



Potentially Preventable Hospitalizations Project Report: Year 3

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Tacoma-Pierce County
Health Department
Healthy People in Healthy Communities

Executive Summary

Potentially preventable hospitalizations (PPH) occur when someone is hospitalized for something that could have been avoided with proper primary care. Often these hospitalizations stem from chronic conditions (e.g. diabetes, heart disease) or communicable diseases like flu or pneumonia. It's possible to prevent many of these hospitalizations with regular healthcare visits and/or immunizations.

In 2017, the Washington State Office of Financial Management (OFM) released a report detailing rates of PPH across the state. The report, based on data from the U.S. Agency for Healthcare Research (AHRQ), uncovered the highest PPH rates in six zip codes within the 27th and 29th legislative districts. The zip codes – 98404, 98405, 98408 (27th legislative district) and 98409, 98418, 98444 (29th legislative district) all fall within Pierce County.

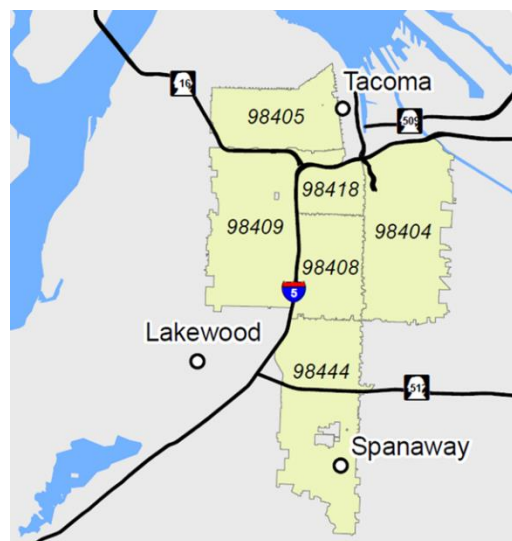


Figure 1: Map of the original PPH target zip codes

Upon receiving the report, Tacoma-Pierce County Health Department (TPCHD) assembled a team to address PPH in the target zip codes. Since then, the PPH project, which officially launched in 2018, has grown to include local health systems, provider organizations, and community-based organizations. We aim to reduce the rates of PPH in our target zip codes, with a goal of improving health outcomes and reducing healthcare costs.

PPH Project Goals		
Immunization	Screening, Brief Intervention, Referral to Treatment (SBIRT)	Improving Heart Failure
Increase flu and bacterial pneumonia immunization rates.	Increase number of patients screened and referred to treatment.	Unite PPH partners and stakeholders to address heart failure in Pierce County.
Increase access to vaccines.	Increase resources available in 6 PPH zip codes.	Increase alignment of care coordination across health systems.
Encourage use of Washington State Immunization Information System (WAIIS).	Provide prevention education about tobacco, alcohol, other drugs, and depression.	Support wide-reaching education and concentrated patient interventions to reduce heart failure.

Year 3 Accomplishments

Immunizations

- Provided flu vaccine to our PPH partner health centers and for community-based flu clinics which serve people living homeless.
- Supported 17 TPCHD community-based flu clinics (12 drive-through, five serving people living homeless).
- Incorporated infrastructure and lessons learned from flu clinics into COVID-19 vaccine delivery planning.

Screening, Brief Intervention, and Refer to Treatment (SBIRT)

- Conducted an SBIRT training for 37 Tacoma Public School counselors and teachers.
- Developed and promoted the TPCHD provider Refer to Treatment resource page, a comprehensive list of behavioral health resources in Pierce County.
- Launched Freedom from Nicotine Dependence, a virtual tobacco cessation support group to serve as a referral destination for PPH partners and local providers.

Improving Heart Failure

- Hosted three PPH Learning Collaboratives, educating 135 unique individuals from 64 different organizations between March and May.
- Launched a Community Health Worker (CHW) pilot program to provide care coordination to high risk patients with heart failure.

Year 3 Challenges and Lessons

- COVID-19 response limited the time, resources, and capacity of our constituents because it was a top priority for TPCHD and PPH partners.
- Due to COVID-19 and shifting priorities at the state level, 2019 Comprehensive Hospital Abstract Reporting System (CHARS) data was not available until 2021. We rely on this data to evaluate changes to PPH in the region, making it difficult for us to make up-to-date decisions based on that dataset during 2020.
- Many of our initiatives moved to a virtual setting to accommodate social distancing. While virtual sessions may be more convenient for some people, some participants noted a preference for in-person events; virtual events may even be a barrier for people with limited access to technology.

What's Next in Year 4?

While the exact implications are yet to be known, we anticipate the COVID-19 pandemic will have a considerable effect on chronic conditions, health outcomes, and the rate of potentially preventable hospitalizations. In the upcoming year we will maintain our current strategies while also staying attuned to the emerging needs in our community. TPCHD and the PPH project will:

- Collaborate with community partners to continue trainings on SBIRT, heart disease, and patient-centered care.
- Supply immunization equipment to partner agencies as needed.
- Cultivate a CHW network with special focus on patients with heart failure.
- Develop an infrastructure for analyzing all-payer claims data to share costs and data with partner agencies.
- Evaluate the impact of previous and ongoing PPH initiatives.
- Work closely with TPCHD's Communities of Focus initiative to center health equity in our work and reduce health disparities.
- Expand to people living in an additional two zip codes: 98439 and 98498.

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Introduction

Potentially preventable hospitalizations (PPH) occur when someone is hospitalized for something that could have been avoided with proper primary care. Often these hospitalizations stem from chronic conditions (e.g. diabetes, heart disease) or communicable diseases like flu or pneumonia. It's possible to prevent many of these hospitalizations with regular healthcare visits and/or immunizations.

In 2017, the Washington State Office of Financial Management (OFM) released a report detailing rates of PPH across the state. [The report](#), based on data from the U.S. Agency for Healthcare Research (AHRQ), uncovered the highest PPH rates in six zip codes within the 27th and 29th legislative districts. The zip codes – 98404, 98405, 98408 (27th legislative district) and 98409, 98418, 98444 (29th legislative district) all fall within Pierce County.

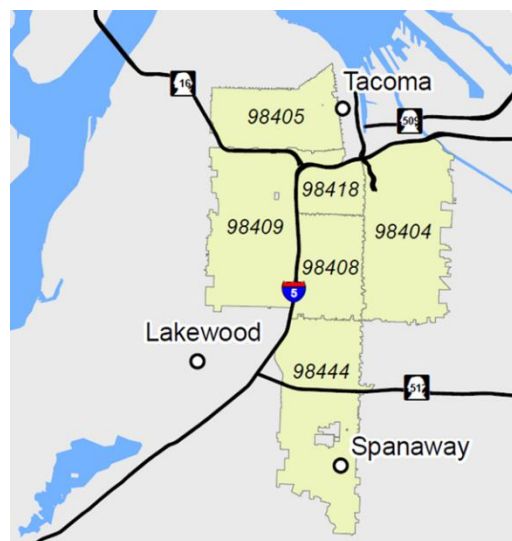


Figure1: Map of the original PPH target zip codes

Upon receiving the report, Tacoma-Pierce County Health Department (TPCHD) formed a unique strike team of local healthcare leaders to address PPH in the target zip codes. Since then, the PPH project, which officially launched in 2018, has grown to include local health systems, provider organizations, and community-based organizations (see Table 1 for participant list). The five participating healthcare organizations represent all 14 of the primary care locations in the PPH target zip codes. Our team works in concert to improve PPH contributing factors, like insufficient vaccination rates and gaps in the care continuum. We aim to reduce the rates of PPH in our target zip codes, with a goal of improving health outcomes and reducing healthcare costs.

Table 1: PPH Steering Committee Members

PPH Participant	Role
Tacoma-Pierce County Health Department	Convener
MultiCare Health System	Partner
Kaiser Permanente	Partner
Virginia Mason Franciscan Health	Partner
Sea Mar	Partner
Community Health Centers (CHC)	Partner
Korean Women's Association (KWA)	Contractor
Elevate Health	Contractor
Heidi Henson	Contractor

PPH data update

The OFM findings were based on AHRQs Prevention Quality Indicators (PQI) from 2013-2015, and prior project reports have used that period as a baseline. Starting last year, our reports have used 2016-2018 data as a baseline as it represents a more recent time period and better aligns with project implementation, which began in 2018. In addition, AHRQ data depend on ICD codes, which transitioned from ICD-9 to ICD-10 diagnosis codes in October 2015. We have chosen the following as primary indicators of interest due to their high contribution to preventable hospitalizations and their potential responsiveness to intervention: overall PPH (PQI 90), PPH due to bacterial pneumonia (PQI 11), and PPH due to congestive heart failure (PQI 08).

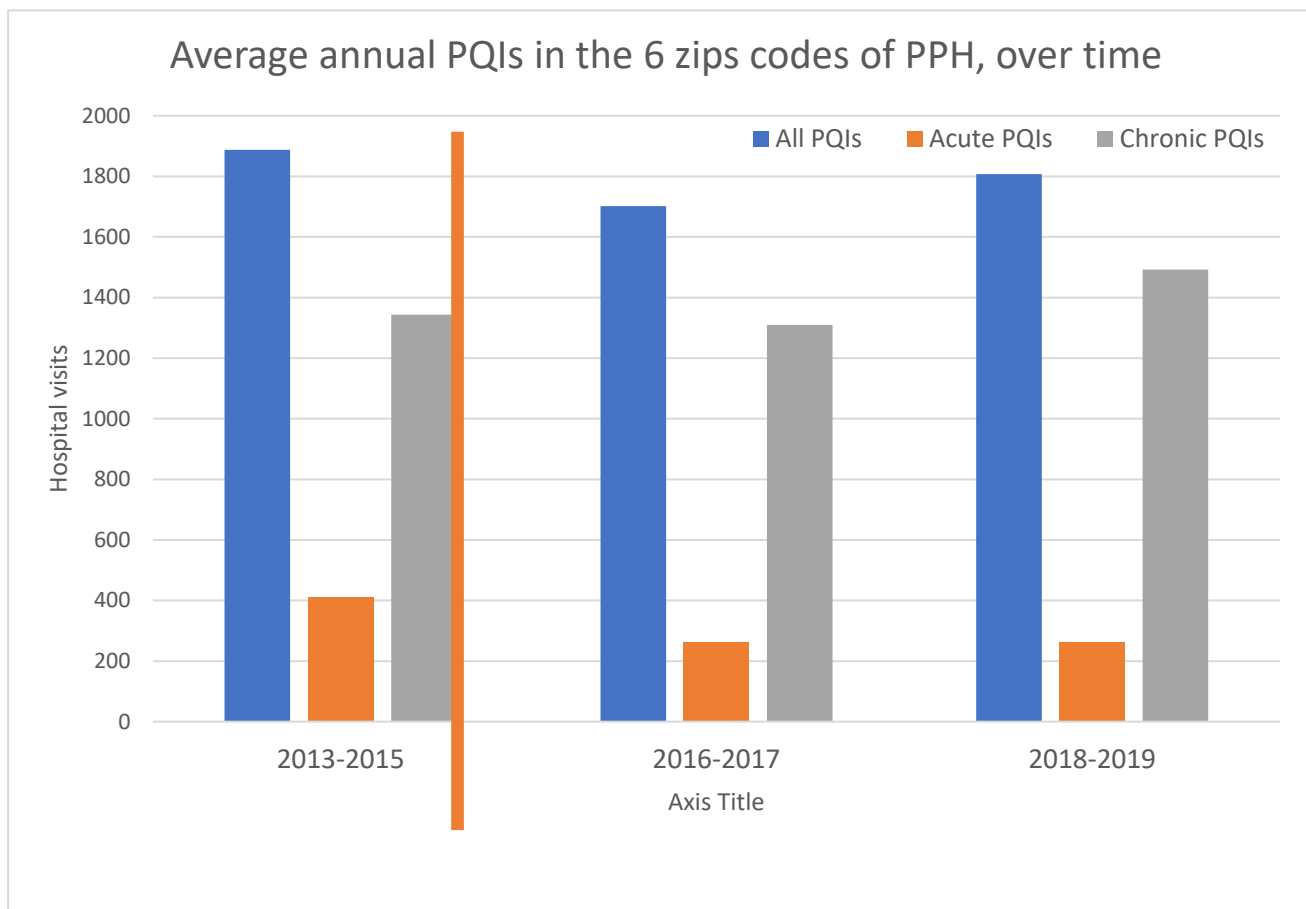


Figure 2: Average annual PQIs, composite PPH zip codes. Note that ICD codes changed in 2015 from ICD9 to ICD10. They are not directly comparable to future analyses.

The total number of PQIs has increased slightly since 2016. However, if parsed further, Acute PQIs remained relatively constant or declining, while Chronic PQIs – which include heart failure, diabetes-related PQIs, and COPD/asthma in older adults – appear to have increased slightly.

We have also broken down the data by individual PQIs (below). Improving heart failure has been a major focus of the PPH project given the disproportionately high number of congestive heart failure (PQI 08) hospital visits, compared to other PQIs. As with previous years, congestive heart failure potentially

preventable hospitalizations increased from 2018 to 2019, indicating it should remain a focal point of the PPH project. Chronic Obstructive Pulmonary Disease (COPD)/asthma in older adults (PQI 05) is the second most common PQI. Although it has typically trended downward, the PPH project continues to address these hospitalizations through our SBIRT strategy and nicotine cessation initiatives.

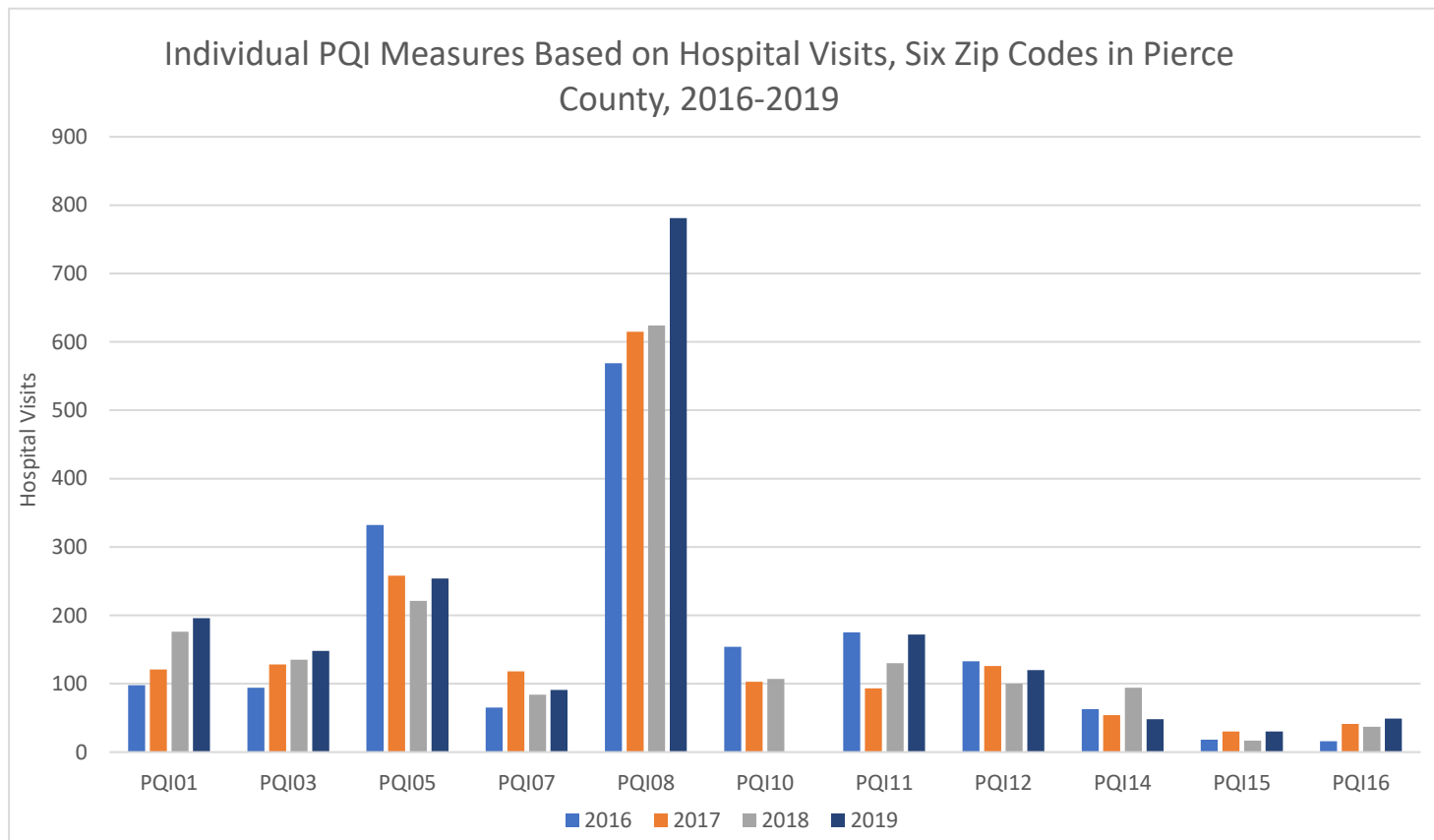


Figure 3: Individual PQI measures based on hospital visits, composite of size PPH zip codes, 2016-2019.

While it is important that we track this data over time, it will be difficult to link any current changes in CHARS data to the PPH program directly, due in part to the first two project years being largely developmental. The COVID-19 pandemic is an additional factor that will likely affect PQI data. We will see the initial impact of the pandemic in the 2020 data, which should be available by fall of this year.

Although the overarching goals of the PPH project have remained consistent since 2018, strategies and initiatives have evolved to ensure our efforts continually align with target region’s strengths and challenges. Each project year’s work summary is outlined in Table 2 (below). PPH project goals became even more important during COVID-19. Preventing avoidable hospitalizations frees up hospital capacity for COVID-19 patients or for those who require non-elective procedures. Capacity was imperative early in the pandemic when many hospitals were struggling to accommodate a surge in COVID-19 cases. Furthermore, the PPH project focuses on individuals with chronic conditions, whom we know are at a higher risk of COVID-19 complications. For example, according to the CDC, people with heart conditions, chronic lung diseases, smoking, or substance use disorders can be more likely to get severely ill from COVID-19. The PPH project works to prevent or improve all these conditions.

The remainder of this report will detail PPH Year 3.0’s primary focus areas (Immunizations, SBIRT, and Improving Heart Failure), as well as the individual initiatives within each strategy.

Table 2: PPH Project Work Summary

Year 1—July 2018-June 2019	Year 2—July 2019-June 2020	Year 3—July 2020-June 2021	Year 4 – July 2021-June 2022
Distributed bacterial pneumonia and influenza vaccines.	Increased access to vaccines through community immunization clinics.	Offered a virtual tobacco cessation support group to serve as a referral destination for PPH partners and local providers.	Collaborate with community partners to provide trainings on SBIRT, heart disease, and patient-centered care.
Trained community partners in immunizations and WAIS.	Conducted 5 additional SBIRT/MI trainings for community providers and staff.	Supported efforts to improve heart failure with free knowledge- and skill-building trainings.	Support TPCHD and PPH partner’s pneumococcal, influenza, and COVID-19 immunization efforts.
Assessed community partner agencies’ use of screening, brief intervention, and referral to treatment (SBIRT) and motivational interviewing (MI).	Learned about community partners’ use of data.	Launched a community health workers pilot program to provide specialized care for heart failure patients.	Cultivate a CHW network, focused on patients with heart failure.
Conducted 2 SBIRT/MI trainings for community providers and staff.	Worked on ways to share data across health systems to improve patient care and care coordination.	Contributed to vaccine distribution and assisted with TPCHD immunization efforts.	Develop an infrastructure for analyzing all-payer claims data to share costs and data with partner agencies.
		Encouraged data sharing across health systems to improve patient care and care coordination.	Evaluate the impact of previous and ongoing PPH initiatives.
		Created a Refer to Treatment webpage to simplify the referral to treatment stage of SBIRT for county providers.	Work closely with TPCHD’s Communities of Focus initiative to center health equity and reduce health disparities

Strategies

I. Immunizations

Bacterial pneumonia hospitalizations can be prevented through vaccination. Since 2018, the PPH project has worked to improve rates of pneumococcal and influenza immunizations in Pierce County. This year, we focused on increasing access to bacterial pneumonia, influenza (flu), and COVID-19 vaccines for community members living in PPH zip codes, including uninsured and under-insured adults as well as those experiencing homelessness and living in congregate settings.

Immunization Goals

- Increase flu and bacterial pneumonia immunization rates.
- Increase access to vaccines.
- Encourage use of WAIS.

Accomplishments

- Provided flu vaccine to our PPH partner health centers and for community-based flu clinics which serve people living homeless.
- Supported 17 TPCHD community-based flu clinics (12 drive-through, five serving people living homeless).
- Incorporated infrastructure and lessons learned from flu clinics into COVID-19 vaccine delivery planning. Staff also served as experts in providing vaccine-related educational materials and responded to community requests for flu clinics.
- Provided immunizations coolers, temperature logs, and an immunization freezer to community partners so that they could hold off-site community-based immunization clinics for flu, bacterial pneumonia, and COVID-19 vaccine.

Challenges and Lessons

- Washington state does not require providers and pharmacies to enter adult vaccine information into the statewide database (WAIS) which makes it difficult for providers to know if an adult patient is up to date on immunization.
- COVID-19 vaccines provided an opportunity for health care providers to enter adult immunizations into WAIS either manually or via data transfer.

What's Next in Year 4?

PPH will continue to provide pneumococcal and influenza vaccines for un- and under-insured people, as well as people living homeless. PPH will continue to provide COVID-19 vaccine until there is no longer a need in our communities. As an ongoing effort, the project will encourage and support partners in using WAIS for documenting adult immunizations.

II. SBIRT

Managing a chronic health condition, like diabetes, heart failure, and chronic obstructive pulmonary disease (COPD), can require commitment and strict adherence to a health action plan. Individuals with substance use or mental health issues may have more difficulty managing their chronic condition, which can lead to worsening health outcomes and preventable hospitalizations.

In response, we have worked to expand the use of screening, brief intervention, and referral to treatment (SBIRT), an evidence-based approach to identifying and referring a patient to substance or mental health services. In previous years we laid a foundation to SBIRT utilization by assessing our partners' existing screening and referral practices; facilitating SBIRT and motivational interviewing (MI) trainings; and evaluating improvements in SBIRT-related knowledge among training participants.

SBIRT and MI Goals

Increase number of patients screened and referred to treatment.

Increase resources available in the 6 PPH zip codes.

Provide prevention education about tobacco, alcohol, other drugs, and depression.

This year, we offered new tools and additional trainings so that service providers may fully leverage the advantages of SBIRT. For example, after learning that providers found value in SBIRT but had difficulty knowing where to refer a patient who screened positively for mental health or substance use needs, we created the Refer to Treatment webpage. The Refer to Treatment webpage is a comprehensive and sortable list of behavioral health providers in Pierce County; it includes contact information and zip code for each resource and can be readily accessed on our website by providers or the general public. Additionally, we launched our own weekly tobacco cessation support group. We advertised the free, virtual group to our PPH partners so that providers can easily refer patients looking for cessation services.

In continued partnership with Korean Women's Association (KWA), the PPH project hosted additional SBIRT/MI trainings, this time in the context of working with heart failure patients. The training was relevant for previous training participants and for those entirely new to SBIRT.

Accomplishments

- Conducted an SBIRT training for 37 TPS counselors and teachers.
- Assessed organizational use of SBIRT to understand improvements and help guide technical assistance and support to our partners
- Created the TPCHD provider Refer to Treatment resource page, a comprehensive list of behavioral health resources in Pierce County.
- Launched Freedom from Nicotine Dependence, a virtual tobacco cessation support group to serve as a referral destination for PPH partners and local providers.
- Conducted the inaugural Ask, Advise & Refer Brief Intervention Training to teach providers best practices related to nicotine cessation interventions.
- Planned additional training on mental health brief interventions (scheduled for June 17, 2021); over 100 service providers have registered as of May 26.

Challenges and Lessons

- We initially planned to train providers to host their own nicotine cessation support groups. However, as a result of the pandemic, providers were engrossed with COVID-19 response and in-person meetings/provider-led groups were not feasible.

- To date, Freedom from Nicotine Dependence participation has been low (albeit consistent). Reduced in-person care has limited the reach of traditional marketing methods (e.g. flyers and brochures), making it difficult to advertise the support group directly to patients in a clinic setting.

What's Next in Year 4?

We are continuing to refine our SBIRT initiatives by expanding our reach and improving the accessibility of our resources. We will continue hosting the Freedom from Nicotine Dependence support group (three times per week) and the Ask, Advise & Refer Brief Intervention Training (bimonthly or dependent on provider demand). We are also investigating the feasibility of making the Freedom from Nicotine Dependence support group accessible for individuals with limited English proficiency.

In addition to our nicotine cessation work, we will take two approaches to evaluate our ongoing SBIRT initiatives. First, we will conduct a follow-up survey to the PPH 2.0 trainings during which we trained over 200 healthcare staff and providers in SBIRT and MI. This post-survey will allow us to measure the longer-term impacts of those 2019 trainings. Secondly, we will conduct a third SBIRT organizational self-assessment (previously conducted in 2018 and 2019).

Finally, we recognize that in the aftermath of the COVID-19 pandemic, behavioral health needs may become more prevalent. We must also be cognizant that there is a shortage of Black, Indigenous and People of Color (BIPOC) behavioral health providers. With these concerns in mind, we will collaborate with TPCHD colleagues and community partners as we consider ways to assess the cultural responsiveness of Pierce County behavioral health services.

III. Improving Heart Failure

At the culmination of PPH Year 2.0, Comprehensive Hospital Abstract Reporting System (CHARS) hospital discharge data showed that potentially preventable hospitalizations were increasing among patients with heart failure. In response, we have launched several heart failure-specific initiatives over the past year.

Given that individuals with heart failure are not always well established with a medical provider, more proximal service providers (i.e. community health workers, patient navigators, etc.) may be better able to counsel patients about their condition. These workers have an important role in encouraging behavior change or medical treatment but are often unequipped to do so. To improve heart failure-related knowledge and skills among community service providers, we partnered with KWA to design and host four learning collaboratives. These events were free, virtual, and open to all interested service providers. Participants learned about heart disease basics, healthy action planning, motivational interviewing, SBIRT, and the impact of social needs on heart disease patients. As of the May Learning Collaborative, more than 60 people have participated in each session. Registrants represent more than 20 zip codes, including all six of the project's target areas.

Improving Heart Failure Goals

Unite PPH partners and stakeholders.

Increase alignment of care coordination across health systems.

Support education and patient interventions to reduce heart failure.

Learning Collaborative Topics

- **March:** Heart Disease & COVID-19. Culturally Responsive and Trauma-Informed Care
- **April:** Healthy Action Plan for Heart Disease Patients, using Motivational Interviewing
- **May:** Social Determinants of Health Care Coordination for Heart Disease Patients
- **June:** Mental Health Brief Interventions for Heart Disease Patients (*scheduled for June 17th, 2021*)

“One of the most interesting and helpful sessions I[‘ve] attended.”

– March Learning Collaborative Participant

The March and April Learning Collaboratives were extremely well-received with over 99% of respondents noting they were satisfied or very satisfied with the training (0% were unsatisfied to any degree). Participants especially enjoyed the collaborative environment, with one participant stating: “[I] liked how education was combined with group discussion. [I] felt like we all have stake in this, and our own experiences can help us educate others.”

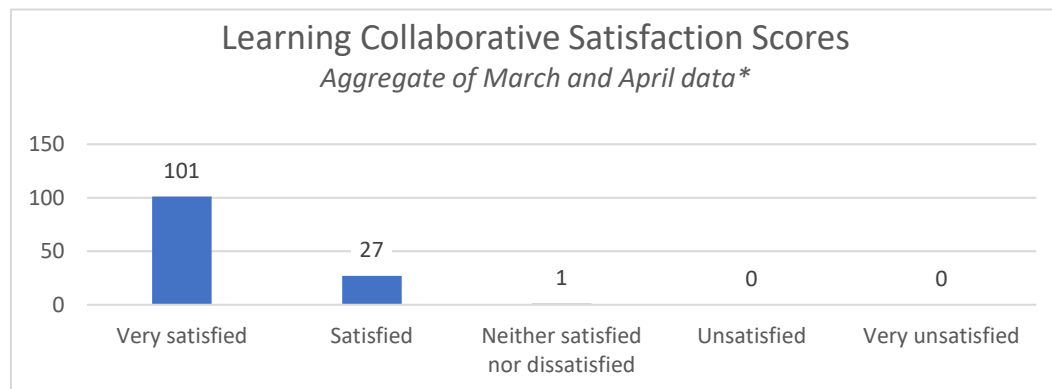


Figure 4: PPH Learning Collaborative Satisfaction Scores (March and April 2021)

*May Learning Collaborative data has not been analyzed yet.

The Learning Collaboratives increased participants' knowledge in both March and April (May Learning Collaborative results have not yet been analyzed). Most knowledge questions were “select all that apply,” meaning it was possible to receive partial credit (0% accuracy would mean they did not select any of the correct answers and selected all the incorrect answers). Average accuracy improved for all knowledge questions; detailed results from March are below. As an example, when asked to select the different types of heart disease, the average person received a 76% credit prior to the Learning Collaborative. After the session, average accuracy increased to nearly 90%. Results indicate that many participants were somewhat familiar with the subject matter, but still benefited from the training.

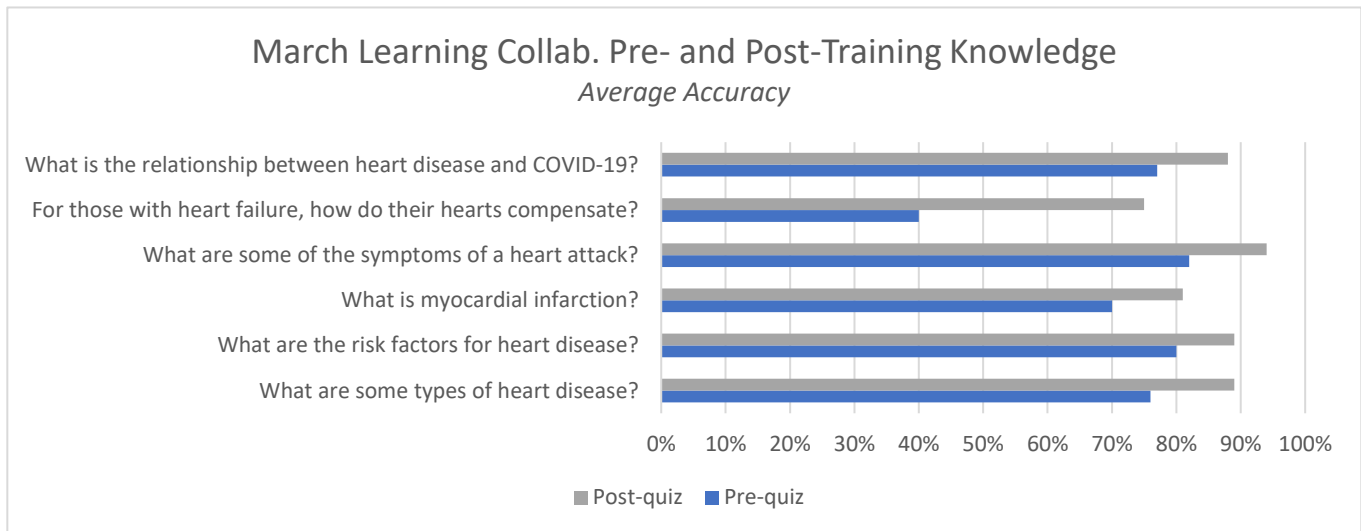


Figure 5: March Learning Collaborative Pre- and Post- Training Knowledge, Average Accuracy

While the Learning Collaboratives offered broad sweeping education to a large group of providers, we also launched a more concentrated intervention for high-risk heart failure patients already connected to a medical provider. In partnership with Elevate Health, we started a Community Health Worker (CHW) pilot program in which a physician refers eligible heart failure patients to the CHW, who then works closely with the patients to reduce their barriers to care. This program launched in April 2021 and is ongoing.

Accomplishments

- Hosted three PPH Learning Collaboratives, educating 135 unique individuals from 64 different organizations between March and May 2021.
- Launched a Community Health Worker (CHW) pilot program to provide care coordination to high risk patients with heart failure.
- Convened and engaged a workgroup of primary care providers and cardiologists to develop solutions to address rising PPH due to heart failure. Our team collected qualitative data from workgroup members about care management and coordination for patients with HF and presented these data back to the group to facilitate learning and inform ongoing, collaborative work.
- Engaged community partners to regularly submit data on Third Next Available Appointment (TNAA); created and shared a quarterly TNAA summary report to help identify areas for improvement

“I have been learning a lot from this training that I will put into practice with the clients.”

– April Learning Collaborative Participant

Challenges and Lessons

- Limited time and COVID-19 priorities made it difficult for some providers to attend the learning collaboratives.

- While virtual sessions may be more convenient for some people, some participants noted a preference for in-person events.
- An online learning collaborative landing page with recorded presentations and resource links will allow attendees, and those who missed the sessions, to easily access materials.

What's Next in Year 4?

Both initiatives are ongoing and will continue into year 4 of the PPH project. Learning Collaboratives, in partnership with KWA, will occur monthly. The subject matter will remain related to SBIRT, heart disease, and patient-centered care, but the exact topic will be dependent on participant feedback. Relatedly, the PPH Steering Committee is evaluating a proposal from KWA and the Northwest Addiction Technology Transfer Center to offer a four-session series on SBIRT/MI, which would provide continuing education credits for participants.

The CHW pilot program will continue and may expand to include additional PPH provider organizations. We are also evaluating potential partnerships between TPCHD, Elevate Health, and other community partners to better align with existing CHW initiatives in Pierce County.

Impact of COVID-19

COVID-19 has affected nearly every aspect of life and the PPH project is no exception. We experienced many challenges stemming from the pandemic, some of which are listed below.

- **Competing priorities for PPH partners:** Naturally, COVID-19 response and vaccinations became top priority for providers. As a result, our partners had reduced capacity to engage in PPH initiatives.
- **TPCHD capacity:** Similarly, many health department employees were deployed for COVID-19 response. There is some overlap between COVID-19 and PPH initiatives (e.g. immunization efforts), but the number of people and hours dedicated explicitly to the PPH project was reduced.
- **Virtual learning environment:** Many of our initiatives were initially planned as in-person events but moved to a virtual setting during the pandemic. This allowed for broader participation as Zoom can accommodate 300 guests (more than the TPCHD auditorium) and does not require travel. However, the virtual environment does not allow for in-person networking, which was originally a crucial aspect of some of our initiatives (e.g. SBIRT trainings, Improving Heart Failure Learning Collaboratives).
- **Data delays:** We depend on CHARS data to evaluate changes to potentially preventable hospitalizations in the region. Due to COVID-19 and shifting priorities at the state level, we did not have access to 2019 CHARS data until 2021 – making it difficult for us to make up-to-date decisions based on that dataset during 2020. We expect to receive 2020 CHARS data by fall of 2021.

The challenges described above are specific to PPH project administration. COVID-19 has had a broader influence on health and access to healthcare, which may impact potentially preventable hospitalizations. For example, we learned in our [Pierce County COVID-19 Health Equity Assessment](#) that many

communities faced new or exacerbated barriers to both behavioral and physical healthcare. Nearly all the engaged communities (including Black/African American, Native Hawaiian or Other Pacific Islander, Latinx, and Communities of Focus) identified worsening mental health and an urgent demand for basic needs assistance. Fear of COVID-19 exposure also emerged as a common barrier to care. An inability (or unwillingness) to access necessary or preventative care throughout the past year could lead to poorer health status and more hospitalizations in the future.

In relatively few ways, the COVID-19 pandemic may have had some positive influence on certain areas of health. For example, a positive side effect of social distancing is that flu activity in Pierce County remained low (sometimes extremely or unusually low) throughout the 2020-2021 flu season. Such low flu incidence may help reduce some potentially preventable hospitalizations.

Summary and What's Next

During year 3, the PPH project:

- Supported pneumococcal, influenza, and COVID-19 immunization efforts.
- Improved the practicality of SBIRT by creating new and identifying existing behavioral health resources.
- Produced high-level, wide-reaching trainings on improving heart failure, and launched an individualized CHW pilot for patients with heart disease.

With funding earmarked in the Washington state budget for the 2021-23 biennium, we look forward to continuing and refining our efforts over the next two years expanding the PPH project to include two additional zip codes: 98498 and 98439.

While the exact implications are yet to be known, we anticipate the COVID-19 pandemic will have a considerable effect on chronic conditions, health outcomes, and the rate of potentially preventable hospitalizations. In the upcoming year we will maintain our current strategies while also staying attune to the emerging needs in our community. TPCHD and the PPH project will:

- Collaborate with community partners to provide trainings on SBIRT, heart disease, and patient-centered care.
- Supply immunization equipment to partner agencies as needed.
- Cultivate a CHW network with a special focus on patients with heart failure.
- Develop an infrastructure for analyzing all-payer claims data to share costs and data with partner agencies.
- Evaluate the impact of previous and ongoing PPH initiatives.

Finally, there is considerable overlap between the PPH project's target region and TPCHD's [Communities of Focus](#), including zip codes 98404, 98409, 98439, 98444, and 98498 (see Figure 6 below). These areas have poorer health outcomes and lower life expectancy compared to adjacent zip codes. The PPH project will continue to work alongside the Communities of Focus initiative to promote health equity and reduce health disparities.

Figure 6: PPH zip code map, Year 4.

