Eaton Rapids Medical Center

Community Health Needs Assessment Implementation Plan Beginning Fiscal Year 2015

Prioritization: Setting a Shared Course

Prioritization Methodology

The Healthy! Capital Counties Community Health Profile and Health Needs Assessment produced a variety of data from a variety of sources about the health issues in the tri-county area. The report was used to identify the health issues to be prioritized. The work group and project staff utilized the consensus criteria method, as outlined below:

- Identifying the criteria to be considered when evaluating the issues;
- Selecting weights for each criteria;
- Identifying the issues to be evaluated, based upon the community profile and health needs assessment report;
- Engaging stakeholders in selecting the most important issues for each criteria; and
- Applying the weights to the stakeholder feedback

Identifying the criteria

Based upon the experience garnered from the methods used in the 2012 assessment work, the decision was made to use the same four criteria for evaluating the issues to be prioritized. Those criteria are:

- Seriousness (how serious is the health issue)
- Control (how much control do we have to affect the issue)
- Capacity (what is our capability, as a community, to address an issue)
- Catalytic (how much does this issue affect other health issues)

Selecting the weights of the criteria

In order to identify a broad spectrum of priorities that speak to the spheres of influence for all the project partners and that reflect the broad constellation of factors that influence health, the weighting scale was adjusted in this cycle of the project. Further analysis and study indicated that the weight assigned to the Catalytic criterion contributed significantly to those priorities. For the 2015 process, the work group discussed this weighting process at length with project staff to identify a strategy that would reveal both upstream and downstream priorities. The consensus of the group was that one weighting scheme was not sufficient to identify a broad range of priorities. The work group agreed to identify two sets of weight to the voting results and to combine the results of the two weighting schemes into one list of priorities. Below are the weights agreed upon by the workgroup:

Criteria and Definition	Upstream weights	Downstream weights
a. Seriousness (how serious is the health issue)	4	4
b. Control (how much control do we have to affect the health issue)	2	3
c. Capacity (what is our ability, as a community to act on a particular health issue)	1	2
d. Catalytic (how much does this issue affect other health issues)	3	1

Identifying the issues to be evaluated

The complete report, along with an executive summary, was provided to the Work Group members in preparation for prioritizing the issues. All members were polled, via email, by project staff to identify the issues that would be put before the community stakeholders. This step produced the following set of issues:

Access to Quality Healthcare
Access to Affordable Housing
Access to Healthy Food
Access to opportunities for physical activity, adults
Access to opportunities for physical activity, children and teens
Access to Primary Healthcare Providers
Access to programs/services in the community
Child Health (incl. asthma, diabetes, accidents)
Chronic Disease (incl. cardiovascular, diabetes, multiple chronic illnesses)
Communicable Disease, adults (incl. STDs, influenza, pneumonia, vaccinations for preventable diseases)
Communicable Disease, children and teens (incl. STDs, influenza, pneumonia, vaccinations for preventable diseases)
Environmental Quality (clean air, clean water, toxic exposures)
Financial stability (incl. poverty, living wage, income)
Mental Health, adults (incl. stress, depression, access to services)
Mental Health, children and teens (incl. stress, depression, bullying)
Obesity, adults
Obesity, children and teens
Safe and connected neighborhoods and communities (incl., safety, feeling connected, support for healthy choices)
Substance Abuse (adults) (incl. alcohol, narcotics, illegal drugs)
Substance Abuse, teens (incl. alcohol, binge drinking, narcotics, illegal drugs)
Tobacco use (adults) (incl. smoking, chewing tobacco)
Tobacco use, teens (incl. Smoking, chewing tobacco)

Engaging stakeholders in selecting priorities

All project partners were encouraged to invite key stakeholders to the meeting where the health issues would be prioritized. The meeting was held on October 21, 2015, and was attended by 68 participants. Project staff presented an overview of the Healthy! Capital Counties project as well as the project's community profile and health needs assessment report. The list of issues to be prioritized was also provided and participants were encouraged to review these and ask questions prior to the selection process.

Using the program "Poll Everywhere," participants were asked to use the issues list and respond to each of the following questions:

- Which three issues are most serious?
- Which three issues do we have enough control to affect?
- Which three issues do we have the greatest capacity to address?
- Which three issues affect other health issues?

Staff were available throughout the polling process to assist with using the text program and their cell phones to vote. Alternate voting methods were used for participants without cell phones.

Applying the weights

Upstream

Two sets of weights were applied to the votes received. The first set of weights, where the catalytic criteria was weighted high, produced the scoring matrix on the following page. The top five priorities that emerged were:

- ◊ Access to primary healthcare providers
- ◊ Mental health, adults
- ◊ Financial stability
- ◊ Access to quality health care
- ◊ Chronic disease

Downstream

The second set of weights is based upon the catalytic criteria being set low. This approach produced the second scoring matrix below. The top priorities that emerged were:

- ◊ Access to primary healthcare providers
- ◊ Mental health, adults
- ◊ Access to quality healthcare
- ◊ Chronic disease
- ◊ Financial stability

Putting both sets of results together generated the following list of priorities:

- ♦ Access to primary healthcare providers
- ♦ Access to quality healthcare
- ♦ Financial stability (incl. poverty, living wage, income)
- ♦ Mental health, adults (incl. stress, depression, access to services)
- ♦ Chronic disease (incl. cardiovascular, diabetes, multiple chronic illnesses)

Results with Catalytic Criteria Set High (Upstream)

Issue to Assess	Seriousness	Control	Capacity	Catalytic	Weighted Score
Weight	4	2	1	3	
Access to Quality Healthcare	60	24	9	39	**132**
Access to Affordable Housing	20	8	9	30	67
Access to Healthy Food	12	36	14	21	83
Access to opportunities for physical activity, adults	8	22	3	3	36
Access to opportunities for physical activity, children and	12	20	7	0	39
Access to Primary Healthcare Providers	100	34	11	42	**187**
Access to programs/services in the community	0	40	20	33	93
Child Health	28	6	6	3	43
Chronic Disease	68	22	8	27	**125**
Communicable Disease, adults	4	2	6	0	12
Communicable Disease, children and teens	16	14	8	3	41
E**nvironmental Quality**	12	14	6	15	47
Financial stability	60	6	7	93	**166**
Mental Health, adults	100	16	6	51	**173**
Mental Health, children and teens	72	14	6	21	113
Obesity, adults	28	12	6	21	67
Obesity, children and teens	36	8	6	15	65
Safe and connected neighborhoods and communities	8	10	16	42	76
Substance Abuse, adults	20	0	3	9	32
Substance Abuse, teens	16	4	3	0	23
Tobacco use, adults	28	18	2	12	60
Tobacco use, teens	4	8	4	6	22

Results with Catalytic Criteria Set Low (Downstream)

Issue to Assess	Seriousness	Control	Capacity	Catalytic	Weighted Score
Weight	4	3	2	1	
Access to Quality Healthcare	60	36	18	13	**127**
Access to Affordable Housing	20	12	18	10	60
Access to Healthy Food	12	54	28	7	101
Access to opportunities for physical activity, adults	8	33	6	1	48
Access to opportunities for physical activity, children and	12	30	14	0	56
Access to Primary Healthcare Providers	100	51	22	14	**187**
Access to programs/services in the community	0	60	40	11	111
Child Health	28	9	12	1	50
Chronic Disease	68	33	16	9	**126**
Communicable Disease, adults	4	3	12	0	19
Communicable Disease, children and teens	16	21	16	1	54
E**nvironmental Quality**	12	21	12	5	50
Financial stability	60	9	14	31	**114**
Mental Health, adults	100	24	12	17	**153**
Mental Health, children and teens	72	21	12	7	112
Obesity, adults	28	18	12	7	65
Obesity, children and teens	36	12	12	5	65
Safe and connected neighborhoods and communities	8	15	32	14	69
Substance Abuse, adults	20	0	6	3	29
Substance Abuse, teens	16	6	6	0	28
Tobacco use, adults	28	27	4	4	63
Tobacco use, teens	4	12	8	2	26

After the prioritization meeting, two members of the Work Group asked what the list would look like if those issues that were labeled for adults and children were aggregated. When this analysis was conducted, the list of priorities was as follows:

- ◊ Access to quality healthcare
- ◊ Access to primary healthcare providers
- ◊ Financial stability
- ◊ Mental health
- ◊ Obesity

This new list was sent to all Work Group members asking if the original list of priorities should be revised. All who responded indicated the original list should be the final list.

The final list of priorities:

- **Access to Primary Healthcare Providers**
- **Access to Quality Healthcare**
- **Financial Stability**
  includes poverty, living wage, income inequality, and other economic factors
- **Mental Health**
  includes stress, depression, access to services, safety
- **Chronic Disease**
  includes cardiovascular disease, diabetes, asthma, cancer, multiple chronic illnesses

2015 Healthy! Capital Counties Project Partners:

Barry-Eaton District Health Department

Eaton Rapids Medical Center

HGB
HAYES GREEN BEACH MEMORIAL HOSPITAL

Ingham County Health Department

McLaren
GREATER LANSING

PREVENTIVE HEALTH SERVICES
MID-MICHIGAN DISTRICT
HEALTH DEPARTMENT
CLINTON*MONTCALM*GRATIOT

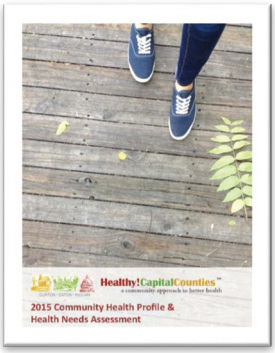
Sparrow

CLINTON * EATON * INGHAM

Healthy!CapitalCountiesSM
a community approach to better health

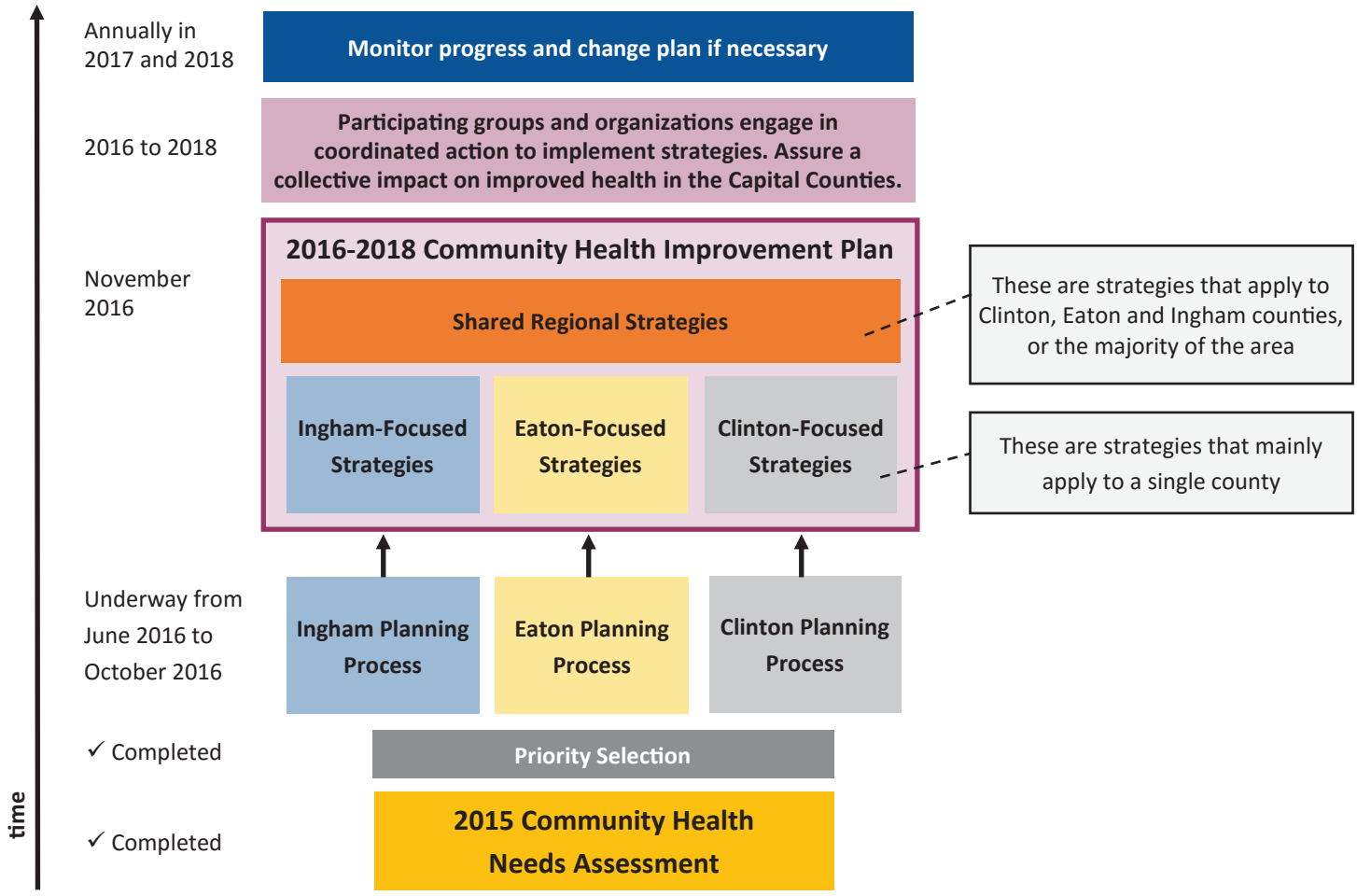
Community Health Improvement Planning Process

In October 2015, a group of partners came together to publish the 2015 Community Health Profile, a Community Health Needs Assessment of the Capital Area. The project gathered information, data, and input from community members throughout 2015. Based on this information, community stakeholders selected a set of priority health issues for Clinton, Eaton, and Ingham counties. These priorities help us to focus on what to work on as organizations, as counties, and as a region to achieve the best health for the people in our area. *See list of priority issues on next page.*



Click here to view the 2015 Community Health Profile report

Now, we are embarking on the next step — planning what we will do as a community to improve health. This is called the Community Health Improvement Plan, or CHIP. Because none of us can do this work alone, this plan will help us to work together to achieve the largest impact on health. Each county will coordinate a planning process for organizations and partners in their community. We will also identify which strategies are *regional* strategies, affecting residents in the majority of the area. The county plans plus the regional strategies together comprise the CHIP for Clinton, Eaton, and Ingham counties. It will be possible for people to view the entirety of the plan if they are concerned about the region, or just to focus in on a single county if desired. Each health department will ensure that efforts are monitored and evaluated each year to change plans, if necessary.



Priority Areas for the Capital Counties:

Access to **Quality Healthcare** and Access to **Primary Healthcare Providers**

People need the highest quality healthcare possible that is safe, effective, appropriate, and includes preventive care. People should have access to a primary care provider who is nearby, accessible, and affordable. People should have comprehensive healthcare coverage that protects them from financial distress and encourages healthy behaviors and prevention, and covers all aspects of health, including mental health and dental care.

Financial Stability (including poverty, living wage, income inequality, and other economic factors)

Health is intricately linked to wealth and income, from the top to the bottom of the income range. The more financial security our community has, the better our health will be. Children especially suffer from the effects of growing up in poverty. Adults need opportunities to earn wages that pay for their basic needs. As a community, we should aim to reduce income inequality, as the greater the income inequality, the worse the health of all.

Mental Health (includes stress, depression, access to services, safety)

People should live in a community that supports good mental health, which requires prevention, early intervention, prompt and appropriate treatment, and intensive help for those in crisis. People should have opportunities to manage stress in positive ways. Communities should be safe places where crime and violence are discouraged and prevented.

Chronic Disease (includes cardiovascular disease, diabetes, asthma, cancer, multiple chronic illnesses)

People suffer the greatest sickness and death from chronic diseases, which are often (but not always) preventable. Behaviors and social factors often predict who will be affected by these conditions. People need access to effective, appropriate care for chronic disease, from childhood through adulthood. This care should include evidence-based prevention and treatment strategies. Our communities, schools, and workplaces should be designed to help us choose the healthy choice. People should be connected with supports to assure they can make behavioral changes to improve their health.

How to become involved:

We welcome broad community input and participation into the community health improvement planning processes. Visit our website at www.healthycapitalcounties.org/ for continuing updates.

For Ingham County:

Please contact Janine Sinno, Ph.D at jsinno@ingham.org for more information on the process for Ingham County.

For Eaton County:

Please contact Susan Peters, DVM, MPH at speters@bedhd.org for more information on the process for Eaton County.

For Clinton County:

Please contact Marcus Cheatham, Ph.D at mcheatham@mmdhd.org for more information on the process for Clinton County.

What if we serve more than one county? What if we serve all three?

We recognize that many organizations and groups are concerned with health in more than one county — that's why we are planning a shared regional strategy portion of the CHIP. You may participate in all of the processes if you wish, or just one. The health departments in each county will compare their plans and assure that those strategies relevant across the counties appear as regional strategies.

The CHIP Process is facilitated by:

Barry-Eaton District Health Department
Be Active • Be Safe • Be Healthy

Ingham County Health Department

Mid-Michigan District Health Department

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Mental Health

Goal/Strategy Statement #1:	Provide more mental & behavioral health services

Objective #1:	Increase provider availability and programs

Activity	Timeframe	Responsible Parties	Assets Available/ Resources Required	Anticipated Results or Products	Policy change needed?	Collaboration with outside organizations or alignment with other local/state/US priorities
1. Build in social work and mental health visits based on identified referrals from existing family practice visits	Immediately	Lisa Jackinchuck, LMSW		Provide immediate access to a mental health provider, eliminate the wait.	No	Barry Eaton District Health Department Pathways Community Health Workers, Community Mental Health
2. Expand number of ERMC social workers providing mental and behavioral health services	Immediately	Lisa Jackinchuck, LMSW	Cost of 3 full-time Social Workers	Increase access to mental health providers	No	
3. Create a dedicated service area for the mental and behavioral health program	Spring of 2018	Lisa Jackinchuck, LMSW	Cost to build the space in the new building	The space will be more private and more appropriate for the social work.	No	
4. Explore implementing tele-psychiatry within the Family Practice		Lisa Jackinchuck, LMSW		Assist patients requiring a higher level of mental health care	No	

Objective #2:	Increase staff education on mental health issues (clinical and non-clinical)

Activity	Timeframe	Responsible Parties	Assets Available/ Resources Required	Anticipated Results or Products	Policy change needed?	Collaboration with outside organizations or alignment with other local/state/US priorities
1. Promote and support ERMC staff in attending Mental Health First Aid trainings	Ongoing	Lindsay Peters, Director of Marketing	Cost to attend trainings	Increase the number of people who can help people showing symptoms of mental illness or in a mental health crisis	No	Community Mental Health, Eaton Rapids Health Alliance

Access to Primary Care Providers

Goal/Strategy Statement #1:	Increase access to primary care providers

Objective #1:	Develop the medical workforce

Activity	Timeframe	Responsible Parties	Assets Available/ Resources Required	Anticipated Results or Products	Policy change needed?	Collaboration with outside organizations or alignment with other local/state/US priorities
1. Host LCC College of Nursing and MSU College of Human Medicine and College of Nursing clinical rotations and high school job shadowing opportunities	Ongoing	Kris Allen, V.P. of Clinical Services		Educate future health care professionals	No	Michigan State University, Lansing Community College
2. Offer nursing scholarships	Annually	Lindsay Peters, Director of Marketing	$2,000/year	Assist students pursuing a career in nursing	No	Eaton Rapids High School, Springport High School

Objective #2:	Recruit and retain primary care physicians in the ERMC service area

Activity	Timeframe	Responsible Parties	Assets Available/ Resources Required	Anticipated Results or Products	Policy change needed?	Collaboration with outside organizations or alignment with other local/state/US priorities
1. Physician Liaison will attend physician recruitment events to promote Eaton County as a desirable worksite	Ongoing	Candy Parker, Physician Liaison		Attract primary care providers	No	Capital Area Health Alliance
2. Facilitate and support existing primary care providers in Eaton Rapids	Ongoing	Candy Parker, Physician Liaison		Better coordination of care	No	External primary care providers
3. Offer medical student loan repayment programs	Ongoing	Kris Allen, V.P. of Clinical Services		Attract primary care providers	No	

Objective #3:	Increase the availability of primary care providers

Activity	Timeframe	Responsible Parties	Assets Available/ Resources Required	Anticipated Results or Products	Policy change needed?	Collaboration with outside organizations or alignment with other local/state/US priorities
1. Change provider schedules to allow for 20 minute visits	Immediately	Kris Allen, V.P. of Clinical Services		Allows more patient visits per day per provider	No	
2. Change hours of operation to accommodate early morning and late appointments	2018	Kris Allen, V.P. of Clinical Services		Convenient appointment times available for patients	No	
3. Implement automatic transitional care appointments for patients discharged from inpatient unit	2017	Kris Allen, V.P. of Clinical Services		Follow up with a primary care provider within 7 days of discharge, decrease in the number of readmissions	No	
4. Increase medical assistant staffing	2017	Kris Allen, V.P. of Clinical Services		Accommodate more patients and improve workflow, decrease patient wait times	No	

Chronic Disease

Goal/Strategy Statement #1:	Better manage chronic disease

Objective #1:	Create a multi-disciplinary healthcare team to manage chronic disease in family practice patients

Activity	Timeframe	Responsible Parties	Assets Available/ Resources Required	Anticipated Results or Products	Policy change needed?	Collaboration with outside organizations or alignment with other local/state/US priorities
1. Build in chronic disease/healthy lifestyles 15 minute visits based on identified referrals from existing family practice visits	Immediately	Family Practice		Social Workers will help patients manage behaviors that impact chronic disease	No	BEDHD Pathways Community Health Workers
2. Hire an RN Care Coordinator	2017	Kris Allen, V.P. of Clinical Services and Jill Oesterle, RHC Manager	Cost of a full-time individual	Better management of wellness visits for Medical patients, coordination of care and connection to resources	No	Connect patients to outside resources such as Community Mental Health or the Barry Eaton District Health Department.

Goal/Strategy Statement #2:	Prevent chronic disease

Objective #1:	Decrease the number of people with two or more chronic diseases

Activity	Timeframe	Responsible Parties	Assets Available/ Resources Required	Anticipated Results or Products	Policy change needed?	Collaboration with outside organizations or alignment with other local/state/US priorities
1. Continue education programs (Second Grade Tours, health fairs, Girl Scout badges, Senior Center education series)	Ongoing	Lindsay Peters, Director of Marketing and managers		Spread education and awareness of health behaviors	No	Various community organizations
2. Continue to host and promote Eaton Rapids Medical Center Farmers Market	Ongoing	Leslie Neubecker-Czubko, RD and Lindsay Peters, Director of Marketing	Space and time	Fresh, local produce available in Eaton Rapids on a regular basis in the summer months	No	Eaton Rapids Health Alliance
3. Implement Prescription for Health Program in conjunction with the Eaton Rapids Medical Center Farmers Market to promote consumption of fresh fruits and vegetables	Implement for the 2017 Farmers Market season.	Leslie Neubecker-Czubko, RD and Lindsay Peters, Director of Marketing	The Barry-Eaton District Health Department has applied for a grant from the Health Endowment Fund and would fund this project if approved. $13,424	Increase nutrition education and the consumption of fresh, local produce.	No	Barry-Eaton District Health Department, ERMC Farmers Market, local primary care providers
4. Provide education to ERMC physicians and dietitians about Prescription for Health Program	Implement for the 2017 Farmers Market season.	Leslie Neubecker-Czubko, RD and Lindsay Peters, Director of Marketing		Increase nutrition education and the consumption of fresh, local produce.	No	Local primary care providers

Financial Stability

Goal/Strategy Statement #1:	Promote nutrition

Objective #1:	Make fresh, local produce available and affordable

Activity	Timeframe	Responsible Parties	Assets Available/ Resources Required	Anticipated Results or Products	Policy change needed?	Collaboration with outside organizations or alignment with other local/state/US priorities
1. Continue to accept and promote the use of Double Up Food Bucks and Project Fresh coupons and EBT machine at Eaton Rapids Medical Center Farmers Market	Annually during the Farmers Market season	Leslie Neubecker-Czubko, RD	Space and time	Increase the consumption of fresh, local produce among Bridge Card users	No	ERMC Farmers Market, Eaton Rapids Health Alliance
2. Organize the local Michigan Harvest Gathering food drive.	Annually in October and November	Leslie Neubecker-Czubko, RD		Help combat food insecurity	No	Heart & Hands, St. Vincent de Paul

Goal/Strategy Statement #2:	Attract residents and businesses to Eaton Rapids promote commercial investment and spur economic growth

Objective #1:	Participate in the Eaton Rapids Marketing Alliance

Activity	Timeframe	Responsible Parties	Assets Available/ Resources Required	Anticipated Results or Products	Policy change needed?	Collaboration with outside organizations or alignment with other local/state/US priorities
1. Financial and staff support to Eaton Rapids Marketing Alliance to promote business investment within the community	Ongoing	Lindsay Peters, Director of Marketing	$10,000/year and time	Economic development and growth, attract potential residents and business owners.	No	City of Eaton Rapids, Downtown Development Authority, Chamber of Commerce, Local Development & Finance Authority
2. Staff will provide technical assistance for Eaton Rapid's application to the Michigan Main Street Program	Due November 2016	Lindsay Peters, Director of Marketing	Time	Acceptance into the Michigan Main Street Program	No	City of Eaton Rapids, Downtown Development Authority, Chamber of Commerce, Local Development & Finance Authority
3. If the Eaton Rapids application to the Michigan Main Street Program is approved, ERMC will provide financial support to staff program	Potentially begins on January 1, 2017 and is renewed annually	Lindsay Peters, Director of Marketing	Time	Economic development and growth	No	Michigan Main Street

Access to Quality Health Care

Goal/Strategy Statement #1:	Improve and streamline processes

Objective #1:	Become ISO 900 Quality Management-certified from DNV GL

Activity	Timeframe	Responsible Parties	Assets Available/ Resources Required	Anticipated Results or Products	Policy change needed?	Collaboration with outside organizations or alignment with other local/state/US priorities
1. Achieve ISO certification to promote measurable quality improvement progress and documentation	Fall 2017	Hospital-wide	Lean training, ISO training	Streamlined processes, reduction of waste	No	DNV-GL accrediting body
2. Implementation of Document Committee to ensure standardization of facility forms and documents	Revise and approve all forms within 1 year, continue to meet as necessary	Document Control Committee, managers		Forms conform to the policies. Elimination of multiple and/or outdated versions of forms.	Internal	Work with external vendors to make sure forms adhere to the established guidelines.

Goal/Strategy Statement #2:	ERMC will focus on better managing pain patients

Objective #1:	Increase number of patients who answered “Always” to HCAHPS question 13 on inpatient and emergency patient sati

Activity	Timeframe	Responsible Parties	Assets Available/ Resources Required	Anticipated Results or Products	Policy change needed?	Collaboration with outside organizations or alignment with other local/state/US priorities
1. Participation in the MHA Keystone Pain Management Initiative	Calendar Year 2016, as well as BCBS Pay for Performance (P4P) Performance Program Years (April 1, 2015-March 31, 2016, as well as April 1, 2016-March 31, 2017)	Heather Schragg, Director, Patient Experience, Quality, Compliance, Risk		Educating patients and engaging them in their care will help communicate risks and better alternatives.	No	Michigan Health & Hospital Association (MHA) Keystone Center
2. Implement pain management contracts	Calendar Year 2016, as well as BCBS Pay for Performance (P4P) Performance Program Years (April 1, 2015-March 31, 2016, as well as April 1, 2016-March 31, 2017)	Heather Schragg, Director, Patient Experience, Quality, Compliance, Risk		Better manage drug-seeking behaviors. Make sure patients understand that pain is expected in some cases	Yes, internal	

Goal/Strategy Statement #3:	Better manage primary care patients

Objective #1:	Improve the quality of care in the Family Practice

Activity	Timeframe	Responsible Parties	Assets Available/ Resources Required	Anticipated Results or Products	Policy change needed?	Collaboration with outside organizations or alignment with other local/state/US priorities
1. Implement direct patient messaging to provider within the patient portal	2017	Kris Allen, V.P. of Clinical Services and Jill Oesterle, RHC Manager		Allow the patient to electronically communicate with a provider 24/7	No	
2. Dedicate an individual to focus on quality metrics required by insurance companies	Ongoing	Kris Allen, V.P. of Clinical Services and Jill Oesterle, RHC Manager		Maximize wellness programs and positively impact patient outcomes	No	
3. Dedicate an individual to focus on referrals.	2017	Kris Allen, V.P. of Clinical Services and Jill Oesterle, RHC Manager		Connect patients to specialists in a timely manner	No	
4. Hire an RN Care Coordinator	2017	Kris Allen, V.P. of Clinical Services and Jill Oesterle, RHC Manager	Cost of a full-time individual	Better management of wellness visits for Medical patients, coordination of care and connection to resources	No	Connect patients to outside resources such as Community Mental Health or the Barry Eaton District Health Department.