Environmental and Policy Indicators for Cardiovascular Health in Minnesota

Summary Report

MINNESOTA MDH DEPARTMENT OF HEALTH

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Introduction

In Minnesota, as in the United States, **cardiovascular disease (CVD)** is of paramount public health importance because of its high prevalence in the population and the potential for intervention. In Minnesota, heart disease and stroke account for more deaths, disability and health care costs than any other type of illness or injury.

While individual behavioral changes are at the core of reducing heart disease and stroke risk, system-wide changes in the environment can be effective in supporting these individual decisions. Policy and environmental interventions have the potential of affecting large numbers of individuals and contribute positively to changing and supporting community norms and environments that encourage health behavior and reduce the burden of cardiovascular diseases which on the individual level is hard to achieve.

Between 1999-2001, the Cardiovascular Health Branch of the Division of Adult and Community Health at the **Centers for Disease Control and Prevention (CDC)** developed a working list of measures that showed promise for enhancing cardiovascular health promotion and disease prevention and control in the form of policies and environmental change strategies. This list was crafted through a lengthy decision-making process that began with the Environmental, Policy, and Evaluation Workshop hosted in May 1999 by the Cardiovascular Health Branch.[1] Members of state cardiovascular health programs, subject matter experts, and representatives from CDC's Division of Adolescent and School Health, Division of Nutrition and Physical Activity, and Office on Smoking and Health contributed to this process.

From the resulting list, the same groups selected a shorter pilot list of indicators for potential surveillance.[2] The purpose of this list was to establish a set of measures that could be used by staff in state cardiovascular health programs to track local policy and environmental actions that impact cardiovascular health. The list contained 31 indicators across four public health channels: communities, schools, worksites, and health care systems (see Appendix A for full list of indicators). These indicators were selected based on a review of the literature, knowledge of current efforts, and the following criteria:

- An emphasis on heart-healthy policy and environmental changes related to physical activity, nutrition, and/or tobacco control
- Quality – accuracy, sensitivity, reliability, validity
- Feasibility – cost, ease of data collection
- Acceptability – to the practice setting and to the cardiovascular health programs
- Effectiveness of the indicator – based on science and experience

In 2001, the **Minnesota Department of Health Center for Health Promotion** identified, reviewed, and summarized existing data sources that could be used to measure the pilot indicators. This report presents a summary of the results of that investigation and provides recommendations for future work.

Methods

In 2001, staff from the Minnesota Heart Disease and Stroke Prevention Initiative used interviews, literature reviews, and web searches to find data sources and information on the indicators. Specifically, experts of cardiovascular health and leaders (principals of schools, community leaders, leaders of health organizations, etc.) of various settings were interviewed to review and identify existing policies and environment indicators. Standard sets of questions were asked. Samples of the questions are listed below:

- Do you know of any programs that have been successful at addressing heart disease or stroke in your community, school or worksite?
- Do you or your organization currently or in the past collect data related to the indicators? If so, what is the method? And is it public accessible?
- Do you know anyone or any organization might collect such data in Minnesota?
- Would you willing to help collecting data or measure indicators if you were asked to?

Forms of data for policies and environment indicators usually fell into one of the following categories:

- Text documents (e.g., copies of state laws, policies, regulations, usually available both in hardcopies and electronic-versions)
- Survey data (e.g., the Behavioral Risk Factor Surveillance System [BRFSS] and the School Health Policy and Programs Study [SHPPS]) and/or data stored in secondary datasets
- Expert knowledge (e.g., experts at the Minnesota Departments of Health, Transportation and Education, state lawmakers, and experts on various settings like school principals, community leaders etc.)

Telephone interviews, internet searches, and requested printed materials were used to take inventory of the data concerning the pilot indicators. The results are summarized for Minnesota state and local level policies and environment indicators according to the following settings: communities, schools, worksites, and health care organizations.

Findings

In Minnesota, data sources were currently available to reliably measure only nine of the 31 pilot indicators. The results that follow summarize the data for each setting.

Community Indicators

No reliable statewide data on the first five community indicators (Table 1) were found, but some potential sources were identified. Data were readily available for the two of the remaining indicators.

Table 1: Community Indicators*

1. Percent of highway funds devoted to transportation alternatives.
2. Percent of counties/municipalities with policies requiring sidewalks.
3. Percent of counties/municipalities that promote recreation facilities.
4. State policies and percent of counties/municipalities that promote bicycle use for transportation purposes.
5. Percent of milk sales in the state that is low-fat (1% or less).
6. Number of farmers' markets per capita in the state.
7. State indoor air laws for restaurants, day care centers, and other public places.
8. Proportion of smokers with smoking not allowed inside their home.

* The indicators in this table are abbreviated to reflect the essential elements of content. See Appendix A for the full text of pilot indicators.

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1. Percent of highway funds devoted to transportation alternatives.

This information existed at the Federal level in the form of TEA-21, found on the United States Department of Transportation website (www.dot.gov). TEA-21 (Transportation Equity Act for the 21st century) specified that, in each state, a certain percentage of funding must go to support recreational trails. Between 1998-2003 a total of $270 million in contract authority was authorized to provide and maintain recreational trails. States must have had a state recreational trails advisory committee to represent motorized and non-motorized trail users.

Funding sources for bicycle and pedestrian projects could come from the following federal sources:
1) Federal-aid highway program,
2) Federal transit program,
3) Highway safety programs, and
4) Federal/state matching requirements.
Bicycle and pedestrian projects were broadly eligible for funding from almost all the major federal-aid highway, transit, safety and other programs. Bicycle projects must have been 'principally for transportation, rather than recreation, purposes' and must have been designed and located pursuant to the transportation plans required of States and Metropolitan Planning Organizations." The Minnesota Department of Transportation did not collect specific bicycle expenditures information. It was possible, however, to get an estimate of the percent of funds spent under TEA-21 for bicycle and pedestrian features. The National Transportation Enhancements Clearinghouse (NTEC) maintains a database of TEA-21 enhancement projects, which is updated annually and is searchable over the internet.[3]

2. Percent of counties/municipalities with policies requiring sidewalks.

These types of policies vary widely among different Minnesota cities and often vary widely within a city, because different policies have existed at different periods in a city's lifespan. For example, the city engineer in Brooklyn Park reported that they currently had a city sidewalk policy, but they hadn't in the past. Thus, some areas of the city have sidewalks, while others do not. In addition, Minnesota Planning's "Model Ordinance's For Sustainable Development" project had exact specifications for sidewalk design, placement and maintenance. According to Minnesota Planning, the "Model Ordinances" could be considered state policy even though it is currently considered "optional" for communities to follow them. Because this is not mandated, there were no requirements for data to be collected.

3. Percent of counties/municipalities that promote recreation facilities.

Jean Coleman, from Biko & Associates reported that most new developments in Minnesota generally had some type of connection to recreation, mainly hike/bike trails and open space, more than recreation facilities. However, there wasn't any law in Minnesota that says this "connection" must be done. She reported that it was more of a "trend" than anything, (and that this trend seems to have coincided with the trend of not putting in sidewalks).

4. State policies and percent of counties or municipalities that promote bicycle use for transportation purposes.

In terms of state policies, the Minnesota Department of Transportation had "Plan B: The Comprehensive State Bicycle Plan – Realizing the Bicycle Dividend" (1992), which discussed the "state of bicycling" in the early 1990s, as well as goals, objectives and recommendations for "Designing the Bicycle Future" in Minnesota. This represented Minnesota's vision statement for promotion of bicycling, especially from a transportation perspective.

Minnesota Department of Transportation also had the "Minnesota Bicycle Transportation Planning and Design Guidelines" (1996), which addressed policy and goals, trail design and maintenance, the bicycle network planning process, and more. This guide was intended to assist cities and counties in the planning, design and maintenance of bike lanes and trails (e.g., city engineers).

While it was state policy to promote bicycle use as a form a transportation (so technically all communities have a bicycle policy) it was not mandated or enforced, thus it was unknown how many actually exist.

5. Percent of milk sales in the State that are low-fat (1% or less).

This information is collected and reported nationally and regionally. It is not collected or reported by state, because milk and milk products that are produced and packaged in one state can be sold in other nearby states. For example, Minnesota is a part of what the United States Department of Agriculture (USDA) Agricultural Marketing Service (AMS) calls the "Upper Midwest Milk Marketing Area" (UMMMA). This is an area that encompasses all of Minnesota and Wisconsin, part of western Michigan, part of northern Illinois, and the eastern half of North and South Dakota. There are 10 of these "Milk Marketing Areas" nationally and the data they produce accounts for 93% of all milk sales in the United States.

Minnesota's regional data is available through UMMMA, with each month's sales and production data posted in their monthly newsletter, "The Upper Midwest Dairy News." (under "Utilization & Classification"). In order to get the percent of milk sales in the region that are 1% or less (i.e. "low-fat" or "fat free"), divide the product pounds by the "total packaged disposition" (i.e., all fluid milk products), and then multiply by 100. For example, in June of 2001, low-fat milk represented 14% of total fluid milk sales. Fat free milk represented ~26% of total fluid milk sales. Interestingly, 2% or "Reduced Fat Milk" still constitutes ~ 39% of total fluid milk sales in the upper Midwest.

6. Number of farmers' markets per capita in the state.

Most of this information was readily accessible through the Minnesota Grown web site[4] and through their yearly directory. One potential pitfall is that the Minnesota Grown organization doesn't exclusively list farmers' markets, they list a variety of Minnesota grown products, including meats, eggs, hay, bedding plants, and herbs, to name a few. For this report, only the places that sold "5-a-day" items were counted. "Farmers' markets" were defined as what Minnesota Grown had listed as, "farmers' markets + berry farms + orchards + stands + farms that sell already grown produce."[-]

According to this definition, there were 271 "farmers' markets" listed in the state of Minnesota in 2001. They were found in 70 of 87 counties. Many of counties in greater Minnesota only had one or two farmers' markets, while there were many markets listed for the seven-county metro area. Current estimate of farmer's markets per capita = 271/4,919,479 population = < .01% (0.00006) or one farmers' market for every 18,153 Minnesotans.

7. State indoor air laws for restaurants, day care centers, and other public places.

The Minnesota Clean Indoor Air Act (MCIAA) was enacted in 1975 to protect public health by restricting smoking in offices. The rules were amended in 2002 to include new requirements for offices, factories, warehouses, and similar places of work. The new rules, effective September 23, 2003, regulate ventilation requirements in smoking-permitted areas of offices, factories, warehouses, and similar places of work. There are currently no indoor air laws that apply to restaurants. Descriptions of the MCIAA can be found on the Minnesota Department of Health web site (www.health.state.mn.us) or on the state legislature web site (http://www.revisor.leg.state.mn.us) As of March 2004, only a handful of communities in Minnesota have ordinances banning cigarette smoking in restaurants and bars (Olmsted County, Moose Lake, Duluth, and Cloquet).

8. Proportion of smokers with smoking not allowed inside their home.

An optional Tobacco Indicator module in the BRFSS asks respondents if smoking is allowed in their homes.[5] However, no Minnesota data were currently available on this topic.

School indicators

Several potential sources of data existed for the school setting (Table 3). The School Health Policies and Programs Study (SHPPS) surveyed all state Departments of Education and a nationally representative sample of districts and schools every six years.[6] This means no conclusions could be made about district and school policies on a state-by-state basis. The School Health Education Profile (SHEP) Survey, however, measured all seven of the state policy indicators (school indicators #1-7). [Recently a report[7] on this and physical activity measures was released by the Minnesota Department of Education which addresses several of the indicators.]

[-] It should be noted that according to Carol Milligan at the Minnesota Department of Agriculture, there were likely more "farmer's markets" than are listed through Minnesota Grown, as there is no license or registration required for farmers to sell their produce. Thus, this measurement strategy likely underestimates the actual number of farmer's markets.

Table 2: School Indicators*

1. State policies that require daily PE for K-12.
2. State policies that require schools to assess students per PE standards.
3. States policies requiring that foods and beverages outside of the school meal programs be healthy.
4. State policies that require newly hired school food service managers to have certification in food service.
5. State policies that require newly hired staff who teach PE to be certified in physical education.
6. State policies that require newly hired staff who teach health education to be certified in health education.
7. States policies that require schools to assess students per health education standards.
8. Percent of schools that provide health education instruction that includes physical activity, nutrition, and tobacco use prevention topics from School Health Index.
9. Proportion of schools with School Health Councils.
10. Proportion of schools with tobacco-free school policies.

* The indicators in this table are abbreviated to reflect the essential elements of content. See Appendix A for the full text of pilot indicators.

1. State policies that require daily PE for K-12.

In 2001, there was no state level requirement for days or hours of physical education. There previously was an in-state statute that required "seat time" within 9^{th} –12^{th} grades. Minnesota is a local-control state, such that districts determine standards.

[In 2002, Minnesota's graduation requirements were based on the Profile of Learning; Learning Area 8 addressed what students were to know and be able to demonstrate in health education and physical education. However, in 2003, the Minnesota Legislature repealed the Profile of Learning and deleted the language that required health and physical education in kindergarten through 12^{th} grade. As of the 2003-2004 school year, health and physical education became elective standards in grades 9-12 only. Current standards for health and physical education are available at www.mnschoolhealth.com.]

2. State policies that require schools to assess students per PE standards.
No information was found on this indicator.

3. States policies requiring that foods and beverages outside of the school meal programs be healthy.

In 2001, Minnesota did not have any statewide policies that were more stringent than the US Department of Agriculture's "Foods of Minimal Nutritional Value" or the Competitive Foods Rule. Foods of minimal nutritional value were prohibited from being sold during the lunch and breakfast periods (e.g. soda water, water ices, chewing gum, and certain candies, not to include those containing nuts, peanut butter, caramel, coconut, nougat or milk based fillings), unless "all income from the sale of such foods accrues to the benefit of the nonprofit school food service or the school or student organizations approved by the school." However, according to state rule, these items may be sold at other times during the school day. Furthermore, just because some food items are not on the "minimal nutrition" list doesn't mean they meet the principles of the Dietary Guidelines for Americans (e.g. candy bars, ice cream, chips, etc.). Some schools

adopted more stringent nutrition policies for themselves. For example, Minneapolis North High School banned soft drinks from being sold in vending machines located in the school building.

4. State policies that require newly hired school food service managers to have certification in food service.

There was no requirement that food service directors (FSDs) [In Minnesota, there are "food service directors"(FSD) and there are "cook managers" (CM); there are no definite rules governing how these titles are given.] have a food or nutrition related degree, and similarly, there was no certification requirement, although it was highly recommended by both MDE and the Minnesota School Food Service Association (MSFSA). The American School Food Service Association (ASFSA) has a National Certification and Credentialing Program.

Credentialing requires that the applicant have at least a 2-year college degree, at least one-year experience in school food service in the past 5 years, plus 30 semester hours of specialized training beyond an A.A. degree in food service management, business nutrition or related field. Credentialing is generally for upper level management. The credentialing period is for three years, and 45 continuing education units are required every three years to maintain the credential.

Certification is for anyone who works in food service. There are 3 levels of certification. Level 1 is for workers without a high school diploma; level 2 is for people with a high school diploma; level 3 is for workers with at least some college (this designation can include cook managers and regular staff). CEU's required to maintain the certification is: Level 1 = 15 hours; Level 2 = 30 hours; Level 3 = 45 hours every three years.

In Minnesota, there were ~26 individuals (as of July 2001) who were ASFSA credentialed, but at least half of those are people who work for the State. A total of 2,281 food service staff held certifications (current exact number of food service employees is unknown).

5. State policies that require newly hired staff who teach physical education to be certified in physical education. [AND]

6. State policies that require newly hired staff who teach health education to be certified in health education.

According to the personnel licensure staff at the Minnesota Department of Education, all teachers in Minnesota were required to be licensed, including physical education teachers. Unless they were a "Community Expert" (this is very rare), in which case they would need to procure their license within 3 years of starting teaching. Of course, for each emphasis area of teaching, there are different requirements. To teach "Health" in Minnesota K-12 schools one must be licensed to teach health. According to the licensure office, health teachers were also responsible for teaching nutrition curriculum. This was specified in the document, "A Framework for Minnesota Standards-Based Education in Health and Physical Education: section 3.11, Assessment of Student Learning."

7. States policies that require schools to assess students per health education standards.

As specified in "A Framework for Minnesota Standards-Based Education in Health and Physical Education, section 4.9, Assessment of Student Learning," learning and skills were to be assessed using performance packages, which were "state modeled packages or district-approved packages used to gather data which show evidence of student learning." Packages were to address the language of the standard and include tasks specifically designed to meet the language. How students were assessed on physical education varied by district and even by school, depending on the specifics of the performance package adopted by their school or district.

[Minnesota had a state policy that requires schools to assess students on both knowledge and skills as specified by the "Minnesota Graduation Standards," but this policy was repealed in 2003.]

8. Percent of schools that provide health education instruction that includes physical activity, nutrition, and tobacco use prevention topics from School Health Index.

In theory, 100% of schools in Minnesota provided instruction on these topics. There is a state rule, addressed in Learning Area 8, but there was no state monitoring of compliance. Because of local control, it is the obligation of local school boards to be in compliance of state law – there is the "expectation" that they implement state statutes. As previously mentioned, how to implement the rule is left up to the school district. To find out specifics or a percentage, Minnesota Department of Health (or Department of Education) would need to survey at the district, and maybe even the school level.

9. Proportion of schools with School Health Councils.

In 2001, there were six School Health Councils organized and funded by Coordinated School Health with money from the Centers for Disease Control and Prevention (CDC). But there were other existing School Health Councils, sometimes called "committees." These exist at varying levels of activity, and organization.

10. Proportion of schools that have adopted tobacco-free policies, that meet CDC recommendations.

By state law, Minnesota schools must be tobacco-free in school buildings and vehicles. No data on the proportion of schools for which this tobacco-free policy is enforced were found.

Worksite indicators

In Minnesota, no data sources were found to be available to measure policies at individual worksites. The only indicator that addressed state Indoor air laws (worksite indicator #7) could be measured by examining the text of the Minnesota Clean Indoor Air Act (MCIAA). (Additional information about MCIAA is available on the World Wide Web at http://www.health.state.mn.us/divs/eh/indoorair/mciaa/index.html)

However, a survey of worksites around Minnesota conducted by the Minnesota Department of Health is scheduled to be completed in April 2004. Several measures of the presence of policies and environmental supports at the worksite will be queried. This survey will address most of the indicators (worksite indicators 1-6, 8). Results from this study will be ready mid-2004.

Table 3: Worksite Indicators*

1. Percent of worksites that support physical activity during work time.
2. Percent of worksites that provide showers and changing facilities.
3. Percent of worksites that provide/promote on-going on-site employee physical activity programs.
4. Percent of worksites with vending machines and/or snack bars that offer the heart-healthy food and beverage choices.
5. Percent of worksites with cafeterias that offer heart-healthy* food and beverage choices.
6. Percent of worksites that offer nutrition or weight management classes or counseling.
7. States indoor air laws for government and private worksites.
8. Proportion of worksites that cover smoking cessation programs.

* The indicators in this table are abbreviated to reflect the essential elements of content. See Appendix A for the full text of pilot indicators.

Health care indicators

There are no state-level data sources that measure the policies of managed care organizations or health insurance plans (see Table 5). The proportion of smokers who received advice to quit smoking in the past year (health care indicator #5) is collected by the optional tobacco indicator module of the Behavioral Risk Factor Surveillance Survey (BRFSS), which was not used in Minnesota recently (Centers for Disease Control and Prevention. (2001). Behavioral Risk Factor Surveillance System (BRFSS).CDC. World Wide Web: http://www.cdc.gov/nccdphp/brfss/)

Table 4: Health Care Indicators*

1. Percent of managed care organizations that adopt CVH primary prevention guidelines.
2. Percent of managed care organizations that adopt CVH treatment guidelines.
3. Percent of managed care organizations that have policies or guidelines to provide/reimburse for assessments/counseling for physical activity, medical nutrition therapy, and tobacco cessation.
4. Percent of health insurance plans that have policies/guidelines to routinely provide/reimburse for assessments and counseling for physical activity, medical nutrition therapy, and tobacco cessation.
5. Proportion of current and recent smokers who received advice to quit smoking from a health professional.

* The indicators in this table are abbreviated to reflect the essential elements of content. See Appendix A for the full text of pilot indicators.

Discussion and Recommendations

While several data sources provided information for the indicators, much more information is needed to determine gaps and needs in developing policies and environmental strategies. Setting-specific conclusions and recommendations are discussed below.

Communities

In Minnesota, specific information in this area would be best obtained at the local/city level. Policies concerning community design vary widely among cities, and often vary widely within a city, because different policies have existed at different periods in a city's lifespan. Minnesota Planning's "Model Ordinance's For Sustainable Development" project had exact specifications for sidewalk design, placement and maintenance. According to Minnesota Planning, the Model Ordinances could be considered a state policy even though it is currently considered "optional" for Minnesota communities to follow them.

The three indicators that address county and municipal policies (community indicators #2-4) require developing a survey tool with questions about specific policies for each feature of interest (sidewalks, recreation facilities, and bicycle use for transportation). This survey should be administered to city administrators, engineers and planners.

Schools

The School Health Education Profile (SHEP) survey should continue to collect data on specific topics around physical activity, nutrition, and tobacco use. In addition, it may be useful to collect self-assessments of school health programs and policies (the School Health Index) from schools across the state. When considering

data collection in the schools, care must be taken not to bring additional burden to an already over-surveyed population, school administrators and teachers.

Worksites

To obtain data on the remaining worksite indicators (worksite indicators #1-6 and 8), a mail-back survey is currently being conducted [March 2004] on a random sample of Minnesota businesses. This survey will be gathering data on health promotion practices and barriers that employers face to implementing policies and environmental strategies related to cardiovascular health behaviors. Additional surveys, focus groups, and in-depth interviews can provide additional insight into the progress that worksites make towards developing policies and physical environments supportive of cardiovascular health.

Health Care

Although no data sources currently collect information about the policies of managed care organizations (MCOs), the related indicators (health care indicators #1-3) could be relatively easy to assess in Minnesota because only ten companies cover 75% of the people with this type health insurance.[8] All ten organizations are accredited by the National Committee for Quality Assurance (NCQA), which requires the organizations to adopt policies that incorporate nationally accredited standards.[10]

Because of the small number of companies in Minnesota, telephone interviews could be used to capture relevant information. Standard survey questions would ensure that complete and accurate information is collected about the MCO policies. Specific survey questions are needed to ensure complete and accurate information is collected about the policies of health insurance plans. Some effort would also be required to create an appropriate sample frame, based on the insurance companies operating in the state.

Conclusions

This summary report provides a brief overview of the initial efforts of the Minnesota Heart Disease and Stroke Prevention Initiative to document current knowledge of the pilot indicators developed for measuring policies and environmental strategies related to cardiovascular health in Minnesota. While it will be important to collect indicator data, it will be just as important that the information gathered meets the needs of all parties. In addition, it would be more beneficial to understand deeper issues behind the lack of policies and environmental strategies in the various settings. Thus, surveys, focus groups, in-depth interviews, and working group meetings should be held to determine needs as well as strategies to address gaps.

Appendix A: Pilot Indicators for CVH State Surveillance

Communities

1. Percent of highway funds devoted to transportation alternatives (e.g., bicycle lanes linked to public transportation, mass transit systems, facilities and roadway changes, supports such as parking hubs and bicycle racks).
2. Percent of counties or municipalities with policies requiring sidewalks in all new and redeveloped residential and mixed-use communities.
3. Percent of counties or municipalities with policies that promote recreation facilities (e.g., bikeways, parks, fields, gyms, pools, tennis courts, and playgrounds) in new and redeveloped residential and mixed-used communities.
4. States policies and percent of counties or municipalities with policies and strategic plans to promote bicycle use for transportation purposes.
5. Percent of milk sales in the State that is low-fat (1% or less).
6. Number of farmers' markets per capita in the state.
7. State with laws on smoke-free indoor air that prohibit smoking or limit it to separately ventilated areas in restaurants, day care centers, and other public places.
8. Proportion of smokers who report that smoking is not allowed anywhere inside their home.

Schools

1. State policies that require daily physical education, or its equivalent in minutes per week, for all students in K-12, with no substitution of other courses or activities for physical education
2. State policies that require schools to assess students on the knowledge and skills specified by the State's physical education standards, frameworks, or guidelines.
3. State policies requiring that the foods and beverages available at schools outside of the school meal programs reinforce the principles of the Dietary Guidelines for Americans.
4. State policies that require newly hired school food service managers to have a nutrition-related baccalaureate or graduate degree and certification/credentialing in food service from either the State or the American School Food Service Association
5. State policies that require all newly hired staff who teach physical education to be certified, licensed, or endorsed by the State to teach physical education
6. State policies that require all newly hired staff who teach health education to be certified, licensed, or endorsed by the State to teach health education.
7. States policies that require schools to assess students on the knowledge and skills specified by the State's health education standards, frameworks, or guidelines.
8. Percent of schools that provide health education instruction that includes the physical education, nutrition, and tobacco use prevention topics, listed in CDC's School Health Index.
9. Proportion of schools with School Health Councils.
10. Proportion of schools that have adopted tobacco-free school policies that meet CDC recommendations.

Worksites

1. Percent of worksites that have policies supporting the engagement of all employees in physical activity during work time, (e.g., flexible scheduling, relaxed dress codes).
2. Percent of worksites that provide showers and changing facilities to support physically active employees.

3. Percent of worksites that provide and promote on-going on-site employee physical activity programs (e.g., walking, stretching, aerobics) during the previous 24 months.
4. Percent of worksites with vending machines and/or snack bars that offer the heart-healthy food and beverage choices, including water or flavored water, 1% or less milk products, 100% juice products, fruits, vegetables, and products labeled low or reduced calorie, low or reduced sodium, and those labeled 3 g. or less of fat per serving.
5. Percent of worksites with cafeterias that offer heart-healthy food and beverage choices including water or flavored water, 1% or less milk products, 100% juice products, fruits, vegetables, and products labeled low or reduced calorie, low or reduced sodium, and those labeled 3 g. or less of fat per serving.
6. Percent of worksites that offer nutrition or weight management classes or counseling.
7. States with laws on smoke-free indoor air that prohibit smoking or limit it to separately ventilated areas in government and private worksites.
8. Proportion of worksites (segmented by number of employees) that cover smoking cessation programs.

Health Care

1. Percent of managed care organizations that adopt a policy to incorporate nationally accredited guidelines (e.g., the AHA Guide to Primary Prevention of Cardiovascular Diseases) as part of their standard care package.
2. Percent of managed care organizations that adopt a policy to incorporate nationally accredited guidelines (e.g., the AHA Guide to Comprehensive Risk Reduction for Patients with Coronary and other Vascular Disease) as part of their standard care package.
3. Percent of managed care organizations (e.g., health maintenance organizations, independent provider organizations, and preferred provider organizations) that have policies or guidelines to routinely provide or reimburse for assessments and counseling for physical activity, medical nutrition therapy, and tobacco cessation to plan members as part of their standard care package, according to the Guide to Clinical Preventive Services.
4. Percent of health insurance plans that have policies or guidelines to routinely provide or reimburse for assessments and counseling for physical activity, medical nutrition therapy, and tobacco cessation to plan members as a covered benefit, according to the Guide to Clinical Preventive Services.
5. Proportion of current and recent smokers who received advice to quit smoking from a health professional.

Appendix B: References

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