All Children's Hospital

Strategic Community Benefit Plan

Fiscal Year 2013

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I. Executive Summary

All Children's Hospital (the Hospital) is a member of the Johns Hopkins Health System (JHHS) and a fully integrated member of Johns Hopkins Medicine (JHM). As one of only two specialty licensed children's hospitals in Florida, All Children's Hospital delivers on its mission to create healthy tomorrows for all children by providing access to the most advanced pediatric care in Florida. We embrace our mission to treat any child who needs our specialized services, regardless of ability to pay. We are the largest provider of pediatric services to low-income children in Florida; with more than 70 percent of our patient care in 2010 provided through the Florida Medicaid program. The Hospital also extends its mission through our continued support of community initiatives that address widespread child health problems such as obesity and infant mortality. Our mission extends beyond our buildings and direct services to encompass the well-being of the communities we serve. As non-profit institutions, JHHS hospitals aim to fulfill both our mission of community service and our charitable, tax-exempt purpose, especially in the context of the new IRS provisions that require non-profit hospitals to conduct a health needs assessment every three years and develop an implementation strategy to meet the identified needs.

The Hospital's approach to the community health needs assessment is based on the IRS notice issued in July 2011 regarding community health needs assessments.

The 2012 Community Health Needs Assessment (CHNA) and the subsequent Community Benefit Plan focus is on Pinellas County, FL. Focusing All Children's Hospital CHNA on this geographic area facilitates the alignment of the hospital's efforts with community and government partners, specifically the health department, schools, and multiple community-based organizations.

Target populations for All Children's Hospital Community Benefit initiatives were identified through a community input and planning process, collaborative efforts, and the CHNA. Our target populations focus on medically-underserved and vulnerable children and families in Pinellas County. Our most vulnerable populations include children and families, ethnic and linguistic minorities and those living in poverty.

The implementation strategy provides a plan for the hospital to address the most pressing needs of the community identified in the CHNA. The most pressing needs identified through the prioritization process were Birth Outcomes, Chronic Disease with a focus on childhood obesity, and Substance Abuse and Mental Health. This Strategic Community Benefit Plan was endorsed by the hospital's Board of Directors.

II. Introduction

The All Children's Hospital Strategic Community Benefit Plan is a companion report to the All Children's Community Health Needs Assessment (CHNA) as required by the Treasury Department ("Treasury") and the Internal Revenue Service (IRS) in response to new regulations set forth in the Affordable Care Act (ACA). The ACA, enacted in March 23, 2010, requires not-for-profit hospital organizations to conduct a CHNA once every three taxable years that meets the requirements of the Internal Revenue Code 501(r). It also requires each hospital to adopt an implementation strategy that addresses the community health needs identified in the CHNA.

The development of the CHNA and the Strategic Community Benefit Plan was led by the Marketing & Community Relations Department and Health Resources in Action (HRiA), a non-profit public health consulting organization located in Boston, MA which provided strategic guidance and facilitation of the CHNA, strategic planning process and developed both reports. The CHNA and the Strategic Community Benefit Plan involved the contributions of over 100 individuals through interviews, focus groups and health priority work groups. Key stakeholder groups included but were not limited to, community residents, members of faith based organizations, health care providers, neighborhood association leaders, elected officials, health professionals, All Children's Hospital leadership and other experts both internal and external to the Hospital.

The CHNA is a systematic study of the health of a community, including quantitative and qualitative data on health status and community health needs and assets. The Strategic Community Benefit Plan is a list of specific goals, strategies and objectives that demonstrate how All Children's Hospital plans to meet the CHNA-identified needs of the residents in the communities surrounding the Hospital. This Strategic Community Benefit Plan has been prepared for approval by the All Children's Hospital Board of Trustees.

A. Overview

All Children's Hospital is the only specialty licensed children's hospitals in Florida's west coast. Founded in 1926, the Hospital has grown into a leading pediatric referral center that is dedicated to its mission of providing leadership in child health by advancing treatment, education, research and advocacy. All Children's vision is *Creating healthy tomorrows… for one child, for All Children*. The Hospital has 259 licensed beds and a total of 9,732 inpatient admissions in FY 2010.

B. The Community We Serve

For the purpose of defining a Community Benefit Service Area (CBSA), All Children's focused on Pinellas County. The population of Pinellas County is a predominantly White, aging population, with wide variations in socioeconomic level and educational attainment, and high numbers of female-headed households. While the population in Pinellas County is primarily White (82.1%), census data indicate that the Hispanic population has grown by nearly 75% in the last decade (U.S. Census Bureau; Census 2010). Despite perceived community resources, economic challenges and income inequality were frequently cited by assessment participants, and were described as a root cause of health issues in the county. The median household income in Pinellas

County ($45,258) is lower than that of Florida ($47,661) and the U.S. ($51,914) and 17.7% of Pinellas County children live in poverty (U.S. Census Bureau; American Community Survey, 2006-2010 American Community Survey 5-Year Estimates). Additionally, between 2006 and 2010, over one-third of children in the county lived in households headed by a single parent. Female-headed households are disproportionately affected by poverty in Pinellas County, with more than one quarter living in poverty. Also, the proportion of Black children living below poverty (38.8%) in Pinellas County was more than three times that of their White counterparts (10.5%) (U.S. Census Bureau; Census 2010). Furthermore, one quarter of the county's adult population had a bachelor's degree or higher, 61% had a high school diploma or some college, and 11.9% had less than a high school diploma. (U.S. Census Bureau; American Community Survey, 2006-2010 American Community Survey 5-Year Estimates). Within this CBSA, All Children's is focused on certain target populations, such as at-risk children and adolescents, uninsured families, women of childbearing age, and underinsured and low-income families and households.

III. Development of the All Children's Hospital Community Benefit Plan

To develop a shared vision, mission and values, plan for improved community health, and help sustain community benefit efforts, the assessment and planning process engaged an Advisory Committee comprised of leadership from local nonprofit and governmental organizations, and key personnel from the All Children's Hospital team. The Advisory Committee was also responsible for overseeing the community health assessment and identifying health priorities. In addition, Advisory Committee members were asked to identify individuals to potentially participate in the planning and development of the Strategic Community Benefit Plan as Work Group members during a full day planning session on March 21, 2013.

A. Community Benefit Vision, Mission and Core Values

The All Children's Hospital Community Benefit Vision, Mission and Core Values were developed and recommended by the Advisory Committee.

Vision Statement

Healthy children and nurturing families thriving in vibrant neighborhoods within our healthy community.

Mission Statement

All Children's Community Benefit initiative educates, advocates, and collaborates with the community to ensure all children grow up to be healthy

Core Values

Collaboration Commitment Compassion/Caring Impact Innovation Integrity Respect

B. Health Priorities

In early February 2013, the preliminary CHNA Report was distributed to the Advisory Committee members for their review and feedback. A summary of the CHNA findings

was presented on February 13, 2013. Following the presentation, the Advisory Committee identified 15 potential health priorities and several cross-cutting strategies.

Environment	Substance Abuse related birth outcomes
Air Quality	Oral Health
Food Security and Hunger	Communicable Disease
Wellness	Chronic Disease
Birth Outcomes	Chronic Disease Prevention
Obesity, Diabetes and Asthma	Sexual Health
Mental Health	Injuries
Substance Abuse	

While all of the areas were important, three priority areas were identified based on a clear set of criteria to facilitate a targeted focus that will lead to greater community impact. Thus, after identifying the 15 potential health priorities, each committee member was given a Rating and Ranking worksheet to complete (See Appendix A). Participants were asked to rate each health priority based on four specific sets of selection criteria, using a scale of 1-4 for each criterion. These ratings were summed, resulting in an overall rating between 4 and 16 for each health priority. The rating process was followed by a ranking process, in which each participant ranked the health priorities from 1 to 15 based on the overall rating number each priority received. The following health priorities received the highest average ratings and rankings:

Health Priorities	**Rating** (average)	**Ranking** (average)
Birth Outcomes	14.62	1.82
Chronic Disease	14.58	1.92
Substance Abuse	13.46	2.43
Mental Health	12.67	2.50

C. Final Health Priorities

Based on the ranking results and further discussion, the group decided to combine Substance Abuse with Mental Health.

Below is the final list of the health priorities identified by the Advisory Committee:

1. Birth Outcomes
2. Chronic Disease (with a focus on childhood obesity and the built environment)
3. Substance Abuse and Mental Health

D. Cross Cutting Strategies

Cross cutting strategies are those strategies that will be considered in the development of all elements of the Strategic Community Benefit Plan. The following three areas were identified as cross cutting strategies by the Advisory Committee:

1. Prevention
2. Social determinants of health (defined below)
3. Wellness

E. Identified Needs Addressed in the Strategic Community Benefit Plan

All Children's Hospital convened a day long planning session in March 2013. Key community partners were invited to participate in Work Groups based on interest and expertise in the three identified priority areas. These facilitated work groups resulted in the development of goals, objectives, strategies, and partner organizations for the highest priority needs. The Work Group facilitators provided sample evidence-based strategies from a variety of resources including The Community Guide to Preventive Health Services, The Clinical Guide to Preventive Health Services and Healthy People 2020 for the strategy setting session. As policy is inherently tied to sustainability and effectiveness, the Work Groups were encouraged to identify strategies that would result in a policy change.

F. Unaddressed Identified Needs

A rating and ranking process (see Appendix A), that included agreed upon selection criteria, was used to prioritize the many pressing community health needs identified in the CHNA. The additional topic areas that were identified by the CHNA process (environment, air quality, food security and hunger, wellness, oral health, communicable disease, sexual health, and injuries) had a lower ranking during the prioritization process. While All Children's Hospital will focus the majority of our efforts on the identified needs in the Strategic Community Benefit Plan outlined in the table below, we will review the complete set of priorities as they emerge to determine our response and make any adjustments in our plans.

IV. Strategic Community Benefit Implementation Plan

(See table below)

Maternal and Child Health (Birth Outcomes)

GOAL 1: Create an environment for all men and women in our community to be physically, spiritually and emotionally healthy in order to give birth to healthy babies who will reach their full potential.

#	Community Health Need	Target Population	Objectives	Action Plan Strategies	Proposed Partner Organizations
1.1	**Maternal and Child Health (Birth Outcomes)**	Pregnant women, new mothers and newborns (within the first year of life)	By June 2016, reduce overall infant mortality rate from 6.6/1000 live births to 6.2/1000 live births and By June 2016, reduce black infant mortality rate from 13.9/1000 live births to 11.5/1000 live births.	a. Encourage all men and women to apply/enroll and become insured. b. Utilize community health workers (CHW) to help navigate the health insurance eligibility system and select a medical home. c. Continue to use home visiting (or other evidence-based practices) to provide education and support throughout pregnancy d. Use school setting to provide the majority of wellness and preventive services and health education to youth. e. Integrate behavioral health services in primary care/medical home setting (decrease stigma and barriers).	- Juvenile Welfare Board (JWB) - Agency for Health Care Administration (AHCA) - Center for Medicaid and Medicare - Community CHC's - Healthy Start Coalition - Healthy Start Federal (FHS) – Pinellas County Health Department (PinCHD)

#	Community Health Need	Target Population	Objectives	Action Plan Strategies	Proposed Partner Organizations
1.2	**Maternal and Child Health (Birth Outcomes)**	Pregnant women	By June 2016, reduce overall incidence of low birth weight from 8.8% to 8.3% and black incidence of low birth weight from 12.7% to 12.1%.	a. Implement counseling and interventions to prevent tobacco use among pregnant women. b. Identify or develop videos that are culturally competent on problems related to low birth weight (LBW) and preterm births. c. Utilize medical appointments to provide multidisciplinary education. d. Provide videos to OB offices, primary care providers and pediatric offices to educate patients about risk factors of LBW including smoking and substance abuse. e. Implement screening and behavioral counseling in primary care settings to reduce alcohol and tobacco use among pregnant women. f. Increase tobacco use cessation programs and implement provider reminders and efforts to educate providers to identify and intervene with tobacco-using patients, as well as provide supplementary education materials.	- Area for Health Education Centers (AHEC) - Students Working Against Tobacco (SWAT-PinCHD)) - OG/GYN Offices - Healthy Start and PinCHD - Tobacco Coalition

#	Community Health Need	Target Population	Objectives	Action Plan Strategies	Proposed Partner Organizations
1.3	**Maternal and Child Health (Birth Outcomes)**	High risk pregnant women and families	By June 2016, reduce preterm birth rate from 12.9 to 12.1	a. Implement a health communication and social marketing campaign that includes mass media and health related product distribution (recommend media campaign to cover all objectives for this priority area) b. Expand programs that deliver coordinated services for pregnant women in identified high risk communities.	- Healthy Start (Federal) - Local media - Hospitals - Local community / neighborhood papers & magazines
1.4	**Maternal and Child Health (Birth Outcomes)**	Maternal and Child Health Service Providers	By 2016, develop a linguistically and culturally appropriate action plan to address and reduce identified health inequities and disparities that impact birth outcomes.	a. Develop a process to evaluate outcomes of action plan. b. Identify (prioritize) two systems which greatly impact health disparities that impact birth outcomes. c. Research, identify and administer a community assessment tool to identify personal and systemic biases that impact birth outcomes. d. Develop and implement evidence-based training programs for grassroots leaders and providers to enhance knowledge of skills in community/system change for birth outcomes and ensure cultural competence. e. Integrate health equity strategies into all priority areas of the CB Plan. f. Promote CHW (navigators and educators) certification program to increase culturally competent care.	- Addressing Racism and Creating Health Equality (ARCHE) - YWCA - Community of Tampa Bay - St. Pete Together - Council of Neighborhood Associations (CONA) - People's Institute - for survival and Beyond (PIB) - WK Kellogg Foundation and City Match

#	Community Health Need	Target Population	Objectives	Action Plan Strategies	Proposed Partner Organizations
1.5	**Maternal and Child Health (Birth Outcomes)**	Community leaders, community members, Maternal & Child Health Service Providers, etc.	By June 2014, develop a Maternal and Child Health Coalition using the Connect2Protect coalition development model	a. Determine the goal of the coalition (i.e. address objectives 1.2-1.4) b. Develop a list of coalition members to lead the change initiative c. Convene the first coalition meeting and set up regularly scheduled coalition meetings. d. Develop a coalition vision and mission e. Communicate the vision and mission and gain buy-in by ensuring that as many people as possible understand and accept the vision f. Identify a list of short-term wins so as to create success as soon as possible	- Healthy Start - OB/GYN Offices - PinCHD - Community members (pregnant women, mother's, women of childbearing age reflective of high risk population)

Goal 2: Promote healthy eating and active living in our communities so that all children may attain and maintain a healthy weight.

#	Community Health Need	Target Population	Objectives	Action Plan Strategies	Proposed Partner Organizations
2.1	**Chronic Disease (Childhood Obesity)** .	School age children (5-18 years of age)	By June 2016, increase by 5% the percentage of school age children consuming 2 servings of fruit and 3 servings of vegetables daily	a. Implement evidence-based nutrition education program or curriculum during school day and in after-school and summer programs. b. Advocate for increase in SNAP benefits for healthy foods (example BOGO for fruits and vegetables). c. Create a strategic, coordinated, culturally competent social marketing campaign to include print, TV, radio, and social media focused on: 1. Budget friendly, quick to prepare healthy meals, 2. Fast food nutrition facts, 3. Reading nutrition labels, 4. Other, TBD	– YMCA – R Club – Pinellas County Schools – Coordinated child care – Parks and Recreation – Faith based organizations/ groups – More Health – Local grocery stores – Safe Kids – Safe Routes to School
2.2	**Chronic Disease (Childhood Obesity)**	School age children (5-18 years of age)	By June 2016, increase the percentage of school age children who spend at least 210 minutes per week on moderate to vigorous physical activity.	a. Advocate for policy change to include physical education requirement for all grades. b. Partner with local pro sports teams to create a 'rec on the run' physical activity program to bring physical activity opportunities to local neighborhoods. c. Provide and promote use of 'fitness log' for all community members, possibly offer incentive program. d. Advocate for increased standards for physical education teachers in school district	– PTA – Pinellas County Health Department – Pinellas County Schools and School Board – Physician Associations – Be Fit Kids – City councils – Safe Kids – YMCA – Boys and Girls Club – School Nurses – More Health (has example log) – FL Department of Education – Local media outlets – SRTs

#	Community Health Need	Target Population	Objectives	Action Plan Strategies	Proposed Partner Organizations
2.3	**Chronic Disease (Childhood Obesity)**	Pregnant and Postpartum women New Dads	By June 2016, increase the rate of breastfeeding initiation from 71% to 76%. By June 2016, increase the percentage of breast feeding moms who breast feed their child for a minimum of three months from 9.9% to 12.6%.	a. Increase the number of "Baby Friendly" accredited hospitals in the region. b. Increase access to lactation consultants before and after birth. c. Educate parents on the long term benefits to baby and the mother-child bond (include required video on breastfeeding). d. Increase the number of nursing friendly locations in public places. e. Educate new moms on the importance of healthy eating and a healthy lifestyle for both the mom and the baby and the benefits to the baby of breast feeding for the last 6 months.	– OB/GYNS – Hospitals – Pediatricians – WIC – Health Insurers – Lactation consultants – Le Leche League – nurses – Employers and local businesses

#	Community Health Need	Target Population	Objectives	Action Plan Strategies	Proposed Partner Organizations
2.4	**Chronic Disease (Childhood Obesity)**	Entire community with a focus on areas of greatest need. School age children	By June 2016, increase the miles of safe, bike-able and walkable routes throughout Pinellas County.	a. Compile a list of public improvement projects throughout Pinellas County that have been planned and budgeted for improving bikeability and walkability (including sidewalks, footpaths, walking trials, and pedestrian crossings). b. Advocate for inclusion of health related data into decision making processes, Health Impact Assessments (HIAs). c. Continue to increase the number of walking school bus programs. d. Provide bike safety education programs to middle school students	– Neighborhood Associations – Homeowner associations – Utility companies – Community traffic safety teams – County commission/city councils – Metropolitan Planning Organization (MPO) – MORE Health – STEPS committee (Pinellas County Schools) – Students and parents/caregivers – Parks and rec – Afterschool programs – All Children's Safe Routes to School staff – Safe Kids

#	Community Health Need	Target Population	Objectives	Action Plan Strategies	Proposed Partner Organizations
2.5	**Chronic Disease (Childhood Obesity)**	Families with school age children living in low income communities.	By June 2016, increase the number of alternative options for access to nutritious foods in low income communities by 5%.	**Community Gardens** a. Promote school based gardens throughout Pinellas County Schools b. Allow community garden participation as another alternative option to physical education c. Allow access to community gardens on closed school properties via joint use agreements d. Provide schools with an incentive for establishing and sustaining a community garden e. Establish partnerships with faith based organizations to support and sustain community gardens. **Farmers Markets** a. Promote farmers markets on county buses. b. Increase # of farmers markets that accept EBT card. c. Implement mobile farmers markets ('fruit and veggie mobiles') throughout Pinellas County. d. Review and revise land use agreements within municipalities to encourage the establishment of farmers markets. e. Establish partnership with faith-based organizations to f. support and sustain farmers markets. g. Coordinate and collaborate to improve transportation to food purchase locations. h.	– Pinellas County Schools – County Commissioners – Faith-based organizations – Public Defender's Office – Existing community gardens – Pinellas County Extension Office – Peace Patch Project (Dr. Kip Curtis)

#	Community Health Need	Target Population	Objectives	Action Plan Strategies	Proposed Partner Organizations
2.6	**Chronic Disease (Childhood Obesity)**	Community leaders, community members.	By September 2014, develop a chronic disease/childhood obesity coalition using the Connect2Protect coalition development model.	a. Determine the goal of the coalition b. Develop a list of coalition members to lead the change initiative c. Convene the first coalition meeting and set up regularly scheduled coalition meetings. d. Develop a coalition vision and mission e. Communicate the vision and mission and gain buy-in by ensuring that as many people as possible understand and accept the vision f. Identify a list of short-term wins so as to create success as soon as possible	– Pediatric Providers (Specialist's, RD's, General Peds) – PinCHD – Pinellas County Schools – Coordinated Child Care – YMCA's – Heart Association (?) – Early Learning Coalition – Florida Blue – Tampa Bay Times (do we want a media representative – Rays (sports figure?) – City Leaders (St. Pete, Largo, Seminole, Clearwater, Palm Harbor, Tarpon Springs) – Peace Patch (Community and School Gardens) – Zoe's Garden (of course I mean Tyson)

Mental Health & Substance Abuse

Goal 3: Ensure access to comprehensive substance abuse and mental health services through education and an integrated system of care.

#	Community Health Need	Target Population	Objectives	Action Plan Strategies	Proposed Partner Organizations
3.1	**Mental Health & Substance Abuse**	Children and families	By June 2016, increase access to outpatient substance abuse/mental health services for children and families.	a. Assist in the integration of substance abuse/mental health screening into primary care practices. b. Improve communication and coordination of care among providers through substance abuse/mental health information exchange. c. Integrate primary and behavioral health care into a single setting throughout the county.	– National Alliance on Mental Health – Pediatricians / Family Practice – Healthy Start Programs – Operation Par – Briggins Counseling, llc – Health Care Connections of Tampa – Florida Alcohol and Drug Abuse Association – Windmoor Healthcare of Clearwater – Alcoholics Anonymous (AA) – Narcotics Anonymous (NA) – Pinellas County Health Department – 211 Tampa Bay Cares – Personal Enrichment Through Mental Health Service (PEMHS) – Suncoast Center – Behavioral Health & Psychiatric Services

#	Community Health Need	Target Population	Objectives	Action Plan Strategies	Proposed Partner Organizations
3.2	**Mental Health & Substance Abuse**	Parents Child service providers	By June 2016, decrease the incidence of child abuse.	a. Educate parents on the effects of exposure to violence on children's mental health through training, mass media campaign and culturally appropriate educational materials. b. Create a substance abuse/mental health toolkit of resources and strategies for child services providers (schools, childcare, and pediatricians). c. Develop and implement training and resource toolkit. d. Implement Positive Parenting Program in Pinellas County	– National Alliance on Mental Health – Pediatricians / Family Practice – Healthy Start Programs – Operation Par – Briggins Counseling, llc – Health Care Connections of Tampa – Florida Alcohol and Drug Abuse Association – Windmoor Healthcare of Clearwater – Alcoholics Anonymous (AA) – Narcotics Anonymous (NA) – Pinellas County Health Department – 211 Tampa Bay Cares – Personal Enrichment Through Mental Health Service (PEMHS) – Suncoast Center – Behavioral Health & Psychiatric Services
3.3	**Mental Health & Substance Abuse**	Women of childbearing age Pregnant women Medical professionals	By June 2016, decrease the # of substance abuse exposed newborns.	a. Implement SBIRT and drug testing for all women of childbearing age at all OBGYN and midwifery practices. b. Educate women of childbearing age about the effects of ATOD, including prescription drugs, on birth outcomes. c. Promote pregnancy testing to all prescribing professionals prior to issuing prescription narcotics.	– National Alliance on Mental Health – Pediatricians / Family Practice – Healthy Start Programs – Operation Par – Briggins Counseling, llc – Health Care Connections of Tampa – Florida Alcohol and Drug Abuse Association – Windmoor Healthcare of Clearwater – Alcoholics Anonymous (AA) – Narcotics Anonymous (NA) – Pinellas County Health Department – 211 Tampa Bay Cares – Personal Enrichment Through Mental Health Service (PEMHS) – Suncoast Center – Behavioral Health & Psychiatric Services

Appendix A: Rating and Ranking Worksheet

Step 1: Rate Key Health Issues using Criteria

Instructions: Rate each health issue based on how well it meets each of the criteria provided
1=low, **2**=medium, **3**=high, **4**=very high
Add your four ratings for each health issue and enter the total in the Total Column.

Key Health Issues (list below):	Selection Criteria				Total Rating
	RELEVANCE *How Important Is It?*	**APPROPRIATENESS** *Should We Do It?*	**IMPACT** *What Will We Get Out of It?*	**FEASIBILITY** *Can We do It?*	
	- Burden (magnitude and severity ; economic cost; urgency) of the problem - Community concern - Focus on equity and accessibility	- Ethical and moral issues - Human rights issues - Legal aspects - Political and social acceptability - Public attitudes and values	- Effectiveness - Coverage - Builds on or enhances current work - Can move the needle and demonstrate measureable outcomes - Proven strategies to address multiple wins	- Community capacity - Technical capacity - Economic capacity - Political capacity/will - Socio-cultural aspects - Ethical aspects - Can identify easy short-term wins	
a.					
b.					
c.					
d.					
e.					
f.					
g.					
h.					

Step 2: Rank Health Issues

Referring to your Total Rating numbers, rank order each of the Heath Issues with "1" being the Health Issue with the highest total score, "2" being the Health Issue with the second highest total score, etc.

In the case of identical totals, use your best judgment to assign a unique rank number to each health issue to break the tie.

Rank Order of **Health Issues** (use each number only once):

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