

Appendix C

Indicator Summaries

These indicator summaries provide clear and comprehensive measurement definitions for each indicator. Additionally, they contain information about the rationale for selecting each indicator, intended use of data collected on the indicator, frequency of data collection, and consistency with relevant agencies, initiatives, and guidance documents. The appendix begins with a map that explains the layout and content of the indicator summaries.

Map to Indicator Summaries

- 1 Performance Measures labeled "I" are implementation measures, or measures of program processes. Performance Measures labeled "O" are outcome measures, or measures of program effects or results.
- 2 As with the performance measures, indicators labeled "I" are implementation indicators, and indicators labeled "O" are outcome indicators. Indicators have the same numbers as their associated performance measures. Some performance measures have multiple indicators; these are labeled sequentially (e.g., I-4.1 and I-4.2).
- 3 The rationale for each indicator explains the significance of the indicator within the Steps Program foundation or theory.
- 4 The primary intended use of the core performance measures is to demonstrate that resources allocated to the Steps Program are accounted for and used wisely. This section explains how each indicator will be used to demonstrate accountability for program resources. This section also describes additional uses of these data by Steps communities, CDC, and other public health programs.
- 5 The data source tells you where you will find the information needed to report on this indicator. Possible data sources include program records and documentation, Behavioral Risk Factor Survey (BRFS) reports, and Youth Risk Factor Survey (YRBS) reports.
- 6 This section explains how the indicator is measured. For implementation indicators, it states what specific information is required to report on the indicator. For outcome indicators, it provides the numerator and denominator.
- 7 The numerator is the top part of a fraction used to calculate a ratio or percentage. Taken with the denominator, it explains how the general concept identified in the indicator will be measured. The numerator specifies the criteria needed in order to meet this indicator.
- 8 The denominator is the bottom part of a fraction used to calculate a ratio or percentage. Taken with the numerator, it explains how the general concept identified in the indicator will be measured. The denominator specifies the population of interest, or all people surveyed who could possibly meet the criteria for this indicator and be part of the numerator.
- 9 Survey questions are the specific questions that must be asked in order to report on this indicator. These questions are taken from the instrument listed in the data sources section. This section is only included for outcome measures.
- 10 The special instructions provide any additional information needed to understand or collect data for this indicator.
- 11 The data collection schedule section states how often communities will collect data on the indicator and report the data to the Steps Program Office (SPO).
- 12 Relevant resources are listed here, as applicable, to provide additional information or further reading.
- 13 This section lists agencies, initiatives, and guidance documents with which the indicator is consistent. Consistency does not necessarily indicate exact replication of performance measures or indicators from the referenced source.

Performance Measure O-10	Improved health-related quality of life.
Indicator O-10.1	Mean number of Healthy Days among adults aged 18 or older.

Rationale for Selecting This Indicator
 Health-related quality of life is "an individual's or group's perceived physical and mental health over time." This definition is consistent with the World Health Organization's definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Health-related quality of life is a particularly important measure for chronic disease surveillance because effective disease management, which may lead to improved health-related quality of life, is a successful outcome for programs addressing chronic diseases. Research shows that the Healthy Days measure (i.e. the number of days per month when an individual's physical and mental health were both good) is a valid and reliable measure of health-related quality of life. Healthy Days correlate, as expected, with physical activity, obesity and overweight, tobacco use, and access to healthcare. Healthy Days can also serve as a proxy measure for the perceived burden of symptoms associated with chronic health conditions. This indicator captures all of the long-term outcomes of the Steps Program: an increase in the mean number of Healthy Days may reflect improved self-management of diabetes and asthma, a slowed upward trend of overweight and obesity, reduced complications of asthma and diabetes, and progress toward improved health-related quality of life.

Intended Use of Data
 CDC's Steps Program Office (SPO) staff will use these data to track progress toward long-term outcomes related to improved health-related quality of life. SPO staff will also use the data to make evidence-based decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions that address multiple diseases and risk factors. Steps communities will use site-specific data for program planning, data-driven decision making, and local evaluation. These data will be used to recognize successes and to determine progress toward intended outcomes, achieved through integration across multiple diseases and risk factors. Lessons learned through analyzing the data will be shared with all Steps communities and with other interested public health programs.

Data Source(s)
 2005 Behavioral Risk Factor Survey (BRFS)
 Core Section 2: Healthy Days

How Indicator is Measured

Numerator: Mean number of healthy days in the past 30 days.

Denominator: Respondents aged ≥ 18 years who report number of days in the past 30 days that their physical and mental health were not good (including zero; excluding unknowns and refusals).

Survey Question(s)

2.1 Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

2.2 Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

Special Instructions
 The methodology used to calculate data for this indicator is based on the methodology presented in the report "Measuring Healthy Days" (see Resources section).

Data Collection Schedule
 Collected annually.

Resources
 Measuring Healthy Days
<http://www.cdc.gov/hrqol/monograph.htm>

Consistency with relevant agencies, initiatives, and guidance documents
 Centers for Disease Control and Prevention (CDC), FY 2005 Performance Plan:
<http://www.cdc.gov/od/perplan/index.htm>
 The Community Indicators Handbook:
<http://www.communityinitiatives.com/pubs/indicats.html>
 The Future of the Public's Health in the 21st Century, The Institute of Medicine (IOM):
<http://www.iom.edu/report.asp?id=4304>
 Government Performance and Results Act (GPRA):
<http://www.whitehouse.gov/omb/mgmt-gpra/index.html>
 Healthy People 2010: <http://www.healthypeople.gov/default.htm>
 Indicators for Chronic Disease Surveillance: <http://www.cdc.gov/mmwr/PDF/RR/RR5311.pdf>
 Secretary Mike Leavitt's 500-Day Plan:
<http://www.hhs.gov/secretary/page.html> and <http://www.hhs.gov/500DayPlan/500DayPlan.pdf>
 Steps program announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

Performance	Align the budget with program goals and intended
Indicator I-1.1	Fiscal resources allocated to address Steps focus areas

Rationale for Selecting This Indicator

A performance budget, or activity-based budget, is a performance plan that shows the relationship between allocated funds, program activities, and expected results.¹ These budgets show how programs use funds for certain activities, how those activities are expected to generate certain outputs, and how those outputs should lead to intended outcomes. Performance budgets allow programs to demonstrate that fiscal resources are allocated to address program focus areas and intended health outcomes.

With growing competition for limited resources, the federal government is increasingly interested in having programs account for the federal dollars they spend.² The Program Assessment Rating Tool (PART) is the primary assessment tool that the Federal government uses to improve program performance so that it can achieve better results.³ This performance measure and indicator are consistent with a PART budget question and with the government’s general move toward performance budgeting.³

Linking budget to performance by using an activity-based budget is a core element of the Steps Program. Documenting that Steps communities use activity-based budgets is an important component of demonstrating accountability for how federal dollars are spent.

Intended Use of Data

Documenting that they submit activity-based budgets shows that Steps communities fulfilled a core requirement of the Steps Program. Communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use data submitted on this indicator to make data-driven decisions regarding priorities for technical assistance to improve the program. CDC also uses this information to disseminate examples of effective performance budgets and to share lessons learned about linking fiscal resources to program focus areas and key health outcomes with all Steps communities and other interested public health programs.

Data Source

Steps community program records

How Indicator is Measured

Steps communities send CDC the following data:

- A statement that an activity-based budget form was (or was not) submitted to CDC.
 - The date the activity-based budget form was submitted.
 - Any contextual information or supplemental data that further explain or support the data for this indicator.
-

Special Instructions

None

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

The Future of the Public's Health in the 21st Century, The Institute of Medicine (IOM):
<http://www.iom.edu/report.asp?id=4304>

Program Assessment Rating Tool (PART): <http://www.whitehouse.gov/omb/part/index.html>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and
<http://www.healthierus.gov/steps/2004grants.html>

¹ Mercer J. Performance budgeting for federal agencies (Fairfax: AMS, 2002). Available at http://www.john-mercer.com/library/Performance_Budgeting_FA.pdf.

² GAO. *21st Century challenges: performance budgeting could help promote necessary reexamination*. (Publication Number GAO-05-709T). Washington, D.C.: GAO; 2005. Available at: <http://www.gao.gov/new.items/d05709t.pdf>

³ OMB. *Program assessment rating tool (PART)* [online]. 2006. Available at <http://www.whitehouse.gov/omb/part/>.

Performance	Ensure that community objectives and activities are
Indicator I-2.1	Objectives and activities linked to the work of state

Rationale for Selecting This Indicator

Coordinating national, state, and local public health activities and programs is vital, as evidenced by this statement from the Institute of Medicine:

An effective public health system that can assure the nation’s health requires the collaborative efforts of a complex network of people and organizations in the public and private sectors, as well as an alignment of policy and practice of governmental public health agencies at the national, state, and local levels.”¹

CDC supports state programs that promote healthy behaviors and reduce risk for disease, including programs that address all the diseases and risk factors targeted by the Steps Program.^{2,3} Furthermore, CDC recommends that state health departments develop plans that describe the health problems they will address, how they will address those problems, and how program activities will be funded and evaluated.⁴

Programs funded through the Steps cooperative agreement are required to coordinate with and reinforce, but not duplicate, related federal, state, and local activities. By coordinating with state and local programs, communities can maximize resources, reduce duplication of services, and ensure that their efforts complement state categorical programs and increase their effect on health outcomes. The Program Assessment Rating Tool (PART) is the primary assessment tool that the Federal government uses to improve program performance so that the government can achieve better results.⁵ This performance measure and indicator are consistent with a PART question that pertains to reducing the number of programs that duplicate other federal, state, local government, or private programs.³

Intended Use of Data

Documenting that they coordinate their activities with those of state and local programs shows that Steps communities fulfilled a core requirement of the Steps Program. Communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use data submitted on this indicator to make data-driven decisions regarding priorities for technical assistance to improve the program. CDC also uses this information to disseminate examples of community activities that are linked with related state activities and to share lessons learned about such collaborations with all Steps communities and other interested public health programs.

Data Source

Steps community program records

How Indicator is Measured

Steps communities send CDC the following data:

- Whether or not there is a state plan for each Steps focus area.
 - Whether or not the state receives federal dollars other than funds from the Steps Program for each focus area.
 - A short description of how Steps community program objectives or activities are consistent with state plans for each Steps focus area (if applicable).
 - Any contextual information or supplemental data that further explain or support the data for this indicator.
-

Special Instructions

None

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

The Future of the Public's Health in the 21st Century, The Institute of Medicine (IOM):
<http://www.iom.edu/report.asp?id=4304>

Program Assessment Rating Tool (PART): <http://www.whitehouse.gov/omb/part/index.html>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and
<http://www.healthierus.gov/steps/2004grants.html>

¹ Institute of Medicine. *The future of the public's health in the 21st century*. National Academies Press. p. 96. November 2002.

² CDC. *State Programs in Action. Exemplary Work to Prevent Chronic Disease and Promote Health*. Atlanta: U.S. Department of Health and Human Services; 2005. Available at <http://www.cdc.gov/nccdphp/publications/Exemplary>.

³ CDC. *National Asthma Control Program Grantees and Nonfunded Asthma Contacts*. Available at <http://www.cdc.gov/asthma/contacts/default.htm>.

⁴ CDC. *Promising practices in chronic disease prevention and control: a public health framework for action*. Atlanta, GA: Department of Health and Human Services, 2003.

⁵ OMB. *Program assessment rating tool (PART)* [online]. 2006. Available at <http://www.whitehouse.gov/omb/part/>.

Performance	Expand the resources available to Steps community
Indicator I-3.1	Resources secured to supplement funds received via the

Rationale for Selecting This Indicator

Mobilizing community members or organizations to help with a public health program is one of twelve best practices for improving communities.¹ Doing so ensures that enough people are available to plan, implement, adapt, and run program activities and events. Generating resources (financial and human) is a critical part of community mobilization.

The Steps Program announcements require matching funds from non-Federal sources for large cities and urban communities and state-coordinated small cities and rural communities funded in 2004. The program announcements encourage, but do not require, matching funds for Tribes and Tribal entities funded in 2004 and for all communities funded in 2003. Matching funds (whether cash, in-kind, or donated services) extend the program’s reach and service capacity and play a role in building relationships between communities and their key partners.

Intended Use of Data

Documenting that supplemental resources were secured shows that Steps communities fulfilled a core requirement of the Steps Program. Communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use data submitted on this indicator to make data-driven decisions regarding priorities for technical assistance to improve the program. CDC also uses this information to disseminate examples of supplemental funding or in-kind contributions generated by communities and to share lessons learned about securing such resources with all Steps communities and other interested public health programs.

Data Source

Steps community program records

How Indicator is Measured

Steps communities send CDC the following data:

- Name of each organization that provided support.
 - A short description of any direct funding provided, including why it was provided or how it was used.
 - A short description of any in-kind labor provided, including why it was provided or how it was used.
 - A short description of any other type of contribution (e.g., free meeting space, printing services).
 - Approximate value in dollars of each type of contribution.
 - Any contextual information or supplemental data that further explains or supports the data for this indicator.
-

Special Instructions

None

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

The Future of the Public's Health in the 21st Century, The Institute of Medicine (IOM):
<http://www.iom.edu/report.asp?id=4304>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and
<http://www.healthierus.gov/steps/2004grants.html>

¹ Work Group for Community Health and Development at the University of Kansas. *Community tool box: best processes and practices that promote community change and improvement* [online]. 2006. Available at: http://ctb.ku.edu/tools/bp/en/tools_bp_6.jsp.

Implementation	Participate in coordinated monitoring and evaluation activities that include 1) collecting data and reporting on common performance measures and 2) planning and implementing national evaluation activities.
Indicator I-4.1	Submission of data on core performance measures according to established schedule.

Rationale for Selecting This Indicator

The core performance measures are the heart of the national evaluation and are an essential component of data-based decision making throughout the entire Steps Program. Across Steps communities, program evaluation uses a set of standard measures that are consistent with those of other federal programs and guidance documents. The core performance measures include both implementation and outcome measures so that we can generate knowledge about *how* programs achieve outcomes as well as *what* outcomes are achieved.

One of the core requirements for Steps communities is data collection and reporting on performance measures. The Program Assessment Rating Tool (PART) is the primary assessment tool that the Federal government uses to improve program performance so that it can achieve better results.¹ This performance measure and indicator are consistent with a PART question concerned with the collection of timely and credible performance data.¹ Obtaining timely, systematic, multi-site data allows the Centers for Disease Control and Prevention (CDC) to measure whether communities implemented required elements and how much progress they made toward intended outcomes. In addition, we can see how outcome data from each community compares with state and national data.

Intended Use of Data

Documenting submission of data on core performance measures shows that Steps communities fulfilled a core requirement of the Steps Program. Communities use site-specific data for program planning, data-driven decision making, and local evaluation. CDC uses data submitted on this indicator to make data-driven decisions regarding priorities for technical assistance to improve the program. CDC also uses this information to disseminate examples of performance measurement and to share lessons learned about implementing and evaluating programs—specifically measuring program processes and progress toward intended outcomes—with all Steps communities and other interested public health programs.

Data Source

Steps community program records

How Indicator is Measured

Steps communities send CDC the following data:

- A statement of whether or not data are submitted on each indicator.
 - Any contextual information or supplemental data that further explain or support the data for this indicator.
-

Special Instructions

None

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

10 Essential Public Health Services: <http://www.cdc.gov/od/ocph/nphpsp/EssentialPHServices.htm>

The Future of the Public's Health in the 21st Century, The Institute of Medicine (IOM):
<http://www.iom.edu/report.asp?id=4304>

National Association of County & City Health Officials: <http://www.naccho.org/>

Program Assessment Rating Tool (PART): <http://www.whitehouse.gov/omb/part/index.html>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and
<http://www.healthierus.gov/steps/2004grants.html>

¹ OMB. *Program assessment rating tool (PART)* [online]. 2006. Available at <http://www.whitehouse.gov/omb/part/>

Implementation Measure I-4	Participate in coordinated monitoring and evaluation activities that include 1) collecting data and reporting on common performance measures and 2) planning and implementing national evaluation activities.
Indicator I-4.2	Participation in national evaluation tasks (e.g., sending feedback to Steps Program Office (SPO) on draft documents, task-specific workgroups, conference calls).

Rationale for Selecting This Indicator

Evaluation is one of the essential public health services set forth by the National Public Health Performance Standards Program.¹ For a successful evaluation, stakeholder engagement is critical. Stakeholders are “the persons or organizations having an investment in what will be learned from an evaluation and what will be done with the knowledge.”² Steps communities are key stakeholders in the national evaluation of the Steps Program. Stakeholder engagement ensures that stakeholders’ perspectives are understood, and it minimizes the likelihood that evaluation findings will be ignored, criticized, or resisted because they do not address the stakeholders’ needs or values.²

Participation in national evaluation planning and implementation is a core requirement of the program. By involving Steps communities, the program ensures that the national evaluation meets the needs and realities of communities, captures their diverse experiences, and considers situations from their perspectives.

Intended Use of Data

Documenting their participation in national evaluation tasks shows that Steps communities fulfilled a core requirement of the program. Communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use data submitted on this indicator to make data-driven decisions regarding priorities for technical assistance to improve the program, to generate knowledge that will shape and strengthen future evaluation, and to promote collaboration on evaluation among the communities and between communities and CDC. CDC also uses this information to disseminate examples of community participation in the national Steps Program evaluation and to share lessons learned about program evaluation—specifically conducting multisite evaluations—with all communities and with other interested public health programs.

Data Source

Steps community program records

How Indicator is Measured

Steps communities send CDC the following data:

- Examples of how they participated in national program evaluation.
 - Any contextual information or supplemental data that further explain or support the data for this indicator.
-

Special Instructions

None

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

10 Essential Public Health Services: <http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm>

The Future of the Public's Health in the 21st Century, The Institute of Medicine (IOM):
<http://www.iom.edu/report.asp?id=4304>

National Association of County & City Health Officials: <http://www.naccho.org/>

Program Assessment Rating Tool (PART): <http://www.whitehouse.gov/omb/part/index.html>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and
<http://www.healthierus.gov/steps/2004grants.html>

¹ CDC. *National public health performance standards program: The essential public health services* [online]. Available at <http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm>

² CDC. Framework for program evaluation in public health. MMRW 1999;48(No. RR-11. US Department of Health and Human Services.

Implementation Measure I-5	Expand existing surveillance mechanisms to collect representative Behavioral Risk Factor Surveillance System (BRFSS) data on adults annually and representative data from the Youth Risk Behavior Surveillance System (YRBSS) on high school students every two years.
Indicator I-5.1	Appropriate and representative data collected via Behavioral Risk Factor Surveillance System.

Rationale for Selecting This Indicator

The use of surveillance data for planning and evaluation ensures the highest quality information for accountability and program improvement across multi-site programs. Using existing surveillance systems allows programs to maximize resources and increase consistency in measurement.¹ The Behavioral Risk Factor Surveillance System (BRFSS) is the primary source of information on lifestyle risk factors that contribute to the leading causes of death and chronic disease in the United States; the BRFSS is used by all 50 states, the District of Columbia, and three territories. Using this surveillance system allows Steps communities to maximize resources and enhance comparability of their data with those of the nation, state, and selected local areas. Data collection via the BRFSS generates timely, community-level data about relevant risk factors and behaviors and is the key source of information about Steps Program outcomes among adults.

Communities are required to expand existing surveillance mechanisms and collect representative data on factors of interest to the program. Investing in the annual collection of chronic disease surveillance data via the BRFSS demonstrates enhanced capacity for public health practice at the local level and serves as an example of community-level surveillance. Moreover, expanding disease and risk factor surveillance to the community level is a primary expected achievement of the program; such an expansion should improve community planning for health promotion activities.

Intended Use of Data

Documenting data collection via the BRFSS shows that Steps communities fulfilled a core requirement of the Steps Program. Communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use data submitted for this indicator to make data-driven decisions regarding priorities for technical assistance to improve the program. CDC also uses this information to disseminate examples of participation in surveillance systems at the local level and to share lessons learned about disease and risk factor surveillance with all Steps communities and interested public health programs.

Data Source

Behavioral Risk Factor Survey (BRFS) Report

How Indicator is Measured

Steps communities send CDC the following data:

- A statement that that they participated (or did not participate) in the BRFS.
 - The number of completed surveys.
 - A statement that their BRFS data was (or was not) weighted.
 - A description of any deviations from standard surveillance data collection procedures.
 - Any contextual information or supplemental data that further explain or support the data for this indicator.
-

Special Instructions

None

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

10 Essential Public Health Services: <http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm>

Centers for Disease Control and Prevention (CDC), *FY 2005 Performance Plan*:

<http://www.cdc.gov/od/perfplan/Index.htm>

The Future of the Public's Health in the 21st Century, The Institute of Medicine (IOM):

<http://www.iom.edu/report.asp?id=4304>

Government Performance and Results Act (GPRA): <http://www.whitehouse.gov/omb/mgmt-gpra/index.html>

National Association of County & City Health Officials: <http://www.naccho.org/>

Program Assessment Rating Tool (PART): <http://www.whitehouse.gov/omb/part/index.html>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and

<http://www.healthierus.gov/steps/2004grants.html>

¹ MacDonald G, Garcia D, Zaza S, Schooley M, Compton D, Bryant T, et al. Steps to a HealthierUS Cooperative Agreement Program: foundational elements for program evaluation planning, implementation, and use of findings. Preventing Chronic Disease [serial online] 2006 Jan. Available from: http://www.cdc.gov/PCD/issues/2006/jan/05_0136.htm

Implementation Measure I-5	Expand existing surveillance mechanisms to collect representative Behavioral Risk Factor Surveillance System (BRFSS) data on adults annually and representative data from the Youth Risk Behavior Surveillance System (YRBSS) on high school students every two years.
Indicator I-5.2	Appropriate and representative data collected via Youth Risk Behavior Surveillance System.

Rationale for Selecting This Indicator

The use of surveillance data for planning and evaluation ensures the highest quality information for accountability and program improvement across multi-site programs. Using existing surveillance systems allows programs to maximize resources and increase consistency in measurement.¹ The Youth Risk Behavior Surveillance System (YRBSS) is widely used to monitor priority health-risk behaviors that contribute to the leading causes of death, disability, and social problems among young people and adults in the United States: in 2005, 44 states and 23 large urban school districts participated. In addition, 22 of the 24 Steps communities funded in 2003 participated in the 2005 YRBSS. Communities funded in 2003 and 2004 will participate in the 2007 YRBSS. Data collection via the YRBSS generates timely, community-level data about relevant risk factors and behaviors and is the key source of information about Steps Program outcomes among young people.

Communities are required to expand existing surveillance mechanisms and collect representative data on factors of interest to the program. Investing in the biennial collection of chronic disease surveillance data via the YRBSS demonstrates enhanced capacity for public health practice at the local level and serves as an example of community-level surveillance. Moreover, expanding disease and risk factor surveillance to the community level is a primary expected achievement of the program; such an expansion should improve community planning for health promotion activities.

Intended Use of Data

Documenting data collection via the YRBSS shows that Steps communities fulfilled a core requirement of the Steps Program. Communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use data submitted for this indicator to make data-driven decisions regarding priorities for technical assistance to improve the program. CDC also uses this information to disseminate examples of participation in surveillance systems at the local level and to share lessons learned about disease and risk factor surveillance with all Steps communities and interested public health programs.

Data Source

Youth Risk Behavior Survey (YRBS) Report

How Indicator is Measured

Steps communities send CDC the following data:

- A statement that that they participated (or did not participate) in the YRBSS.
 - The number of completed surveys.
 - A statement that their YRBS data was (or was not) weighted.
 - A description of any deviations from standard surveillance data collection procedures and whether parental consent was active or passive.
 - Any contextual information or supplemental data that further explain or support the data for this indicator.
-

Special Instructions

None

Data Collection Schedule

Collected biennially

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

10 Essential Public Health Services: <http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm>

Centers for Disease Control and Prevention (CDC), *FY 2005 Performance Plan*:
<http://www.cdc.gov/od/perfplan/Index.htm>

The Future of the Public's Health in the 21st Century, The Institute of Medicine (IOM):
<http://www.iom.edu/report.asp?id=4304>

Government Performance and Results Act (GPRA): <http://www.whitehouse.gov/omb/mgmt-gpra/index.html>

National Association of County & City Health Officials: <http://www.naccho.org/>

Program Assessment Rating Tool (PART): <http://www.whitehouse.gov/omb/part/index.html>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and
<http://www.healthierus.gov/steps/2004grants.html>

¹ MacDonald G, Garcia D, Zaza S, Schooley M, Compton D, Bryant T, et al. Steps to a HealthierUS Cooperative Agreement Program: Foundational elements for program evaluation planning, implementation, and use of findings. *Preventing Chronic Diseases* [online]. 2006. Available at: http://www.cdc.gov/pcd/issues/2006/jan/05_0136.htm

Performance Measure I-6	Use multiple, evidence-based public health strategies.
Indicator I-6.1	Documented evidence for activities related to all the diseases and risk factors of interest to the Steps Program.

Rationale for Selecting This Indicator

This is the single most important performance measure and is the theoretical foundation for the Steps Program. Evidence-based public health is the process of using evidence-based interventions that are compatible with community preferences in order to improve the health of populations.^{1,2} The evidence base for interventions may include scientific evidence from a wide range of disciplines and/or practice-based wisdom.^{1,2} By implementing evidence-based strategies, Steps communities focus their efforts on the most effective interventions and demonstrate that funds are being used in the best way possible to reduce the burden of chronic disease in their communities.

Implementing evidence-based interventions to address all Steps focus areas (i.e. obesity, diabetes, asthma, poor nutrition, physical inactivity, and tobacco use) is a required element of the program. Communities are required to rely on current knowledge of what works in chronic disease prevention and health promotion in order to ensure progress toward intended outcomes. In doing so, communities draw from a wide range of sources of evidence. Using evidence-based strategies allows communities to increase their knowledge and begin implementing interventions with a minimum of time devoted to program planning.

Intended Use of Data

Documenting that interventions are evidence-based shows that Steps communities fulfilled a core requirement of the Steps Program. Communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use data submitted on this indicator to make data-driven decisions regarding priorities for technical assistance to improve the program. CDC also uses this information 1) to disseminate examples of the range of evidence available to support evidence-based chronic disease prevention and health promotion programs and 2) to share lessons learned about selecting and implementing evidence-based interventions with all Steps communities and other interested public health programs.

Data Source

Steps community program records

How Indicator is Measured

Steps communities send CDC the following data:

- A list of each intervention.
 - The source of evidence for each intervention.
 - An indication of which Steps Program focus areas (i.e. obesity, diabetes, asthma, nutrition, physical activity, and tobacco use) each intervention addresses.
 - Any contextual information or supplemental data that further explain or support the data for this indicator.
-

Special Instructions

Steps communities can draw from a wide range of evidence, including systematic reviews, published studies, unpublished studies, expert opinions, and practice-based wisdom.

Data Collection Schedules

Collected annually

Resources

Appendix G lists sources of evidence relevant to Steps interventions. It is an optional tool that Steps communities may use to show the evidence base for selected interventions. This list is not exhaustive or prescriptive, and Steps communities are not limited to the sources on this list.

Consistency with relevant agencies, initiatives, and guidance documents

The Future of the Public's Health in the 21st Century, The Institute of Medicine (IOM):
<http://www.iom.edu/report.asp?id=4304>

The Guide to Community Preventive Services: <http://www.thecommunityguide.org/>

National Association of County & City Health Officials: <http://www.naccho.org/>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and
<http://www.healthierus.gov/steps/2004grants.html>

The U.S. Preventive Services Task Force (AHRQ): <http://www.ahrq.gov/clinic/uspstfix.htm>

¹ Brownson R, Gurney J, & Land G. Evidence based decision making in public health. *Journal of Public Health Management Practice*. 1999;5(5):86-97.

² Kohatsu N, Robinson J, & Torner J. Evidence-based public health: an evolving concept. *American Journal of Preventive Medicine*. 2004;27(5): 417-21.

Performance Measure I-7	Improve integration of program components.
Indicator I-7.1	Implementation of 1) interventions that address at least two diseases or risk factors and 2) at least one intervention at each key sector.

Rationale for Selecting This Indicator

The Institute of Medicine (IOM) calls for chronic disease management programs to address “all of the leading chronic disease conditions that affect the population being served.”¹ The integration of chronic disease intervention activities is a process of coordinating programs and activities to prevent multiple chronic diseases and reduce related risk factors. Steps community programs implement interventions that cut across multiple chronic diseases and their associated risk factors in order to increase their effect on disease rates and the overall health of the population, to create awareness of the shared aims of most chronic disease prevention programs, and to facilitate more effective solving of persistent problems.² In addition, an integrated approach improves efficiency and cost effectiveness and reduces duplication.²

Community entities such as schools, volunteer organizations, religious congregations, businesses, and the media all have a role to play in shaping the public’s health. Indeed, the IOM identifies “communities and their many entities (e.g., schools, organizations, and religious congregations), businesses and employers, and the media as potential actors in the public health system.”³ Steps community programs implement interventions in a number of key sectors, including the following: healthcare settings, schools, workplaces, and the community.

Implementing interventions that address two or more of the Steps focus areas (i.e. obesity, diabetes, asthma, poor nutrition, physical inactivity, and tobacco use) and implementing interventions in all key sectors are required elements of the program. This integrated approach to disease prevention and health promotion distinguishes the program from categorical approaches to disease prevention and risk reduction. Implementing crosscutting interventions allows communities to maximize their resources and create synergies at the state and local level to spur progress toward intended outcomes.

Intended Use of Data

Documenting implementation of 1) interventions that address at least two diseases or risk factors and 2) at least one intervention at each key sector shows that Steps communities fulfilled core requirements of the Steps Program. Communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use data submitted on this indicator to make data-driven decisions regarding priorities for technical assistance to improve the program. CDC also uses this information to disseminate examples of crosscutting chronic disease prevention and health promotion interventions and to share lessons learned about implementing such interventions with all Steps communities and other interested public health programs.

Data Source

Steps community program records

How Indicator is Measured

Steps communities send CDC the following data:

- A list of each intervention.
 - An indication of which Steps Program focus areas (i.e. obesity, diabetes, asthma, poor nutrition, physical inactivity, and tobacco use) each intervention addresses.
 - An indication of which Steps Program key sectors (i.e. healthcare access, quality, and use; schools; workplace; community) each intervention addresses.
 - Any contextual information or supplemental data that further explain or support the data for this indicator.
-

Special Instructions

None

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

10 Essential Public Health Services: <http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm>

The Future of the Public's Health in the 21st Century, The Institute of Medicine (IOM): <http://www.iom.edu/report.asp?id=4304>

National Association of County & City Health Officials: <http://www.naccho.org/>

Secretary Mike Leavitt's 500-Day Plan: <http://www.hhs.gov/secretaryspage.html> and <http://www.hhs.gov/500DayPlan/500DayPlan.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ IOM. *Fostering rapid advances in health care: leaning from system demonstrations*. Washington, DC: The National Academies Press; 2002. Available at: <http://www.nap.edu/catalog/10565.html>.

² Partnership for Prevention and National Association of Chronic Disease Directors. *Comprehensive and integrated chronic disease prevention: action planning handbook for states and communities, version 2.0* [online]. 2005. Available from: http://www.prevent.org/images/stories/action_planning_handbook.pdf

³ IOM. *The future of the public's health in the 21st century*. Washington, DC: The National Academies Press; 2003. Available at: <http://www.iom.edu/CMS/3793/4720/4304.aspx>.

Performance Measure I-7	Improve integration of program components.
Indicator I-7.2	Implementation of evidenced-based interventions that address access to healthcare, quality of healthcare, and use of healthcare.

Rationale for Selecting This Indicator

In the United States, population health and individual access to quality healthcare are inextricably linked; according to the Institute of Medicine, “adequate population health cannot be achieved without making comprehensive and affordable health care available to every person residing in the United States.”¹ Interventions to improve access to healthcare, quality of healthcare, and use of the healthcare system are therefore important components of population-based chronic disease prevention and health promotion. For example, *The Guide to Community Preventive Services* recommends healthcare system interventions in several areas, including tobacco use cessation, diabetes disease management, and diabetes self management.²

Implementation of evidence-based interventions that improve healthcare access, quality, and use is a required element of the Steps Program. By integrating public health services and clinical services and by having public health professionals partner with clinical health professionals, Steps communities increase access to healthcare and improve the quality of care for people in their intervention areas. This provides access to the range of resources essential for chronic disease prevention and health promotion.

Intended Use of Data

Documenting implementation of evidence-based interventions that improve access to healthcare, quality of healthcare, and use of healthcare shows that Steps communities fulfilled a core requirement of the Steps Program. Communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use data submitted on this indicator to make data-driven decisions regarding priorities for technical assistance to improve the program. CDC uses this information to disseminate examples of chronic disease prevention and health promotion interventions to improve access to healthcare, quality of healthcare, and use of the healthcare system. In addition, CDC shares lessons learned about implementing those interventions with all Steps communities and with other interested public health programs.

Data Source

Steps community program records

How Indicator is Measured

Steps communities send CDC the following data:

- A list of each intervention.
 - The source of evidence for each intervention.
 - An indication of which interventions address healthcare access, quality, and use.
 - Any contextual information or supplemental data that further explain or support the data for this indicator.
-

Data Collection Schedules

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

10 Essential Public Health Services: <http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm>

The Future of the Public's Health in the 21st Century, The Institute of Medicine (IOM):
<http://www.iom.edu/report.asp?id=4304>

National Association of County & City Health Officials: <http://www.naccho.org/>

Secretary Mike Leavitt's 500-Day Plan: <http://www.hhs.gov/secretaryspage.html> and
<http://www.hhs.gov/500DayPlan/500DayPlan.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and
<http://www.healthierus.gov/steps/2004grants.html>

¹ IOM. *The future of the public's health in the 21st century*. Washington, DC: The National Academies Press; 2003.
Available at: <http://www.iom.edu/CMS/3793/4720/4304.aspx>

² Zaza S, Bris PA, Harris KW (eds). *Guide to community preventive services: what works to promote health*. Task Force on Community Preventive Services. New York, NY: Oxford University Press; 2005.

Performance Measure I-7	Improve integration of program components.
Indicator I-7.3	Implementation of evidence-based interventions across the socio-ecological model (i.e., individual, interpersonal, organizational, community, and public policy).

Rationale for Selecting This Indicator

Community entities such as schools, volunteer organizations, religious congregations, businesses, and the media all have a role to play in shaping the public’s health. Indeed, the Institute of Medicine calls for “adopting a population health approach that considers the multiple determinants of health.”¹ One such approach is the ecological perspective, which emphasizes the interaction between, and interdependence of, factors within and across all levels of a health problem.² The socio-ecological model identifies five levels of influence for health-related behaviors and conditions: individual, interpersonal, organizational, community, and public policy.³ By targeting factors that influence health at all five of these levels, programs can have a greater effect on individual and population health than if they focus on only one or a few of these levels.

Implementing evidence-based interventions across the socio-ecological model is a core element of the Steps Program. Recognizing the contributions of individual, social, and environmental influences to the diseases and risk factors targeted by the program, Steps communities use interventions that focus on all five levels of the socio-ecological model.

Intended Use of Data

Documenting that evidence-based interventions were implemented across the socio-ecological model shows that Steps communities fulfilled a core requirement of the Steps Program. Communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use data submitted on this indicator to make data-driven decisions regarding priorities for technical assistance to improve the Steps Program. CDC also uses this information to disseminate examples of interventions at all levels of the socio-ecological model and to share lessons learned about implementing those interventions with all Steps communities and other interested public health programs.

Data Source

Steps community program records

How Indicator is Measured

Steps communities send CDC the following data:

- A list of each intervention.
 - The source of evidence for each intervention.
 - An indication of which level(s) of the socio-ecologic model (i.e., individual, interpersonal, organizational, community, and public policy) each intervention addresses.
 - Any contextual information or supplemental data that further explain or support the data for this indicator.
-

Special Instructions

In general terms, individual-level interventions target the characteristics of individuals (e.g., their knowledge, attitudes, behavior, and skills). At the interpersonal level, interventions target social norms and influences within formal and informal networks, including families, work groups, and friendship networks. Interventions at the organizational level target rules and regulations, management support (or lack of support) for certain activities, work structures, workplace policies, and the institutionalization of programs. Community-level interventions promote coordination among agencies, coalition-building, and increased access for residents of Steps communities to community power structures. Interventions at the public policy level seek to affect local, state, or national laws and policies.

Interventions may target more than one socio-ecological level. For example, a walking program may target changes at the individual level (e.g., knowledge and awareness), the interpersonal level (e.g., social norms), and the community or organizational level (e.g., access to places for physical activity).

Data Collection Schedule

Collected annually

Resources

McLeroy, K., Bibeau, D., Steckler, A., & Glanz, K. (1988). An Ecological perspective on health promotion programs. *Health Education Quarterly*, 15, 351-377.

Consistency with relevant agencies, initiatives, and guidance documents

10 Essential Public Health Services: <http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm>

The Future of the Public's Health in the 21st Century, The Institute of Medicine (IOM): <http://www.iom.edu/report.asp?id=4304>

National Association of County & City Health Officials: <http://www.naccho.org/>

Secretary Mike Leavitt's 500-Day Plan: <http://www.hhs.gov/secretaryspage.html> and <http://www.hhs.gov/500DayPlan/500DayPlan.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ IOM. *The future of the public's health in the 21st century*. Washington, DC: The National Academies Press; 2003. Available at: <http://www.iom.edu/CMS/3793/4720/4304.aspx>.

² National Cancer Institute. *Theory at a glance: a guide for health promotion practice*, 2nd edition. NIH (NIH Publication No. 05-3896); 2005. Available at: <https://cissecure.nci.nih.gov/ncipubs/details.asp?pid=1302>.

³ McLeroy KR, Bigeau D, Steckler A, Glanz K. An ecological perspective on health promotion programs. *Health Education Quarterly*. 1988;15(4): 351-377.

Implementation Measure I-7	Improve integration of program components.
Indicator I-7.4	Partnership with the YMCA of the USA, or local affiliate, to improve access to places for physical activity.

Rationale for Selecting This Indicator

Physical inactivity is a primary cause of overweight and obesity, and physical activity can reduce the risk of a wide variety of chronic and acute illnesses. *The Guide to Community Preventive Services* strongly recommends increasing access to places for physical activity as a successful strategy for improving physical activity levels.¹ Collectively, YMCAs are the largest not-for-profit community service organization in the United States.² In 2004, the YMCA of the USA received \$4 million to support and enhance chronic disease prevention and health promotion in Steps communities. The YMCA of the USA distributed this money to local affiliates to strengthen cooperative efforts with Steps communities to improve access to places for physical activity.

Intended Use of Data

Documenting that they work with the YMCA, or a local affiliate, to improve access to places for physical activity shows that Steps communities partnered with the YMCA as intended by Steps Program Announcement 04134.³ Communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use data submitted on this indicator to make data-driven decisions regarding priorities for technical assistance to improve the Steps Program. CDC also uses this information to disseminate examples of collaboration between communities and local YMCA affiliates and to share lessons learned about improving access to physical activity with all Steps communities and other interested public health programs.

Data Source

Steps community program records

How Indicator is Measured

Steps communities send CDC the following data:

- Whether or not there is a local affiliate of the YMCA in their community.
 - Whether or not the local affiliate was funded by YMCA of the USA to support Steps activities.
 - Examples of how the Steps community is working with the local YMCA affiliate to improve access to places for physical activity.
 - Any contextual information or supplemental data that further explain or support the data for this indicator.
-

Special Instructions

None

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

10 Essential Public Health Services: <http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm>

The Future of the Public's Health in the 21st Century, The Institute of Medicine (IOM):
<http://www.iom.edu/report.asp?id=4304>

The Guide to Community Preventive Services: <http://www.thecommunityguide.org/>

National Association of County & City Health Officials: <http://www.naccho.org/>

Secretary Mike Leavitt's 500-Day Plan: <http://www.hhs.gov/secretaryspage.html> and
<http://www.hhs.gov/500DayPlan/500DayPlan.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html>
<http://www.healthierus.gov/steps/2004grants.html> and <http://edocket.access.gpo.gov/2003/03-26628.htm>

¹ Zaza S, Bris PA, Harris KW (eds). *Guide to community preventive services: what works to promote health*. Task Force on Community Preventive Services. New York, NY: Oxford University Press; 2005.

² YMCA. *About the YMCA* [online]. Available at: http://www.ymca.net/about_the_ymca/

³ Program Announcement 04134: Steps to a HealthierUS: national organization partnerships. Fed Regist 2004 April 23; 69(79):22055-60. Available at: <http://www.healthierus.gov/steps/rfa/2004OrgsRFA/FR04232004.htm>

Implementation Measure I-7	Improve integration of program components.
Indicator I-7.5	Composition and function of Steps Leadership Team (e.g., inclusion of non-traditional agencies or partners, state or local categorical programs, key community-based organizations, or representatives of the healthcare sector.)

Rationale for Selecting This Indicator

Building leadership is a core requirement for any community program.¹ The Steps Program calls for a form of leadership that reflects and supports its complex, integrated nature: “a collaboration among several groups and individuals is often needed to address a complex issue, and a collaboration needs collaborative leadership.”² Partnerships with government agencies and with nongovernmental lay and professional groups can be effective in chronic disease prevention and control.³ Such partnerships allow programs to coordinate activities, maximize limited resources, and avoid duplication of efforts.

Establishing and coordinating a formal leadership team that provides direction and expertise throughout program planning, implementation, and evaluation is a core requirement of the program. The specific composition and function of the Steps Leadership Team varies from community to community; however, each team should consist of representatives of the various public and private partner organizations, the various populations served in the intervention area, and any other local groups relevant to the Steps focus areas. The team should be an example of the collaborative relationships that guide and support integrated community programs to prevent chronic disease and promote health.

Intended Use of Data

Documenting the composition of the Steps Leadership Team, and which group each team member represents, shows that Steps communities fulfilled a core requirement of the Steps Program. Communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use data submitted on this indicator to make data-driven decisions regarding priorities for technical assistance to improve the Steps Program. CDC also uses this information to disseminate examples of effective leadership teams and to share lessons learned about leadership and management with all Steps communities and other interested public health programs.

Data Source

Steps community program records

How Indicator is Measured

Steps communities send CDC the following data:

- The names of Leadership Team participants.
 - The affiliation of Leadership Team participants.
 - A description of the key functions of the Leadership Team.
 - Any contextual information or supplemental data that further explain or support the data for this indicator.
-

Special Instructions

Communities may use different names for the Steps Leadership Team required by the Steps Program announcements. This indicator refers to the team responsible for overseeing project activities and determining project budgets and subcontracts. It does not refer to a staff management team or to a community consortium.

Data Collection and Assessment Schedules

Collected and assessed annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

10 Essential Public Health Services: <http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm>

The Future of the Public's Health in the 21st Century, The Institute of Medicine (IOM): <http://www.iom.edu/report.asp?id=4304>

National Association of County & City Health Officials: <http://www.naccho.org/>

Program Assessment Rating Tool (PART): <http://www.whitehouse.gov/omb/part/index.html>

Secretary Mike Leavitt's 500-Day Plan: <http://www.hhs.gov/secretaryspage.html> and <http://www.hhs.gov/500DayPlan/500DayPlan.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ Work Group for Community Health and Development at the University of Kansas. *Community tool box: building leadership* [online]. 2006. Available at: http://ctb.ku.edu/tools/tk/en/tools_tk_6.jsp.

² Work Group for Community Health and Development at the University of Kansas. *Community tool box: collaborative leadership*. [online]. 2006. Available at: http://ctb.ku.edu/tools/en/sub_section_main_1874.htm.

³ CDC. *Promising practices in chronic disease prevention and control: a public health framework for action*. Atlanta, GA: HHS; 2003.

Implementation Measure I-7	Improve integration of program components.
Indicator I-7.6	Composition and function of Steps State-Community Management Team (e.g., inclusion of coordinated Steps communities, non-traditional agencies or partners, state or local categorical programs, key community-based organizations, or representatives of the healthcare sector.) (State only)

Rationale for Selecting This Indicator

Building leadership is a core requirement for any community program.¹ The Steps Program calls for a form of leadership that reflects and supports its complex, integrated nature: “a collaboration among several groups and individuals is often needed to address a complex issue, and a collaboration needs collaborative leadership.”² Partnerships with government agencies and with nongovernmental lay and professional groups can be effective in chronic disease prevention and control.³ Such partnerships allow programs to coordinate activities, maximize limited resources, and avoid duplication of efforts.

Establishing and coordinating a formal State-Community Management team that provides direction and expertise throughout program planning, implementation, and evaluation is a core requirement of the Steps Program. The specific composition and function of the Steps State-Community Management Team varies from community to community; however, each team should include representatives of state-coordinated Steps communities; the state health department, education agency, and Office of Rural Health; any non state-coordinated Steps communities within the state borders; and other key public and private sector partners. The team should be an example of the collaborative relationships that guide and support integrated community programs to prevent chronic disease and promote health.

Intended Use of Data

Documenting the composition of the Steps State-Community Management Team, and which group each team member represents, shows that states that coordinate multiple Steps communities fulfilled a core requirement of the Steps Program. Communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use data submitted on this indicator to make data-driven decisions regarding priorities for technical assistance to improve the Steps Program. CDC also uses this information to disseminate examples of effective Steps State-Community Management Teams and to share lessons learned about leadership and management with all Steps communities and other interested public health programs.

Data Source

Steps community program records

How Indicator is Measured

States that coordinate multiple Steps communities send CDC the following data:

- The names of State-Community Management Team participants.
 - The affiliation of State-Community Management Team participants.
 - A description of the key functions of the State-Community Management Team.
 - Any contextual information or supplemental data that further explain or support the data for this indicator.
-

Special Instructions

This indicator applies to state departments of health that coordinate multiple Steps community programs within their state. Small cities or rural areas, large cities or urban areas, and tribes or tribal entities funded by the Steps Program do not report on this indicator.

Communities may use different names for the State-Community Management Team required by the Steps Program announcements. This indicator refers to the team responsible for coordinating community objectives with state health plans, ensuring collaboration between state-coordinated Steps communities and other chronic disease prevention and control programs, and establishing and maintaining project staff sufficient to provide oversight and technical assistance to state-coordinated Steps communities.

Data Collection and Assessment Schedules

Collected and assessed annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

10 Essential Public Health Services: <http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm>

The Future of the Public's Health in the 21st Century, The Institute of Medicine (IOM): <http://www.iom.edu/report.asp?id=4304>

National Association of County & City Health Officials: <http://www.naccho.org/>

Program Assessment Rating Tool (PART): <http://www.whitehouse.gov/omb/part/index.html>

Secretary Mike Leavitt's 500-Day Plan: <http://www.hhs.gov/secretaryspage.html> and <http://www.hhs.gov/500DayPlan/500DayPlan.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ Work Group for Community Health and Development at the University of Kansas. *Community tool box: building leadership* [online]. 2006. Available at: http://ctb.ku.edu/tools/tk/en/tools_tk_6.jsp.

² Work Group for Community Health and Development at the University of Kansas. *Community tool box: collaborative leadership*. [online]. 2006. Available at: http://ctb.ku.edu/tools/en/sub_section_main_1874.htm.

³ CDC. *Promising practices in chronic disease prevention and control: a public health framework for action*. Atlanta, GA: HHS; 2003.

Implementation Measure I-7	Improve integration of program components.
Indicator I-7.7	Provision of technical assistance to state-coordinated Steps communities (State only).

Rationale for Selecting This Indicator

Technical assistance is a “process of connecting groups to expertise and resources that address needs and provide support ... to communities over time as they plan, implement, evaluate, and sustain efforts for making a difference.”¹ Staff in community-based programs have expressed the need for “timely and accessible technical assistance across all program phases,” particularly in areas such as data-based decision making, using an ecological approach, successfully implementing evidence-based interventions, and evaluating programs.² Technical assistance may help communities enhance competencies and specialized knowledge, increase their potential to effect change, connect to essential resources, increase the chance of successful implementation and sustainability, and overcome barriers to addressing needs.¹

Technical assistance may be provided in many forms, including workshops and other training, mentoring, in person or Internet-based support systems, written materials, and individual consultations.^{1,3} Effective technical assistance systems strike a balance between responding to the expressed needs of individual communities versus proactively stimulating discussion of overall program priorities; they also must balance activities intended to strengthen the capacity of local staff and activities directly focused on program implementation.²

In recent years, many government programs have shifted responsibility for program implementation from the federal to the local level, and state governments are now often expected to establish technical assistance systems that “nurture and support local community-based initiatives.”² Providing technical assistance to state-coordinated Steps communities is a core requirement of the Steps Program for funded state departments of health. The program announcements identify key topic areas for technical assistance to state-coordinated communities, including monitoring disease burden, risk factor surveillance, program evaluation, evidence-based practices, community support, intervention selection and development, and resource development.

Intended Use of Data

Documenting the provision of technical assistance to state-coordinated Steps communities shows that funded states fulfilled a core requirement of the Steps Program. Communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use data submitted on this indicator to make data-driven decisions regarding priorities for technical assistance to improve the Steps Program. CDC also uses this information to disseminate examples of technical assistance to support the activities of state-coordinated communities and to share lessons learned about providing such support with all Steps communities and other interested public health programs.

Data Source

Steps community program records

How Indicator is Measured

States that coordinate multiple Steps communities send CDC the following data:

- At least one example of each type of technical assistance provided to state-coordinated Steps communities. Types of technical assistance include site visits to Steps communities; direct technical assistance (e.g. individual consultations or mentoring); training; and linking communities to existing programs, resources, or infrastructure.
- An indication of which relevant topics were addressed by each type of technical assistance (see special instructions).
- Any contextual information or supplemental data that further explain or support the data for this indicator.

Special Instructions

This indicator applies to state departments of health that coordinate multiple Steps community programs within their state. Small cities or rural areas, large cities or urban areas, and tribes or tribal entities funded by the Steps Program do not report on this indicator.

Relevant topics include obesity, diabetes, asthma, poor nutrition, physical inactivity, tobacco use, monitoring disease burden, risk factor surveillance, program evaluation, evidence-based practices, community support, intervention selection and development, resource development, integration, sustainability, partnership/collaboration, health disparities, media/communications, and policy.

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

10 Essential Public Health Services: <http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm>

Centers for Disease Control and Prevention (CDC), *FY 2005 Performance Plan*:
<http://www.cdc.gov/od/perfplan/Index.htm>

The Future of the Public's Health in the 21st Century, The Institute of Medicine (IOM):
<http://www.iom.edu/report.asp?id=4304>

Government Performance and Results Act (GPRA): <http://www.whitehouse.gov/omb/mgmt-gpra/index.html>

National Association of County & City Health Officials: <http://www.naccho.org/>

Secretary Mike Leavitt's 500-Day Plan: <http://www.hhs.gov/secretaryspage.html> and
<http://www.hhs.gov/500DayPlan/500DayPlan.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and
<http://www.healthierus.gov/steps/2004grants.html>

¹ Work Group for Community Health and Development at the University of Kansas. *Community tool box: assuring technical assistance* [online]. 2006. Available at: http://ctb.ku.edu/tools/bp/en/tools_bp_9.jsp

² Mitchell RE, Florin P, Stevenson J. Supporting community-based prevention and health promotion initiatives: developing effective technical assistance systems. *Health education & behavior*. 2002;29:620-639.

³ Roussos ST, Fawcett SB. A review of collaborative partnerships as a strategy for improving community health. *Annual review of public health*. 2000;21:369-402.

**Implementation
Measure I-8**

**Document that intended populations participate in Steps
communities' activities and interventions.**

Indicator I-8.1

**Reach (i.e. service to intervention areas or specific
populations identified in community action plan)**

Rationale for Selecting This Indicator

Reach is the “proportion of intended target audience that participates in an intervention.”¹ It is important to note that *reach* is not simply a count of participants. Rather, measures of reach are concerned with whether or not the intended audience participates in a given activity or intervention. Documenting reach is a key component of process evaluation: for a program to achieve its intended outcomes, activities and interventions must reach intended participants. The selected indicator is a proxy measure of reach. Given the reality of the resources available to the Steps Program, it is not feasible to measure reach using the above definition. This indicator addresses the essential question of a measure of reach: did funded communities provide service to intended intervention areas or specific populations?

As a required element of the Steps Program, Steps communities provide services to specific intervention areas or populations. Each community defines its intervention areas and populations based on local needs and context.

Intended Use of Data

Documenting service to specific intervention areas or populations shows that Steps communities fulfilled a core requirement of the Steps Program. Communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use data submitted on this indicator to make data-driven decisions regarding priorities for technical assistance to improve the Steps Program. CDC also uses this information to disseminate examples of the program's intended audiences and to share lessons learned about implementing interventions to reach those audiences with all Steps communities and other interested public health programs.

Data Source

Steps community program records

How Indicator is Measured

Steps communities send CDC the following data:

- A list of each intervention.
 - Whether or not the intervention was implemented in the population(s) identified in the community action plan.
 - An indication of which population(s) participated in the intervention.
 - Any contextual information or supplemental data that further explain or support the data for this indicator.
-

Special Instructions

Steps communities may wish to use the space for contextual information to document any challenges or successful strategies for reaching intended populations identified in the community action plan. They may also wish to use this space to provide examples of participation in activities that go beyond interventions (e.g., planning or evaluation).

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

The Future of the Public's Health in the 21st Century, The Institute of Medicine (IOM):
<http://www.iom.edu/report.asp?id=4304>

Program Assessment Rating Tool (PART): <http://www.whitehouse.gov/omb/part/index.html>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and
<http://www.healthierus.gov/steps/2004grants.html>

¹ Steckler A, Linnan L, eds. *Process evaluation in public health interventions*. San Francisco: Jossey-Bass; 2002.

Performance Measure O-1	Increased knowledge and awareness about healthy behaviors such as healthful eating, physical activity, and avoiding tobacco use.
Indicator O-1	Community-specific indicators.

Rationale for Selecting This Indicator

Multiple factors influence any given health-related behavior. Knowledge and awareness about healthy behaviors are among the factors that predispose individuals or populations to change their behavior.¹ Health behavior theories show that knowledge, awareness, and other predisposing factors are precursors to behavior change, so changes in these short-term outcomes are expected to contribute to desired behavior changes. Specifically, increased knowledge and awareness about healthy behaviors can lead to more healthful eating, increased physical activity, and avoidance of tobacco use—changes which can contribute to the prevention or reduction of complications of chronic diseases, including obesity, diabetes, and asthma.

There is little scientific consensus on appropriate indicators to measure knowledge and awareness about healthy behaviors. The Centers for Disease Control and Prevention (CDC) reviewed existing guidance documents and indicators, consulted with Steps Program stakeholders, including staff from CDC divisions whose primary responsibility is one of the Steps Program focus areas, and reviewed relevant survey items currently used by Steps communities. While there is a range of program activities and indicators, there is also considerable overlap between leading indicators from communities and other sources. The indicators listed in the Core Performance Measures matrix (Appendix B) are recommendations based on these reviews and consultations.

Indicators, data sources, and survey questions for this performance measure will be determined by each Steps community and will vary from one community to another. Communities will select these items based on the context and focus of their programs.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. CDC uses these data to track progress toward short-term outcomes related to more healthful eating, increased physical activity, and reduced tobacco use. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions targeting increased knowledge and awareness about healthy behaviors. These data are used to recognize successes and to determine progress toward intended outcomes related to increased knowledge and awareness about healthy behaviors. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source

Community-specific data sources

How Indicator Is Measured

Determined by each community

Survey Question(s)

Determined by each community

Special Instructions

Indicators, data sources, and survey items for this performance measure will vary by Steps community.

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

10 Essential Public Health Services: <http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and
<http://www.healthierus.gov/steps/2004grants.html>

¹ Green, L. W. & M. W. Kreuter. *Health promotion planning: an educational and ecological approach*, 3rd edition. Mountain View, CA: Mayfield; 1999.

Performance Measure O-2	Increased knowledge about getting appropriate preventive screenings.
Indicator O-2	Community-specific indicators.

Rationale for Selecting This Indicator

Multiple factors influence any given health-related behavior. Knowledge about healthy behaviors is one factor that predisposes individuals or populations to change their behavior.¹ Health behavior theories show that knowledge, awareness, and other predisposing factors are precursors to behavior change, so changes in these short-term outcomes are expected to contribute to desired behavior changes. Specifically, increased patient or provider knowledge about getting appropriate preventative screenings can lead to increased use of those preventive screenings, which in turn can contribute to the prevention or reduction of complications of chronic diseases, including obesity, diabetes, and asthma.

There is little scientific consensus on appropriate indicators to measure knowledge about getting appropriate preventive screenings. Indicators, data sources, and survey questions for this performance measure are determined by each Steps community and vary from one community to another. Communities select indicators, data sources, and survey questions based on the context and focus of their programs. However, indicators for all communities should reinforce the recommendations of the U.S. Preventive Services Task Force contained in the *Guide to Clinical Preventive Services*.²

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward short-term outcomes related to improved access to and quality of clinical services for diabetes, asthma, and tobacco use cessation. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions targeting increased knowledge about getting appropriate preventive screenings. These data are used to recognize successes and to determine progress toward intended outcomes related to increased knowledge about getting appropriate preventive screenings. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source

Community-specific data sources

How Indicator Is Measured

Determined by each community

Survey Question(s)

Determined by each community

Special Instructions

Indicators, data sources, and survey items for this performance measure will vary by Steps community.

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

10 Essential Public Health Services: <http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and
<http://www.healthierus.gov/steps/2004grants.html>

¹ Green, L. W. & M. W. Kreuter. *Health promotion planning: an educational and ecological approach, 3rd edition*. Mountain View, CA: Mayfield; 1999.

² USPSTF. *Guide to Clinical Preventive Services, 2005*. (Publication No. AHRQ 05-0570). Rockville, MD: Agency for Healthcare Research and Quality; 2005. Available at: <http://www.ahrq.gov/clinic/pocketgd.htm>

Performance Measure O-3

Increased physical activity and healthful eating for children and adults.

Indicator O-3.1

Fruit and vegetable consumption among adults aged 18 or older.

Rationale for Selecting This Indicator

High consumption of fruits and vegetables is associated with low dietary fat intake and low incidence of several chronic diseases, including cardiovascular disease and some cancers.¹ For both adults and school-age children, there is an inverse association between eating fruit and body mass index (BMI): as fruit consumption increases, BMI decreases.² High BMI (indicating either overweight or obesity) is a risk factor for high blood pressure, high cholesterol, heart disease, diabetes, several forms of cancer, and other chronic health problems.³ Having populations adopt healthy diets, including increasing consumption of fruits and vegetables, can help to prevent or reduce the prevalence of overweight, obesity, and their related health risks.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward intermediate outcomes related to increases in healthful eating. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions targeting nutrition. These data are used to recognize successes and to determine progress toward intended outcomes related to improved nutrition. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source

2005 Behavioral Risk Factor Survey (BRFS)
Core Section 17: Fruits and Vegetables

How Indicator Is Measured

Numerator: Respondents aged ≥ 18 years who report eating ≥ 5 fruits and vegetables per day.

Denominator: Respondents aged ≥ 18 years who report eating any fruits and vegetables per day, including zero (excluding unknowns and refusals).

Survey Question(s)

17.1 How often do you drink fruit juices such as orange, grapefruit, or tomato?

17.2 Not counting juice, how often do you eat fruit?

17.3 How often do you eat green salad?

17.4 How often do you eat potatoes not including french fries, fried potatoes, or potato chips?

17.5 How often do you eat carrots?

17.6 Not counting carrots, potatoes, or salad, how many servings of vegetables do you usually eat? (Example: A serving of vegetables at both lunch and dinner would be two servings.)

Special Instructions

All six questions must be asked in the prescribed order to obtain valid data on the indicator.

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

The Guide to Community Preventive Services: <http://www.thecommunityguide.org/>

Healthy People 2010: <http://www.healthypeople.gov/default.htm>

Indicators for Chronic Disease Surveillance: <http://www.cdc.gov/mmwr/PDF/RR/RR5311.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ Ness AR, Powles JW. High costs of poor eating patterns in the United States. In: Frazao E, editor. *America's eating habits: changes and consequences*. (Agriculture Information bulletin No. AIB750). Washington, DC: U.S. Department of Agriculture, Economic Research Service; 1999:5-32.. Available at: www.ers.usda.gov/publications/aib750

² Lin B-H & Morrison RM. Higher fruit consumption linked with lower body mass index. *Food Review (Economic Research Service, USDA)*. 2002;25:28-32.

³ NHLBI. *Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults*. (NIH Publication No. 98-4083). NIH; 1998. Available at: http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.pdf

Performance Measure O-3

Increased physical activity and healthful eating for children and adults.

Indicator O-3.2

Fruit and vegetable consumption among youth.

Rationale for Selecting This Indicator

High consumption of fruits and vegetables is associated with low dietary fat intake and low incidence of several chronic diseases, including cardiovascular disease and some cancers.¹ For both adults and school-age children, there is an inverse association between eating fruit and body mass index (BMI): as fruit consumption increases, BMI decreases.² High BMI (indicating either overweight or obesity) is a risk factor for high blood pressure, high cholesterol, heart disease, diabetes, several forms of cancer, and other chronic health problems.³ Overweight adolescents have a 70% chance of becoming overweight or obese adults.⁴ Establishing healthy eating behaviors can help young people achieve normal body weight, thereby reducing the health risks associated with being overweight or obese.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward intermediate outcomes related to increases in healthful eating. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions targeting nutrition. These data are used to recognize successes and to determine progress toward intended outcomes related to improved nutrition. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source

2007 Youth Risk Behavior Survey (YRBS)
Food Section

How Indicator Is Measured

Numerator: Respondents in grades 9–12 who report eating ≥ 5 fruits and vegetables per day during the past 7 days.

Denominator: Respondents in grades 9–12 who report eating any number of fruits and vegetables per day in the past 7 days, including zero (excluding those who did not answer).

Survey Question(s)

72. During the past 7 days, how many times did you drink 100% fruit juices such as orange juice, apple juice, or grape juice? (Do not count punch, Kool-Aid, sports drinks, or other fruit-flavored drinks)
73. During the past 7 days, how many times did you eat fruit? (Do not count fruit juice.)
74. During the past 7 days, how many times did you eat green salad?
75. During the past 7 days, how many times did you eat potatoes? (Do not count French fries, fried potatoes, or potato chips.)
76. During the past 7 days, how many times did you eat carrots?
77. During the past 7 days, how many times did you eat other vegetables? (Do not count green salad, potatoes or carrots.)

The above questions are questions 23 – 28 on the 2007 Steps YRBS questionnaire, a short version of the core YRBS questionnaire that contains questions relevant to the Steps Program focus areas.

Special Instructions

None

Data Collection Schedule

Collected biennially

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

Healthy People 2010: <http://www.healthypeople.gov/default.htm>

Indicators for Chronic Disease Surveillance: <http://www.cdc.gov/mmwr/PDF/RR/RR5311.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ Ness AR, Powles JW. High costs of poor eating patterns in the United States. In: Frazao E, editor. *America's eating habits: changes and consequences*. (Agriculture Information bulletin No. AIB750). Washington, DC: U.S. Department of Agriculture, Economic Research Service; 1999:5-32.. Available at: www.ers.usda.gov/publications/aib750

² Lin B-H & Morrison RM. Higher fruit consumption linked with lower body mass index. *Food Review (Economic Research Service, USDA)*. 2002;25:28-32.

³ NHLBI. *Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults*. (NIH Publication No. 98-4083). NIH; 1998. Available at: http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.pdf

⁴ HHS. *The Surgeon General's call to action to prevent and decrease overweight and obesity*. Rockville, MD: HHS, Public Health Service, Office of the Surgeon General; 2001. Available at: <http://www.surgeongeneral.gov/topics/obesity/>

Performance Measure O-3

Increased physical activity and healthful eating for children and adults.

Indicator O-3.3

Recommended physical activity among adults aged ≥ 18 years.

Rationale for Selecting This Indicator

Research shows that virtually everyone benefits from regular physical activity.¹ The Surgeon General recommends that adults get at least 30 minutes of moderate physical activity most days of the week.² Low levels of activity, resulting in fewer kilocalories used as energy than consumed as food, contribute to the high prevalence of obesity in the United States.¹ Physical activity reduces the risk of premature mortality in general, and of coronary heart disease, hypertension, colon cancer, and diabetes mellitus in particular. Physical activity also improves mental health; is important for the health of muscles, bones, and joints; and appears to improve health-related quality of life.¹ Having people engage in regular, moderate physical activity provides important health benefits and helps prevent or reduce the prevalence of overweight and obesity and their related health risks.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward intermediate outcomes related to increases in physical activity. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions promoting physical activity. These data are used to recognize successes and to determine progress toward intended outcomes related to increased physical activity. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source(s)

2005 Behavioral Risk Factor Survey (BRFS)
Core Section 18: Physical Activity

How Indicator Is Measured

Numerator: Number of adults aged ≥ 18 years who report moderate physical activity for ≥ 30 minutes ≥ 5 times/week or who report vigorous physical activity for ≥ 20 minutes ≥ 3 times/week.

Denominator: Number of adults aged ≥ 18 years who report any or no physical activity within the previous month (excluding unknowns and refusals).

Survey Question(s)

- 18.2 Now, thinking about the moderate physical activities you do ... in a usual week, do you do moderate activities for at least 10 minutes at a time, such as brisk walking, bicycling, vacuuming, gardening, or anything else that causes small increases in breathing or heart rate?
- 18.3 How many days per week do you do these moderate activities for at least 10 minutes at a time?
- 18.4 On days that you do moderate activities for at least 10 minutes at a time, how much total time per day do you spend doing these activities?
- 18.5 Now, thinking about the vigorous physical activities you do ... in a usual week, do you do vigorous activities for at least 10 minutes at a time, such as running, aerobics, heavy yard work, or anything else that causes large increases in breathing or heart rate?
- 18.6 How many days per week do you do these vigorous activities for at least 10 minutes at a time?
- 18.7 On days that you do vigorous activities for at least 10 minutes at a time, how much total time per day do you spend doing these activities?
-

Special Instructions

All six questions must be asked in the prescribed order to obtain valid data on the indicator.

Data Collection Schedule

Collected annually.

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

The Community Indicators Handbook: <http://www.communityinitiatives.com/pubs/indicats.html>

The Guide to Community Preventive Services: <http://www.thecommunityguide.org/>

Healthy People 2010: <http://www.healthypeople.gov/default.htm>

Indicators for Chronic Disease Surveillance: <http://www.cdc.gov/mmwr/PDF/RR/RR5311.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ U.S. Department of Health and Human Services. *Physical Activity and Health: A Report of the Surgeon General*. Atlanta, GA: CDC, NCCDPHP; 1996.

² HHS. *The Surgeon General's call to action to prevent and decrease overweight and obesity*. Rockville, MD: HHS, Public Health Service, Office of the Surgeon General; 2001. Available at: <http://www.surgeongeneral.gov/topics/obesity/>

Performance Measure O-3

Increased physical activity and healthful eating for children and adults.

Indicator O-3.4

Recommended physical activity among youth.

Rationale for Selecting This Indicator

The Surgeon General recommends that children get at least 60 minutes of moderate physical activity most days.¹ Participation in regular physical activity helps build and maintain healthy bones and muscles; control weight and reduce fat; reduce feelings of depression and anxiety; and promote psychological well-being.² Low levels of participation in vigorous physical activity during grades 9-12 and sedentary leisure time behaviors, such as television viewing, are associated with risk of being overweight.³ Positive experiences with physical activity at a young age help lay the basis for being regularly active throughout life.² Physical activity can help adolescents achieve normal body weight and body composition, thereby reducing the health risks of being overweight or obese.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward intermediate outcomes related to increases in physical activity. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions promoting physical activity. These data are used to recognize successes and to determine progress toward intended outcomes related to increased physical activity. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source

2007 Youth Risk Behavior Survey (YRBS)
Physical Activity Section

How Indicator Is Measured

Numerator: Respondents in grades 9–12 who report doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes per day on ≥ 5 of the past 7 days.

Denominator: Respondents in grades 9–12 who report doing any or no physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes per day on ≥ 5 of the past 7 days (excluding those who did not answer).

Survey Question(s)

80. During the past 7 days, on how many days were you physically active for a total of **at least 60 minutes per day**? (Add up all the time you spend in any kind of physical activity that increases your heart rate and makes you breathe hard some of the time.)

The above question is question 30 on the 2007 Steps YRBS questionnaire, a short version of the core YRBS questionnaire that contains questions relevant to the Steps Program focus areas.

Special Instructions

None

Data Collection Schedule

Collected biennially

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

The Community Indicators Handbook: <http://www.communityinitiatives.com/pubs/indicats.html>

The Guide to Community Preventive Services: <http://www.thecommunityguide.org/>

Healthy People 2010: <http://www.healthypeople.gov/default.htm>

Indicators for Chronic Disease Surveillance: <http://www.cdc.gov/mmwr/PDF/RR/RR5311.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ HHS. *The Surgeon General's call to action to prevent and decrease overweight and obesity*. Rockville, MD: HHS, Public Health Service, Office of the Surgeon General; 2001. Available at: <http://www.surgeongeneral.gov/topics/obesity/>

² U.S. Department of Health and Human Services. *Physical Activity and Health: A Report of the Surgeon General*. Atlanta, GA: CDC, NCCDPHP; 1996.

³ Grunbaum JA, Kann L, Kinchen S, Ross J, Hawkins J, Lowry R, et al. Youth Risk Behavior Surveillance—United States, 2003. *MMWR*. 2004;53(SS-2):1–95.

Performance Measure O-3	Increased physical activity and healthful eating for children and adults.
Indicator O-3.5	Television viewing among youth.

Rationale for Selecting This Indicator

Television viewing is the principal sedentary leisure time behavior in the United States, and television viewing by young people is associated with obesity.^{1,2} National surveys show a positive association between the number of hours children watch television and their risk of being overweight.³ This correlation has several probable causes: television watching may displace participation in calorie-burning physical activities, and children may consume more high-calorie snack foods while watching television than while engaged in other activities.⁴ Decreases in television viewing by young people may be associated with increases in physical activity and healthful eating, thereby indicating reduced risk of overweight or obesity and their related health risks.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward intermediate outcomes related to increases in physical activity and healthful eating. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions promoting physical activity and healthful eating. These data are used to recognize successes and to determine progress toward intended outcomes related to increased physical activity and healthful eating. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source

2007 Youth Risk Behavior Survey (YRBS)

Physical Activity Section

How Indicator Is Measured

Numerator: Respondents in grades 9–12 who report watching television for ≥ 3 hours on an average school day.

Denominator: Respondents in grades 9–12 who report watching television for any number of hours, including zero, on an average school day (excluding those who did not answer).

Survey Question(s)

81. On an average school day, how many hours to you watch TV?

The above question is question 31 on the 2007 Steps YRBS questionnaire, a short version of the core YRBS questionnaire that contains questions relevant to the Steps Program focus areas.

Special Instructions

None

Data Collection Schedule

Collected biennially

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

Healthy People 2010: <http://www.healthypeople.gov/default.htm>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ Crespo CJ, Smith E, Troian RP, Bartlett SJ, Macera CA, & Anderson RE. Television watching, energy intake, and obesity in US children. *Archives of Pediatric and Adolescent Medicine*. 2001;155:360-365.

² Kaur H, Choi WS, Mayo MS, & Harris KJ. Duration of television watching is associated with increased body mass index. *Journal of Pediatrics*. 2003;143(4):506-511.

³ Andersen, R, Crespo C, Bartlett S, Cheskin L, & Pratt M. Relationship of physical activity and TV watching with body weight and level of fatness among children: results for the third National Health and Nutrition Examination Survey. *JAMA*. 1998;279(12):938-42.

⁴ Clancy-Hepburn K, Hickey AA, & Nevill G. Children's behavior responses to TV food advertisements. *J Nutr Educ*. 1974;6:93-6.

Performance Measure O-4	Improved access to and quality of clinical services for diabetes, asthma, and tobacco use cessation.
Indicator O-4.1	Health care access.

Rationale for Selecting This Indicator

Having health insurance, a high income, and a regular primary care provider or other source of ongoing health care are all strong predictors of access to quality health care.¹ Access to health care significantly influences whether people use the health care system and, ultimately, improves health outcomes. People with a usual source of health care are more likely than those without a usual source of health care to receive a variety of preventive health care services.² National data collected in 2003 show that during the 12 months before being surveyed, more adults without health care insurance (41.3%) than adults with health insurance (8.6%) were unable to see a doctor when they needed to, because of cost.³ Uninsured adults are much more likely to report being in poor or fair health than are adults who are insured. Nationally, 20.4% of uninsured adults self-report their health as *fair* or *poor* (rather than *good*, *very good*, or *excellent*), compared with 11.7% of insured adults.³ Improved access to health care can contribute to increased use of health services and to the prevention or reduction of complications of chronic diseases, including obesity, diabetes, and asthma.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward intermediate outcomes related to improved access to clinical services for diabetes, asthma, and tobacco use cessation. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions to increase access to care. These data are used to recognize successes and to determine progress toward intended outcomes related to increased access to care. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source

2005 Behavioral Risk Factor Survey (BRFS)
 Core Section 3: Health Care Access

How Indicator Is Measured

Because this indicator is not a calculated variable, each survey item has its own numerator and denominator, as shown in the table below. The fourth survey item (frequency of routine medical checkups) has four numerators, one to determine the ratio of respondents who report having a routine medical checkup within the previous 12 months, a second to determine the ratio of respondents who report having a routine medical checkup between 1 and 2 years ago, a third to determine the ratio of respondents who report having a routine medical checkup between 2 and 5 years ago, and a fourth to determine the ratio of respondents who report having a routine medical checkup 5 or more years ago.

BRFS Data Report Item Label	Numerator	Denominator
Health Plan	Respondents aged ≥ 18 years who report having any kind of health care coverage.	Respondents aged ≥ 18 years who report having or not having any kind of health care coverage (excluding unknowns and refusals).
Personal Doctor	Respondents aged ≥ 18 years who report having one person they think of as their personal doctor or health care provider.	Respondents aged ≥ 18 years who report having or not having one person they think of as their personal doctor or health care provider (excluding unknowns and refusals).
Medical Cost	Respondents aged ≥ 18 years who report a time in the past 12 months when they needed to see a doctor but could not because of cost (excluding unknowns and refusals).	Respondents aged ≥ 18 years who report experiencing or not experiencing a time in the past 12 months when they needed to see a doctor but could not because of cost (excluding unknowns and refusals).
Routine Medical Checkup		
Within the previous 12 months	Respondents aged ≥ 18 years who report having visited a doctor for a routine checkup in the past 12 months (1-12 months).	Respondents aged ≥ 18 years who report having visited or not visited a doctor for a routine checkup in the past 12 months (excluding unknowns and refusals).
Between 1 and 2 years ago?	Respondents aged ≥ 18 years who report having visited a doctor for a routine checkup between 1 and 2 years ago.	
Between 2 and 5 years ago?	Respondents aged ≥ 18 years who report having visited a doctor for a routine checkup between 2 and 5 years ago.	
5 or more years ago	Respondents aged ≥ 18 years who report having visited a doctor for a routine checkup 5 or more years ago.	

Survey Question(s)

- 3.1 Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare?
 - 3.2 Do you have one person you think of as your personal doctor or health care provider?
 - 3.3 Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?
 - 3.4 About how long has it been since you last visited a doctor for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.
-

Special Instructions

This indicator is not a calculated variable. Instead, the indicator comprises four individual survey items that, taken together, describe a person's overall access to health care.

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

10 Essential Public Health Services: <http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm>

Agency for Healthcare Research and Quality (AHRQ), *National Healthcare Disparities Report* and *National Healthcare Quality Report*: <http://www.qualitytools.ahrq.gov/disparitiesreport/browse/browse.aspx> and <http://www.qualitytools.ahrq.gov/qualityreport/browse/browse.aspx>

The Community Indicators Handbook: <http://www.communityinitiatives.com/pubs/indicats.html>

Healthy People 2010: <http://www.healthypeople.gov/default.htm>

Secretary Mike Leavitt's 500-Day Plan: <http://www.hhs.gov/secretaryspage.html> and <http://www.hhs.gov/500DayPlan/500DayPlan.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ HHS. *Healthy People 2010: understanding and improving health, 2nd ed.* Washington, DC: GPO; 2000. Available at <http://www.healthypeople.gov/Document/tableofcontents.htm>

² Moy, E.; Bartman, B.A.; & Weir, M.R. Access to hypertensive care: effects of income, insurance, and source of care. *Archives of Internal Medicine*. 1995;155(14):1497-1502.

³ State Health Access Data Assistance Center. *Characteristics of the uninsured: a view from the states*. Minneapolis, MN: University of Minnesota; 2004. Available at <http://www.rwjf.org/research/researchdetail.jsp?id=1364&ia=132>

Performance Measure O-4**Improved access to and quality of clinical services for diabetes, asthma, and tobacco use cessation.****Indicator O-4.2****Foot examination among adults aged 18 or older with diabetes.****Rationale for Selecting This Indicator**

An estimated 20.8 million Americans (7% of the population) have diabetes, and for 6.2 million of those people, their diabetes is undiagnosed.¹ Diabetes is the sixth leading cause of death in the United States² and the leading cause of non-traumatic lower-limb amputations.³ People with diabetes are at increased risk for pathologic changes of their lower extremities; these changes can lead to serious foot problems, including amputation.⁴ The American Diabetes Association recommends annual foot examinations to identify high-risk foot conditions for people with diabetes.⁵ Comprehensive foot care programs can reduce amputation rates by 45% to 85%.⁶ Clinical foot examinations are an indicator of quality clinical services; they promote early detection and treatment of problems and can prevent diabetes-related complications, including amputation.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward intermediate outcomes related to improvements in the quality of clinical services for diabetes. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions targeting diabetes care. These data are used to recognize successes and to determine progress toward intended outcomes related to improved clinical services. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source

2005 Behavioral Risk Factor Survey (BRFS)
Core Section 5: Diabetes; Module 1: Diabetes

How Indicator Is Measured

Numerator: Respondents aged ≥ 18 years ever told by a doctor that they have diabetes (excluding women who were told only when pregnant) who report having a clinical foot exam within the past 12 months.

Denominator: Respondents aged ≥ 18 years ever told by a doctor that they have diabetes (excluding women who were told only when pregnant, refusals, and unknowns).

Survey Question(s)

- 5.1 Have you ever been told by a doctor that you have diabetes? (Core Section 5: Diabetes)
9. About how many times in the past 12 months has a health professional checked your feet for any sores or irritations? (Module 1: Diabetes)

Special Instructions

Respondents who answer the diabetes core question 5.1 and indicate that they were told by a doctor they have diabetes (1. Yes) must be asked the six diabetes module questions listed in Appendix D. These six questions must be asked in the prescribed order even if not all the questions in the BRFSS diabetes module are used. If the six diabetes module questions not required for the core performance measures are not asked, the data columns for those questions should be filled in with the code for refusal.

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

10 Essential Public Health Services: <http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm>

Agency for Healthcare Research and Quality (AHRQ), *National Healthcare Disparities Report* and *National Healthcare Quality Report*: <http://www.qualitytools.ahrq.gov/disparitiesreport/browse/browse.aspx> and <http://www.qualitytools.ahrq.gov/qualityreport/browse/browse.aspx>

Centers for Disease Control and Prevention (CDC), *FY 2005 Performance Plan*: <http://www.cdc.gov/od/perfplan/Index.htm>

Government Performance and Results Act (GPRA): <http://www.whitehouse.gov/omb/mgmt-gpra/index.html>

The Guide to Community Preventive Services: <http://www.thecommunityguide.org/>

Healthy People 2010: <http://www.healthypeople.gov/default.htm>

Indicators for Chronic Disease Surveillance: <http://www.cdc.gov/mmwr/PDF/RR/RR5311.pdf>

Secretary Mike Leavitt's 500-Day Plan: <http://www.hhs.gov/secretaryspage.html> and <http://www.hhs.gov/500DayPlan/500DayPlan.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ CDC. *National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2005*. Atlanta, GA: HHS, CDC; 2005. Available at: http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2005.pdf

² Anderson RN & Smith BL. Deaths: leading causes for 2002. *National vital statistics reports*; vol 53 no 17. Hyattsville, MD: National Center for Health Statistics; 2005. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_17.pdf

³ Reiber GE, Smith D, McNamara K, & Preston S: The epidemiology of amputation in the United States, 1989-1992. In National Diabetes Data Group, ed. *Diabetes in America, 2nd ed* (NIH Publication No. 95-1468). Washington, DC: HHS, NIH, National Institute of Diabetes and Digestive and Kidney Diseases; 1995.

⁴ CDC. Indicators for chronic disease surveillance. *MMWR*. 2004;53(RR11):1-6. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5311a1.htm>

⁵ American Diabetes Association. Standards of medical care in diabetes. *Diabetes Care*. 2005;28(Supplement 1):S4-36.

⁶ Bild DE, Selby JV, Sinnock P, Browner WS, Braveman P & Showstack JA. Lower-extremity amputation in people with diabetes: epidemiology and prevention. *Diabetes Care*. 1989;12:24-31.

Performance Measure O-4**Improved access to and quality of clinical services for diabetes, asthma, and tobacco use cessation.****Indicator O-4.3****Dilated eye examination among adults aged 18 or older with diabetes.****Rationale for Selecting This Indicator**

An estimated 20.8 million Americans (7% of the population) have diabetes, and for 6.2 million of those people, their diabetes is undiagnosed.¹ Diabetes is the sixth leading cause of death in the United States² and the leading cause of new cases of blindness for adults aged 20-74 years.³ The American Diabetes Association recommends annual dilated eye examinations for people with diabetes.⁴ Detecting and treating diabetic eye disease with laser therapy can reduce the development of severe vision loss by an estimated 50% to 60%.⁵ Annual eye examinations are an indicator of quality clinical services; they promote early detection and treatment of problems and can prevent diabetes-related complications, including loss of vision.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward intermediate outcomes related to improvements in the quality of clinical services for diabetes. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions targeting diabetes care. These data are used to recognize successes and to determine progress toward intended outcomes related to improved clinical services. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source

2005 Behavioral Risk Factor Survey (BRFS)
Core Section 5: Diabetes; Module 1: Diabetes

How Indicator Is Measured

Numerator: Respondents aged ≥ 18 years ever told by a doctor that they have diabetes (excluding women who were told only when pregnant) who report having received a dilated eye exam within the past 12 months.

Denominator: Respondents aged ≥ 18 years ever told by a doctor that they have diabetes (excluding women who were told only when pregnant, refusals, and unknowns).

Survey Question(s)

- 5.1 Have you ever been told by a doctor that you have diabetes? (Core Section 5: Diabetes)
10. When was the last time you had an eye exam in which the pupils were dilated? This would have made you temporarily sensitive to bright light. (Module 1: Diabetes)

Special Instructions

Respondents who answer the diabetes core question 5.1 and indicate that they were told by a doctor they have diabetes (1. Yes) must be asked the six diabetes module questions listed in Appendix D. These six questions must be asked in the prescribed order even if not all the questions in the BRFSS diabetes module are used. If the six diabetes module questions not required for the core performance measures are not asked, the data columns for those questions should be filled in with the code for refusal.

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

10 Essential Public Health Services: <http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm>

Agency for Healthcare Research and Quality (AHRQ), *National Healthcare Disparities Report* and *National Healthcare Quality Report*: <http://www.qualitytools.ahrq.gov/disparitiesreport/browse/browse.aspx> and <http://www.qualitytools.ahrq.gov/qualityreport/browse/browse.aspx>

Centers for Disease Control and Prevention (CDC), *FY 2005 Performance Plan*: <http://www.cdc.gov/od/perfplan/Index.htm>

Government Performance and Results Act (GPRA): <http://www.whitehouse.gov/omb/mgmt-gpra/index.html>

The Guide to Community Preventive Services: <http://www.thecommunityguide.org/>

Healthy People 2010: <http://www.healthypeople.gov/default.htm>

Indicators for Chronic Disease Surveillance: <http://www.cdc.gov/mmwr/PDF/RR/RR5311.pdf>

Secretary Mike Leavitt's 500-Day Plan: <http://www.hhs.gov/secretaryspace.html> and <http://www.hhs.gov/500DayPlan/500DayPlan.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ CDC. *National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2005*. Atlanta, GA: HHS, CDC; 2005. Available at: http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2005.pdf

² Anderson RN & Smith BL. Deaths: leading causes for 2002. *National vital statistics reports*; vol 53 no 17. Hyattsville, MD: National Center for Health Statistics; 2005. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_17.pdf

³ Klein R & Klein BEK. Vision disorders in diabetes. In National Diabetes Data Group, ed. *Diabetes in America, 2nd ed* (NIH Publication No. 95-1468). Washington, DC: HHS, NIH, National Institute of Diabetes and Digestive and Kidney Diseases; 1995.

⁴ American Diabetes Association. Standards of medical care in diabetes. *Diabetes Care*. 2005;28(Supplement 1):S4-36.

⁵ Ferris FL. How effective are treatments for diabetic retinopathy? *JAMA*. 1993;269:1290-1.

Performance Measure O-4

Improved access to and quality of clinical services for diabetes, asthma, and tobacco use cessation.

Indicator O-4.4

Glycosylated hemoglobin measurement at least twice a year among adults aged 18 or older with diabetes.

Rationale for Selecting This Indicator

An estimated 20.8 million Americans (7% of the population) have diabetes, and for 6.2 million of those people, their diabetes is undiagnosed.¹ Diabetes is the sixth leading cause of death in the United States² and can lead to serious complications such as heart disease, stroke, high blood pressure, blindness, kidney damage, and lower-limb amputations.³ Glycemic control for adults with diabetes helps prevent or delay the onset or progression of diabetes-related complications (e.g., retinopathy, lower extremity amputations, and end-stage renal disease).⁴ In general, for every 1% reduction in results of A1C blood tests, the risk of developing microvascular diabetic complications (eye, kidney, and nerve disease) is reduced by 37%.⁵ The American Diabetes Association recommends performing the A1C test (glycosylated hemoglobin measurement) at least twice a year for patients who meet treatment goals and who have stable glycemic control.⁶ Regular glycosylated hemoglobin measurements are an indicator of quality clinical services; such measurements help people with diabetes control glucose levels, which may prevent or reduce diabetes-related complications.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward intermediate outcomes related to improvements in the quality of clinical services for diabetes. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions targeting diabetes care. These data are used to recognize successes and to determine progress toward intended outcomes related to improved clinical services. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source

2005 Behavioral Risk Factor Survey (BRFS)
Core Section 5: Diabetes; Module 1: Diabetes

How Indicator Is Measured

- Numerator: Respondents aged ≥ 18 years ever told by a doctor that they have diabetes (excluding women who were told only when pregnant) who report having received a glycosylated hemoglobin measurement (“A one C”) at least twice a year.
- Denominator: Respondents aged ≥ 18 years ever told by a doctor that they have diabetes (excluding women who were told only when pregnant, refusals, and unknowns).

Survey Question(s)

- 5.1 Have you ever been told by a doctor that you have diabetes? (Core Section 5: Diabetes)
8. A test for "A one C" measures the average level of blood sugar over the past three months. About how many times in the past 12 months has a doctor, nurse or other health professional checked you for "A one C"? (Module 1: Diabetes)
-

Special Instructions

Respondents who answer the diabetes core question 5.1 and indicate that they were told by a doctor they have diabetes (1. Yes) must be asked the six diabetes module questions listed in Appendix D. These six questions must be asked in the prescribed order even if not all the questions in the BRFSS diabetes module are used. If the six diabetes module questions not required for the core performance measures are not asked, the data columns for those questions should be filled in with the code for refusal.

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

10 Essential Public Health Services: <http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm>

Agency for Healthcare Research and Quality (AHRQ), *National Healthcare Disparities Report* and *National Healthcare Quality Report:* <http://www.qualitytools.ahrq.gov/disparitiesreport/browse/browse.aspx> and <http://www.qualitytools.ahrq.gov/qualityreport/browse/browse.aspx>

The Guide to Community Preventive Services: <http://www.thecommunityguide.org/>

Healthy People 2010: <http://www.healthypeople.gov/default.htm>

Secretary Mike Leavitt's 500-Day Plan: <http://www.hhs.gov/secretaryspace.html> and <http://www.hhs.gov/500DayPlan/500DayPlan.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ CDC. *National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2005.* Atlanta, GA: HHS, CDC; 2005. Available at: http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2005.pdf

² Anderson RN & Smith BL. Deaths: leading causes for 2002. *National vital statistics reports*; vol 53 no 17. Hyattsville, MD: National Center for Health Statistics; 2005. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_17.pdf

³ National Diabetes Data Group, ed. *Diabetes in America, 2nd ed* (NIH Publication No. 95-1468). Washington, DC: HHS, NIH, National Institute of Diabetes and Digestive and Kidney Diseases; 1995

⁴ CDC. Indicators for chronic disease surveillance. *MMWR* 2004; 53 (No. RR-11): 98.

⁵ Stratton IM, Adler AI, Neil HA, et al. Association of glycaemia with macrovascular and microvascular complications of type 2 diabetes (UKPDS 35): prospective observational study. *BMJ.* 2000;321:405-412.

⁶ American Diabetes Association. Standards of medical care in diabetes. *Diabetes Care.* 2005;28(Supplement 1):S4-36.

Performance Measure O-4**Improved access to and quality of clinical services for diabetes, asthma, and tobacco use cessation.****Indicator O-4.5****Adults with asthma aged 18 or older receiving routine checkups for asthma.****Rationale for Selecting This Indicator**

Asthma affects almost 20 million people, or 7% of the U.S. population.¹ Asthma is responsible for about 500,000 hospitalizations,² 5,000 deaths,² and 134 million days of restricted activity³ a year. Periodic clinical assessment and monitoring are essential for asthma management and can help determine whether the goals of asthma therapy are being achieved.⁴ These goals include preventing chronic and troublesome symptoms, maintaining normal pulmonary function, maintaining normal physical activity levels, preventing recurrent exacerbations of asthma, and minimizing the need for emergency department visits or hospitalizations. An expert panel of the National Asthma Education and Prevention Program recommends that people with asthma receive at least two routine checkups each year.⁴ Routine checkups for asthma are an indicator of quality clinical services; they promote early detection and treatment of problems and can prevent or reduce asthma exacerbations.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward intermediate outcomes related to improvements in the quality of clinical services for asthma. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions targeting asthma care. These data are used to recognize successes and to determine progress toward intended outcomes related to improved clinical services. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source

2005 Behavioral Risk Factor Survey (BRFS)
Core Section 9: Asthma; Module 9: Adult Asthma History

How Indicator Is Measured

Numerator: Respondents aged ≥ 18 years who report receiving ≥ 2 routine checkups for asthma in the past 12 months.

Denominator: Respondents aged ≥ 18 years who report ever told by a doctor or health professional that they have asthma and have had an episode of asthma or an asthma attack in the past 12 months (excluding unknowns and refusals).

Survey Question(s)

- 9.1 Have you ever been told by a doctor, nurse, or other health professional that you had asthma? (Core Section 9: Asthma)
- 9.2 Do you still have asthma? (Core Section 9: Asthma)
- 2. During the past 12 months, have you had an episode of asthma or an asthma attack? (Module 9: Adult Asthma History)
- 5. During the past 12 months, how many times did you see a doctor, nurse, or other health professional for a routine checkup for your asthma? (Module 9: Adult Asthma History)

Special Instructions

None

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

10 Essential Public Health Services: <http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm>

Healthy People 2010: <http://www.healthypeople.gov/default.htm>

National Asthma Education and Prevention Program (NAEPP): <http://www.nhlbi.nih.gov/about/naepp/>

Secretary Mike Leavitt's 500-Day Plan: <http://www.hhs.gov/secretaryspage.html> and <http://www.hhs.gov/500DayPlan/500DayPlan.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ CDC. *National Health Interview Survey data: 2003 asthma data* [online]. HHS, CDC, National Center for Environmental Health. 2003. Available at <http://www.cdc.gov/asthma/NHIS/default.htm>.

² NHLBI. *Data Fact Sheet: Asthma Statistics*. Bethesda, MD: NIH, Public Health Service PHS; 1999.

³ Collins, JG. *Prevalence of selected chronic conditions: United States 1990-1992*. National Center for Health Statistics: Vital Health Statistics. 10(194); 1997. Available at http://www.cdc.gov/nchs/data/series/sr_10/sr10_194.pdf

⁴ NAEPP. *Clinical practice guidelines: expert panel report 2: guidelines for the diagnosis and management of asthma*. (NIH Publication No. 97-4051). NIH, NHLBI; 1997. Available at: <http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.pdf>

Performance Measure O-4**Improved access to and quality of clinical services for diabetes, asthma, and tobacco use cessation.****Indicator O-4.6****Adults aged 18 or older advised by health care provider to quit smoking.****Rationale for Selecting This Indicator**

Cigarette smoking causes approximately 440,000 deaths in the United States each year, making it the nation's leading preventable cause of death.¹ Smoking increases the risk of heart disease, cancer, stroke, and chronic lung disease. Quitting smoking has major and immediate health benefits. For example, people who quit smoking before age 50 have half the risk of dying during the next 15 years compared with people who continue to smoke.² Evidence shows that people are more likely to quit smoking when a health care professional advises them to do so.³ For this reason, experts recommend that health care providers advise patients who smoke to quit smoking.³ An increase in the number of adult smokers advised by their health care providers to quit smoking indicates an improvement in the quality of clinical services for tobacco use cessation. This improvement may help to increase the number of tobacco users who quit and to prevent tobacco-related diseases, including diabetes complications and asthma exacerbations.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward intermediate outcomes related to improvements in the quality of clinical services for tobacco use cessation. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions targeting tobacco use cessation. These data are used to recognize successes and to determine progress toward intended outcomes related to improved clinical services. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source

2005 Behavioral Risk Factor Survey (BRFS)

Core Section 11: Tobacco Use; Module 21: Smoking Cessation

How Indicator Is Measured

Numerator: Respondents aged ≥ 18 years who report having been advised to quit smoking by a doctor or other health provider in the past 12 months.

Denominator: Respondents aged ≥ 18 years who report having smoked 100 cigarettes in their lifetime and are current smokers on every day or some days and saw a doctor, nurse, or other health professional to get any kind of care in the past 12 months (excluding unknowns and refusals).

Survey Question(s)

- 11.1 Have you smoked at least 100 cigarettes in your entire life? (Core Section 11: Tobacco Use)
- 11.2 Do you now smoke cigarettes every day, some days, or not at all? (Core Section 11: Tobacco Use)
- 2. In the past 12 months, how many times have you seen a doctor, nurse, or other health professional to get any kind of care for yourself? (Module 21: Smoking Cessation)
- 3. In the past 12 months, on how many visits were you advised to quit smoking by a doctor, or other health provider? (Module 21: Smoking Cessation)

Special Instructions

None

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

10 Essential Public Health Services: <http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm>

Agency for Healthcare Research and Quality (AHRQ), *National Healthcare Disparities Report* and *National Healthcare Quality Report:* <http://www.qualitytools.ahrq.gov/disparitiesreport/browse/browse.aspx> and <http://www.qualitytools.ahrq.gov/qualityreport/browse/browse.aspx>

The Guide to Community Preventive Services: <http://www.thecommunityguide.org/>

Healthy People 2010: <http://www.healthypeople.gov/default.htm>

Secretary Mike Leavitt's 500-Day Plan: <http://www.hhs.gov/secretaryspage.html> and <http://www.hhs.gov/500DayPlan/500DayPlan.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

The U.S. Preventive Services Task Force (AHRQ): <http://www.ahrq.gov/clinic/uspstfix.htm>

¹ CDC. Annual smoking-attributable mortality, years of potential life lost, and economic costs – U.S., 1995-1999. *MMWR*. 2002;51(14):300-3. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5114a2.htm#top>

² HHS. *The health benefits of smoking cessation*. (HHS Publication No. (CDC) 90-8416). Atlanta, GA: HHS, Public Health Service, CDC, NCCDPHP, OSH;1990.

³ Fiore MC, Bailey WC, Cohen SJ, et al. *Treating tobacco use and dependence: clinical practice guideline*. Rockville, MD: HHS, Public Health Service; June 2000. Available at: <http://www.surgeongeneral.gov/tobacco/default.htm>

Performance Measure O-4

Improved access to and quality of clinical services for diabetes, asthma, and tobacco use cessation.

Indicator O-4.7

Tobacco use cessation attempts by adolescent smokers.

Rationale for Selecting This Indicator

Cigarette smoking causes about 440,000 deaths each year in the United States, making it the nation's leading preventable cause of death.¹ Tobacco use begins primarily during adolescence; almost 90% of adult smokers began by age 18 years.² Young people who are established smokers are at high risk of becoming addicted to cigarettes, increasing the likelihood they will use tobacco products throughout adulthood and subsequently be at risk for tobacco-related diseases such as lung cancer, heart disease, and emphysema.³ Quitting smoking has major and immediate health benefits. For example, people who quit smoking before age 50 have half the risk of dying during the next 15 years compared with people who continue to smoke.⁴ Evidence shows that people are more likely to quit smoking when a health care professional advises them to do so.³ For this reason, experts recommend that health care providers advise patients who smoke to quit smoking.⁵ An increase in the number of adolescent smokers advised by their health care providers to quit smoking would indicate an improvement in the quality of clinical services for tobacco use cessation. This improvement may help to increase the number of tobacco users who quit and to prevent tobacco-related diseases, including diabetes complications and asthma exacerbations.

This indicator is a proxy for the stated performance measure. Data are not available to measure the number of young people advised by their health care providers to quit smoking, which would be an indicator of the quality of clinical services for tobacco use cessation (the stated performance measure). Instead, adolescents' attempts to stop smoking are used as an indicator that may reflect advice from health professionals to quit smoking.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward intermediate outcomes related to improvements in the quality of clinical services for tobacco use cessation. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions targeting tobacco use cessation by young people. These data are used to recognize successes and to determine progress toward intended outcomes related to improved clinical services. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source

2007 Youth Risk Behavior Survey (YRBS)

Tobacco Use Section

How Indicator Is Measured

Numerator: Respondents in grades 9-12 who report that they have tried to quit smoking in the past 12 months.

Denominator: Respondents in grades 9-12 who report that they are a current smoker (excluding those who did not answer).

Survey Question(s)

30. During the past 30 days, on how many days did you smoke cigarettes?
35. During the past 12 months, did you ever try to quit smoking cigarettes?

The above questions are questions 10 and 15 on the 2007 Steps YRBS questionnaire, a short version of the core YRBS questionnaire that contains questions relevant to the Steps Program focus areas.

Special Instructions

None

Data Collection Schedule

Collected biennially

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

10 Essential Public Health Services: <http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm>

Centers for Disease Control and Prevention (CDC), *FY 2005 Performance Plan*:
<http://www.cdc.gov/od/perfplan/Index.htm>

Government Performance and Results Act (GPRA): <http://www.whitehouse.gov/omb/mgmt-gpra/index.html>

The Guide to Community Preventive Services: <http://www.thecommunityguide.org/>

Healthy People 2010: <http://www.healthypeople.gov/default.htm>

Indicators for Chronic Disease Surveillance: <http://www.cdc.gov/mmwr/PDF/RR/RR5311.pdf>

Secretary Mike Leavitt's 500-Day Plan: <http://www.hhs.gov/secretaryspage.html> and
<http://www.hhs.gov/500DayPlan/500DayPlan.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and
<http://www.healthierus.gov/steps/2004grants.html>

¹ CDC. Annual smoking-attributable mortality, years of potential life lost, and economic costs – U.S., 1995-1999. *MMWR*. 2002;51(14):300-3. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5114a2.htm#top>

² HHS. *Preventing tobacco use among young people: a report of the Surgeon General*. Atlanta, GA: CDC; 1994.

³ Jackson C & Dickinson D. Cigarette consumption during childhood and persistence of smoking through adolescence. *Archives of Pediatric & Adolescent Medicine*. 2004;158(11):1050-6.

⁴ HHS. *The health benefits of smoking cessation*. (HHS Publication No. (CDC) 90-8416). Atlanta, GA: HHS, Public Health Service, CDC, NCCDPHP, OSH;1990.

⁵ Fiore MC, Bailey WC, Cohen SJ, et al. *Treating tobacco use and dependence: clinical practice guideline*. Rockville, MD: HHS, Public Health Service; June 2000. Available at: <http://www.surgeongeneral.gov/tobacco/default.htm>

Performance Measure O-5

Increased identification of persons with pre-diabetes and diabetes.

Indicator O-5.1

Reduce the overall rate of diabetes that is clinically diagnosed among adults.

Rationale for Selecting This Indicator

An estimated 20.8 million Americans (7% of the population) have diabetes, and for 6.2 million of those people, their diabetes is undiagnosed.¹ Diabetes is the sixth leading cause of death in the United States² and can lead to serious complications such as heart disease, stroke, high blood pressure, blindness, kidney damage, and lower-limb amputations.³ Identifying people with undiagnosed diabetes is important because people with diabetes and their health care providers can work together to reduce diabetes-related complications by controlling levels of blood glucose, blood pressure, and blood lipids and by following other recommended preventive care practices.⁴

Although increasing the identification of people with pre-diabetes and undiagnosed diabetes is a key outcome of the Steps Program, its measurement is not feasible. A precise indicator for this performance measure would require data about the incidence of diabetes (i.e., the number of new cases of diabetes that occur during a given period). To measure the proportion of adults with diabetes whose condition has been diagnosed, we would need to know the number of newly diagnosed cases of diabetes and the number of people with undiagnosed diabetes. The selected indicator is a proxy measure for the stated performance measure. Because of the difficulties in measuring incidence, prevalence (e.g., the total number of people with diagnosed diabetes) is often used as a proxy measure. The overall rate of diabetes that is clinically diagnosed among adults (as measured by this indicator) may initially increase as screening improves and more people with undiagnosed diabetes are identified. Ultimately, however, reductions in the rate of diagnosed diabetes probably indicate improved prevention efforts.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward intermediate outcomes related to the identification of people with undiagnosed diabetes. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions targeting diabetes. These data are used to recognize successes and to determine progress toward intended outcomes related to increased identification of people with undiagnosed diabetes and reduced complications of diabetes. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source

2005 Behavioral Risk Factor Survey (BRFS)

Core Section 5: Diabetes

How Indicator Is Measured

Numerator: Respondents aged ≥ 18 years who report ever having been told by a doctor that they have diabetes other than diabetes during pregnancy.

Denominator: Respondents aged ≥ 18 years who report ever or not ever having been told or by a doctor that they have diabetes (excluding unknowns and refusals).

Survey Question(s)

5.1 Have you ever been told by a doctor that you have diabetes?

Special Instructions

None

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

10 Essential Public Health Services: <http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm>

Healthy People 2010: <http://www.healthypeople.gov/default.htm>

Indicators for Chronic Disease Surveillance: <http://www.cdc.gov/mmwr/PDF/RR/RR5311.pdf>

Secretary Mike Leavitt's 500-Day Plan: <http://www.hhs.gov/secretarypage.html> and <http://www.hhs.gov/500DayPlan/500DayPlan.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ CDC. *National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2005*. Atlanta, GA: HHS, CDC; 2005. Available at: http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2005.pdf

² Anderson RN & Smith BL. Deaths: leading causes for 2002. *National vital statistics reports*; vol 53 no 17. Hyattsville, MD: National Center for Health Statistics; 2005. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_17.pdf

³ National Diabetes Data Group, ed. *Diabetes in America, 2nd ed* (NIH Publication No. 95-1468). Washington, DC: HHS, NIH, National Institute of Diabetes and Digestive and Kidney Diseases; 1995

⁴ CDC. *National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2003*. Rev ed. Atlanta, GA: HHS, CDC; 2004. Available at <http://www.cdc.gov/diabetes/pubs/factsheet.htm>.

Performance Measure O-5**Increased identification of persons with pre-diabetes and diabetes.****Indicator O-5.2****Reduce the overall rate of diabetes that is clinically diagnosed among youth.****Rationale for Selecting This Indicator**

An estimated 20.8 million Americans (7% of the population) have diabetes, and for 6.2 million of those people, their diabetes is undiagnosed.¹ Diabetes is one of the most common chronic diseases among children in the United States. About 150,000 young people under 18 years have diabetes.¹ In the last two decades, the prevalence of type 2 diabetes among U.S. children and adolescents has increased. Researchers estimate that between 8% and 43% of new childhood cases of diabetes are type 2 diabetes.² Diabetes is the sixth leading cause of death in the United States³ and can lead to serious complications such as heart disease, stroke, high blood pressure, blindness, kidney damage, and lower-limb amputations.⁴ Identifying people with undiagnosed diabetes is important because people with diabetes and their health care providers can work together to reduce diabetes-related complications by controlling levels of blood glucose, blood pressure, and blood lipids and by following other recommended preventive care practices.⁵

Although increasing the identification of people with pre-diabetes and undiagnosed diabetes is a key outcome of the Steps Program, its measurement is not feasible. A precise indicator for this performance measure would require data about the incidence of diabetes (i.e., the number of new cases of diabetes that occur during a given period). To measure the proportion of young people with diabetes whose condition has been diagnosed, we would need to know the number of newly diagnosed cases of diabetes and the number of young people with undiagnosed diabetes. The selected indicator is a proxy measure for the stated performance measure. Because of the difficulties in measuring incidence, prevalence (e.g., the total number of young people with diagnosed diabetes) is often used as a proxy measure for incidence. The overall rate of diabetes that is clinically diagnosed among young people (as measured by this indicator) may initially increase as screening improves and more young people with undiagnosed diabetes are identified. Ultimately, however, reductions in the rate of diagnosed diabetes probably indicate improved prevention efforts.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward intermediate outcomes related to the identification of people with undiagnosed diabetes. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions targeting diabetes in young people. These data are used to recognize successes and to determine progress toward intended outcomes related to increased identification of people with undiagnosed diabetes and reduced complications of diabetes. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source

2007 Steps Youth Risk Behavior Survey (Steps YRBS)

How Indicator Is Measured

Numerator: Respondents in grades 9-12 who report ever having been told by a doctor or nurse that they have diabetes.

Denominator: Respondents in grades 9-12 who report ever or not ever having been told by a doctor or nurse that they have diabetes (excluding those who did not answer).

Survey Question(s)

35. Has a doctor or nurse ever told you that you have diabetes?

Note: The number above refers to the 2007 Steps YRBS questionnaire, a short version of the core YRBS questionnaire that contains questions relevant to the Steps Program focus areas. This question is not included on the core YRBS questionnaire.

Special Instructions

None

Data Collection Schedule

Collected biennially

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

10 Essential Public Health Services: <http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm>

Secretary Mike Leavitt's 500-Day Plan: <http://www.hhs.gov/secretaryspage.html> and <http://www.hhs.gov/500DayPlan/500DayPlan.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ CDC. *National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2005*. Atlanta, GA: HHS, CDC; 2005. Available at: http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2005.pdf

² CDC. *SEARCH for Diabetes in Youth: fact sheet*. 2005. Available at <http://www.cdc.gov/diabetes/pubs/factsheets/search.htm>

³ Anderson RN & Smith BL. Deaths: leading causes for 2002. National vital statistics reports; vol 53 no 17. Hyattsville, MD: National Center for Health Statistics; 2005. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_17.pdf

⁴ National Diabetes Data Group, ed. *Diabetes in America, 2nd ed* (NIH Publication No. 95-1468). Washington, DC: HHS, NIH, National Institute of Diabetes and Digestive and Kidney Diseases; 1995

⁵ CDC. *National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2003*. Rev ed. Atlanta, GA: HHS, CDC; 2004. Available at <http://www.cdc.gov/diabetes/pubs/factsheet.htm>.

Performance Measure O-6	Improved self-management of diabetes and asthma.
Indicator O-6.1	Self blood-glucose monitoring among adults aged 18 or older with diabetes.

Rationale for Selecting This Indicator

An estimated 20.8 million Americans (7% of the population) have diabetes, and for 6.2 million of those people, their diabetes is undiagnosed.¹ Diabetes is the sixth leading cause of death in the United States² and can lead to serious complications such as heart disease, stroke, high blood pressure, blindness, kidney damage, and lower-limb amputations.³ Glycemic control for adults with diabetes helps prevent or delay the onset or progression of diabetes-related complications (e.g., retinopathy, lower extremity amputations, and end-stage renal disease).⁴ In general, for every 1% reduction in results of A1C blood tests (glycosylated hemoglobin measurement), the risk of developing microvascular diabetic complications (eye, kidney, and nerve disease) is reduced by 37%.⁵ Self blood-glucose monitoring can help people with diabetes control glucose levels and is associated with a decreased likelihood of diabetes-related complications.^{6,7}

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward long-term outcomes related to improved self-management of diabetes. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions targeting diabetes self-management. These data are used to recognize successes and to determine progress toward intended outcomes related to increased effective self-management of diabetes and reduced complications of diabetes. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source

2005 Behavioral Risk Factor Survey (BRFS)
 Core Section 5: Diabetes; Module 1: Diabetes

How Indicator Is Measured

Numerator: Respondents aged ≥ 18 years ever told by a doctor that they have diabetes (excluding women who were told only when pregnant) who report self-blood glucose monitoring ≥ 2 times daily.

Denominator: Respondents aged ≥ 18 years ever told by a doctor that they have diabetes (excluding women who were told only when pregnant, refusals, and unknowns).

Survey Question(s)

- 5.1 Have you ever been told by a doctor that you have diabetes? (Core Section 5: Diabetes)
4. About how often do you check your blood for glucose or sugar? Include times when checked by a family member or friend, but do not include times when checked by a health professional. (Module 1: Diabetes)
-

Special Instructions

Respondents who answer the diabetes core question 5.1 and indicate that they were told by a doctor they have diabetes (1. Yes) must be asked the six diabetes module questions listed in Appendix D. These six questions must be asked in the prescribed order even if not all the questions in the BRFSS diabetes module are used. If the six diabetes module questions not required for the core performance measures are not asked, the data columns for those questions should be filled in with the code for refusal.

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

The Guide to Community Preventive Services: <http://www.thecommunityguide.org/>

Healthy People 2010: <http://www.healthypeople.gov/default.htm>

Indicators for Chronic Disease Surveillance: <http://www.cdc.gov/mmwr/PDF/RR/RR5311.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ CDC. *National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2005*. Atlanta, GA: HHS, CDC; 2005. Available at: http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2005.pdf

² Anderson RN & Smith BL. Deaths: leading causes for 2002. *National vital statistics reports*; vol 53 no 17. Hyattsville, MD: National Center for Health Statistics; 2005. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr53_17.pdf

³ National Diabetes Data Group, ed. *Diabetes in America, 2nd ed* (NIH Publication No. 95-1468). Washington, DC: HHS, NIH, National Institute of Diabetes and Digestive and Kidney Diseases; 1995

⁴ CDC. Indicators for chronic disease surveillance. *MMWR* 2004; 53 (No. RR-11): 98.

⁵ Stratton IM, Adler AI, Neil HA, et al. Association of glycaemia with macrovascular and microvascular complications of type 2 diabetes (UKPDS 35): prospective observational study. *BMJ*. 2000;321:405-412.

⁶ CDC. Diabetes-specific preventive-care practices among adults in a managed care population—Colorado Behavioral Risk Factor Surveillance System. *MMWR*. 1997;46:1018-1023.

⁷ HHS. *Healthy People 2010: understanding and improving health, 2nd ed*. Washington, DC: GPO; 2000. Available at <http://www.healthypeople.gov/Document/tableofcontents.htm>.

Performance Measure O-6	Improved self-management of diabetes and asthma.
Indicator O-6.2	Self foot exam among adults aged 18 or older with diabetes.

Rationale for Selecting This Indicator

An estimated 20.8 million Americans (7% of the population) have diabetes, and for 6.2 million of those people, their diabetes is undiagnosed.¹ Diabetes is the sixth leading cause of death in the United States² and the leading cause of non-traumatic lower-limb amputations.³ People with diabetes are at increased risk for pathologic changes of their lower extremities; these changes can lead to serious foot problems, including amputation.⁴ Conducting self foot examinations can allow people with diabetes to detect foot problems before they become severe. Routine self-management, including self foot examinations, can help to reduce diabetes-related complications, including amputation.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward long-term outcomes related to improved self-management of diabetes. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions targeting diabetes self-management. These data are used to recognize successes and to determine progress toward intended outcomes related to increased effective self-management of diabetes and reduced complications of diabetes. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source

2005 Behavioral Risk Factor Survey (BRFS)
 Core Section 5: Diabetes; Module 1: Diabetes

How Indicator Is Measured

Numerator: Respondents aged ≥ 18 years ever told by a doctor that they have diabetes (excluding women who were told only when pregnant, refusals, and unknowns) who report checking their feet ≥ 1 times daily for any sores or irritations.

Denominator: Respondents aged ≥ 18 years ever told by a doctor that they have diabetes (excluding women who were told only when pregnant, refusals, and unknowns).

Survey Question(s)

- 5.1 Have you ever been told by a doctor that you have diabetes? (Core Section 5: Diabetes)
5. About how often do you check your feet for any sores or irritations? Include times when checked by a family member or friend, but do not include times when checked by a health professional. (Module 1: Diabetes)
-

Special Instructions

Respondents who answer the diabetes core question 5.1 and indicate that they were told by a doctor they have diabetes (1. Yes) must be asked the six diabetes module questions listed in Appendix D. These six questions must be asked in the prescribed order even if not all the questions in the BRFSS diabetes module are used. If the six diabetes module questions not required for the core performance measures are not asked, the data columns for those questions should be filled in with the code for refusal.

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ CDC. *National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2005*. Atlanta, GA: HHS, CDC; 2005. Available at: http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2005.pdf

² Anderson RN & Smith BL. Deaths: leading causes for 2002. *National vital statistics reports*; vol 53 no 17. Hyattsville, MD: National Center for Health Statistics; 2005. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_17.pdf

³ Reiber GE, Smith D, McNamara K, & Preston S: The epidemiology of amputation in the United States, 1989-1992. In National Diabetes Data Group, ed. *Diabetes in America, 2nd ed* (NIH Publication No. 95-1468). Washington, DC: HHS, NIH, National Institute of Diabetes and Digestive and Kidney Diseases; 1995.

⁴ CDC. Indicators for chronic disease surveillance. *MMWR*. 2004;53(RR11):1-6. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5311a1.htm>

Performance Measure O-6	Improved self-management of diabetes and asthma.
Indicator O-6.3	Symptom-free days among adults aged 18 or older with asthma.

Rationale for Selecting This Indicator

Asthma affects almost 20 million people, or 7% of the U.S. population.¹ Asthma is responsible for about 500,000 hospitalizations,² 5,000 deaths,² and 134 million days of restricted activity³ a year. Effective asthma self-management can reduce morbidity among children and adults.⁴ Goals of self management include preventing symptoms, reducing hospitalizations and urgent care visits, reducing absenteeism from work or school, and improving quality of life.⁴ Symptom free days are associated with successful asthma self-management, which may lead to a decrease in asthma exacerbations.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward long-term outcomes related to improved self-management of asthma. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions targeting asthma self-management. These data are used to recognize successes and to determine progress toward intended outcomes related to increased effective self-management of asthma and reduced asthma exacerbations. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source

2005 Behavioral Risk Factor Survey (BRFS)

Core Section 9: Asthma; Module 9: Adult Asthma History

How Indicator Is Measured

Numerator: Respondents aged ≥ 18 years who report having no symptoms of asthma in the past 30 days.

Denominator: Respondents aged ≥ 18 years who report ever told by a doctor or health professional that they have asthma and have had an episode of asthma or an asthma attack in the past 12 months (excluding unknowns and refusals).

Survey Question(s)

- 9.1 Have you ever been told by a doctor, nurse, or other health professional that you had asthma? (Core Section 9: Asthma)
 - 9.2 Do you still have asthma? (Core Section 9: Asthma)
 2. During the past 12 months, have you had an episode of asthma or an asthma attack? (Module 9: Adult Asthma History)
 7. Symptoms of asthma include cough, wheezing, shortness of breath, chest tightness and phlegm production when you don't have a cold or respiratory infection. During the past 30 days, how often did you have any symptoms of asthma? (Module 9: Adult Asthma History)
-

Special Instructions

None

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

National Asthma Education and Prevention Program (NAEPP): <http://www.nhlbi.nih.gov/about/naepp/>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ CDC. *National Health Interview Survey data: 2003 asthma data* [online]. HHS, CDC, National Center for Environmental Health. 2003. Available at <http://www.cdc.gov/asthma/NHIS/default.htm>.

² NHLBI. *Data Fact Sheet: Asthma Statistics*. Bethesda, MD: NIH, Public Health Service PHS; 1999.

³ Collins, JG. *Prevalence of selected chronic conditions: United States 1990-1992*. National Center for Health Statistics: Vital Health Statistics. 10(194); 1997. Available at http://www.cdc.gov/nchs/data/series/sr_10/sr10_194.pdf

⁴ NAEPP. *Clinical practice guidelines: expert panel report 2: guidelines for the diagnosis and management of asthma*. (NIH Publication No. 97-4051). NIH, NHLBI; 1997. Available at: <http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.pdf>

Performance Measure O-7	Measurable improvements in healthful eating, physical activity, and tobacco use.
Indicator O-7.1	Tobacco use cessation attempts by adult smokers.

Rationale for Selecting This Indicator

Cigarette smoking causes approximately 440,000 deaths in the United States each year, making it the nation’s leading preventable cause of death.¹ Smoking increases the risk of heart disease, cancer, stroke, and chronic lung disease. Quitting smoking has major and immediate health benefits. For example, people who quit smoking before age 50 have half the risk of dying during the next 15 years compared with people who continue to smoke.² Attempting to quit smoking is an essential step in the process of becoming tobacco-free; increased smoking cessation attempts may lead to an increase in the number of smokers who successfully quit and to a reduction in tobacco use.^{3,4} Thus, smoking cessation attempts may help to prevent tobacco-related diseases, including diabetes complications and asthma exacerbations.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward intermediate outcomes related to reductions in tobacco use. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions targeting tobacco use cessation. These data are used to recognize successes and to determine progress toward intended outcomes related to increased tobacco use cessation. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source

2005 Behavioral Risk Factor Survey (BRFS)

Core Section 11: Tobacco Use

How Indicator Is Measured

Numerator: Respondents aged ≥ 18 years who report having stopped smoking for one day or longer because they were trying to quit smoking in the past 12 months.

Denominator: Respondents aged ≥ 18 years who report having smoked 100 cigarettes in their lifetime and are current smokers on every day or some days (excluding unknowns and refusals).

Survey Question(s)

11.1 Have you smoked at least 100 cigarettes in your entire life?

11.2 Do you now smoke cigarettes every day, some days, or not at all?

11.3 During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?

Special Instructions

None

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

The Guide to Community Preventive Services: <http://www.thecommunityguide.org/>

Healthy People 2010: <http://www.healthypeople.gov/default.htm>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ CDC. Annual smoking-attributable mortality, years of potential life lost, and economic costs – U.S., 1995-1999. *MMWR*. 2002;51(14):300-3. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5114a2.htm#top>

² HHS. *The health benefits of smoking cessation*. (HHS Publication No. (CDC) 90-8416). Atlanta, GA: HHS, Public Health Service, CDC, NCCDPHP, OSH;1990.

³ Starr G, Rogers T, Schooley M, Porter S, Wiesen E & Jamison N. *Key outcome indicators for evaluating comprehensive tobacco control programs*. Atlanta (GA): CDC; 2005.

⁴ Fiore MC, Bailey WC, Cohen SJ, et al. *Treating tobacco use and dependence: clinical practice guideline*. Rockville, MD: HHS, Public Health Service; June 2000. Available at: <http://www.surgeongeneral.gov/tobacco/default.htm>

Performance Measure O-7	Measurable improvements in healthful eating, physical activity, and tobacco use.
Indicator O-7.2	Tobacco use cessation attempts by adolescent smokers.

Rationale for Selecting This Indicator

Cigarette smoking causes approximately 440,000 deaths in the United States each year, making it the nation’s leading preventable cause of death.¹ Tobacco use begins primarily during adolescence; almost 90% of adult smokers began by age 18 years.² Young people who are established smokers are at high risk of becoming addicted to cigarettes, increasing the likelihood they will use tobacco products throughout adulthood and subsequently be at risk for tobacco-related diseases such as lung cancer, heart disease, and emphysema.³ Quitting smoking has major and immediate health benefits. For example, people who quit smoking before age 50 have half the risk of dying during the next 15 years compared with people who continue to smoke.⁴ Attempting to quit smoking is an essential step in the process of becoming tobacco-free; increased smoking cessation attempts may lead to an increase in the number of smokers who successfully quit and to a reduction in tobacco use.^{5,6} Thus, smoking cessation attempts by adolescents may help to prevent tobacco-related diseases, including diabetes complications and asthma exacerbations.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward intermediate outcomes related to reductions in tobacco use. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions targeting tobacco use cessation by adolescents. These data are used to recognize successes and to determine progress toward intended outcomes related to increased tobacco use cessation. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source

2007 Youth Risk Behavior Survey (YRBS)
Tobacco Use Section

How Indicator Is Measured

Numerator: Respondents in grades 9-12 who report having tried to quit smoking in the past 12 months.

Denominator: Respondents in grades 9-12 who report having smoked ≥ 1 day in the past 30 days (excluding those who did not answer).

Survey Question(s)

30. During the past 30 days, on how many days did you smoke cigarettes?

35. During the past 12 months, did you ever try to quit smoking cigarettes?

The above questions are questions 10 and 15 on the 2007 Steps YRBS questionnaire, a short version of the core YRBS questionnaire that contains questions relevant to the Steps Program focus areas.

Special Instructions

None

Data Collection Schedule

Collected biennially

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

The Guide to Community Preventive Services: <http://www.thecommunityguide.org/>

Healthy People 2010: <http://www.healthypeople.gov/default.htm>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ CDC. Annual smoking-attributable mortality, years of potential life lost, and economic costs – U.S., 1995-1999. *MMWR*. 2002;51(14):300-3. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5114a2.htm#top>

² HHS. *Preventing tobacco use among young people: a report of the Surgeon General*. Atlanta, GA: Centers for Disease Control and Prevention; 1994.

³ Jackson C & Dickinson D. Cigarette consumption during childhood and persistence of smoking through adolescence. *Archives of Pediatric & Adolescent Medicine*. 2004;158(11):1050-6.

⁴ HHS. *The health benefits of smoking cessation*. (HHS Publication No. (CDC) 90-8416). Atlanta, GA: HHS, Public Health Service, CDC, NCCDPHP, OSH;1990.

⁵ Starr G, Rogers T, Schooley M, Porter S, Wiesen E & Jamison N. *Key outcome indicators for evaluating comprehensive tobacco control programs*. Atlanta (GA): CDC; 2005.

⁶ Fiore MC, Bailey WC, Cohen SJ, et al. *Treating tobacco use and dependence: clinical practice guideline*. Rockville, MD: HHS, Public Health Service; June 2000. Available at: <http://www.surgeongeneral.gov/tobacco/default.htm>

Performance Measure O-7	Measurable improvements in healthful eating, physical activity, and tobacco use.
Indicator O-7.3	Cigarette smoking among adults aged 18 or older.

Rationale for Selecting This Indicator

Cigarette smoking causes approximately 440,000 deaths in the United States each year, making it the nation’s leading preventable cause of death.¹ Smoking increases the risk of heart disease, cancer, stroke, and chronic lung disease. Exposure to secondhand smoke can lead to lung cancer and heart disease in adults and to health problems such as asthma, sudden infant death syndrome, and lower respiratory infections in children.^{2,3,4} A reduction in cigarette smoking by adults represents measurable improvement in tobacco use and may help to prevent tobacco related diseases, including diabetes complications and asthma exacerbations.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward intermediate outcomes related to reductions in tobacco use. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions targeting tobacco use. These data are used to recognize successes and to determine progress toward intended outcomes related to preventing tobacco use and exposure. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source(s)

2005 Behavioral Risk Factor Survey (BRFS)

Core Section 11: Tobacco Use

How Indicator Is Measured

Numerator: Respondents aged ≥ 18 years who report having smoked 100 cigarettes in their lifetime and are current smokers on every day or some days.

Denominator: Respondents aged ≥ 18 years who report ever or not ever smoking 100 cigarettes in their lifetime and report their current smoking status (excluding unknowns and refusals).

Survey Question(s)

11.1 Have you smoked at least 100 cigarettes in your entire life?

11.2 Do you now smoke cigarettes every day, some days or not at all?

Special Instructions

None

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

The Community Indicators Handbook: <http://www.communityinitiatives.com/pubs/indicats.html>

The Guide to Community Preventive Services: <http://www.thecommunityguide.org/>

Healthy People 2010: <http://www.healthypeople.gov/default.htm>

Indicators for Chronic Disease Surveillance: <http://www.cdc.gov/mmwr/PDF/RR/RR5311.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ CDC. Annual smoking-attributable mortality, years of potential life lost, and economic costs – U.S., 1995-1999. *MMWR*. 2002;51(14):300-3. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5114a2.htm#top>

² HHS. *The health consequences of smoking: a report of the Surgeon General*. Atlanta, GA: CDC; 2004.

³ HHS. *Women and smoking: a report of the Surgeon General*. Washington, DC: GPO; 2001. Available at: <http://www.surgeongeneral.gov/library/womenandtobacco/>

⁴ NCI. *Smoking and Tobacco Control Monograph No. 10: Health effects of exposure to environmental tobacco smoke: the report of the California Environmental Protection Agency*. (NIH Publication No. 99-4645). Bethesda, MD: National Cancer Institute, 1999.

Performance Measure O-7	Measurable improvements in healthful eating, physical activity, and tobacco use.
Indicator O-7.4	Cigarette smoking among youth.

Rationale for Selecting This Indicator

Cigarette smoking causes approximately 440,000 deaths in the United States each year, making it the nation’s leading preventable cause of death.¹ Tobacco use begins primarily during adolescence; almost 90% of adult smokers began by age 18 years.² Each day, more than 5,000 youth try their first cigarette.³ Young people who are established smokers are at high risk of becoming addicted to cigarettes, increasing the likelihood they will use tobacco products throughout adulthood and subsequently be at risk for tobacco-related diseases such as lung cancer, heart disease, and emphysema.⁴ Additionally, exposure to secondhand smoke can lead to lung cancer and heart disease in adults and to health problems such as asthma, sudden infant death syndrome, and lower respiratory infections in children.^{5,6,7} A reduction in cigarette smoking by young people represents measurable improvement in tobacco use and may help to prevent tobacco related diseases, including diabetes complications and asthma exacerbations.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward intermediate outcomes related to reductions in tobacco use. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions targeting tobacco use by young people. These data are used to recognize successes and to determine progress toward intended outcomes related to preventing tobacco use and exposure. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source

2007 Youth Risk Behavior Survey (YRBS)
Tobacco Use Section

How Indicator Is Measured

Numerator: Respondents in grades 9–12 who report having smoked a cigarette on ≥ 1 day during the past 30 days.

Denominator: Respondents in grades 9–12 who report having or not having smoked a cigarette on ≥ 1 day during the past 30 days (excluding those who did not answer).

Survey Question(s)

30. During the past 30 days, on how many days did you smoke cigarettes?

The above question is question 10 on the 2007 Steps YRBS questionnaire, a short version of the core YRBS questionnaire that contains questions relevant to the Steps Program focus areas.

Special Instructions

None

Data Collection Schedule

Collected biennially

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

Centers for Disease Control and Prevention (CDC), *FY 2005 Performance Plan*:

<http://www.cdc.gov/od/perfplan/Index.htm>

The Community Indicators Handbook: <http://www.communityinitiatives.com/pubs/indicats.html>

Government Performance and Results Act (GPRA): <http://www.whitehouse.gov/omb/mgmt-gpra/index.html>

The Guide to Community Preventive Services: <http://www.thecommunityguide.org/>

Indicators for Chronic Disease Surveillance: <http://www.cdc.gov/mmwr/PDF/RR/RR5311.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ CDC. Annual smoking-attributable mortality, years of potential life lost, and economic costs – U.S., 1995-1999. *MMWR*. 2002;51(14):300-3. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5114a2.htm#top>

² HHS. *Preventing tobacco use among young people: a report of the Surgeon General*. Atlanta, GA: CDC; 1994.

³ SAMHSA. *Summary of findings from the 2000 National Household Survey on Drug Abuse*. (DHHS Pub. No. (SMA) 01-3549). Rockville, MD: HHS; 2001. Available at www.samhsa.gov/news/click3_frame.html

⁴ Jackson C & Dickinson D. Cigarette consumption during childhood and persistence of smoking through adolescence. *Archives of Pediatric & Adolescent Medicine*. 2004;158(11):1050-6.

⁵ HHS. *The health consequences of smoking: a report of the Surgeon General*. Atlanta, GA: CDC; 2004.

⁶ HHS. *Women and smoking: a report of the Surgeon General*. Washington, DC: GPO; 2001. Available at: <http://www.surgeongeneral.gov/library/womenandtobacco/>

⁷ NCI. *Smoking and Tobacco Control Monograph No. 10: Health effects of exposure to environmental tobacco smoke: the report of the California Environmental Protection Agency*. (NIH Publication No. 99-4645). Bethesda, MD: National Cancer Institute, 1999.

Performance Measure O-8	Slowed upward trend of overweight and obesity in Steps communities.
Indicator O-8.1	Prevalence of overweight or obesity among adults aged 18 or older.

Rationale for Selecting This Indicator

The United States is experiencing a rising prevalence of overweight and obesity that has reached epidemic proportions among men and women of all ages, races, and ethnic groups.¹ In 2000, an estimated 65% of adults were overweight or obese.² Body Mass Index (BMI) is a measure of weight in relation to height that is frequently used as a screening tool to identify possible weight problems for adults. Although it does not measure body fat directly, it is a reliable indicator of total body fat.³ Having a BMI of 25 or greater (indicating either overweight or obesity) is a risk factor for high blood pressure, high cholesterol, heart disease, diabetes, several forms of cancer, and other chronic health problems.⁴ Both modest and large weight gains are associated with increased risk of disease.⁵ Slowing the rate of increase in prevalence of overweight or obesity may contribute to a reduction of overweight- or obesity-related health problems, including type 2 diabetes and its complications.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward long-term outcomes related to slowing the upward trend of overweight and obesity. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions targeting reductions in overweight and obesity. These data are used to recognize successes and to determine progress toward intended outcomes related to preventing overweight and obesity. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source(s)

2005 Behavioral Risk Factor Survey (BRFS)
Core Section 13: Demographics

How Indicator Is Measured

Numerator: Respondents aged ≥ 18 years who have a body mass index (BMI) ≥ 25.0 kg/m² calculated from self-reported weight and height.

Denominator: Respondents aged ≥ 18 years for whom BMI can be calculated from their self-reported weight and height (excluding unknowns or refusals to provide weight or height).

Survey Question(s)

13.10 How much do you weigh without shoes?

13.11 About how tall are you without shoes?

Special Instructions

None

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

The Community Indicators Handbook: <http://www.communityinitiatives.com/pubs/indicats.html>

The Guide to Community Preventive Services: <http://www.thecommunityguide.org/>

Healthy People 2010: <http://www.healthypeople.gov/default.htm>

Indicators for Chronic Disease Surveillance: <http://www.cdc.gov/mmwr/PDF/RR/RR5311.pdf>

Secretary Mike Leavitt's 500-Day Plan: <http://www.hhs.gov/secretaryspage.html> and <http://www.hhs.gov/500DayPlan/500DayPlan.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ Eberhardt MS, Ingram DD, Makuc DM, et al. *Urban and rural health chartbook: health, United States, 2001*. Hyattsville, MD: NCHS; 2001.

² Flegal KM, Carroll MD, Ogden CL & Johnson CL. Prevalence and trends in obesity among US adults, 1999-2000. *JAMA*. 288:1723-7;2002.

³ CDC. *BMI – body mass index: about BMI for adults*. Atlanta, GA: HHS, CDC, 2006. Available at http://www.cdc.gov/nccdphp/dnpa/bmi/adult_BMI/about_adult_BMI.htm

⁴ NHLBI. *Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults*. (NIH Publication No. 98-4083). NIH; 1998. Available at: http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.pdf

⁵ Ford ES, Williamson DF & Liu S. *Weight change and diabetes incidence: findings from a national cohort of US adults*. *Am J Epidemiol*. 1997;146(3):214-22.

Performance Measure O-8	Slowed upward trend of overweight and obesity in Steps communities.
Indicator O-8.2	Obesity prevalence among adults aged 18 or older.

Rationale for Selecting This Indicator

The United States is experiencing a rising prevalence of overweight and obesity that has reached epidemic proportions among men and women of all ages, races, and ethnic groups.¹ In 2000, an estimated 31% of adults were obese.² Body Mass Index (BMI) is a measure of weight in relation to height that is frequently used as a screening tool to identify possible weight problems for adults. Although it does not measure body fat directly, it is a reliable indicator of total body fat.³ Having a BMI of 25 or greater (indicating either overweight or obesity) is a risk factor for high blood pressure, high cholesterol, heart disease, diabetes, several forms of cancer, and other chronic health problems.⁴ Furthermore, obese adults (those with a BMI of 30 or greater) have a 50 to 100 percent increased risk of premature death from all causes compared to adults with a normal weight (BMI in the range of 20 – 25).⁵ In 2000, obesity was associated with an estimated 111,909 deaths.⁶ Slowing the rate of increase in prevalence of obesity may contribute to a reduction of obesity-related health problems, including type 2 diabetes and its complications.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward long-term outcomes related to slowing the upward trend of overweight and obesity. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions targeting reductions in overweight and obesity. These data are used to recognize successes and to determine progress toward intended outcomes related to preventing overweight and obesity. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source

2005 Behavioral Risk Factor Survey (BRFS)

Core Section 13: Demographics

How Indicator Is Measured

Numerator: Respondents aged ≥ 18 years who have a body mass index (BMI) ≥ 30.0 kg/m² calculated from self-reported weight and height.

Denominator: Respondents aged ≥ 18 years for whom BMI can be calculated from their self-reported weight and height (excluding unknowns or refusals to provide weight or height).

Survey Question(s)

13.10 How much do you weigh without shoes?

13.11 About how tall are you without shoes?

Special Instructions

None

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

The Community Indicators Handbook: <http://www.communityinitiatives.com/pubs/indicats.html>

The Guide to Community Preventive Services: <http://www.thecommunityguide.org/>

Healthy People 2010: <http://www.healthypeople.gov/default.htm>

Indicators for Chronic Disease Surveillance: <http://www.cdc.gov/mmwr/PDF/RR/RR5311.pdf>

Secretary Mike Leavitt's 500-Day Plan: <http://www.hhs.gov/secretaryspage.html> and <http://www.hhs.gov/500DayPlan/500DayPlan.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ Eberhardt MS, Ingram DD, Makuc DM, et al. *Urban and rural health chartbook: health, United States, 2001*. Hyattsville, MD: NCHS; 2001.

² Flegal KM, Carroll MD, Ogden CL & Johnson CL. Prevalence and trends in obesity among US adults, 1999-2000. *JAMA*. 288:1723-7;2002.

³ CDC. *BMI – body mass index: about BMI for adults*. Atlanta, GA: HHS, CDC, 2006. Available at http://www.cdc.gov/nccdphp/dnpa/bmi/adult_BMI/about_adult_BMI.htm

⁴ NHLBI. *Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults*. (NIH Publication No. 98-4083). NIH; 1998. Available at: http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.pdf

⁵ HHS. *The Surgeon General's call to action to prevent and decrease overweight and obesity*. Rockville, MD: HHS, Public Health Service, Office of the Surgeon General; 2001. Available at <http://www.surgeongeneral.gov/topics/obesity/>

⁶ Flegal KM, Graubard BI, Williamson DF, Gail MH. Excess deaths associated with underweight, overweight, and obesity. *JAMA*. 2005;293:1861-1867.

Performance Measure O-8	Slowed upward trend of overweight and obesity in Steps communities.
Indicator O-8.3	Overweight prevalence among youth

Rationale for Selecting This Indicator

The United States is experiencing a rising prevalence of overweight and obesity that has reached epidemic proportions among men and women of all ages, races, and ethnic groups.¹ In 2000, an estimated 16% of young people aged 6-19 years were overweight.² In 2001-2002 there were more than twice as many overweight children and three times as many overweight adolescents as there were in 1980.³ Body Mass Index (BMI) is a measure of weight in relation to height that is recommended as a screening tool to identify possible weight problems for children. Although it does not measure body fat directly, it is a reliable indicator of total body fat for most children and adolescents.⁴ For young people under age 20, BMI is age- and sex-specific; children and adolescents are considered overweight if their BMI is in the 95th percentile of the CDC BMI-for-age growth chart for their age and sex.⁴ Overweight young people have more cardiovascular risk factors (including high cholesterol and high blood pressure) than young people with normal weight.⁵ Additionally, overweight adolescents are at greater risk of becoming overweight or obese as adults⁶ and experiencing related problems such as high blood pressure, high cholesterol, heart disease, diabetes, and several forms of cancer.⁷ Slowing the rate of increase in prevalence of overweight among young people may contribute to a reduction of overweight- and obesity-related health problems, including type 2 diabetes and its complications.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward long-term outcomes related to slowing the upward trend of overweight and obesity. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions targeting reductions in the number of overweight young people. These data are used to recognize successes and to determine progress toward intended outcomes related to preventing overweight and obesity. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source

2007 Youth Risk Behavior Survey (YRBS)
Demographics Section

How Indicator Is Measured

Numerator: Respondents in grades 9–12 with a body mass index (BMI) at or above the sex- and age-specific 95th percentile from CDC Growth Charts: United States.

Denominator: Respondents in grades 9–12 who answer height and weight questions (excluding those who did not answer).

Survey Question(s)

6. How tall are you without your shoes on?
7. How much do you weigh without your shoes on?

The above questions are questions 6 and 7 on the 2007 Steps YRBS questionnaire, a short version of the core YRBS questionnaire that contains questions relevant to the Steps Program focus areas.

Special Instructions

None

Data Collection Schedule

Collected biennially

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

The Community Indicators Handbook: <http://www.communityinitiatives.com/pubs/indicats.html>

Healthy People 2010: <http://www.healthypeople.gov/default.htm>

Indicators for Chronic Disease Surveillance: <http://www.cdc.gov/mmwr/PDF/RR/RR5311.pdf>

Secretary Mike Leavitt's 500-Day Plan: <http://www.hhs.gov/secretarypage.html> and <http://www.hhs.gov/500DayPlan/500DayPlan.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ Eberhardt MS, Ingram DD, Makuc DM, et al. *Urban and rural health chartbook: health, United States, 2001*. Hyattsville, MD: NCHS; 2001.

² Ogden CL, Flegal KM, Carroll MD & Johnson CL. Prevalence and trends in overweight among US children and adolescents, 1999-2000. *JAMA*. 2002;288:1728-1732.

³ Hedley AA, Ogden CL, Johnson CL, Carroll MD, Curtin LR & Flegal KM. Prevalence of overweight and obesity among US children, adolescents, and adults, 1999-2002. *JAMA*. 2004;291(23):2847-2850.

⁴ CDC. *BMI – body mass index: about BMI for children and teens*. Atlanta, GA: HHS, CDC, 2006. Available at http://www.cdc.gov/nccdphp/dnpa/bmi/childrens_BMI/about_childrens_BMI.htm

⁵ Freedman DS, Dietz WH, Srinivasan SR & Berenson GS. The relation of overweight to cardiovascular risk factors among children and adolescents: the Bogalusa Heart Study. *Pediatrics*. 1999;103:1175–1182.

⁶ Whitaker RC, Wright JA, Pepe MS, Seidel KD & Dietz WH. Predicting obesity in young adulthood from childhood and parental obesity. *New England Journal of Medicine*. 1997;37(13):869–873.

⁷ NHLBI. *Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults*. (NIH Publication No. 98-4083). NIH; 1998. Available at: http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.pdf

Performance Measure O-9	Reduced hospitalizations due to diabetes complications and asthma exacerbations.
Indicator O-9.1	Hospitalization with asthma among adults aged 18 or older.

Rationale for Selecting This Indicator

Asthma affects almost 20 million people, or 7% of the U.S. population.¹ Asthma is responsible for about 500,000 hospitalizations,² 5,000 deaths,² and 134 million days of restricted activity³ a year. Effective asthma self-management can reduce morbidity among children and adults.⁴ An asthma exacerbation severe enough to require hospitalization or a visit to the emergency department may indicate 1) a lack of access to medical care for diagnosis, treatment, and monitoring, 2) inadequate long-term management of asthma, or 3) inadequate treatment plans for handling asthma exacerbations.⁴

The survey items used to collect data on this indicator are proxy measures for data on asthma-related hospitalizations. It is often difficult and expensive to collect timely data about hospitalization at the local level. Therefore, the number of health care visits for urgent treatment of worsening asthma symptoms is used instead as a proxy measure. A reduction in the number of these visits probably indicates reductions in asthma-related exacerbations and hospitalizations.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward long-term outcomes related to reductions in asthma exacerbations. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions targeting asthma. These data are used to recognize successes and to determine progress toward intended outcomes related to reduced exacerbations of asthma. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source

2005 Behavioral Risk Factor Survey (BRFS)
Core Section 9: Asthma; Module 9: Adult Asthma History

How Indicator Is Measured

- Numerator:** Respondents aged ≥ 18 years who report having visited an emergency room or urgent care center because of their asthma or having seen a doctor, nurse, or other health professional for urgent treatment of worsening asthma symptoms in the past 12 months.
- Denominator:** Respondents aged ≥ 18 years who report ever told by a doctor or health professional that they have asthma and have had an episode of asthma or an asthma attack in the past 12 months (excluding unknowns and refusals).
-

Survey Question(s)

- 9.1 Have you ever been told by a doctor, nurse, or other health professional that you had asthma? (Core Section 9: Asthma)
 - 9.2 Do you still have asthma? (Core Section 9: Asthma)
 2. During the past 12 months, have you had an episode of asthma or an asthma attack? (Module 9: Adult Asthma History)
 3. During the past 12 months, how many times did you visit an emergency room or urgent care center because of your asthma? (Module 9: Adult Asthma History)
 4. [If one or more visits to Q3, fill in “Besides those emergency room visits,”] During the past 12 months, how many times did you see a doctor, nurse or other health professional for urgent treatment of worsening asthma symptoms? (Module 9: Adult Asthma History)
-

Special Instructions

None

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

Agency for Healthcare Research and Quality (AHRQ), *National Healthcare Disparities Report* and *National Healthcare Quality Report*: <http://www.qualitytools.ahrq.gov/disparitiesreport/browse/browse.aspx> and <http://www.qualitytools.ahrq.gov/qualityreport/browse/browse.aspx>

Centers for Disease Control and Prevention (CDC), *FY 2005 Performance Plan*: <http://www.cdc.gov/od/perfplan/Index.htm>

The Community Indicators Handbook: <http://www.communityinitiatives.com/pubs/indicats.html>

Government Performance and Results Act (GPRA): <http://www.whitehouse.gov/omb/mgmt-gpra/index.html>

Healthy People 2010: <http://www.healthypeople.gov/default.htm>

Indicators for Chronic Disease Surveillance: <http://www.cdc.gov/mmwr/PDF/RR/RR5311.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ CDC. *National Health Interview Survey data: 2003 asthma data* [online]. HHS, CDC, National Center for Environmental Health. 2003. Available at <http://www.cdc.gov/asthma/NHIS/default.htm>.

² NHLBI. *Data Fact Sheet: Asthma Statistics*. Bethesda, MD: NIH, Public Health Service PHS; 1999.

³ Collins, JG. *Prevalence of selected chronic conditions: United States 1990-1992*. National Center for Health Statistics: Vital Health Statistics. 10(194); 1997. Available at http://www.cdc.gov/nchs/data/series/sr_10/sr10_194.pdf

⁴ NAEPP. *Clinical practice guidelines: expert panel report 2: guidelines for the diagnosis and management of asthma*. (NIH Publication No. 97-4051). NIH, NHLBI; 1997. Available at: <http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.pdf>

Performance Measure O-9	Reduced hospitalizations due to diabetes complications and asthma exacerbations.
Indicator O-9.2	Hospitalization with asthma among youth.

Rationale for Selecting This Indicator

Asthma affects over 6 million young people, or 8.5% of the U.S. population under the age of 18.¹ Asthma is the third leading cause of hospitalization for children under 15, is a leading cause of school absenteeism, and often results in unnecessary restriction of activities for young people.^{2,3} Effective asthma self-management can reduce morbidity among children and adults.⁴ An asthma exacerbation severe enough to require hospitalization or a visit to the emergency department may indicate 1) a lack of access to medical care for diagnosis, treatment, and monitoring, 2) inadequate long-term management of asthma, or 3) inadequate treatment plans for handling asthma exacerbations.⁴

The survey items used to collect data on this indicator are proxy measures for data on asthma-related hospitalizations. It is often difficult and expensive to collect timely data about hospitalization at the local level. Therefore, the number of health care visits for urgent treatment of worsening asthma symptoms is used instead as a proxy measure. A reduction in the number of these visits probably indicates reductions in asthma-related exacerbations and hospitalizations.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward long-term outcomes related to reductions in asthma exacerbations. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions targeting asthma in young people. These data are used to recognize successes and to determine progress toward intended outcomes related to reduced exacerbations of asthma. Lessons are shared with all Steps communities and with other interested public health programs.

Data Source

2007 Steps Youth Risk Behavior Survey (Steps YRBS)

How Indicator Is Measured

Numerator: Respondents in grades 9-12 who report still having asthma and visiting an emergency room or urgent care center because of their asthma in the past 12 months.
Denominator: Respondents in grades 9-12 who report still having asthma.

Survey Question(s)

36. Has a doctor or nurse ever told you that you have asthma?
37. Do you still have asthma?
38. During the past 12 months, how many times did you visit an emergency room or urgent care center because of your asthma?

Note: The numbers above refer to the 2007 Steps YRBS questionnaire, a short version of the core YRBS questionnaire that contains questions relevant to the Steps Program focus areas. Questions 36 and 37 are questions 86 and 87 on the core YRBS questionnaire; question 38 is not included on the core YRBS questionnaire.

Special Instructions

None

Data Collection Schedule

Collected biennially

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

Agency for Healthcare Research and Quality (AHRQ), *National Healthcare Disparities Report* and *National Healthcare Quality Report*: <http://www.qualitytools.ahrq.gov/disparitiesreport/browse/browse.aspx> and <http://www.qualitytools.ahrq.gov/qualityreport/browse/browse.aspx>

Centers for Disease Control and Prevention (CDC), *FY 2005 Performance Plan*: <http://www.cdc.gov/od/perfplan/Index.htm>

The Community Indicators Handbook: <http://www.communityinitiatives.com/pubs/indicats.html>

Government Performance and Results Act (GPRA): <http://www.whitehouse.gov/omb/mgmt-gpra/index.html>

Healthy People 2010: <http://www.healthypeople.gov/default.htm>

Indicators for Chronic Disease Surveillance: <http://www.cdc.gov/mmwr/PDF/RR/RR5311.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ CDC. *National Health Interview Survey data: 2003 asthma data* [online]. HHS, CDC, National Center for Environmental Health. 2003. Available at <http://www.cdc.gov/asthma/NHIS/default.htm>

² Popovic JR. *1999 National hospital discharge survey: annual summary with detailed diagnosis and procedure data*. National Center for Health Statistics: Vital Health Statistics. 13(151); 2001. Available at: http://www.cdc.gov/nchs/data/series/sr_13/sr13_151.pdf

³ NHLBI. *National asthma education prevention program resolution on asthma management at school*. NIH, NHLBI; 2005. Available at <http://www.nhlbi.nih.gov/health/public/lung/asthma/resolut.htm>

⁴ NAEPP. *Clinical practice guidelines: expert panel report 2: guidelines for the diagnosis and management of asthma*. (NIH Publication No. 97-4051). NIH, NHLBI; 1997. Available at: <http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.pdf>

Performance Measure O-9	Reduced hospitalizations due to diabetes complications and asthma exacerbations.
Indicator O-9.3	Hospitalization with diabetes among adults aged 18 or older.

Rationale for Selecting This Indicator

An estimated 18.2 million Americans (6.3% of the population) have diabetes, and for 5.2 million of those people, their diabetes is undiagnosed.¹ Diabetes is the sixth leading cause of death in the United States² and can lead to serious complications such as heart disease, stroke, high blood pressure, blindness, kidney damage, and lower-limb amputations.³ Each year approximately 500,000 hospital discharge abstracts list diabetes as the principal diagnosis, and 3.5 million hospital discharge abstracts list diabetes as at least one diagnosis.⁴ A diabetes complication severe enough to require hospitalization may indicate a lack of access to quality healthcare or inadequate adherence to a diabetes self-management plan.

The survey items used to collect data on this indicator are proxy measures for data on diabetes-related hospitalizations. It is often difficult and expensive to collect timely data about hospitalization at the local level. Therefore, the number of health care visits for diabetes is used instead as a proxy measure. A reduction in the number of respondents with 5 or more health care visits per year for diabetes probably indicates reductions in diabetes-related complications and hospitalizations.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward long-term outcomes related to reductions in diabetes complications. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions targeting diabetes. These data are used to recognize successes and to determine progress toward intended outcomes related to reduced complications of diabetes. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source

2005 Behavioral Risk Factor Survey (BRFS)
 Core Section 5: Diabetes; Module 1: Diabetes

How Indicator Is Measured

Numerator: Respondents aged ≥ 18 years ever told by a doctor that they have diabetes (excluding women who were told only when pregnant) who have seen a doctor, nurse, or other health professional for their diabetes ≥ 5 times in the past 12 months.

Denominator: Respondents aged ≥ 18 years ever told by a doctor that they have diabetes (excluding women who were told only when pregnant, refusals, and unknowns).

Survey Question(s)

- 5.1 Have you ever been told by a doctor that you have diabetes? (Core Section 5: Diabetes)
7. About how many times in the past 12 months have you seen a doctor, nurse, or other health professional for your diabetes? (Module 1: Diabetes)
-

Special Instructions

Respondents who answer the diabetes core question 5.1 and indicate that they were told by a doctor they have diabetes (1. Yes) must be asked the six diabetes module questions listed in Appendix D. These six questions must be asked in the prescribed order even if not all the questions in the BRFSS diabetes module are used. If the six diabetes module questions not required for the core performance measures are not asked, the data columns for those questions should be filled in with the code for refusal.

Data Collection Schedule

Collected annually

Resources

None

Consistency with relevant agencies, initiatives, and guidance documents

The Guide to Community Preventive Services: <http://www.thecommunityguide.org/>

Indicators for Chronic Disease Surveillance: <http://www.cdc.gov/mmwr/PDF/RR/RR5311.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and <http://www.healthierus.gov/steps/2004grants.html>

¹ CDC. *National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2003*. Rev ed. Atlanta, GA: HHS, CDC; 2004. Available at <http://www.cdc.gov/diabetes/pubs/factsheet.htm>

² Anderson RN & Smith BL. Deaths: leading causes for 2002. National vital statistics reports; vol 53 no 17. Hyattsville, MD: National Center for Health Statistics; 2005. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_17.pdf

³ National Diabetes Data Group, ed. *Diabetes in America, 2nd ed* (NIH Publication No. 95-1468). Washington, DC: HHS, NIH, National Institute of Diabetes and Digestive and Kidney Diseases; 1995

⁴ CDC. Indicators for chronic disease surveillance. *MMWR*. 2004;53(RR11):1-6. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5311a1.htm>

Performance Measure O-10	Improved health-related quality of life.
Indicator O-10.1	Mean number of Healthy Days among adults aged 18 or older.

Rationale for Selecting This Indicator

Health-related quality of life is “an individual’s or group’s perceived physical and mental health over time.”¹ This is consistent with the World Health Organization’s definition of health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”^{1,2} Health-related quality of life is a particularly important measure for chronic disease surveillance.¹ Research shows that the Healthy Days measure (i.e. the number of days per month when an individual’s physical and mental health were both good) is a valid and reliable measure of health-related quality of life.¹ Healthy Days correlate as expected with physical activity, obesity and overweight, tobacco use, and access to healthcare.¹ Healthy Days can also serve as a proxy measure for the perceived burden of symptoms associated with chronic health conditions.¹ This indicator captures all of the long-term outcomes of the Steps Program: an increase in the mean number of Healthy Days may reflect improved self-management of diabetes and asthma, a slowed upward trend of overweight and obesity, reduced diabetes complications and asthma exacerbations, and progress toward improved health-related quality of life.

Intended Use of Data

Steps communities use site-specific data for program planning, data-driven decision making, and local evaluation. The Centers for Disease Control and Prevention (CDC) use these data to track progress toward long-term outcomes related to improved health-related quality of life. CDC also uses the data to make data-driven decisions regarding priorities for technical assistance related to the selection, implementation, and evaluation of interventions that address multiple diseases and risk factors. These data are used to recognize successes and to determine progress toward intended outcomes across multiple diseases and risk factors. Lessons learned are shared with all Steps communities and with other interested public health programs.

Data Source(s)

2005 Behavioral Risk Factor Survey (BRFS)
 Core Section 2: Healthy Days

How Indicator Is Measured

Numerator: Mean number of healthy days in the past 30 days.
 Denominator: Respondents aged ≥ 18 years who report number of days in the past 30 days that their physical and mental health were not good (including zero; excluding unknowns and refusals).

Survey Question(s)

- 2.1 Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?
 - 2.2 Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?
-

Special Instructions

The methodology used to calculate data for this indicator is based on the methodology presented in the report “Measuring Healthy Days” (see Resources section)

Data Collection Schedule

Collected annually

Resources

Measuring Healthy Days
<http://www.cdc.gov/hrqol/monograph.htm>.

Consistency with relevant agencies, initiatives, and guidance documents

Centers for Disease Control and Prevention (CDC), *FY 2005 Performance Plan*:
<http://www.cdc.gov/od/perfplan/Index.htm>

The Community Indicators Handbook: <http://www.communityinitiatives.com/pubs/indicats.html>

The Future of the Public’s Health in the 21st Century, The Institute of Medicine (IOM):
<http://www.iom.edu/report.asp?id=4304>

Government Performance and Results Act (GPRA): <http://www.whitehouse.gov/omb/mgmt-gpra/index.html>

Healthy People 2010: <http://www.healthypeople.gov/default.htm>

Indicators for Chronic Disease Surveillance: <http://www.cdc.gov/mmwr/PDF/RR/RR5311.pdf>

Secretary Mike Leavitt’s 500-Day Plan: <http://www.hhs.gov/secretaryspage.html> and
<http://www.hhs.gov/500DayPlan/500DayPlan.pdf>

Steps Program Announcements: <http://www.healthierus.gov/steps/2003grants.html> and
<http://www.healthierus.gov/steps/2004grants.html>

¹ CDC. *Measuring healthy days*. Atlanta, GA: CDC; 2000.

² Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.