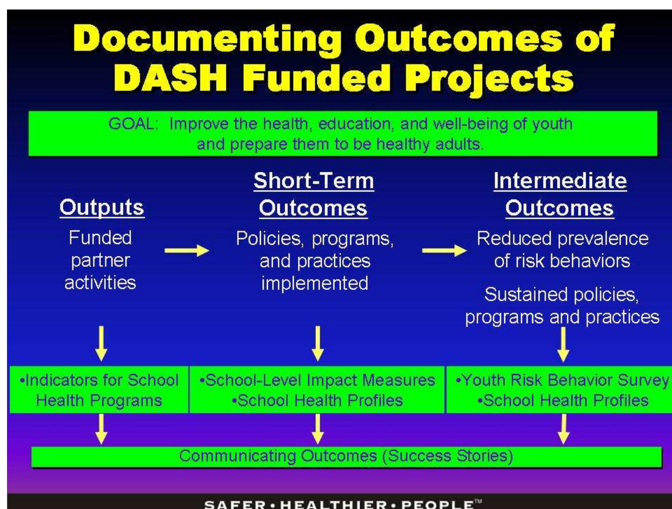
SLIMs Frequently Asked Questions

1. What are SLIMs?
SLIM is the acronym for School Level Impact Measure. SLIMs are measures of the percentage of secondary schools in a jurisdiction that are implementing policies and practices recommended by CDC to address critical health problems faced by children and adolescents.

2. Why does DASH recommend the use of SLIMs?
SLIMs allow you and DASH to assess whether the activities implemented at the state/school district level are making an impact at the school level, and thereby document the impact of CDC funding. As the following segment of a logic model illustrates, SLIMs data provide us with evidence of the extent to which DASH-funded programs are attaining critical short-term outcomes.



3. Why is it important to be able to document short-term outcomes?
It may take years for programs, policies, and practices to lead to changes in intermediate outcomes, such as reductions in risk behaviors and increases in protective behaviors among youth. Short-term outcomes, such as changes in school policies and practices, are crucial to illustrating that you are on the path to achieving your desired intermediate and long-term outcomes. You will be able to use your SLIMs to illustrate to partners and stakeholders (e.g., school officials, parents, media, and elected officials) the progress you are making to improve the health and well-being of youth. In addition, your program is likely to have greater influence on short-term outcomes, such as school policies and practices, than on intermediate outcomes, such as youth risk behaviors, because those behaviors are also influenced by factors outside of the control of schools.

4. How will SLIMs help our project?
You can use SLIMs to plan and allocate resources; guide professional development; advocate for policy, program, and resource development or revision; and describe the status of school health programs in your jurisdiction. The information also can be used to work with schools, parents, community leaders, and other stakeholders to advocate for healthier and safer environments for youth. SLIMs will help you to focus your programmatic activities and your communications about programmatic accomplishments to stakeholders and the public.

5. How many SLIMs will we be asked to select?
The number of SLIMs you will be asked to select is dependent upon the number of priority areas for which you are receiving funding. Select the appropriate number of SLIMs:

- Priority 2: HIV – At least 3.
- Priority 3: CSHP – At least 3.
- Priority 3: PANT – At least 1 Physical Education and Activity, 1 Nutrition, AND 1 Tobacco-Use Prevention.
- Priority 4: Asthma – At least 3.

6. How will we measure SLIMs?
CDC's School Health Profiles is the preferred data source to use to measure SLIMs. The *Profiles* questionnaires were revised for 2008 specifically to assist you in measuring progress on SLIMs at the secondary school level.

7. What are CDC's *School Health Profiles*?
Profiles is a survey of school health policies and practices conducted every two years by state and local education and health agencies among a representative sample or census of middle and high schools. *Profiles* helps state and district education and health agencies monitor the current status of school health education; physical education; school

health policies related to HIV infection/AIDS, tobacco-use prevention, nutrition, and asthma management; and family and community involvement in school health programs.

8. We don't do *Profiles*. How will we measure SLIMs?
If your agency does not currently implement *Profiles*, you should work with your project officer in collaboration with DASH's Surveillance and Evaluation Research Branch (SERB) staff to:

- Discuss the benefits of using *Profiles*,
- Explore issues and questions related to *Profiles*, and
- Learn from other funded partners who implement *Profiles.*

If, after this exploration, you decide not to implement *Profiles,* you will need to identify, in collaboration with DASH staff, another appropriate method to measure the SLIMs you have selected. SERB and other DASH staff are available to review the alternative methods of measuring SLIMs to ensure that the SLIMs selected will be accurately measured by the alternative method.

9. How will we determine target percentages for SLIMs?
You can use weighted data from CDC's 2008 *Profiles* to establish baseline data for your selected SLIMs. If your program did not participate in *Profiles* or get weighted *Profiles* data in 2008, you should work with your project officer to determine an alternate source of baseline data. After your baseline data are analyzed, you should work with your project officer to set target percentages for your selected SLIMS, i.e., the percentage of schools in your jurisdiction that you expect to be implementing the policies and practices measured by each selected SLIM by 2012. Targeted increases need to be substantial enough to be meaningful to stakeholders and the public, but you also need to be realistic about what can be achieved over the course of your current cooperative agreement with CDC/DASH.

10. How much progress do you expect us to make on the SLIMs we select?
The more progress you make, the greater the likelihood of positively impacting the lives of youth. Each agency's progress will vary. We expect you to work with your project officer to establish target percentages that are realistic and meaningful. A reasonable amount of progress is expected based on the objectives and activities you have chosen to address in your workplan.

11. How long will we be monitoring the selected SLIMs?
You will be monitoring SLIMs during the entire five-year funding cycle. During year one you will collect baseline data for SLIMs and use the data to help you select the SLIMs that your program will target for improvement. Data should be collected on the selected SLIMs every two years after that.

12. What if we want to change the SLIMs we have selected?
Rather than changing SLIMs, you should consider changing your objectives and/or activities to help your program achieve your target percentages for the selected SLIMs. We want you to succeed, which is why it is important that you, in collaboration with your project officer, select SLIMs and target percentages that are realistic and feasible, support program goals, and align with strategies. If new opportunities arise, it is important to consider whether these new opportunities will move you closer to meeting your goals or divert resources from your selected priorities. If you feel there are truly extraordinary circumstances that require you to change your SLIMs, please consult with your project officer.

13. How are SLIMs related to our strategic plan?
Your SLIMs and your strategic plan should be complementary. SLIMs reflect the priority improvements you want to see in school health programs and policies as a result of your program activities. Your strategic plan outlines how you expect to make progress toward achieving success.

14. How will DASH use SLIMs information to evaluate our performance?
Your timeliness in selecting and monitoring SLIMs will be considered in evaluating your program's

performance. DASH is particularly interested in highlighting programs that achieve the targeted increases in the percentages of schools implementing the policies and practices measured by their selected SLIMs.

SLIMs are one of a number of measures that will be used to evaluate your performance. Others include: timely responses to weaknesses and recommendations noted in the annual technical review; information gathered from site visits and monthly conference calls; meeting deadlines for and satisfactory completion of the Program Inventory, Strategic Plan, workplan, and Logic Model; mid-year and annual progress reports; success stories; timely submission of continuation applications; and implementing school-based programs and prevention strategies to reduce health disparities among youth disproportionately affected.

15. How will our funding be impacted if we don't achieve the target percentages we set for our selected SLIMs?
Funding decisions are determined by overall program performance. These decisions are not made exclusively on achieving SLIMs targets. SLIMs will be used to evaluate your performance in increasing the percentage of schools in your jurisdiction that are implementing specific, effective policies and practices.

Your overall program performance will be assessed annually based on your continuation application, which is considered when funding decisions are made. The performance measures by which funding decisions are made are listed by priority area in the Funding Opportunity Announcement (FOA) for DP08-801, "Improving Health and Educational Outcomes of Young People."

16. Where will we find *Profiles* data that match the SLIMs we have selected?
Your site's *Profiles* report will include tables that list the percentages of schools in your jurisdiction that are implementing each of the SLIMs.

17. SLIMs don't capture all that my program is doing. Isn't that a problem?
No. SLIMs reflect some of the priorities that you have chosen for your program and indicate progress made on those priorities over time. DASH does not anticipate that everything your program is working on and accomplishing will be captured through SLIMs.

18. Should we only collect and care about *Profiles* data that are directly related to our selected SLIMs?
No. All of the data collected in *Profiles* provide valuable information for a state or district school health program. While you will probably use the data related to your selected SLIMs more frequently, you will very likely find the rest of the *Profiles* data tremendously useful as well.

19. My program is targeting a specific sub-population to effectively address health disparities. How do I document program effectiveness in improving health policies and practices in the schools that serve our target group?
To the extent that the targeted subpopulation is widely dispersed across different secondary schools, SLIMs will be able to assess changes in school policies and practices that impact the target group. If they are concentrated in schools that you can identify, then SERB can help you collect *Profiles* data from these schools (in addition to your survey of schools across your jurisdiction). Please consult with SERB staff if you are interested in pursuing this option. If you cannot measure changes in the percentages of schools that specifically serve your targeted sub-population, you may have other ways to document program effectiveness (see Question 14).

20. How do sites measure SLIMs for specific geographic sub-regions targeted (e.g., a port area or three different zip code areas)?
Sites will not be required to measure sub-regions. SLIMs are intended to measure the impact of your program's activities across your entire jurisdiction because (1) many of your activities will be focused on system-wide changes, and (2) if you target sub-regions, they might be large enough to generate substantial changes in results across the entire

jurisdiction. If you have a list of the schools in the targeted sub-regions, SERB staff can help you collect *Profiles* data from these schools (in addition to your survey of schools across your jurisdiction). Please consult with SERB staff if you are interested in pursuing this option. If you cannot measure changes in the percentages of schools in targeted sub-regions, you may have other ways to document program effectiveness (see Question 14).

21. Should we focus all of our programmatic activities on secondary schools because *Profiles* is conducted only among secondary schools?
No, it is perfectly acceptable to implement activities targeting elementary schools as well as secondary schools. Every activity implemented through your workplan does not need to be aligned with a SLIM.

22. If elementary schools are an important focus of our workplan, may we conduct *Profiles* among elementary schools so that we can measure our success in increasing the percentage of elementary schools that are implementing effective school health policies and practices related to our priority area?
If you are interested in conducting *Profiles* for the elementary schools in your jurisdiction in addition to the regular secondary school survey, please consider the costs and resources involved in doing this and then consult with your project officer and SERB staff. If you cannot measure changes in the percentages of elementary schools implementing your targeted SLIMs, you may have other ways to document program effectiveness (see Question 14).

23. If I pick three SLIMs in my Priority Area, can I still do other planned activities that will not help meet those SLIMs?
Yes. SLIMs are only one of a number of measures used to evaluate program performance. SLIMs are designed to help you assess progress made on particular areas when you place emphasis on improvements in those areas. Other performance measures, such as *Indicators for School Health,* six-month progress reports, and annual reports, can be used to document your progress in areas not related to your SLIMs.

24. We are fine with the SLIMs but think DASH has left out some critical measures that are going to be among our key priorities for improvements in school health policies and practices in our jurisdiction. May we propose our own SLIM for which we would establish SMART objectives?
You may choose to propose additional school-level impact measures similar to the SLIMs developed by DASH, and those measures may be helpful in guiding and improving your program. However, DASH will not consider these as SLIMs that meet DP08-801 program monitoring requirements. Please discuss any individualized measures that you plan to propose with your project officer before including them in your workplan.

DASH welcomes your feedback on SLIMs, including additional SLIMs that you would propose for consideration for a future funding opportunity announcement. Your feedback will be used in our work to improve the SLIMs process in future cycles.

25. We plan to do *Profiles* in 2010 but were unable to do it in 2008. How do I select SLIMs and related SMART objectives in 2008?
Use the data that you have available to do your best in selecting SLIMs. Your project officer and SERB staff can be helpful in assisting you with determining alternatives that might work for your jurisdiction. Note that you may need to adjust your SLIMs or other plans according to your 2010 *Profiles* results.

26. If I fail to get weighted data in *Profiles* 2008, may I used the unweighted data to select SLIMs and establish SMART objectives for improvements?
DASH encourages you to work to get weighted data on *Profiles* to ensure that you can make the best possible decisions on SLIMs. If your *Profiles* results cannot be weighted, please work with your project officer and SERB staff to identify data sources that are best for your jurisdiction.

27. Is DASH willing to accept feedback on SLIMs?

SLIMs Frequently Asked Questions

DASH welcomes your feedback on SLIMs, the selection process, and measuring SLIMs progress. Please share your comments with your DASH project officer.

28. What if I have additional questions related to SLIMs that are not addressed here?
Please work with your project officer to have your additional SLIMs questions answered.

SUBURBAN COOK COUNTY

2012 School-Level Impact Measures (SLIMs)
Weighted Principal and Teacher Survey Results

Part I: Human Immunodeficiency Virus (HIV) Prevention SLIMs

	School-Level Impact Measure (SLIM)	Percentage of Schools Meeting SLIM	95% Confidence Interval
HIV 1. (2010 version)	The percentage of schools that address all of the following in a required course taught during grades 6, 7, or 8: • The differences between HIV and AIDS. • How HIV and other STD are transmitted. • How HIV and other STD are diagnosed and treated. • Health consequences of HIV, other STD, and pregnancy. • The benefits of being sexually abstinent. • How to prevent HIV, other STD, and pregnancy. • How to access valid and reliable health information, products, and services related to HIV, other STD, and pregnancy. • The influences of media, family, and social and cultural norms on sexual behavior. • Communication and negotiation skills related to eliminating or reducing risk for HIV, other STD, and pregnancy. • Goal setting and decision making skills related to eliminating or reducing risk for HIV, other STD, and pregnancy. • Compassion for persons living with HIV or AIDS.	43.7	39.3 - 48.1

SUBURBAN COOK COUNTY

2012 School-Level Impact Measures (SLIMs)
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Part I: Human Immunodeficiency Virus (HIV) Prevention SLIMs

	School-Level Impact Measure (SLIM)	Percentage of Schools Meeting SLIM	95% Confidence Interval
HIV 1. (2012 version)	The percentage of schools that address all of the following in a required course taught during grades 6, 7, or 8: • The differences between HIV and AIDS. • How HIV and other STD are transmitted. • How HIV and other STD are diagnosed and treated. • Health consequences of HIV, other STD, and pregnancy. • The benefits of being sexually abstinent. • How to prevent HIV, other STD, and pregnancy. • How to access valid and reliable health information, products, and services related to HIV, other STD, and pregnancy. • How to create and sustain healthy and respectful relationships. • The influences of media, family, and social and cultural norms on sexual behavior. • Communication and negotiation skills related to eliminating or reducing risk for HIV, other STD, and pregnancy. • Goal setting and decision making skills related to eliminating or reducing risk for HIV, other STD, and pregnancy. • Compassion for persons living with HIV or AIDS.	39.6	35.1 - 44.3

	School-Level Impact Measure (SLIM)	Percentage of Schools Meeting SLIM	95% Confidence Interval
HIV 2. (2010 version)	The percentage of schools that address all of the following in a required course taught during grades 9, 10, 11, or 12: • The relationship among HIV, other STD, and pregnancy. • The relationship between alcohol and other drug use and risk for HIV, other STD, and pregnancy. • The benefits of being sexually abstinent. • How to prevent HIV, other STD, and pregnancy. • How to access valid and reliable health information, products, and services related to HIV, other STD, and pregnancy. • The influences of media, family, and social and cultural norms on sexual behavior. • Communication and negotiation skills related to eliminating or reducing risk for HIV, other STD, and pregnancy. • Goal setting and decision making skills related to eliminating or reducing risk for HIV, other STD, and pregnancy.	-	-
HIV 2. (2012 version)	The percentage of schools that address all of the following in a required course taught during grades 9, 10, 11, or 12: • The relationship among HIV, other STD, and pregnancy. • The relationship between alcohol and other drug use and risk for HIV, other STD, and pregnancy. • The benefits of being sexually abstinent. • How to prevent HIV, other STD, and pregnancy. • How to access valid and reliable health information, products, and services related to HIV, other STD, and pregnancy. • How to create and sustain healthy and respectful relationships. • The influences of media, family, and social and cultural norms on sexual behavior. • Communication and negotiation skills related to eliminating or reducing risk for HIV, other STD, and pregnancy. • Goal setting and decision making skills related to eliminating or reducing risk for HIV, other STD, and pregnancy.	-	-

- Results are suppressed due to insufficient number of respondents.

SUBURBAN COOK COUNTY

2012 School-Level Impact Measures (SLIMs)
Weighted Principal and Teacher Survey Results

Part I: Human Immunodeficiency Virus (HIV) Prevention SLIMs

	School-Level Impact Measure (SLIM)	Percentage of Schools Meeting SLIM	95% Confidence Interval
HIV 3. (2008 version)	The percentage of schools that address all of the following in a required course taught during grades 9, 10, 11, or 12: • Efficacy of condoms, that is, how well condoms work and do not work. • The importance of using condoms consistently and correctly. • How to obtain condoms.	-	-
HIV 3. (2010 version)	The percentage of schools that address all of the following in a required course taught during grades 9, 10, 11, or 12: • Efficacy of condoms, that is, how well condoms work and do not work. • The importance of using condoms consistently and correctly. • How to obtain condoms. • How to correctly use a condom.	-	-

- Results are suppressed due to insufficient number of respondents.

Part I: Human Immunodeficiency Virus (HIV) Prevention SLIMs

	School-Level Impact Measure (SLIM)	Percentage of Schools Meeting SLIM	95% Confidence Interval
HIV 4.	The percentage of schools that deliver HIV, STD, or pregnancy prevention programs (including after school or supplemental programs) that meet the needs of ethnic/racial minority youth at high risk (e.g., black, Hispanic, or American Indian youth) by doing all of the following: • Providing curricula or supplementary materials that include pictures, information, and learning experiences that reflect the life experiences of these youth in their communities. • Providing curricula or supplementary materials in the primary languages of the youth and families. • Facilitating access to direct health services or arrangements with providers not on school property who have experience in serving these youth in the community. • Facilitating access to direct social services and psychological services or arrangements with providers not on school property who have experience in serving these youth in the community. • Requiring professional development for school staff on HIV, STD, and pregnancy prevention issues and resources for these youth.	3.5	2.4 - 5.0
HIV 5.	The percentage of schools that provide parents and families health information to increase parent and family knowledge of HIV prevention, STD prevention, or teen pregnancy prevention.	18.4	15.7 - 21.4
HIV 6. (2008 version)	The percentage of schools in which students' family or community members have helped develop or implement HIV prevention, STD prevention, or teen pregnancy prevention policies and programs.	7.8	6.1 - 9.8
HIV 6. (2010 version)	The percentage of schools in which students' family and community members have helped develop or implement HIV prevention, STD prevention, or teen pregnancy prevention policies and programs.	4.5	3.4 - 6.0

2012 School-Level Impact Measures (SLIMs)
Weighted Principal and Teacher Survey Results

Part I: Human Immunodeficiency Virus (HIV) Prevention SLIMs

	School-Level Impact Measure (SLIM)	Percentage of Schools Meeting SLIM	95% Confidence Interval
HIV 7. (2010 version)	The percentage of schools in which the lead health education teacher received professional development during the past two years on all of the following: • Describing how widespread HIV and other STD infections are and the consequences of these infections. • Understanding the modes of transmission and effective prevention strategies for HIV and other STDs. • Identifying populations of youth who are at high risk of being infected with HIV and other STDs. • Implementing health education strategies using prevention messages that are likely to be effective in reaching youth.	12.4	10.1 - 15.1
HIV 7. (2012 version)	The percentage of schools in which the lead health education teacher received professional development during the past two years on all of the following: • Describing how widespread HIV and other STD infections are and the consequences of these infections. • Understanding the modes of transmission and effective prevention strategies for HIV and other STDs. • Identifying populations of youth who are at high risk of being infected with HIV and other STDs. • Implementing health education strategies using prevention messages that are likely to be effective in reaching youth. • Describing the prevalence and potential effects of teen pregnancy. • Identifying populations of youth who are at high risk of becoming pregnant.	10.7	8.6 - 13.2

	School-Level Impact Measure (SLIM)	Percentage of Schools Meeting SLIM	95% Confidence Interval
HIV 8.	The percentage of schools in which the lead health education teacher received professional development on at least six of the following during the past two years: • Teaching HIV prevention to students with physical, medical, or cognitive disabilities. • Teaching HIV prevention to students of various cultural backgrounds. • Using interactive teaching methods for HIV prevention education, such as role plays or cooperative group activities. • Teaching essential skills for health behavior change related to HIV prevention and guiding student practice of these skills. • Teaching about health-promoting social norms and beliefs related to HIV prevention. • Strategies for involving parents, families and others in student learning of HIV prevention education. • Assessing students' performance in HIV prevention education. • Implementing standards-based HIV prevention education curricula and student assessment. • Using technology to improve HIV prevention education instruction. • Teaching HIV prevention to students with limited English proficiency. • Addressing community concerns and challenges related to HIV prevention education.	10.8	8.7 - 13.4
HIV 9.	The percentage of schools that follow a policy or policies that address all of the following issues: • Attendance of students with HIV infection. • Procedures to protect HIV-infected students and staff from discrimination. • Maintaining confidentiality of HIV-infected students and staff.	58.8	55.0 - 62.6

	School-Level Impact Measure (SLIM)	Percentage of Schools Meeting SLIM	95% Confidence Interval
HIV 10.	The percentage of schools that implement HIV, other STD, and pregnancy prevention strategies that meet the needs of lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth by doing all of the following: • Providing curricula or supplementary materials that include HIV, other STD, or pregnancy prevention information that is relevant to LGBTQ youth (e.g., curricula or materials that use inclusive language or terminology). • Identifying "safe spaces" such as a counselor's office, designated classroom, or student organization where LGBTQ youth can receive support from administrators, teachers, or other school staff. • Prohibiting harassment based on a student's perceived or actual sexual orientation or gender identity. • Facilitating access to providers not on school property who have experience providing health services, including HIV/STD testing and counseling, to LGBTQ youth. • Facilitating access to providers not on school property who have experience in providing social and psychological services to LGBTQ youth. • Encouraging staff to attend professional development on safe and supportive school environments for all students, regardless of sexual orientation or gender identity.	4.5	3.3 - 6.2
HIV 11.	The percentage of schools that teach about all of the following contraceptives in a required course taught during grades 9, 10, 11, or 12: • Birth control pill (e.g., Ortho Tri-cyclen). • Birth control patch (e.g., Ortho Evra). • Birth control ring (e.g., NuvaRing). • Birth control shot (e.g., Depo-Provera). • Implants (e.g., Implanon). • Intrauterine device (IUD; e.g., Mirena, ParaGard). • Emergency contraception (e.g., Plan B).	-	-

- Results are suppressed due to insufficient number of respondents.

2012 School-Level Impact Measures (SLIMs)
Weighted Principal and Teacher Survey Results

Part I: Human Immunodeficiency Virus (HIV) Prevention SLIMs

	School-Level Impact Measure (SLIM)	Percentage of Schools Meeting SLIM	95% Confidence Interval
HIV 12.	The percentage of schools that address all of the following in a required course taught during grades 9, 10, 11, or 12: • How to obtain contraceptives, other than condoms. • How to correctly use contraceptives, other than condoms. • The importance of using contraceptive methods, other than condoms, consistently and correctly. • The importance of using a condom at the same time as another form of contraception to prevent both sexually transmitted diseases (STDs) and pregnancy.	-	-
HIV 13.	The percentage of schools that provide students with direct access or referrals to healthcare providers for all of the following services: • HIV testing and counseling. • STD testing and treatment. • Provision of contraceptives other than condoms (e.g., birth control pill, birth control shot, IUD). • Pregnancy testing. • Prenatal care. • Human papillomavirus (HPV) vaccine administration. • Provision of condoms.	28.0	25.2 - 30.9

- Results are suppressed due to insufficient number of respondents.

2012 School-Level Impact Measures (SLIMs)
Weighted Principal and Teacher Survey Results

Part II: Coordinated School Health and Promotion of Physical Activity, Nutrition, and Tobacco-Use Prevention SLIMs

	Coordinated School Health School-Level Impact Measure (SLIM)	Percentage of Schools Meeting SLIM	95% Confidence Interval
CSH 1.	Data are not available for 2012 report.		
CSH 2. (2008 version)	The percentage of schools that have a group (e.g., school health team) that helps plan and implement school health programs, with representation from 10 or more of the following: • School administration. • Health education teachers. • Physical education teachers. • Mental health or social services staff. • Nutrition or food service staff. • Health services staff (e.g., school nurse). • Maintenance and transportation staff. • Student body. • Parents or families of students. • Community. • Local health departments, agencies, or organizations. • Faith-based organizations. • Businesses. • Local government.	10.1	8.1 - 12.5

	Coordinated School Health School-Level Impact Measure (SLIM)	Percentage of Schools Meeting SLIM	95% Confidence Interval
CSH 2. (2010 version)	The percentage of schools that have a group (e.g., school health team) that helps plan and implement school health programs, with representation from 10 or more of the following: • School administration. • Health education teachers. • Physical education teachers. • Mental health or social services staff. • Nutrition or food service staff. • Health services staff (e.g., school nurse). • Maintenance and transportation staff. • Technology staff. • Library/media center staff. • Student body. • Parents or families of students. • Community. • Local health departments, agencies, or organizations. • Faith-based organizations. • Businesses. • Local government.	17.5	14.8 - 20.5

	Coordinated School Health School-Level Impact Measure (SLIM)	Percentage of Schools Meeting SLIM	95% Confidence Interval
CSH 2. (2012 version)	The percentage of schools that have a group (e.g., school health team) that helps plan and implement school health programs, with representation from 6 or more of the following: • School administration. • Health education teachers. • Physical education teachers. • Classroom teachers. • Nutrition or food service staff. • Health services staff (e.g., school nurse) or mental health or social services staff (e.g., school counselor). • Parents or families of students. • Community members (e.g., local health departments, agencies, or organizations; faith-based organizations; businesses; local government).	34.9	31.5 - 38.6
CSH 3. (2008 version)	The percentage of schools that have ever assessed their policies, activities, and programs by using the School Health Index or a similar self-assessment tool in any of the following areas: • Physical activity. • Nutrition. • Tobacco-use prevention.	40.0	36.5 - 43.7

	Coordinated School Health School-Level Impact Measure (SLIM)	Percentage of Schools Meeting SLIM	95% Confidence Interval
CSH 3. (2010 version)	The percentage of schools that have ever assessed their policies, activities, and programs by using the School Health Index or a similar self-assessment tool in all of the following areas: • Physical activity. • Nutrition. • Tobacco-use prevention.	19.0	16.5 - 21.8
CSH 4.	Data are not available for 2012 report.		
CSH 5.	Data are not available for 2012 report.		
CSH 6.	The percentage of schools in which those who teach health education are provided with all of the following: • Goals, objectives, and expected outcomes for health education. • A written health education curriculum. • A chart describing the annual scope and sequence of instruction for health education. • Plans for how to assess student performance in health education.	57.9	54.3 - 61.5
CSH 7.	The percentage of schools that follow a written health education curriculum that addresses all the following: • Comprehending concepts related to health promotion and disease prevention to enhance health. • Analyzing the influence of family, peers, culture, media, technology, and other factors on health behaviors. • Accessing valid information and products and services to enhance health. • Using interpersonal communication skills to enhance health and avoid or reduce health risks. • Using decision-making skills to enhance health. • Using goal setting skills to enhance health. • Practicing health-enhancing behaviors to avoid or reduce risks. • Advocating for personal, family, and community health.	66.0	62.9 - 69.0

	Coordinated School Health School-Level Impact Measure (SLIM)	Percentage of Schools Meeting SLIM	95% Confidence Interval
CSH 8. (2008 version)	The percentage of schools that provide parents and families health information to increase parent and family knowledge of any of the following health issues: • Tobacco-use prevention. • Physical activity. • Nutrition and healthy eating.	49.9	45.9 - 53.8
CSH 8. (2010 version)	The percentage of schools that provide parents and families health information to increase parent and family knowledge of all of the following health issues: • Tobacco-use prevention. • Physical activity. • Nutrition and healthy eating.	19.9	17.0 - 23.1
CSH 9. (2010 version)	The percentage of schools that have a written school improvement plan that includes health-related goals and objectives on any of the following topics: • Health education. • Physical education and physical activity. • Nutrition services and foods and beverages available at school. • Health services. • Mental health and social services. • Healthy and safe school environment. • Family and community involvement. • Faculty and staff health promotion.	69.4	65.9 - 72.8

Part II: Coordinated School Health and Promotion of Physical Activity, Nutrition, and Tobacco-Use Prevention SLIMs

	Coordinated School Health School-Level Impact Measure (SLIM)	Percentage of Schools Meeting SLIM	95% Confidence Interval
CSH 9. (2012 version)	The percentage of schools that include at least one health and safety objective in their school improvement plan and have completed a self-assessment of school health policies and practices (e.g., the School Health Index) and have reviewed health and safety data during the past year as part of their school improvement planning process.	15.0	12.7 - 17.6
CSH 10.	The percentage of schools that have a group (e.g., school health team) that performs all of the following actions to help plan and implement school health programs: • Identify student health needs based on a review of relevant data. • Recommend new or revised health and safety policies and activities to school administrators or the school improvement team. • Seek funding or leverage resources to support school health and safety priorities for students and staff. • Communicate the importance of health and safety policies and activities to district administrators, school administrators, parent-teacher groups, or community members. • Review health-related curricula or instructional materials.	19.3	16.7 - 22.2

2012 School-Level Impact Measures (SLIMs)
Weighted Principal and Teacher Survey Results

Part II: Coordinated School Health and Promotion of Physical Activity, Nutrition, and Tobacco-Use Prevention SLIMs

	Physical Activity and Physical Education School-Level Impact Measure (SLIM)	Percentage of Schools Meeting SLIM	95% Confidence Interval
PE 1.	Data are not available for 2012 report.		
PE 2.	The percentage of schools in which at least one physical education teacher or specialist received professional development on physical education during the past two years.	95.5	93.6 - 96.9
PE 3.	The percentage of schools in which those who teach physical education are provided with all of the following: • Goals, objectives, and expected outcomes for physical education. • A written physical education curriculum. • A chart describing the annual scope and sequence of instruction for physical education. • Plans for how to assess student performance in physical education.	78.4	75.0 - 81.4
PE 4.	Data are not available for 2012 report.		
PE 5.	The percentage of schools that offer intramural activities or physical activity clubs for all students, including those with disabilities.	85.7	82.8 - 88.2

	Physical Activity and Physical Education School-Level Impact Measure (SLIM)	Percentage of Schools Meeting SLIM	95% Confidence Interval
PE 6.	The percentage of schools that teach about all of the following in a required course: • Physical, psychological, or social benefits of physical activity. • Health-related fitness (i.e., cardiorespiratory endurance, muscular endurance, muscular strength, flexibility, and body composition). • Phases of a workout (i.e., warm-up, workout, cool down). • How much physical activity is enough (i.e., determining frequency, intensity, time, and type of physical activity). • Developing an individualized physical activity plan. • Monitoring progress toward reaching goals in an individualized physical activity plan. • Overcoming barriers to physical activity. • Decreasing sedentary activities such as television viewing. • Opportunities for physical activity in the community. • Preventing injury during physical activity. • Weather-related safety (e.g., avoiding heat stroke, hypothermia, and sunburn while physically active). • Dangers of using performance-enhancing drugs such as steroids.	53.9	50.2 - 57.7
PE 7.	Data are not available for 2012 report.		
PE 8.	The percentage of schools that, either directly or through the school district, have a joint use agreement for shared use of physical activity facilities.	80.4	77.3 - 83.2

	Physical Activity and Physical Education School-Level Impact Measure (SLIM)	Percentage of Schools Meeting SLIM	95% Confidence Interval
PE 9.	The percentage of schools that offer all of the following physical activity opportunities for students at their school: • Required physical education. • Classroom-based physical activity breaks. • Intramural sports or physical activity clubs. • Interscholastic sports.	33.4	30.0 - 36.9

	Nutrition School-Level Impact Measure (SLIM)	Percentage of Schools Meeting SLIM	95% Confidence Interval
NU 1. (2008 version)	The percentage of schools that do not sell the following foods and beverages anywhere at school outside the school food service program: • Baked goods that are not low in fat (e.g., cookies, crackers, cakes, pastries). • Salty snacks that are not low in fat (e.g., regular potato chips). • Candy (i.e., chocolate or non-chocolate candy). • Soda pop or fruit drinks that are not 100% juice.	63.6	60.7 - 66.5
NU 1. (2010 version)	The percentage of schools that do not sell the following foods and beverages anywhere at school outside the school food service program: • Baked goods that are not low in fat (e.g., cookies, crackers, cakes, pastries). • Salty snacks that are not low in fat (e.g., regular potato chips). • Candy (i.e., chocolate or non-chocolate candy). • Soda pop or fruit drinks that are not 100% juice. • Sports drinks (e.g., Gatorade).	57.8	54.9 - 60.7

	Nutrition School-Level Impact Measure (SLIM)	Percentage of Schools Meeting SLIM	95% Confidence Interval
NU 2.	The percentage of schools that always offer fruits or non-fried vegetables in vending machines, school stores, and during celebrations when foods and beverages are offered.	12.5	10.6 - 14.7
NU 3.	The percentage of schools that use at least three of the following strategies anywhere in the school to promote healthy eating: • Price nutritious food and beverage choices at a lower cost while increasing the price of less nutritious foods and beverages. • Collect suggestions from students, families, and school staff on nutritious food preferences and strategies to promote healthy eating. • Provide information on the nutrition and caloric content of foods available. • Conduct taste tests to determine food preferences for nutritious items. • Provide opportunities for students to visit the cafeteria to learn about food safety, food preparation, or other nutrition-related topics.	34.1	30.7 - 37.6
NU 4.	The percentage of schools in which the lead health education teacher received professional development on nutrition education and dietary behavior during the past two years.	41.0	37.4 - 44.7

	Nutrition School-Level Impact Measure (SLIM)	Percentage of Schools Meeting SLIM	95% Confidence Interval
NU 5.	The percentage of schools that teach about all of the following in a required course: • Benefits of healthy eating. • Food guidance using the current Dietary Guidelines for Americans (e.g., MyPlate or MyPyramid). • Using food labels. • Balancing food intake and physical activity. • Eating more fruits, vegetables, and whole grain products. • Choosing foods that are low in fat, saturated fat, and cholesterol. • Using sugars in moderation. • Using salt and sodium in moderation. • Eating more calcium-rich foods. • Food safety. • Preparing healthy meals and snacks. • Risks of unhealthy weight control practices. • Accepting body size differences. • Signs, symptoms, and treatment for eating disorders.	65.0	61.2 - 68.7
NU 6.	The percentage of schools that prohibit all forms of advertising and promotion (e.g., contests and coupons) of less nutritious foods and beverages on school property.	58.2	54.6 - 61.7
NU 7.	The percentage of schools that allow students to have a water bottle with them during the school day and offer free drinking water in the cafeteria during meal times.	74.3	71.0 - 77.3

	Tobacco-Use Prevention School-Level Impact Measure (SLIM)	Percentage of Schools Meeting SLIM	95% Confidence Interval
TOB 1.	The percentage of schools that prohibit tobacco use by students, staff, and visitors in school buildings, at school functions, in school vehicles, on school grounds, and at off-site school events, applicable 24 hours a day and seven days a week.	49.2	45.5 - 52.9
TOB 2.	The percentage of schools that implement a tobacco-use prevention policy in all of the following ways: • Provide visible signage. • Communicate the policy to students, staff, and visitors. • Designate an individual responsible for enforcement. • Have a process in place for addressing violations. • Use remedial rather than punitive sanctions for violators. • Tailor consequences to the severity and frequency of the violation. • Communicate student violations to their parents and families.	7.0	5.4 - 9.0

	Tobacco-Use Prevention School-Level Impact Measure (SLIM)	Percentage of Schools Meeting SLIM	95% Confidence Interval
TOB 3.	The percentage of schools that teach about all of the following in a required course: • Identifying tobacco products and the harmful substances they contain. • Identifying short- and long-term health consequences of tobacco use. • Identifying legal, social, economic, and cosmetic consequences of tobacco use. • Understanding the addictive nature of nicotine. • Effects of tobacco use on athletic performance. • Effects of second-hand smoke and benefits of a smoke-free environment. • Understanding the social influences on tobacco use, including media, family, peers, and culture. • Identifying reasons why students do and do not use tobacco. • Making accurate assessments of how many peers use tobacco. • Using interpersonal communication skills to avoid tobacco use (e.g., refusal skills, assertiveness). • Using goal-setting and decision-making skills related to not using tobacco. • Finding valid information and services related to tobacco-use prevention and cessation. • Supporting others who abstain from or want to quit using tobacco. • Supporting school and community action to support a tobacco-free environment. • Identifying harmful effects of tobacco use on fetal development.	47.1	43.3 - 50.9

	Tobacco-Use Prevention School-Level Impact Measure (SLIM)	Percentage of Schools Meeting SLIM	95% Confidence Interval
TOB 4.	Data are not available for 2012 report.		
TOB 5.	The percentage of schools that provide tobacco-use cessation services to faculty, staff, and students through direct service at school or arrangements with providers not on school property.	22.7	19.9 - 25.7
TOB 6.	The percentage of schools in which the lead health education teacher received professional development on tobacco-use prevention education during the past two years.	22.6	19.7 - 25.7

SUBURBAN COOK COUNTY

2012 School-Level Impact Measures (SLIMs)
Weighted Principal and Teacher Survey Results

Part III: Asthma Management SLIMs

	School-Level Impact Measure (SLIM)	Percentage of Schools Meeting SLIM	95% Confidence Interval
AS 1.	The percentage of schools that have ever assessed their asthma policies, activities, and programs by using the School Health Index or similar self-assessment tool.	16.1	13.5 - 19.2
AS 2.	Data are not available for 2012 report.		
AS 3.	The percentage of schools that have on file an asthma action plan for all students with known asthma.	60.2	56.7 - 63.7
AS 4.	The percentage of schools that implement a policy permitting students to carry and self administer asthma medications in both of the following ways: • Communicate the policy to students, parents, and families. • Designate an individual responsible for implementing the policy.	64.0	60.6 - 67.2
AS 5.	The percentage of schools requiring that all school staff members receive training on recognizing and responding to severe asthma symptoms that require immediate action, as a part of annual staff development.	56.3	52.6 - 60.0
AS 6.	The percentage of schools that have a full-time registered school nurse on-site during school hours.	71.2	68.3 - 74.0
AS 7.	Data are not available for 2012 report.		
AS 8.	Data are not available for 2012 report.		

SUBURBAN COOK COUNTY

2012 School-Level Impact Measures (SLIMs)
Weighted Principal and Teacher Survey Results

Part III: Asthma Management SLIMs

	School-Level Impact Measure (SLIM)	Percentage of Schools Meeting SLIM	95% Confidence Interval
AS 9.	The percentage of schools that identify students with poorly controlled asthma by keeping track of them in at least three of the following ways: • Frequent absences from school. • Frequent visits to the school health office due to asthma. • Frequent asthma symptoms at school. • Frequent non-participation in physical education class due to asthma. • Students sent home early due to asthma. • Calls from school to 911, or other local emergency numbers, due to asthma.	62.0	58.1 - 65.7
AS 10.	The percentage of schools that provide intensive case management for students with poorly controlled asthma at school. These intensive services should include all of the following: • Providing referrals to primary healthcare clinicians or child health insurance programs. • Ensuring an appropriate written asthma action plan is obtained. • Ensuring access to and appropriate use of asthma medications, spacers, and peak flow meters at school. • Offering asthma education for the student with asthma. • Minimizing asthma triggers in the school environment. • Addressing social and emotional issues related to asthma. • Providing additional psychosocial counseling or support services as needed. • Ensuring access to safe, enjoyable physical education and activity. • Ensuring access to preventive medications before physical activity.	30.4	27.1 - 33.8
AS 11.	The percentage of schools that provide parents and families of students with asthma information to increase their knowledge about asthma management.	24.4	21.0 - 28.1