

Mobilizing Child Care Providers in Cultivating Healthy Eating and Physical Activity Opportunities in Los Angeles County

Findings From Choose Health LA Child Care Focus
Groups with Child Care Providers

July 2016

Submitted to the Los Angeles County Department of Public Health



About the Samuels Center

Established nearly 20 years ago, Samuels & Associates, DBA, The Sarah Samuels Center for Public Health Research & Evaluation (Samuels Center), is nationally recognized for its public health research, program and policy evaluation, evaluation technical assistance and training, and strategic planning expertise. We are headquartered in Oakland, California with a satellite office in Los Angeles. Our work is concentrated in low resource and ethnically diverse communities where rates of chronic illness are highest. Our areas of evaluation specialization include nutrition and physical activity, tobacco prevention and control, obesity prevention, healthy food access, community and youth engagement, health policy, and public health practice. For more information, please visit www.samuelscenter.com

Acknowledgements

The Sarah Samuels Center for Public Health Research and Evaluation would like to extend our gratitude to our many collaborators, for which this research would not be possible:

First and foremost, we specially thank the **directors and administrators of the child care centers and homes** who generously gave their time to share insights toward cultivating healthy eating and physical activity opportunities in child care settings in Los Angeles County.

The Choose Health LA Child Care Advisory Committee who provided content expertise in child care policies and practices and whose reviews and feedback on the focus group recruitment and discussion guides helped to ensure the data captured would advance this research.

Members of the Child Care Alliance of Los Angeles and the Child Care Resource Center who provided guidance and logistical support in coordinating focus groups consisting of child care providers representative of the following Los Angeles County Child Care Resource and Referral Agencies: Child Care Resource Center, Pathways, Connections for Children, Crystal Stairs, Mexican American Opportunity Foundation, Options for Learning, and Pomona Unified School District.

Finally, our colleagues from the Los Angeles County Department of Public Health who contributed to this evaluation. Donald Jay Gravink, Janet Scully, Helen O'Connor, Zoe Phillips, and Dr. Robert Gilchick contributed in the acquisition of funding, study design, acquirement of data, implementation, data interpretation, and focus group report review.

This report was made possible with support provided by a contract with the Los Angeles Department of Public Health (Choose Health LA Child Care Focus Groups - #PH-16321557-1).

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Suggested Citation. Los Angeles County Department of Public Health, Maternal, Child and Adolescent Health Programs, Choose Health Los Angeles Child Care Evaluation. Mobilizing Child Care Providers in Cultivating Healthy Eating and Physical Activity Opportunities in Los Angeles County: Findings From Choose Health LA Child Care Focus Groups with Child Care Providers. Prepared by the Sarah Samuels Center for Public Health Research & Evaluation, 2016.

Table of Contents

About the Samuels Center	i
Table of Contents	iv
Executive Summary	v
background	v
methods.....	v
results	v
Conclusions	v
Introduction	1
Choose Health LA Child Care – The intervention	1
Purpose of focus groups.....	2
Methods	3
Participants	3
Procedures	4
Data Analysis.....	4
Results	5
Participant Demographic Characteristics	5
Thematic findings	7
Goal 1: Impact and/or effectiveness of the CHLACC training and coaching model.....	7
Increased knowledge and improved children’s healthy eating and physical activity behaviors	7
Increased knowledge and improved provider health behaviors related to healthy eating and physical activity	8
Goal 2: Perceptions of the impact of CHLACC on the intended audience, the successes and challenges in implementing changes, and thoughts about ways to improve child care provider nutrition and physical activity training and coaching	9
Successes in implementing programmatic changes observed among children.....	9
Successes in implementing programmatic changes observed among parents.....	10
CHLACC resources facilitated communication with parents.....	10
Written policies reinforce health messages.....	11
Challenges and areas for improvement	11
Recommendations for programmatic improvement	12
Concluding remarks	14
CONCLUSION	15
Table 1. Choose Health LA Child Care Focus Groups by Location and Language.....	3
Table 2. Demographics of Choose Health LA Child Care Providers (n=54) in Los Angeles County, California, 2016	5

Executive Summary

BACKGROUND

The Los Angeles County Department of Public Health's Choose Health LA Child Care program (CHLACC) is part of a countywide initiative to prevent early childhood obesity. CHLACC aims to improve nutrition and physical activity (PA) practices in child care settings by providing training and coaching to licensed center and home providers to create and adopt nutrition and PA policies. Our research sought to understand ways in which to engage providers in creating healthy food and physical activity environments through policy, systems, and environmental changes, as there is a paucity of data among similar county-wide child care interventions to address childhood obesity.

METHODS

Seven one-hour focus groups (n=54) were conducted January – April 2016 with providers who received training and coaching. Three were conducted in Spanish and four in English. A healthy snack and \$40 incentive were provided. Sessions were audiotaped; data were transcribed and analyzed, employing a hybrid approach to thematic analysis integrating both inductive and deductive analyses.

RESULTS

Providers reported improvements in physical activity and healthy eating knowledge and behavior both in themselves and among the children in their care. Barriers were identified, such as waning staff motivation, inclement weather, and challenges working with some parents, as well as facilitators, like written policies, parental support, and in-kind resources. Multiple strategies, including modeling and hands-on activities, were described in promoting healthy behaviors as well as strategies to engage parents and children in healthy behaviors.

CONCLUSIONS

Providers can improve the healthful eating and physical activity knowledge and behavior of children in their care through strategic policies and practices. With continued training and tailored coaching, providers are well-positioned to help effectively establish healthy eating and physical activity habits early in life, which can have a powerful impact in the effort to prevent childhood obesity.

Introduction

CHOOSE HEALTH LA CHILD CARE – THE INTERVENTION

Choose Health LA Child Care (CHLACC) is a component of a five-year initiative administered by the Los Angeles County Department of Public Health (DPH) and funded by First 5 LA to improve nutrition, increase physical activity, and reduce obesity in Los Angeles County children aged zero to five and their families. The goals of CHLACC are to reduce the prevalence of overweight and obesity among children in child care; improve nutrition and physical activity practices in child care through the creation and adoption of wellness policies; and communicate nutrition and physical activity policies to parents via newsletters and other venues. Evidence-based guidelines and curricula are utilized to teach child care providers how to develop nutrition and physical activity policies and implement health related activities in their facilities. This program also includes a coaching component to provide support and technical assistance to child care providers that reinforces concepts taught in the training and fosters the creation and adoption of nutrition and physical activity policies.

To implement CHLACC workshops and assist with part of the program evaluation, DPH partnered with the Child Care Resource Center (CCRC), one of the ten agency member organizations comprising the Child Care Alliance of Los Angeles (“the Alliance”), a network of non-profit agencies that provides child care resource and referral services to all areas of LA County. CCRC is collaborating with the other members of the Alliance to collectively conduct the nutrition and physical activity workshops and coaching countywide for child care providers. To date DPH have trained over 5,800 child care providers and coached nearly 2,300.

A multi-method strategy involving quantitative (i.e., self-assessment policies and practices surveys and observational assessments) and qualitative (i.e., focus groups with trained providers) is being employed to address the following evaluation questions:

1. How many licensed child center, licensed home day care, and license-exempt providers and children were reached by CHLACC?
2. In what ways did the CHLACC trainings and coaching change the knowledge, attitude, and readiness to change of the child care providers to improve nutrition and physical activity environments in their child care settings?
3. In what ways have nutrition and/or physical activity policies, practices, and environments changed as a result of CHLACC?
4. What are the barriers and facilitators that child care providers face in efforts to promote healthy nutrition and physical activity?

PURPOSE OF FOCUS GROUPS

During the winter and spring 2016, focus groups were conducted with child care providers to understand their experience with the training and coaching model to improve nutrition and physical activity policies and practices in child care settings. In particular, the purpose of the focus groups were to explore and help understand the:

1. Impact and/or effectiveness of the Choose Health LA Child Care training and coaching model as implemented by the Los Angeles County Department of Public Health and its subcontractors.
2. Perceptions of the impact of Choose Health LA Child Care on the intended audience, the successes and challenges to implementing changes, and thoughts about ways to improve child care provider nutrition and physical activity training and coaching.
3. Ways in which to engage providers and parents in creating healthy food and physical activity environments through policy, systems, and environmental changes.

Methods

PARTICIPANTS

Eligible child care providers were drawn from a list of all trained licensed home or center primary caregivers of children ages zero to five years or employed as a child care provider and currently caring for at least one child aged zero to five years in Los Angeles County. Eligible providers were also required to be over the age of 18 years, a resident of Los Angeles County, speak English or Spanish, and have decision-making authority to implement the Choose Health LA Child Care program and oversee nutrition and physical activity policies and practices at their site. Efforts were made to ensure a balance of provider representation across the following Los Angeles County Child Care Resource and Referral Agencies: Child Care Resource Center (CCRC), Pathways, Connections for Children, Crystal Stairs, Mexican American Opportunity Foundation, Options for Learning, and Pomona Unified School District (Table 1). Two focus groups were conducted in the CCRC region to account for its expansive service area and one focus group drew on providers from the Connections for Children and Crystal Stairs regions given their respective service area's close proximity to one another.

Table 1. Choose Health LA Child Care Focus Groups by Location and Language

<i>Focus Group Location</i>	N	Language	Date	Time
Child Care Resource Center (Chatsworth, CA)	7	English	1/28/16	6:30pm
Mexican American Opportunity Foundation (Commerce, CA)	8	Spanish	2/18/16	6:30pm
Child Care Resource Center (Palmdale, CA)	5	English	2/23/16	6:30pm
Pathways (Los Angeles, CA)	10	Spanish	3/1/16	6:30pm
Options for Learning (Baldwin Park, CA)	9	Spanish	3/3/16	6:30pm
Pomona Unified School District (Pomona, CA)	10	English	3/8/16	6:30pm
Crystal Stairs/Connections for Children (Lawndale, CA)	5	English	4/2/16	10:30am

Seven focus groups with a total of 54 participants were conducted January – April 2016 with licensed center or licensed home providers who received training and coaching (Table 1). Three were conducted in Spanish and four in English. Signed consent forms were obtained from the participants before the beginning of each focus group. A healthy snack and \$40 incentive were provided.

PROCEDURES

Focus group interviews lasted 90 minutes and were conducted in English or Spanish by trained moderators. Participants completed a one-page demographic questionnaire. The discussions were audiotaped and field notes were taken. A semi-structured focus group guide with open-ended questions assessed providers' perceptions of the impact of the Choose Health LA Child Care training and coaching model, successes and challenges in implementing programmatic changes, resources needed to maintain or improve programmatic changes, and ways of engaging parents and other providers as partners in change.

DATA ANALYSIS

Audiotapes were transcribed verbatim by a professional transcription company into Microsoft Word and imported into NVivo version 10 qualitative analysis software and field notes were summarized and analyzed. Research staff identified and coded themes through content analyses. Data were analyzed by integrating both inductive (i.e., interviewee-generated categories) and deductive (i.e., interviewer-generated categories) analyses. Related codes were then linked to capture broad views of the participants. A second reviewer independently identified themes to control potential bias. There was high concordance among the reviewers. Descriptive analyses and frequencies were calculated from demographic questionnaires using SPSS v. 21 (IBM Corp, Armonk, NY, USA).

Results

PARTICIPANT DEMOGRAPHIC CHARACTERISTICS

Fifty-two (96.3%) participants were female and 33 (61.1%) self-identified as Latino. The greatest proportion of participants were between the ages of 46-55 years old (40.7%) and reported having earned some college or technical school experience (31.5%). The majority of participants were licensed home providers (68.52%), had five plus years of experience as a child care provider (79.6%), and 59.26% selected improving food and beverages as their training and coaching goal (Table 2).

Table 2. Demographics of Choose Health LA Child Care Providers (n=54) in Los Angeles County, California, 2016

<i>Characteristic</i>	N	Percent (%)^a
Gender		
Female	52	96.3%
Male	2	3.7%
Age		
25-35 years old	3	5.6%
36-45 years old	14	25.9%
46-55 years old	22	40.7%
56-65 years old	10	18.5%
65+ years old	5	9.3%
Race/Ethnicity		
Black/African American	5	9.3%
White/Caucasian	8	14.8%
Latino/Hispanic	33	61.1%
Asian/South Asian/Pacific Islander	2	3.7%
Other/Mixed	6	11.1%
Highest Level of Education		
8th grade or less	5	9.3%
Some high school	6	11.1%
High school graduate/GED certificate	7	13.0%

Some college or technical school	17	31.5%
College graduate	10	18.5%
Graduate or professional degree	9	16.7%
Current Health Status		
Fair	4	7.4%
Good	19	35.2%
Very good	17	31.5%
Excellent	14	25.9%
Age of Children in Child Care ^b		
Under 2 years	30	55.6%
Between 2-5 years	48	88.9%
6 years or older	21	38.9%
Years Worked as Child Care Provider		
Less than one year	1	1.9%
1-2 years	6	11.1%
3-5 years	4	7.4%
5+ years	43	79.6%
Provider Type		
Licensed Center	17	31.48%
Licensed Home	37	68.52%
Training Topics Selected		
Increasing physical activity	20	37.04%
Improving food and beverages	32	59.26%
Reducing screen time	2	3.7%

^a Percentages may not add up to 100 due to rounding

^b Percentages total more than 100 as participants could check all that apply

THEMATIC FINDINGS

Below are several themes that emerged with supporting quotes as appropriate, organized according to the goals of the study.

Goal 1: Impact and/or effectiveness of the CHLACC training and coaching model

This portion of the findings is divided into two main sections: impact on children and impact on child care providers. These findings focus on the distal, or longer-term, impacts of the CHLACC training and coaching model.

Increased knowledge and improved children's healthy eating and physical activity behaviors

In discussing the impact of the CHLACC training and coaching on children's knowledge and behaviors related to healthy eating and physical activity, the majority of providers observed a positive change in children's health as a result of the intervention. Providers often provided examples of children trying new fruits and vegetables and learning to like them, as well as being more physically active, as a result of the program. Across all focus groups, nearly all providers reported that children's preference for healthy foods increased so much that they would request those foods both at the child care site and in the home.

"Once they like something, then they'll ask for it. Like the little boy who wanted actual food instead of a frozen dinner."

"[A mother said], 'My son told me that you give them apples. When we went to the market, he told me to buy him apples, and he told me to wash them like this. He told me to cut them, and that I didn't take the shell away; that I have to eat it too.'"

In addition to increased nutritional knowledge and preferences, most providers reported positive changes in children's physical health as a result of the CHLACC training and coaching. Some reported children eating healthier foods and/or restricting unhealthy foods, and a number of others discussed children losing weight due to the policy and environmental changes at the child care site.

"I have a boy who came when he was three years old... Even the doctor told the mother that boy has to lose weight... I changed everything for him. In about two months the boy lost almost three pounds. I gave him watermelon, big bananas, and 30-minute walks. He walks with me and talks. The boy lost a lot of weight, and he changed his eating habits. That was a success for me."

“[Child’s name]... didn’t like fruit. Now he eats bananas, and he eats peaches... that’s a success.”

Most providers also noted improvements in children’s physical activity. Several providers gave examples of ways they engage their children in activities, and reported increases in the amount of activity children receive at child care. Modeling appropriate and health-promoting physical activity proved to be an effective strategy at increasing children’s physical activity in child care.

“Physical activity has increased for the children because the staff is engaged in it. Like you said, if you’re moving with them they’re going to move longer and do more.”

Increased knowledge and improved provider health behaviors related to healthy eating and physical activity

Across all seven focus groups, nearly all providers noted a positive impact on providers’ own health as a result of the CHLACC training and coaching. Partly due to participating in meals and activities with children and partly due to an increased understanding of what it means to be healthy, providers reported healthy improvements with regard to both knowledge and behaviors as they relate to healthy eating and physical activity.

Several participants cited an increased understanding of how to read and interpret nutrition labels. A few providers also discussed engaging in nutritional activities with children, so as children learn about healthy eating, they become more aware as well.

“I’m more aware. I read the labels when I get something.”

“It makes me more conscious of what I eat, because I like to eat with the kids... it’s more awareness for myself.”

In employing strategies to facilitate children’s adoption of healthy eating and physical activity many providers spoke of personal health improvements.

“When people are having their lunch breaks we’ll workout. We’ll do that on campus while the kids are asleep, for those that can.”

“I had more energy, was happier, was more willing to do things... even mentally it made a difference.”

Goal 2: Perceptions of the impact of CHLACC on the intended audience, the successes and challenges in implementing changes, and thoughts about ways to improve child care provider nutrition and physical activity training and coaching

Findings in this section are divided into five main areas: successes in implementing programmatic changes observed among children, successes in implementing programmatic changes observed among parents, challenges and area for improvement, recommendations for programmatic improvement, and concluding remarks. These findings focus on the proximal, or shorter-term, outcomes of CHLACC.

Successes in implementing programmatic changes observed among children

Many providers noted multiple strategies used to facilitate healthful eating and physical activity among children. Following training advice, several mentioned great success in getting children to eat healthier when role modeling healthy eating.

“Sometimes I sit down to eat with them and I bring my salad and they [children] say, ‘Why do you eat leaves?’ I said, try it, maybe you will like it. He grabs one, and it looks like he wouldn’t, but he eats it, he finishes it and grabs another one. He tastes several and says, ‘I like this one.’”

Provider modeling also resulted in improvements in children’s physical activity. Many participants across all focus groups noted times when they participated in activities with children to set a positive example, resulting in children following suit and engaging in activities themselves.

“We try to put ourselves more onto their level and encourage them to do more of the physical activities that are out there.”

Incorporating children in gardening activities and directly involving them in meal/snack preparation as well as practicing family-style serving also paid nutritional dividends. There was consensus that these interactive strategies, when used appropriately, positively impact children’s willingness to engage in healthy eating.

“They’re more willing to try any new vegetable that comes from the garden. When they pull it, when they water it they’re much more willing to try it.”

“Our curriculum introduces new food all the time. Probably on a weekly basis. They are experimenting, they are doing actual projects involving food and that really helps them.”

Successes in implementing programmatic changes observed among parents

Most providers mentioned that parents are willing to engage in healthy behaviors to support improvements at the child care setting. Parents were reported to engage in these behaviors both at the child care site and at the home, resulting in positive health behaviors among children. Children's adoption of healthy behaviors is more likely when there is consistent message and practice at the child care site and home.

The majority of providers across all focus groups reported parents getting involved in nutrition and physical activity classes and activities at the child care site.

"I have cooking classes every Friday, and all the parents come, and the children are there every Friday... Everything we cook there we eat together."

"We've added yoga and some of the parents will now come to join us along with it. That's a big success to have not only the children do it but the parents want to come and participate."

Many providers highlighted examples of parental support in promoting healthy eating and physical activity at home. A few examples noted included restricting unhealthy food, offering more healthy options, and urging children to be physically active at home.

"I've had some parents cut some sugar at home. It was a routine every day; they would have chocolate milk in the morning. They would substitute it with plain white milk. I've had parents do that. Like me, they have incorporated more vegetables and fruits in their diets at home because all they were eating was junk."

CHLACC resources facilitated communication with parents

Many participants reported using written resources from CHLACC to start and strengthen communication with parents. Some sent home newsletters to parents describing nutrition information and others offered flyers for parents to pick up at the child care site. Providers used these resources as a method of engaging parents in a dialogue around healthy eating, to encourage parents to comply with nutrition guidelines, and to facilitate a healthy lifestyle for children outside of the child care site.

"We have a parent newsletter [incorporated training information] where they get to read. I focus in on a particular food and how parents can help enhance it at home in having their kids to eat certain foods at home, in the newsletter."

Written policies reinforce health messages

Most providers discussed developing written policies around what foods can be served at the child care site, in order to promote healthy eating habits at the child care site. Most discussed these written policies within the context of establishing healthy celebrations; for example, requiring healthy snacks for birthday celebrations. Some participants described parents bringing vegetable platters and bottled water instead of cakes and juice.

“As part of our policy that if, say for instance, we have celebration and the parent wants to do a birthday party or something, as long as it’s healthy foods. If they bring snacks, it’s healthy snacks.”

“Parents know. If they try to say, ‘Well I didn’t know,’ the policy’s right there on the parent information board anyways. Along with our illness policy.”

Challenges and areas for improvement

While there are many successful outcomes of the CHLACC training and coaching, a number of child care providers reported barriers to success and areas for improvement.

Although most providers reported establishing written guidelines for parents regarding foods allowed at their site, several discussed challenges in ensuring parents read circulated educational materials or follow through with written policies around nutrition.

"You could have all the policies you want; they don't read them. They sign it, here and take my kid. They don't care, or their father lets them, or the mother. They don't care what's in the policy."

"I gave the brochures to the parents, but it's the same as they say: “We get a lot of papers. We don't have time; we get home to sleep, and then the brochure is lost.”

Many participants discussed challenges around changing families’ unhealthy eating habits. Several providers only felt capable of imparting nutrition and physical activity knowledge and activities among children to a limited extent on account of unhealthy habits and influences outside of child care. There was a clear understanding among participants of the importance of a multi-environmental approach to making the healthy choice the easy choice, urging children to eat healthfully and be active both at the child care setting and at home.

“We’ve got a healthy breakfast ready and waiting. Dad will come in and go, ‘He just has all of his doughnuts. All he needs is a little swig of milk.’”

“The children don’t pick the food, parents pick the food. Who do you have to educate? The parents.”

Barriers that impact physical activity were also mentioned. Inclement weather was described by the majority as the main barrier to physical activity. Citing both intolerable cold and hot temperatures, many providers indicated that they are limited in their ability to encourage outdoor activities with children.

“Sometimes I hear teachers saying, ‘oh, it’s too cold’ when we have the rain during the winter season. Or, ‘it’s too cold; it’s too windy.’”

“We are in the classroom because of the weather; cold, hot, there are so many things. They are not allowing us to go outside, and we see the children need it, the activities.”

Some providers also mentioned passive screen time as a barrier to physical activity, as children were bringing in cell phones and using them instead of participating in activities.

“I put a new policy on my contract. No cell phones. No tablets. The parents say, ‘Why?’ I used your information on how it affects the child... Because I tried it before and it didn’t work because they were all like, ‘No. It’s my child, it’s my decision.’ And after I showed them, it worked.”

A few providers discussed how some teachers lack motivation to stay active and implement the training curriculum. Providers added that staff often run out of ideas about how to engage children in structured physical activity. They noted that while teachers eagerly adopt CHLACC training and coaching ideas at first, their motivation wanes as children often demand a steady flow of new ideas and activities. The majority of providers mentioned wanting more training and new ideas for activities.

“That’s mostly the challenge; that you do it as well, not just children do this... and you are just sitting there.”

"It's usually the staff don't feel like it or they're cold, or they don't want to."

Recommendations for programmatic improvement

Most providers discussed wanting more written resources such as flyers, brochures, books, etc. for both providers and parents to continue learning about nutrition and physical activity guidelines. Additionally, providers reported wanting more materials that facilitate hands-on experiential learning for physical activity. Many described the physical activity materials

provided at the training/coaching as effective (e.g., cones, scarves, etc.) and expressed a desire for more ways to actively engage children.

"I think in a flyer. For the caregiver it would be a flyer and we could easily stick it on the kitchen wall, that way everyone can see it."

"Maybe some hands-on material? Let's say, if our center doesn't have hula hoops, if that could be provided? Sometimes because of the budget, we cannot get them something beyond what we have."

In addition to wanting more materials, several providers asked for an increase in the frequency of coaching sessions so as to reinforce and stabilize healthful changes in practice. Some providers suggested that these coaching sessions could be offered at multiple times and via multiple formats so as to align with providers many demands and busy schedules. Some requested online platforms as a way to offer continued training for providers and allow for a sharing of resources among their peers.

"It would probably be another visit. As they did but with more time, with more information. Because I'm always saying, "Yes, we have information." We take it; we put it into practice for two or three months, then we see another, and we forget that one. Mostly to remember a little more of what we saw."

The majority of providers agreed that parents having the knowledge about healthy eating and physical activity is vital in establishing healthy lifestyles early in life. Most suggested that parents ought to be offered similar, complimentary training and coaching. These trainings would help reinforce the health messages and practices instituted by providers.

"I think it would also be nice if they had a training course for the parents... about healthy food because it would help us a lot if the parents understood a bit more about eating healthier. That way the child learns both from us and at home due to our work every day."

"I am interested in seeing if you can guide us to how to invite the parents to be more proactive in healthy habits, because we don't have a choice of the food, but we can make the parents be more oriented to health and food."

A majority of providers discussed wanting to network with other child care providers more, to share challenges and best practices, and to learn from each other. Many cited their focus group experience as a positive way to learn about what others are doing.

"Get them together and talk to them, have regular meetings, even once a month. Because I only know a couple: you and some others."

"Yes, that would be a very good thing to have good communication; being able to tell them what worked for us, sharing that with other providers. Sharing our achievements with kids, that's the most important thing; things that have gone well."

Concluding remarks

Most providers across all focus groups expressed a resounding sense of gratitude for the CHLACC program. Providers learned a lot through the training and coaching, and described many successes in their personal lives as well as in the lives of their children and families as a result of the training and coaching.

"It has helped us a lot, and I hope it continues growing immensely. This is helping not only ourselves, but also the future of the children, the parents, the whole community."

"Thank you very much for the class; it is very interesting, both for me and I imagine for all of us, because we are raising a group of kids who will be the next generation."

"This is the best that each provider can receive; it's a golden gift that can be passed on to the children."

CONCLUSION

These findings suggest that the CHLACC training and coaching model contributed to improved physical activity and healthy eating among providers and children in their care. In order to sustain such improvements there is an expressed need to build upon and expand the training and individual coaching offered. While many child care providers are aware of the importance of healthy eating and physical activity there remains a need to continue to enhance their curricular tool kit so as to maintain motivation among staff and children and keep up-to-date on nutrition and physical activity best practice guidelines. Trainings, specifically those involving management and staff and incorporating demonstrations and hands-on skill building activities held at the child care site are perceived to be most effective in improving the food and physical activity environment at the child care site. Moreover, providers expressed a need for additional peer-to-peer learning opportunities in order to share effective strategies and free resources. The creative ways providers employed materials and resources to establish and maintain a dialogue with parents suggests that trained providers are well positioned to effect change in the child care site and at home. While not all health education material sent home is read by all parents, the multiple communication channels by which providers share key health messages with parents and their health impact on families suggest the need to create simple and consistent health messages that can easily be shared with parents. Additional coordination among health education efforts targeted at child care sites and homes is needed to improve consistency of messages.