennise has been working with you on the Ages and Stages Questionnaire (or ASQ assessment tool) to help you understand where your child is in their stage of development.

7. What do you think about the Ages and Stages Questionnaire?
    a. Do your health care providers also use the ASQ?
    b. What is/was most helpful about the ASQ?
    c. What is/was not helpful or difficult about the ASQ?

8. How has working on the Ages and Stages Questionnaire with Dennise changed the way you think about child care?

9. In what ways has the ASQ changed the way you think about your child's development and learning?

C. Did parents move towards self-sufficiency?

1. Dennise also works with you to support your family's needs by connecting you to resources, (such as housing resources, food, workforce training programs, education scholarships, etc.) and providing parent workshops.
    a. What referrals, parent workshops or other resources have been most helpful? How was it helpful?
    b. What makes it difficult to use the referrals or resources?
        1. Have you experienced difficulty qualifying for resources that you've been referred to? If so, for what reason?
    c. What other support, training, and resources would be helpful? (Probe for specific topics)

Thank you so much for your time. Before we wrap up, I just want to check-in with [co-moderator] to see if there are any remaining questions.

[STOP RECORDING]