Multi-State Learning Collaborative III
Lead States in Public Health Quality Improvement

Guidance for Target Areas

Section 1. Background and Purpose

The goal of the MLC-3 is to bring state and local practitioners and other stakeholders together in a community of practice that will a.) Prepare local and state health departments for national accreditation; b.) Contribute to the development of the national voluntary accreditation program; and c.) Advance the application of quality improvement methods that result in specific, measurable improvements and the institutionalization of quality improvement practice in public health departments. The participant states will apply quality improvement methodologies to improve public health performance and impact related to a menu of up to ten target areas through mini-collaboratives within each state. Among several strategies, the quality improvement activities include:

- Selecting at least two target areas for improvement from a menu of 10 pre-selected targets that will be identified by the MLC team and its partners, and
- Forming mini-collaboratives (including any combination of local health departments, state health departments, and public health partners) within the state that are focused on improving performance and impact related to the selected target areas

Among the participant states, there are numerous structures and approaches under development for selecting targets and forming mini-collaboratives. There is no 'one right approach,' and we are looking forward to supporting and learning from your work. The purpose of this document is to provide additional information about the MLC Menu of Targets and *general* guidance to consider when selecting the targets for your quality improvement work. This document is a work in progress and we intend to update it with your input as the project moves forward.

In the subsequent sections, an overview of how the ten target areas were defined is provided; further details regarding each of the target areas, including high-level (macro) logic models[1] and a section that outlines factors to consider when selecting your targets are also provided. In the appendices, you will find a full page image of the logic models for each target area as well as a table of each of the targets. If you have any questions, concerns, or feedback about this document or selecting targets, please contact Anooj Pattnaik at apattnaik@nnphi.org or 504-301-9822.

Section 2. Defining a "Menu of Targets"

The process for determining the 10 target areas and specific targets within each area involved a collaboration among the National Network of Public Health Institutes (NNPHI), Robert Wood Johnson Foundation (RWJF), the MLC-2 participant states, and our national partners, including the Association of State and Territorial Health Officials (ASTHO), Centers for Disease Control and Prevention (CDC), Muskie School of Public Service at the University of Southern Maine, National Association of County and City Health Officials (NACCHO), National Association of Local Boards of Health (NALBOH), and Public Health Foundation (PHF).

Primary principles to guide the process were outlined and modified with input from all participants. The final "principles of engagement" included:

- *Transparency*: the process for selecting targets was to be visible to all MLC participants
- *Consensus*: to the greatest extent possible, targets were to be selected through a consensus process

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[1] We would like to extend our sincere gratitude to the MLC-3 Evaluation team at the Muskie School of Public Service for developing the logic models to support the target areas - many thanks to Brenda Joly, Maureen Booth, and George Shaler for leading the development of the logic models.

- *Participatory*: representatives from each MLC 2 state should provide input and feedback to the process and selection, as will NNPHI partners
- *Based upon pre-existing work or evidence*: indicators and targets were not to be derived de novo, but rather taken from existing work
- *Half and half*: half the 10 targets selected would represent capacity/process measures, and half would represent health status[2]
- *Target Selection will be based on established criteria*: In order for targets to be selected, they should:
    - Measure an important aspect, result, or outcome of public health's work;
    - Be actionable-the public health system can implement activities to improve performance against the measure; and
    - Have a source of data that is available.

Each MLC-2 state was asked to identify one spokesperson to be responsible for gathering input from their partners and conveying that input during conference calls and/or via email. Over the course of 3 months, three calls were held; one to review and discuss the process; the second to comment on an initial list of proposed targets; and the third to explain a process for ranking the targets. Feedback via email was also sought at multiple points and comment periods were scheduled for each state to compile information or obtain feedback from within their state.

An extensive review of existing tools and data[3] led to the initial menu of targets, which included 9 capacity/process targets and 10 health outcome targets. From this menu, MLC states were asked to rank order their top 5 priorities from the capacity/process targets and their top 5 priorities for health outcome targets. The rankings were tallied and the final menu of 10 targets, based on these rankings, was released on April 15, 2008.

[2] Originally, the intent had been to focus on health outcome targets only. MLC-2 state input led to the decision to incorporate both capacity/process and health outcome areas in the menu of targets.

[3] The following sources of data and information were considered in developing the initial list of targets: Community Health Status Indicators data; Healthy People 2010 Health outcome indicators and Midcourse Review; National Public Health Performance Standards Program assessment tools and data; the Operational Definition of a Functional Local Health Department metrics, MAPP measures; 2002 Institute of Medicine Report measures, MLC-2 project information, standards and measures from MLC-2 states and South Carolina and information from similar projects that have organized consensus building processes to select measures.

Section 3. Target Areas and Logic models

This section outlines each target area in the menu; provides a high-level (macro) logic model that outlines strategies and outcomes related to the target area; and includes a list of resources for each target area that offers additional information including resources for best practices and preferred interventions, when available. It is our hope that this section will continue to grow and evolve with contributions from MLC states and partners.

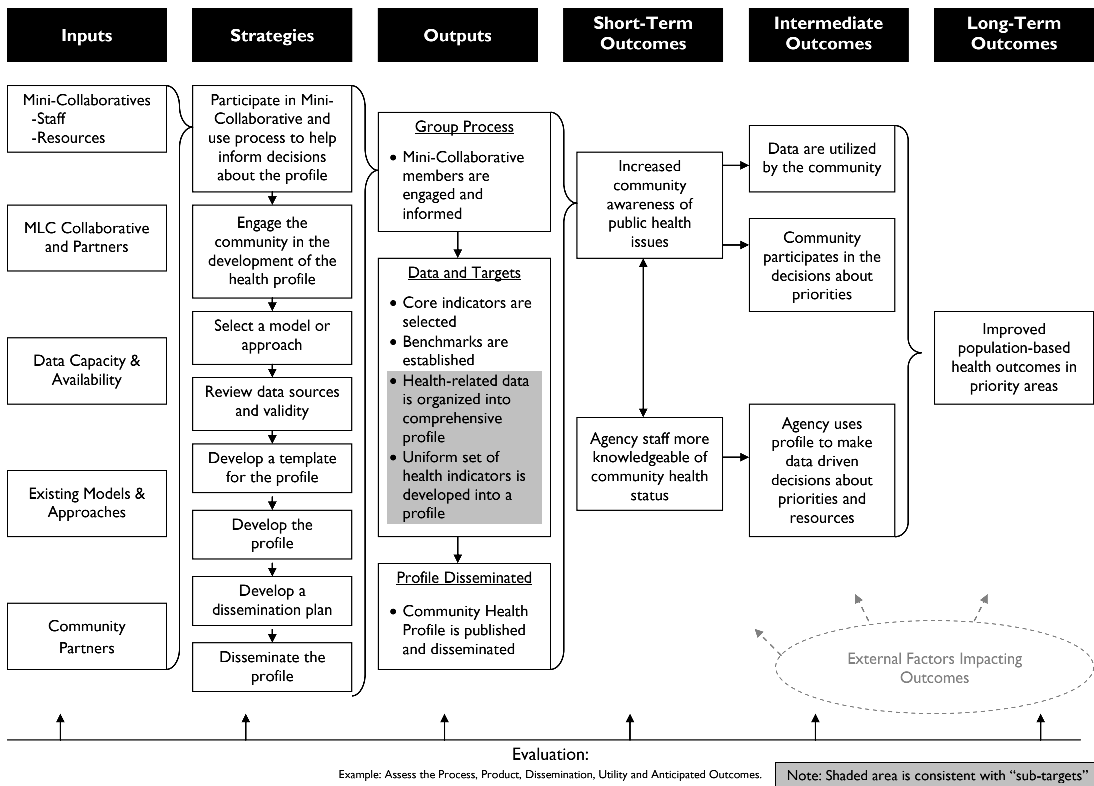
1. Target Area: Community Health Profile (CHP)

A community health profile (CHP) is a comprehensive compilation of measures representing multiple categories, or domains that contribute to a description of health status at a community level and the resources available to address health needs. Measures within each domain may be tracked over time to determine trends, to evaluate health interventions or policy decisions, to compare community data with peer, state, national or benchmark measures, and to establish priorities through an informed community process. (NPHPSP Glossary, http://www.cdc.gov/od/ocphp/nphpsp/documents/glossary.pdf, page 15). Upon reviewing aggregate data from the National Public Health Performance Standards Program (NPHPSP), this area was identified as a potential area for improvement at both the state and local levels. Metrics for creating and using community health profiles are also outlined in the NACCHO Operational Definition for a Local Health Department and Healthy People 2010.

Sub-targets:

1. Health related data is organized into a comprehensive community health profile
2. A uniform set of health indicators is developed into a community health profile that describes the population's health

Target Area #1: Community Health Profile Logic Model



Resources for more information:

1. Sample Community Health Profiles:
   FL: http://www.floridacharts.com/charts/mapp_report.aspx
   NYC: http://www.nyc.gov/html/doh/html/data/data.shtml
   MA: http://masschip.state.ma.us/
2. Mobilizing for Action through Planning and Partnerships - Community Health Status Assessment: http://www.naccho.org/topics/infrastructure/MAPP/Phase4CHSA.cfm

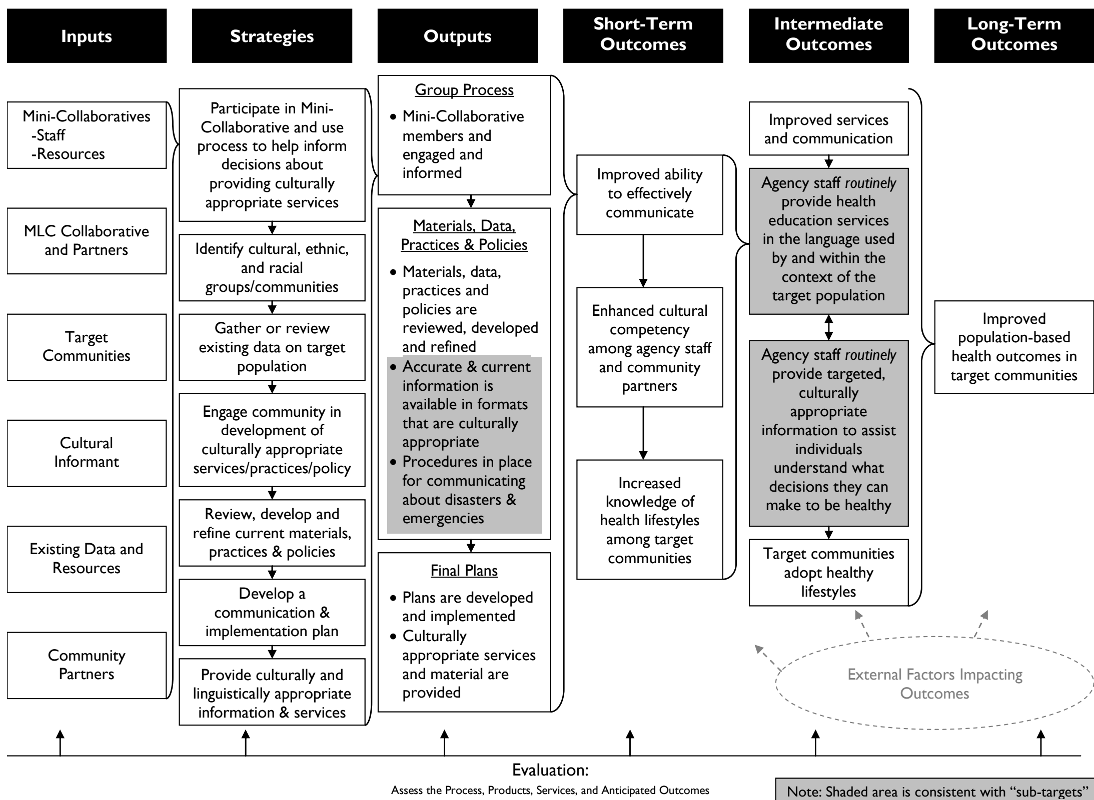
2. Target Area: Culturally Appropriate Services

In order to effectively reach individuals that seek public health services, it is necessary for public health providers to deliver services in a context and manner that understands and appreciates the cultural differences and similarities within, among, and between groups and individuals in a population. Cultural competence requires that the services and service providers draw upon the community-based values, traditions, and customs to work with knowledgeable persons of and from the community in developing targeted interventions and communications. (Adapted from the definition of Cultural Competence in the NPHPSP Glossary located at: http://www.cdc.gov/od/ocphp/nphpsp/documents/glossary.pdf) Upon reviewing aggregate data from the National Public Health Performance Standards Program, this area was identified as a potential area for improvement at both the state and local levels. Metrics for Culturally appropriate services are included in the NACCHO Operational Definition for a Local Health Department.

Sub-targets:

- Target: Accurate and current information is available in formats that are culturally appropriate, linguistically relevant, and accessible to the target populations
- Target: The health department provides health education services in the language used by and within the context of the target population (Operational Definition)
- Target: Procedures are in place for communicating with groups and individuals about disasters and emergencies following established standards
- Target: The health department provides targeted, culturally appropriate information to assist individuals understand what decisions they can make to be healthy

Target Area #2: Culturally Appropriate Services Logic Model



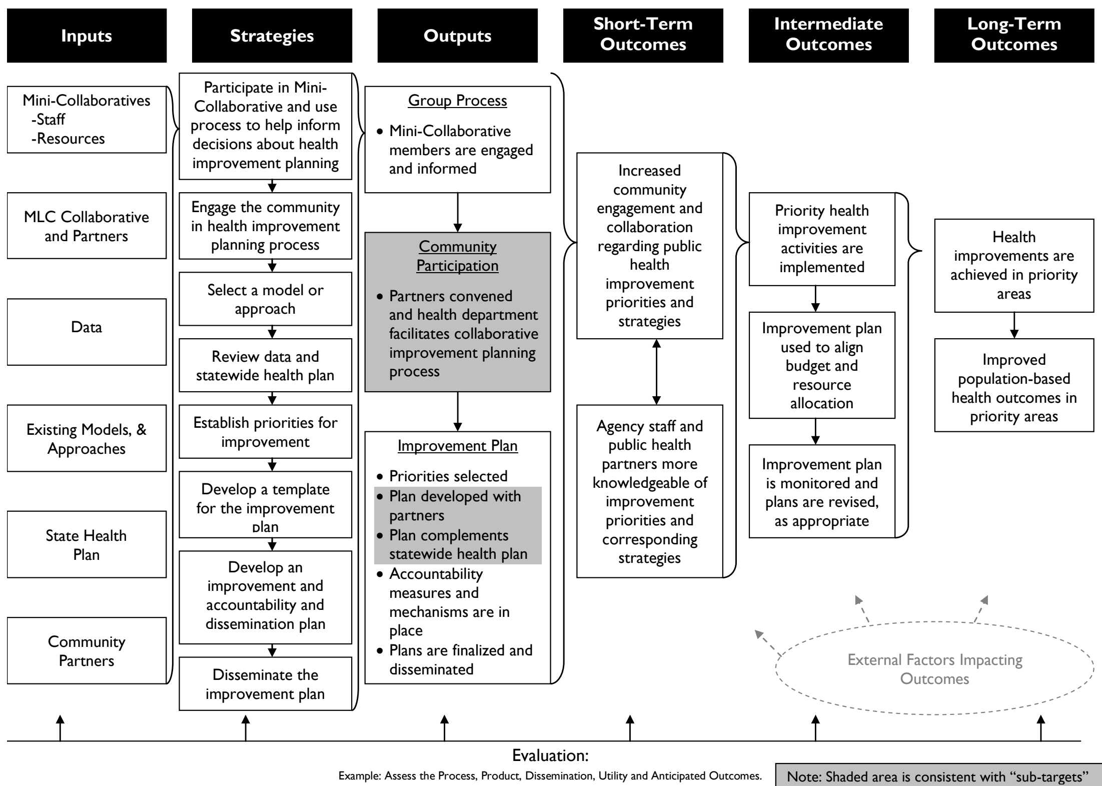
Resources for more information:
1. Office of Minority Health, US Department of Health and Human Services – Cultural Competency section of the website: http://www.omhrc.gov/templates/browse.aspx?lvl=1&lvlID=3 This site includes numerous resources to define cultural competency and national standards for health care.
2. National Center for Cultural Competence: http://www11.georgetown.edu/research/gucchd/nccc/
3. The Community Guide to Preventive Services – Social Environment http://www.thecommunityguide.org/social/ie-sce-culturalcare-012308.htm

3. Target Area: Health Improvement Planning

Of the ten essential services for public health, Essential Service #5 is to develop policies and plans that support individual and community health efforts. Health improvement planning at the state and local level provides an opportunity for public health systems partners to come together to assess public health needs and create a comprehensive health improvement plan that outlines the vision, goals, recommendations and action steps for addressing the identified public health needs. This target was selected because of its importance as an integral component to improving public health practice and outcomes. Standards for health improvement planning are included in the state and local NPHPSP instruments as well as the NACCHO Operational Definition for a Local Health Department, Healthy People 2010 and in the standards of numerous existing assessment programs in MLC-2 states.

Sub-targets:

- Target: A health department led community health improvement planning process convenes partners and facilitates collaboration resulting in an improvement plan including health objectives and improvement strategies (State NPHPS) (please note- this target may appear to have 2 components, convening and facilitating a plan. We believe both aspects should be fulfilled to meet this target)
- Target: A community health improvement plan is developed with partners which complements the statewide health plan (modified from HP 2010) (please note- this target has two components, the development of the plan, and the effort to align with the state plan. Either or both components may be appropriate for your state).



Resources for more information:

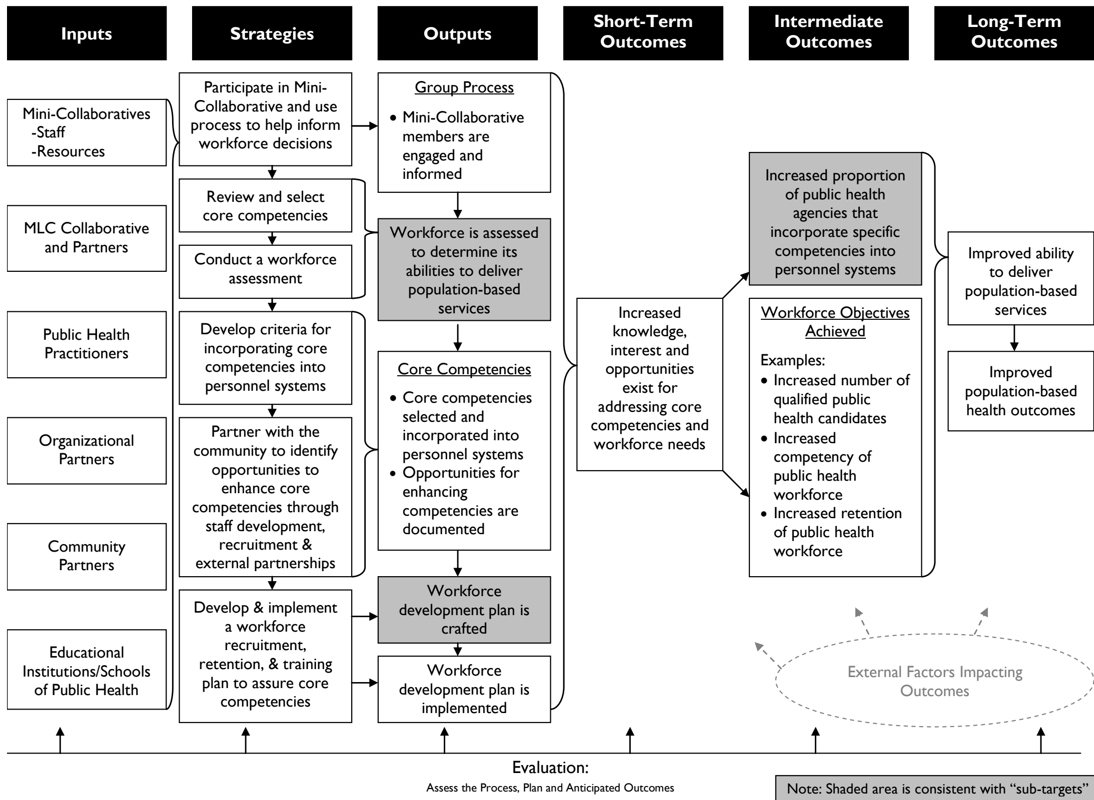
1. Mobilizing for Action through Planning and Partnerships
2. Sample local and community health improvement plans available on the NACCHO website (scroll to the bottom third of the page to view tools and sample local/community level health improvement plans)
3. Sample statewide public health improvement plans:
    a. Illinois Public Health Improvement Plan
    b. Washington Public Health Improvement Plan

4. Target Area: Assure Competent Workforce

Findings from the two most recent ASTHO workforce surveys indicate that the public health workforce is shrinking (2007 State Public Health Workforce Shortage report available at http://www.astho.org/pubs/WorkforceReport.pdf). Moreover, relatively few public health workers have received formal training and preparation in public health before joining the health department workforce. Efforts to build a competent public health workforce are essential to ensure that there is public health capacity to meet the demands and challenges placed upon the nation's public health system. This target was chosen to reflect the importance of building a sustained agency capacity and infrastructure by supporting its most important asset, the public health worker. Standards for workforce are included in the state and local NPHPSP instruments, Operational Definition for Local Health Department, Healthy People 2010 and some existing assessment programs in MLC-2 states.

Sub-targets:

- Target: The workforce is assessed to determine its abilities to deliver population-based services, and a workforce development plan is crafted (State NPHPS) (please note- this is a two part target, and it may be most appropriate for your state to address one or both components: assessment and/or development plan)
- Target: Increase the proportion of public health departments that incorporate specific competencies into personnel systems (HP 2010) (please note- this target can be state, local, or both)



Resources for more information:

1. NACCHO Workforce Training and Development: http://naccho.org/topics/workforce/index.cfm
2. ASTHO Workforce Development:http://www.astho.org/?template=2workforce_development.html
    a. Recently published workforce development report: http://www.astho.org/pubs/WorkforceReport.pdf

Additional resources and information on the public health workforce and core competencies:

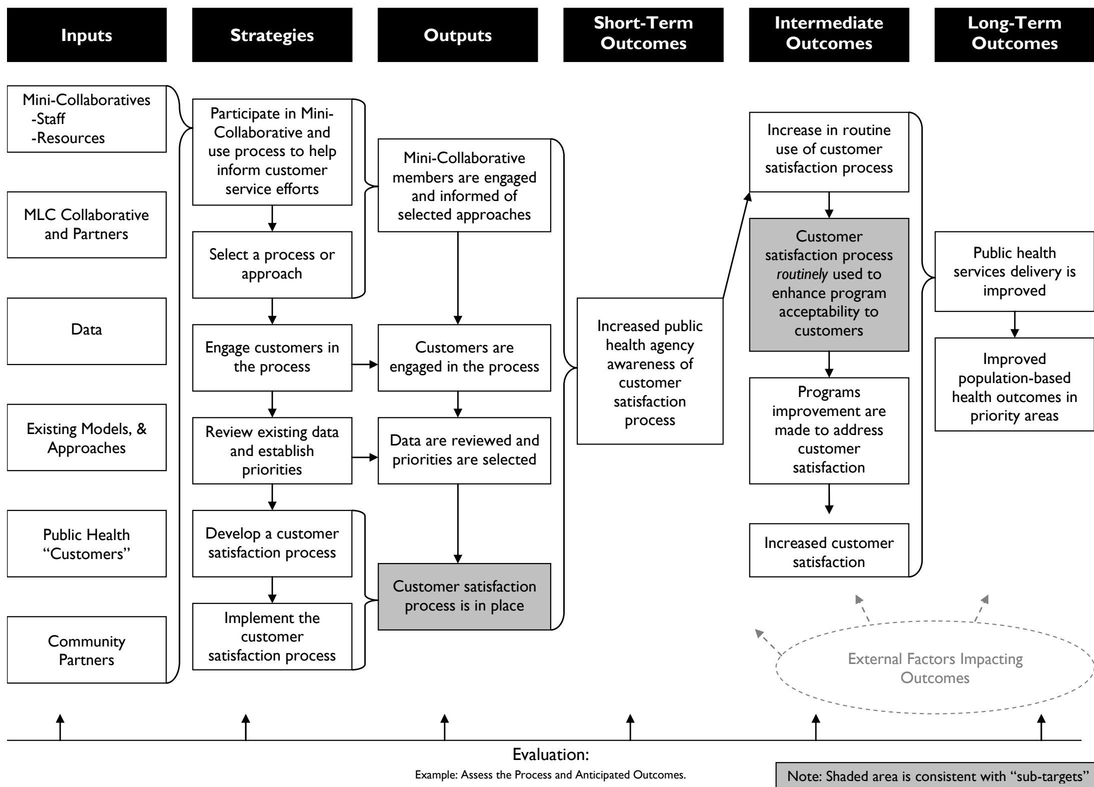
3. Council on Linkages Between Academia and Public Health Practice – Core Competencies for the Public Health Workforce:http://phf.org/Link.htm
4. Public Health Foundation: http://phf.org/phworkforce.htm

5. Target Area: Customer Service and Satisfaction

Understanding your customer base is a key component of an organizational or programmatic quality improvement process. Customer and market focus is the third of the seven criteria assessed in the Baldrige Criteria for Performance Excellence. By establishing a process for evaluating customer service and customer satisfaction, health departments are able to identify opportunities to improve the quality of the public health services that are provided and to increase acceptability. This target area was selected because it had been identified as a potential opportunity for improvement among many health departments.

Sub-targets:

- Target: A customer satisfaction process is in place, and results are routinely utilized to enhance program acceptability to customers (please note- this target has two components, and both are recommended for inclusion)



Resources for more information:

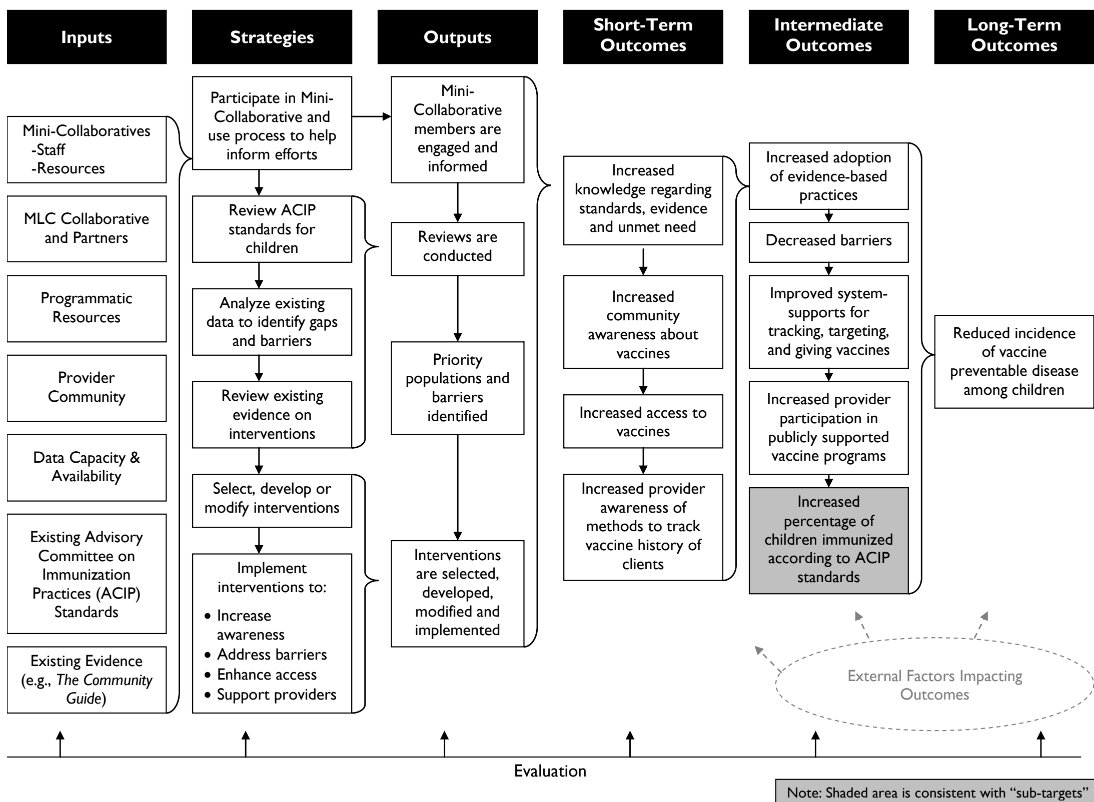
1. Embracing Quality in Local Public Health – Michigan's Quality Improvement Guidebook: http://nnphi.org/CMSuploads/Michigans_QI_Guidebook-47434.pdf Section 2 of the guidebook defines customers, clients and stakeholders.
2. Baldrige Criteria for Performance Excellence – see page 19 for information on the Customer and Market Focus criterion.

6. Target Area: Reduce Vaccine-Preventable Disease

Immunizing children and adults to avoid infectious diseases is a critical service of the public health system. "During the 20th century the United States has seen the incidence of measles, pertussis, and diphtheria fall by more than 98%. This is due primarily to the use of vaccines that immunize children against these illnesses" (http://www.cdc.gov/nis/about_eng.htm, accessed 7.31.08). However, health disparities and other barriers prevent sufficient immunization coverage amongst all populations. Underserved children and adults of many racial and ethnic populations are vulnerable to vaccine preventable diseases because they are not fully immunized. By eliminating the disparities in vaccination coverage, disparities in disease burden could also be reduced. This target was selected due to its relevance to Healthy People 2010 as well as multiple sets of standards from existing state based public health assessment programs.

Sub-targets:

Target: Increase the percentage of children immunized according to ACIP standards (modified Healthy People 2010)



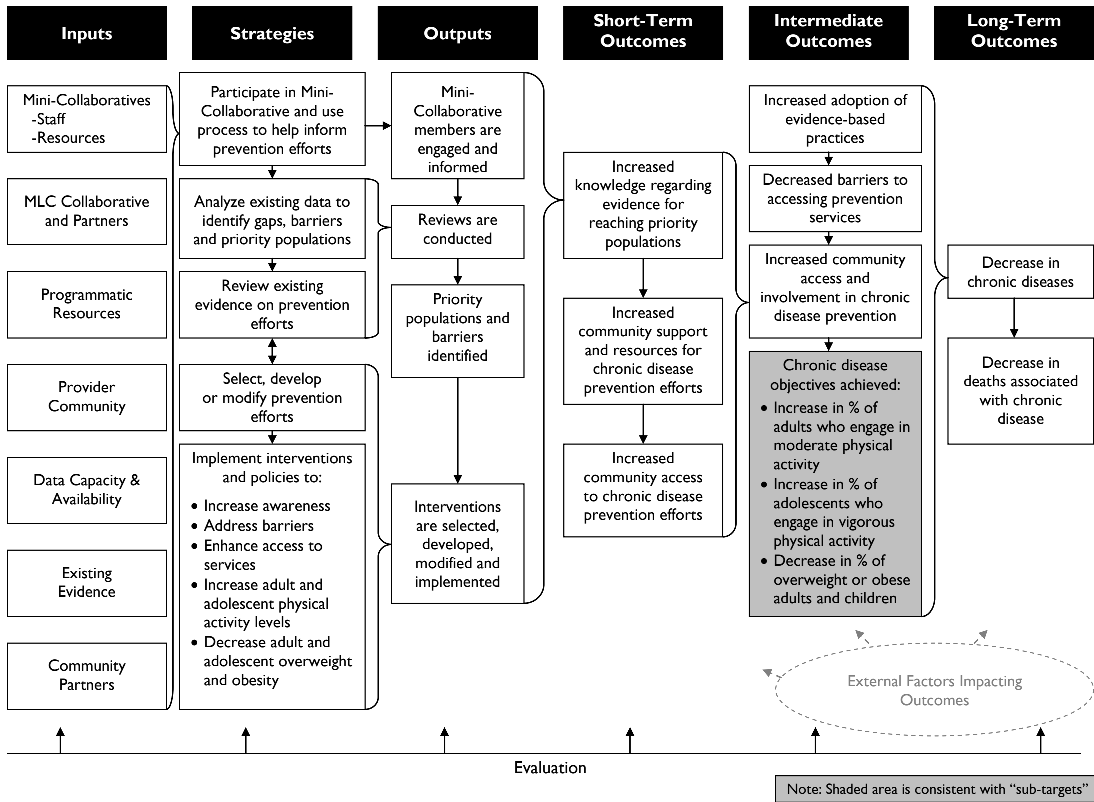
Resources for more information:

1. Centers for Disease Control and Prevention – Advisory Committee on Immunization Practices:
http://www.cdc.gov/vaccines/recs/ACIP/
http://www.cdc.gov/vaccines/pubs/ACIP-list.htm
2. Community Guide to Preventive Services – Section on Vaccines:
http://www.thecommunityguide.org/vaccine/default.htm
3. CDC Office of Minority Health and Health Disparities:
http://www.cdc.gov/omhd/AMH/factsheets/immunization.htm

7. Target Area: Reducing Preventable Risk Factors that Predispose to Chronic Disease
Even though most chronic diseases are preventable, they are among the leading causes of disability and death in the United States. The rising rates of obesity related to limited physical activity and unhealthy eating habits contribute significantly to high rates of chronic disease related disability and death. A recent study by the journal *Obesity* estimates that an excess of 86% of the US population may be overweight or obese by 2030 if current trends are not reversed (Baltimore Examiner, accessed 8.1.08). This target was selected due to the critical need in public health to identify opportunities to reduce the risk factors that lead to chronic disease. Sources referenced to determine this target include Healthy People 2010 and multiple sets of standards from existing state based public health assessment programs.

Sub-targets:
- Target: Increase the percentage of adults 18 years of age and older who engage in 30 minutes of moderate physical activity 5 or more days each week (HP 2010)
- Target: Increase the percentage of adolescents in grades 9-12 who engaged in 20 minutes of vigorous physical activity 3 or more days each week (HP 2010)
- Target: Reduce the percentage of adults age 18 or older who have BMI greater than 25
- Target: Reduce the percentage of obese adults aged 20 or older (HP 2010)
- Target: Reduce the percentage of overweight or obese children and adolescents aged 6-19 (HP 2010)

Target Area #7: Reducing Preventable Risk Factors that Predispose to Chronic Disease Logic Model

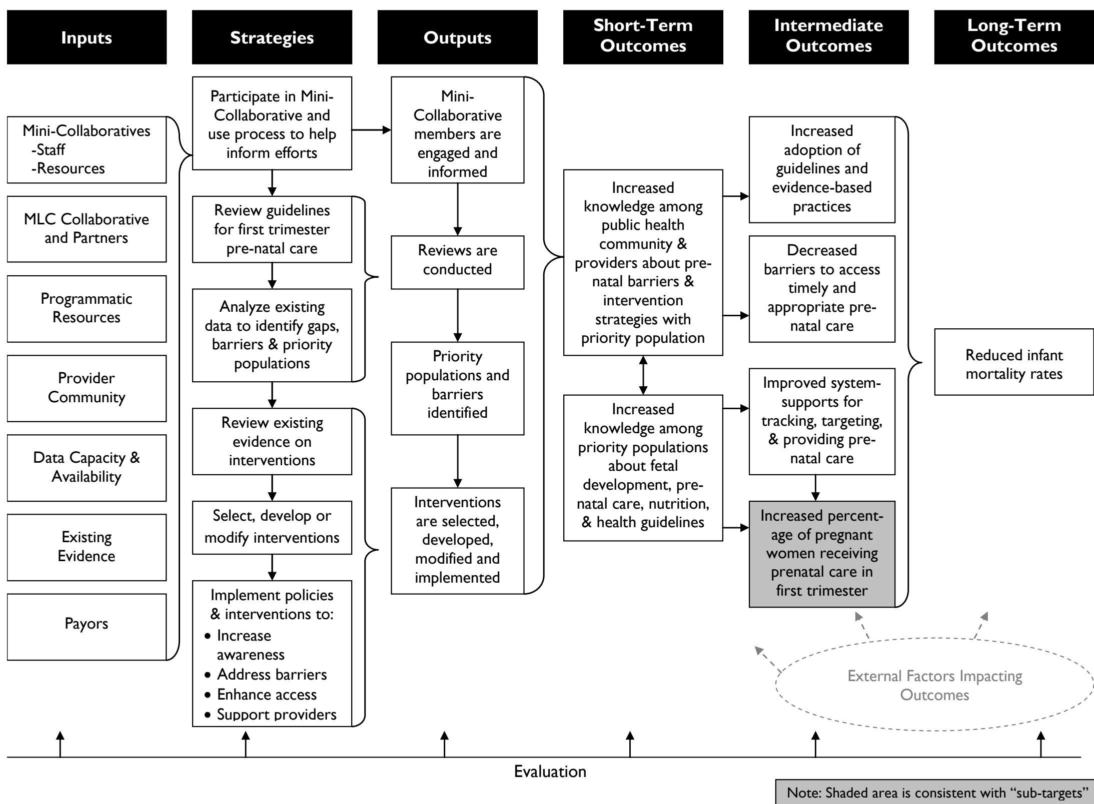


Resources for more information:
1. Community Guide to Preventive Services – Section on Obesity: http://www.thecommunityguide.org/obese/
2. Active Living by Design: http://www.activelivingbydesign.org/

3. Healthier US – Physical Activity: http://www.healthierus.gov/exercise.html
4. World Health Organization – Chronic Disease Risk Factors: http://www.who.int/dietphysicalactivity/media/en/gsfs_chronic_disease.pdf
5. http://www.health.gov/paguidelines/
6. The Community Health Promotion Handbook-Action Guides to Improve Community Health: http://www.prevent.org/actionguides/HandbookIntroduction.pdf
7. Yeah! A website with evidenced based programs, childhood obesity information and resources: http://www.floridayeah.com/
8. Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities. This report includes sample physical activity and nutrition interventions that yield a significant return on investment. http://healthyamericans.org/reports/prevention08/Prevention08.pdf

8. Target Area: Reducing Infant Mortality
The infant mortality rate has declined in recent decades; however, the rate in the United States continues to rank far behind that of other industrialized nations. Health disparities amongst race and ethnic groups contribute to the rate. The infant mortality rate among African Americans is more than double the national rate (http://www.cdc.gov/omhd/AMH/factsheets/infant.htm, accessed 8.1.08). Healthy People 2010 called the public health community to eliminate disparities and reduce infant mortality; however additional efforts are needed to reach the Healthy People 2010 objectives. In addition to Healthy People 2010, Community Health State Indicators and at least one state based public health assessment program include assessing performance on this target area.

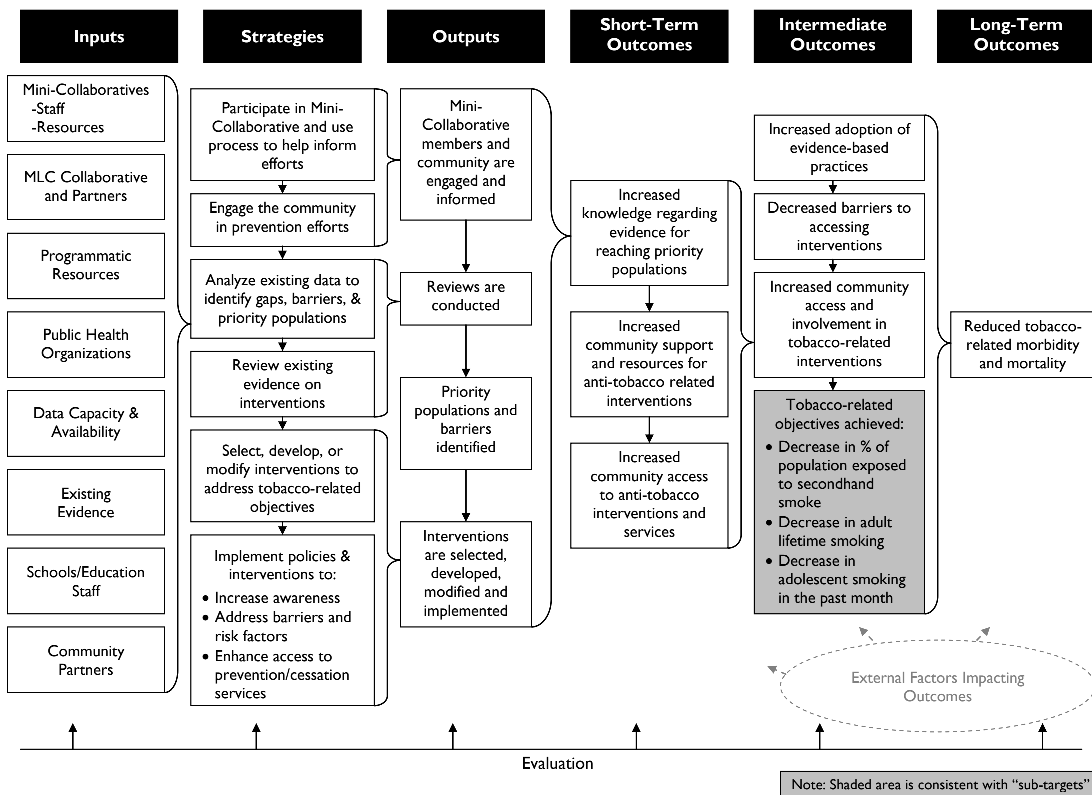
Sub-targets:
- Target: Increase the percentage of pregnant women receiving prenatal care in the first trimester (HP 2010)



Resources for more information:
1. CDC – Office of Minority Health and Health Disparities: http://www.cdc.gov/omhd/AMH/factsheets/infant.htm#1#1
2. Association of Maternal and Child Health Programs (Best practices and other pubs) www.amchp.org
3. HRSA MCH Bureau: http://mchb.hrsa.gov/programs/womeninfants/prenatal.htm

9. Target Area: Reducing the Burden of Tobacco Related Illness
As of 2003, the CDC identified that 21.6% of adults smoke in the United States (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5420a3.htm, accessed 8.01.08). While this prevalence is slowly declining, it is far from reaching national objectives set forth in Healthy People 2010. Furthermore, the prevalence of cigarette use among teenagers has been steady at 21.9% for several years. Similar to adults, the smoking prevalence for youth is far from reaching its related Healthy People 2010 objectives (http://www.cdc.gov/tobacco/data_statistics/MMWR/2008/mm5725a3_intro.htm, accessed 8.01.08). Standards and measures for monitoring the trends of tobacco related illness appeared in almost all assessment sources that were reviewed, including Healthy People 2010, Community Health Status Indicators and multiple state based public health assessment programs. This target was selected with the understanding that the need to address the burden of tobacco related illness is critical to improving the health of communities throughout the United States.

Sub-targets:
- Target: Reduce the percentage of adults age 18 or older who smoked at least 100 cigarettes in their lifetime, and are current smokers (HP 2010)
- Target: Percent of adolescents in grades 9-12 who smoked one or more cigarettes in the past month (HP 2010)
- Target: Reduce the percentage of the population exposed to secondhand smoke (HP 2010)



Resources for more information:
1. Community Guide to Preventive Services – Section on Tobacco: http://www.thecommunityguide.org/tobacco/
2. CDC Best Practices for Comprehensive Tobacco Control Programs (2007)

3. www.Tobaccofreekids.org
4.The Community Health Promotion Handbook-Action Guides to Improve Community Health: http://www.prevent.org/actionguides/HandbookIntroduction.pdf
5. Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities. This report includes sample physical activity and nutrition interventions that yield a significant return on investment. http://healthyamericans.org/reports/prevention08/Prevention08.pdf

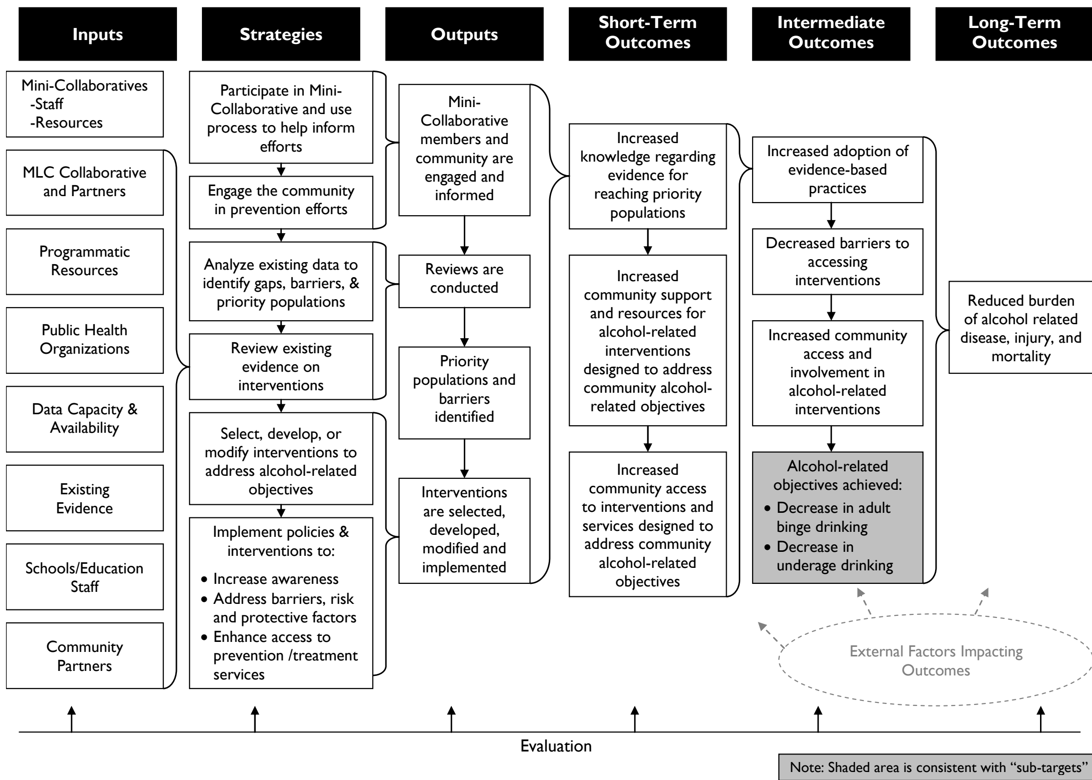
10. Target Area: Reduce the Burden of Alcohol Related Disease and Injury

Alcohol use among adults and youth pose public health problems related to disease and injury. The prevalence of excessive drinking amongst the United States adult population is 17% (http://www.cdc.gov/pcd/issues/2006/apr/05_0182.htm, accessed 8.01.08). The 2006 National Survey on Drug Use and Health reported that 19% of underage youth between the ages of 12-20 reported binge drinking (http://www.cdc.gov/alcohol/quickstats/underage_drinking.htm, accessed 8.01.08). Standards and measures for monitoring the trends of alcohol related disease and injury appeared in almost all sources that were reviewed, including Healthy People 2010, Community Health Status Indicators and multiple state based public health assessment programs. This target was selected with the understanding that the need to address the burden of alcohol related disease is critical to improving the health of communities throughout the United States.

Sub-targets:

- Target: Reduce the percentage of adults 18 years and older who reported binge drinking in the past 30 days (HP 2010)
- Target: Reduce the percentage of adolescents aged 12-17 who reported drinking in the past 30 days (HP 2010)

Target Area #10: Reduce the Burden of Alcohol Related Disease and Injury Logic Model



Resources for more information:

1. CDC – Alcohol and Public Health: http://www.cdc.gov/alcohol/index.htm
2. Community Guide to Preventive Services – Section on Alcohol: http://www.thecommunityguide.org/alcohol/
3. http://www.stopalcoholabuse.gov/

Section 4. Selecting Targets

MLC grantees are asked to choose *at least two* target areas from the menu of ten provided above. We strongly encourage grantees to choose one target area that is capacity/process related and one target area that is health outcome related in order to expand the variety and type of QI collaboratives. By selecting a combination of capacity/process and health outcome targets, we may be able to create bridges in our understanding of how improving our process can lead to improved health outcomes. If it does not make sense in your state to choose one of each of the types of targets, then you should choose the targets that make the most sense for your mini-collaboratives.

State and local collaboration is encouraged when selecting the target areas. Additionally, it might be meaningful to include additional community partners to participate in the selection process and in the mini-collaborative process as well. Before selecting particular target areas, there are a few questions states and/or mini-collaborative members within each state should consider, including but not limited to:

- Has the state or local community participated in a strategic planning or assessment process where you can look to see if priority issues have already been identified?
- Is there accurate and current data available for the selected target either at the state or local level to track progress throughout the process?
- Have you identified process measures and proxy measures to assess your progress that can also be gathered?
- Are there sufficient resources both financial and human to affect change in the selected target area?

After selecting the target areas, the focus should be narrowed to the 'sub-targets' which are provided for each of the 10 broad target areas. Grantees are encouraged to choose from the list of proposed sub-targets that have been provided under each target area. If there is a compelling reason for you to consider a focus outside of the provided sub-targets, please contact Anooj Pattnaik (apattnaik@nnphi.org) at NNPHI to arrange to discuss this with the MLC project team. We would appreciate the opportunity to learn about the alternatives that you are considering and identify potential options in collaboration with you.

If you are implementing different mini-collaboratives in each year of the project, you have the flexibility to decide whether or not you would like to work on the same targets each year, or if you would prefer to work on different targets each year. You may want to consider the time period that would be necessary to demonstrate measureable change when making this decision.

Section 5: Closing Comments

As stated above, this guidance document is meant to evolve and expand as we dive deeper into the project and learn from community to community, state to state and partner to partner about the process and potential for applying quality improvement practices to the defined target areas. We invite you to join us in creating a robust tool that can help support the work of the mini-collaboratives. Your feedback, comments and suggestions are strongly encouraged.

Appendix A: Targets

Capacity/Process Targets

Target area	Sub-targets for the target area
Community Health Profile	▪ Target: Health related data is organized into a comprehensive community health profile (State NPHPS) ▪ Target: A uniform set of health indicators is developed into a community health profile that describes the population's health (modified State, Local NPHPS)
Culturally appropriate services	▪ Target: Accurate and current information is available in formats that are culturally appropriate, linguistically relevant, and accessible to the target populations ▪ Target: The health department provides health education services in the language used by and within the context of the target population (Operational Definition) ▪ Target: Procedures are in place for communicating with groups and individuals about disasters and emergencies following established standards ▪ Target: The health department provides targeted, culturally appropriate information to assist individuals understand what decisions they can make to be healthy
Health Improvement Planning	▪ Target: A health department led community health improvement planning process convenes partners and facilitates collaboration resulting in an improvement plan including health objectives and improvement strategies (State NPHPS) ▪ Target: A community health improvement plan is developed with partners which complements the statewide health plan (modified from HP 2010)
Assure Competent Workforce	▪ Target: The workforce is assessed to determine its abilities to deliver population-based services, and a workforce development plan is crafted (State NPHPS) ▪ Target: Increase the proportion of public health departments that incorporate specific competencies into personnel systems (HP 2010)
Customer Service	▪ Target: A customer satisfaction process is in place, and results are routinely utilized to enhance program acceptability to customers

Health Outcome Targets

Target area	**Sub-targets for the target area**
Reduce the incidence of vaccine preventable disease	▪ Target: Increase the percentage of children immunized according to ACIP standards (modified from many, including HP2010)
Reduce preventable risk factors that predispose to chronic disease	▪ Target: Increase the percentage of adults 18 years of age and older who engage in 30 minutes of moderate physical activity 5 or more days each week (HP 2010) ▪ Target: Increase the percentage of adolescents in grades 9-12 who engaged in 20 minutes of vigorous physical activity 3 or more days each week (HP 2010) ▪ Target: Reduce the percentage of adults age 18 or older who have BMI greater than 25 ▪ Target: Reduce the percentage of obese adults aged 20 or older (HP 2010) ▪ Target: Reduce the percentage of overweight or obese children and adolescents aged 6-19 (HP 2010)
Reduce infant mortality rates	▪ Target: Increase the percentage of pregnant women receiving prenatal care in the first trimester (HP 2010)
Reduce the burden of tobacco related illness	▪ Target: Reduce the percentage of adults age 18 or older who smoked at least 100 cigarettes in their lifetime, and are current smokers (HP 2010) ▪ Target: Percent of adolescents in grades 9-12 who smoked one or more cigarettes in the past month (HP 2010) ▪ Target: Reduce the percentage of the population exposed to secondhand smoke (HP 2010)
Reduce the burden of alcohol related disease and injury	▪ Target: Reduce the percentage of adults 18 years and older who reported binge drinking in the past 30 days (HP 2010) ▪ Target: Reduce the percentage of adolescents aged 12-17 who reported drinking in the past 30 days (HP 2010)

Appendix B: Full Page Images of Macro Logic Models