

Covered California: Request for Input to Inform Refreshing Expectations Designed to Promote Accountability and Delivery System Improvements

Name: Joel Ervice

Organization: Regional Asthma Management and Prevention (RAMP), a project of the Public Health Institute

Contact E-Mail: joel@rampasthma.org

Phone: 510-285-5711

Covered California's Guiding Principles for Promoting Better Care and Delivery Reform

The following are proposed guiding principles for Covered California's efforts to assure its contracted QHP Issuers are held accountable for providing the right care and are promoting needed improvements in the delivery system.

1. Driven by the desire to meet two complementary and overlapping objectives:
 - a. Right Care/Accountability: Ensure our members receive the right care, at the right time, in the right setting, at the right price.
 - b. Delivery System Improvement: Promoting value-enhancing strategies that have the potential to reform the delivery system in the near and long term.
2. Seek to improve the health of the population, improve the experience of care, reduce the cost of care, reduce administrative burden, and reduce health care disparities.
3. Success will be assessed by outcomes, measured at the most appropriate level, in preference to adoption of specific strategies.
4. We will promote alignment with other purchasers as much as possible.
5. Consumers will have access to networks offered through the contracted QHP Issuers that are based on high quality and efficient providers.
6. Enrollees have the tools needed to be active consumers including both provider selection and shared clinical decision making.
7. Payment will increasingly be aligned with value and proven delivery models.
8. Variation in the delivery of quality care will be minimized by assuring that each provider meets minimum standards.

Please note your agreement or disagreement with the guiding principles and provide any questions, concerns, or suggested additions you may have.

RAMP supports these guiding principles and appreciates their comprehensiveness. We also applaud Covered California for including the reduction of health care disparities as an explicit principle.

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Suggestions for two of the principles follow:

- Principle 2: Alter to read, “Seek to improve the health of the population, improve the experience of care including the delivery of culturally-competent care, reduce the cost of care, reduce administrative burden, and reduce health care disparities.”
 - o Rationale: As California’s population continues to diversify, providing health care that understands and respects different cultural beliefs and practices will be an ever more important part of the care experience, and should be highlighted in the principle.
- Principle 8: Alter to read, “The delivery of quality care will be maximized, including reducing variation in care delivery by assuring each provider meets minimum quality standards.”
 - o Rationale: By focusing on minimizing variation through minimum standards, this principle sets a low care delivery bar.

Current QHP Issuer Contract Terms: Quality, Network Management, Delivery System Standards and Improvement Strategy (Attachment 7 – 2017-2020)

In the current Attachment 7 of the QHP Issuer Contract, Covered California aims to promote care that reduces excessive costs, minimizes unpredictable quality and reduces inefficiencies of the current system (<https://hbex.coveredca.com/insurance-companies/PDFs/QHP-Model-Contract-2017-2019-Amended-for-2017-and-2018.pdf>). Covered California also expects all contracted issuers to balance the need for provider accountability and transparency with the need to reduce administrative burden on providers. The requirements within Attachment 7 consist of the following focus areas:

- Article 1: Improving Care, Promoting Better Health and Lowering Costs: Ensuring networks are based on value, addressing high cost providers and high cost pharmaceuticals
- Article 2: Provision and Use of Data and Information for Quality of Care: Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers & Systems (CAHPS), Quality Rating System (QRS) reporting and IBM Watson data submissions
- Article 3: Reducing Health Disparities and Ensuring Health Equity: Increasing self-identification of race or ethnicity and measuring and narrowing disparities
- Article 4: Promoting Development and Use of Effective Care Models: Primary care provider (PCP) matching, promotion of patient-centered medical homes (PCMH) and integrated healthcare models (IHMs), supporting primary care through value-based payment, increasing mental and behavioral health integration with medical care, and using telehealth
- Article 5: Hospital Quality and Safety: Payment models to increase value, reducing hospital acquired conditions (HACs) and unnecessary C-Sections
- Article 6: Population Health: Preventive Health, Wellness and At-Risk Enrollee Support: Wellness services, community health, supporting at-risk enrollees, and diabetes prevention
- Article 7: Patient-Centered Information and Support: Price and quality transparency for enrollees, shared decision making, reducing overuse, and using the statewide provider directory
- Article 8: Payment Incentives to Promote Higher Value Care: Increasing value-based reimbursement
- Article 9: Accreditation

Please provide any overarching or specific feedback on the current Attachment 7 that we should consider as we approach the revision.

RAMP generally supports the Articles within Attachment 7.

We are particularly pleased the Attachment specifically addresses population health (including preventive health) as well as health disparities/health equity, since asthma is a significant issue in California. For example, per the California Health Interview Survey, 15.4% of Californians -- over 5.8 million people -- have been diagnosed with asthma. Among African Americans, 22% have been diagnosed compared to 17% of Whites (non-Latino). Properly addressing asthma requires strategies

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that are tailored to reduce health disparities and promote population health (including preventive health).

Contractual Expectation Domains and Strategies

Covered California is considering reorganizing the initiatives and strategies addressed in Attachment 7 into two broad domains with a total of 13 distinct individual strategies:

Right Care/Accountability: We are looking for more transparency into issuer oversight of care delivery, what kinds of problems are being found and how are they being addressed.

1. Chronic Care, General Health Care, and Access
2. Hospital Care
3. Major/Complex Care – Identification of High-Risk or High-Cost Individuals and Getting them the Right Care
4. Mental/Behavioral Health and Substance Use Disorder Treatment
5. Health Equity: Disparities in Healthcare
6. Preventive Services
7. Pharmacy Management

Delivery System Improvements: With these longer term efforts, we seek to redesign care delivery to be more effective in meeting the triple aim, reducing administrative burden, and reducing disparities.

8. Networks Based on Value (narrow or limited physician, hospital, and ancillary provider networks, Centers of Excellence)
9. Promotion of Effective Primary Care (PCP matching or assignment, patient-centered medical home or other models)
10. Promotion of Integrated Healthcare Models (IHMs) and Accountable Care Organizations (ACOs)
11. Alternate Sites of Care Delivery (e.g., telehealth, alternatives to emergency room use, retail clinics)
12. Consumer and Patient Engagement (e.g., quality and cost tools, personal health record, patient shared decision-making)
13. Population-based and Community Health Promotion Beyond Enrolled Population

NOTE: High level questions for input follow – for a detailed outline of questions and some specific issues regarding particular strategies see the Addendum: Detailed Questions – Contractual Expectation Domains and Strategies at the end of this survey.

A. Please comment on these domains as a way to reorganize Attachment 7.

RAMP is generally supportive of the proposed reorganization, particularly since the themes of the new domains are consistent with the current Attachment 7: Health Equity: Disparities in Healthcare; Preventive Services; and Population-Based and Community Health Promotion. As noted above, properly addressing the burden of asthma in California requires strategies tailored to reduce health disparities and promote prevention and population health.

D. Recognizing these strategies are all “priority” elements, we request your ranking of the 13 strategies from high to low priority for Covered California, looking ahead 2-5 years. If applicable, please include any other strategies identified in the previous question.

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| Strategy | Your Ranking for Covered California's Prioritization 2021-2023 Contract |
|--|---|
| | Rank from Highest to Lowest (1 to 13) |
| Chronic Care, General Health Care, and Access | |
| Hospital Care | |
| Major/Complex Care | |
| Mental/Behavioral Health and Substance Use Disorder Treatment | |
| Health Equity: Disparities in Healthcare | |
| Preventive Services | |
| Pharmacy Management | |
| Networks Based on Value | |
| Promotion of Effective Primary Care | |
| Promotion of Integrated Healthcare Models and Accountable Care Organizations | |
| Alternate Sites of Care Delivery | |
| Consumer and Patient Engagement | |
| Population-based and Community Health Promotion Beyond Enrolled Population | |
| Other: | |
| Other: | |
| Other: | |

RAMP disagrees with the inclusion of a ranking system for these different strategies. Given the complexity of California's health care needs and care system, ranking the different strategies is a far too blunt tool to yield helpful information. Since all of the strategies are deemed important for inclusion, Covered California should strive for excellence across all of them. A ranking system implies otherwise.

Addendum: Detailed Questions -- Contractual Expectation Domains and Strategies

In this section, please provide any comments or suggestions for us to consider in thinking about each strategy. If you have no comments or considerations for a strategy, please feel free to leave blank. Where relevant, please refer to and/or attach any relevant supporting or reference material.

3. Major/Complex Care – Identification of High-Risk or High-Cost Individuals and Getting them the Right Care

a. General comments/observations on this strategy for Covered California as an area of focus:

As noted in the current Attachment 7, Contractors must identify and proactively manage Enrollees with existing and newly diagnosed chronic conditions, including asthma. A related requirement is that Contractors provide care and network strategies that focus on supporting a proactive approach to At-Risk Enrollee intervention and care management.

RAMP requests the inclusion of asthma home visiting services as one of the required strategies for Enrollees with poorly controlled asthma. Asthma home visiting services are a well-documented intervention for improving health outcomes, lowering health care utilization costs, improving patient care, and reducing health care disparities.

Asthma home visiting services include asthma education, home environmental asthma trigger assessments, and home environmental trigger remediation by qualified professionals. Specifically:

- Asthma education means providing information about basic asthma facts, the use of medications, self-management techniques and self-monitoring skills, and actions to mitigate or control environmental exposures that exacerbate asthma symptoms.
- Environmental asthma trigger assessment means the identification of environmental asthma triggers commonly found in and around the home, including allergens and irritants. This assessment guides the self-management education about actions to mitigate or control environmental exposures as well as remediation activities.
- Home environmental trigger remediation means conducting specific actions to mitigate or control environmental exposures. Most home visiting programs provide minor to moderate environmental asthma trigger remediation, such as providing and putting on dust-proof mattress and pillow covers, providing products such as high-efficiency particulate air vacuums, asthma-friendly cleaning products, dehumidifiers and small air filters, and utilizing integrated pest management including performing minor repairs to the home's structure, such as patching cracks and small holes through which pests can enter.

The benefits of asthma education and environmental trigger remediation are well established. The Guidelines for the Diagnosis and Management of Asthma (EPR-3), developed by the National Institutes of Health, include four vital components for effective asthma management:¹

- Assessment of disease severity and control
- Comprehensive pharmacologic therapy
- Patient education

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- Environmental control measures to avoid or eliminate factors that contribute to asthma onset and severity

While the first two components are routinely addressed during medical visits, evidence indicates declining rates of patient education.ⁱⁱ Meanwhile, reducing environmental triggers in the home – where people spend the vast majority of their time – can be difficult to support from a distant clinic. That’s where asthma home visiting services come in.ⁱⁱⁱ Comprehensive in-home education and environmental interventions significantly reduce Emergency Department (ED) visits and associated costs, as well as missed days of school and work.^{iv} According to a study by America’s Health Insurance Plans (AHIP), health plan designs that support home-based asthma assessments and trigger remediation reduce ED visits and improve patient experiences.^v

Asthma home visiting services can save money too by significantly reducing the use of more expensive health care services. The national Community Preventive Services Task Force’s comprehensive, research-based assessment found cost-benefits from \$5.30 to \$14 per \$1 invested among home-based asthma interventions for children and adolescents.^{vi} OptimaHealth, a managed care organization, was awarded the EPA National Environmental Leadership Award in Asthma Management for a comprehensive home-based asthma care program that returned an estimated \$4.40 for every \$1 invested.^{vii} Among interventions that incorporated home visits into multifaceted asthma interventions, ROIs grew as high as \$23.75 for every \$1 spent.^{viii} While the cost-benefit evidence is stronger for interventions targeting children, adults may also benefit from such interventions.

Another reason these services are effective is that they are often provided by professionals especially qualified to support members that need help the most. For example, the Community Preventive Services Task Force specifically cites the value of community health workers (CHWs) in asthma interventions: “[I]t is beneficial to hire and train CHWs to implement this intervention for the purpose of reaching out to primarily low-income, ethnic minority populations. CHWs play an essential role in the implementation of interventions, bridging the gaps between underserved populations and researchers. Especially when they are from the same community, CHWs can connect culturally with local populations and build trusting relationships with clients and their families.”^{ix} Researchers Kim et al, share, “Interventions by [CHWs] appear to be effective when compared with alternatives... particularly when partnering with low-income, underserved, and racial and ethnic minority communities.”^x Of course, CHWs represent one type of professional that has successfully implemented asthma home visiting services. Depending on needs and capacities, MCOs can pick from a range of qualified professionals, both licensed and non-licensed, including community health workers, promotoras de salud, certified asthma educators, lay asthma educators, social workers, respiratory therapists, healthy homes specialists, nurses and others.

Asthma home visiting services can also support Contractors’ quality improvement initiatives. For example, one of Attachment 7’s measurement specifications included in Appendix 2 is the Asthma Medication Ratio, which assesses whether members are receiving the right ratio of controller medications to total asthma medications. During asthma home visits, staff can reinforce key educational messages provided during the clinic visit. These include messages about the importance of following prescribed medication regimens. Additionally, home visitors often excel at identifying barriers to medication compliance and helping the families overcome those barriers.

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Asthma home visiting services are not a new idea, and a variety of technical assistance and resources are available to assist Covered California and Contractors with implementing these services. RAMP would be happy to be a source of support moving forward.

5. Health Equity: Disparities in Healthcare

a. General comments/observations on this strategy for Covered California as an area of focus:

As mentioned earlier, RAMP fully supports the inclusion of health equity/health disparities as a Covered California priority. To reiterate one example, 22% of African Americans in California have been diagnosed with asthma compared to 17% of Whites (non-Latino) according to the California Health Interview Survey. Of course, asthma is but one health condition where disparities exist across different populations; it's critical Covered California maintains this important focus.

Moving forward, Covered California should maintain asthma as a measure selected for improvement as detailed in Article 3, Reducing Health Disparities and Ensuring Health Equity, in the current Attachment 7. The asthma-related measurement specifications included in Appendix 2 of Attachment 7 should also be maintained. Collectively, the asthma-related measured (e.g., asthma medication ratio, asthma-related hospitalizations, etc.) help provide a useful snapshot of the state of the asthma burden among Enrollees.

Improvement measures for all selected conditions should also continue to be reported by race/ethnicity and gender. Where not already doing so, Covered California should make improvement measures publicly available as expeditiously as possible at the Contractor level.

b. To what extent should Covered California and contracted issuers move or shift emphasis toward addressing “upstream” determinants of health? What areas do you think are relevant to specific attention on the part of issuers and providers?

Under Strategy 3 above, we recommend ways in which Contractors can better address asthma among Enrollees by providing education and addressing environmental asthma triggers in the home. However, Covered California and Contractors should also consider an even further upstream approach to housing. To start, it's well-documented that housing conditions play a significant role in health. Healthy homes are dry, clean, safe, well-ventilated, pest- and contaminant-free, well-maintained, and thermally controlled. Deficiencies in any of these areas can lead to adverse health impacts. For example:

- Indoor moisture and mold contribute to respiratory diseases, such as asthma;
- Inadequate ventilation is associated with an increased risk of respiratory symptoms, cardiovascular disease and cancer;
- Pests, such as cockroaches and rodents, are connected to a range of communicable and respiratory diseases;
- Improper heating and cooling create temperature extremes that can exacerbate illnesses or cause death; and,
- Stress from unhealthy housing conditions can have mental health impacts, including depression.

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The above factors that address housing quality are important. However, when addressing housing as a determinant of health, it's important Covered California and Contractors focus not just on housing quality but housing stability, which includes but is not limited to housing quality. Stable housing is central to communities having the secure jobs, high achieving schools, and the strong civic engagement needed to promote health. Housing is stable when tenants are protected from excessive rent increases and eviction. Housing is stable when homes are safe and well maintained. Housing is stable when housing costs are affordable (taking up no more than 30% of income). This stability is the foundation for healthy and equitable communities.

A lack of any one of these factors can erode the structures that promote health in communities, and this erosion inevitably has a disproportionate, harmful impact on communities of color. When tenants are not protected from excessive rent increases or eviction, then they are at increased risk of being displaced or becoming homeless which can negatively impact their jobs, education, and social supports. Employers, schools, and civic activity in a community are negatively impacted if their staff, students, and residents are constantly turning over. If housing is unsafe and tenants are trapped in unhealthy conditions, then they are at increased risk of a range of illnesses and injuries that can threaten job security or academic achievement due to missed work or school days and reduced productivity. If housing is unaffordable, then families have fewer resources for other health supportive activities such as health care, healthy foods, and recreation. This financial strain can cause additional stress that can harm both physical and mental health and, in the worst case, lead to displacement or homelessness.

We recognize the fact that Contractors engaging in very upstream approaches presents a variety of challenges, not the least of which is determining how a traditional health care stakeholder can get involved in a sector not traditionally associated with health care. However, examples from the field are emerging. For example, last year Kaiser Permanente committed \$200 million for affordable housing, and earlier this year purchased a building in Oakland for use as affordable housing. Housing stability is a topic Covered California and Contractors should further explore and advance.

13. Population-based and Community Health Promotion Beyond Enrolled Population

- a. General comments/observations on this strategy for Covered California as an area of focus:

The current contract language notes “promoting better health for Enrollees also requires [Contractor] engagement and promotion of community-wide initiatives that foster better health, healthier environments and the promotion of healthy behaviors across the community.” Several programs are listed as examples, including partnerships with public health departments and external health organizations providing services such as CalFresh.

We recommend adding language to encourage Contractors to support and connect Enrollees to housing weatherization programs. As mentioned above, it's well-documented that housing conditions play a significant role in health. Healthy homes are dry, clean, safe, well-ventilated, pest- and contaminant-free, well-maintained, and thermally controlled. Deficiencies in any of these areas can lead to adverse health impacts. For example:

- Indoor moisture and mold contribute to respiratory diseases, such as asthma;
- Inadequate ventilation is associated with an increased risk of respiratory symptoms, cardiovascular disease and cancer;

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- Pests, such as cockroaches and rodents, are connected to a range of communicable and respiratory diseases;
- Improper heating and cooling create temperature extremes that can exacerbate illnesses or cause death; and,
- Stress from unhealthy housing conditions can have mental health impacts, including depression.

In many ways, residential weatherization/energy efficiency (EE) programs aimed at reducing energy use and greenhouse gas emissions associated with climate change can improve housing conditions and health. Common EE measures such as adding or replacing insulation, air sealing, and improving heating, cooking and ventilations systems, can reduce humidity and moisture that contribute to mold and pest problems, remove unhealthy gasses and particulates in the indoor air, help stabilize temperatures, and create a more comfortable living environment overall.

With support from the California Department of Public Health Office of Health Equity and in partnership with Contra Costa Health Services, RAMP developed a guide¹ to inform health stakeholders about weatherization and EE programs and highlight examples of ways health stakeholders have successfully coordinated with EE programs to better connect those most in need with services to improve their housing conditions.

The connection between EE and health is backed up by scientific literature. Two systematic reviews of the academic literature studying the health impacts of EE improvements found significant health benefits from EE work. “HomeRx: The Health Benefits of Home Performance: A Review of the Current Evidence”² and “Occupant Health Benefits of Residential Energy Efficiency”³ found evidence that EE upgrades improved: reports of overall health; respiratory health, including reduced COPD symptoms and asthma-related symptoms, hospitalizations, and medication use; allergies, colds and sinus infections; headaches; blood pressure and other cardiovascular conditions; and mental health.

The reports also noted that several studies demonstrated improved housing conditions such as reduced radon, particulate matter and formaldehyde exposure which would reduce cancer and other health risks, although the health impacts of these reductions were not measured in these studies.

Perhaps most significant for health stakeholders, these reviews and studies point out that the health benefits of EE are the greatest among those with pre-existing health conditions linked to unhealthy housing, like asthma. By understanding which patients or clients benefit the most from housing improvements, health stakeholders are ideally situated to serve as a bridge connecting those patients and clients to EE programs in their community.

¹ <http://www.rampasthma.org/D:Web%20Siteswww.rampasthma.org/wp-content/uploads/2018/12/Energy-Efficiency-and-Health-Guide-for-Public-Health-and-Health-Care-Professionals.pdf>

² https://www.energystar.gov/sites/default/files/asset/document/Home%20Rx%20The%20Health%20Benefits%20of%20Home%20Performance%20-%20A%20Review%20of%20the%20Current%20Evidence_FINAL.pdf

³ <https://e4thefuture.org/wp-content/uploads/2016/11/Occupant-Health-Benefits-Residential-EE.pdf>

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ⁱ The best practice guidelines, called the EPR 3 Guidelines on Asthma, were developed by an expert panel commissioned by the National Asthma Education and Prevention Program (NAEPP) Coordinating Committee, coordinated by the National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health. <https://www.nhlbi.nih.gov/health-topics/guidelines-for-diagnosis-management-of-asthma>. Accessed September 2018.

ⁱⁱ Lee MG, Cross KJ, Yang WY, Sutton BS, Jiroutek MR. Frequency of asthma education in primary care in the years 2007-2010. *The Journal of Asthma*. 2016;53:220-226.

ⁱⁱⁱ Health Resources in Action. Investing in Best Practices for Asthma: A Business Case. 2010. http://asthmaregionalcouncil.org/wp-content/uploads/2014/02/2010_Investing-in-Best-Practices-for-Asthma-A-Business-Case.pdf. Accessed September 2018.

^{iv} Shani, et al. Effect of a home intervention program on pediatric asthma in an environmental justice community. *Health Promotion Practice*. Mar 2015; 16(2): 291-298.

Bhaumik U et al. (2017). Boston children's hospital community asthma initiative: Five-year cost analyses of a home visiting program. *Journal of Asthma*, 54(2), 134-142.

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Turyk et al. A multifaceted community-based asthma intervention in Chicago: effects of trigger reduction and self-management education on asthma morbidity. *J Asthma*, 2013; 50(7): 729-736

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^v Home-Based Asthma Interventions: Keys to Success. America's Health Insurance Plans. 2017.

^{vi} Nurmagambetov TA, Barnett SBL, Jacob V, Chattopadhyay SK, Hopkins DP, Crocker DD, Dumitru GG, Kinyota S, Task Force on Community Preventive Services. Economic value of home-based, multi-trigger, multicomponent interventions with an environmental focus for reducing asthma morbidity: a Community Guide systematic review Adobe PDF File [PDF - 873 kB]. *Am J Prev Med* 2011;41(2S1):S33-47.

^{vii} Optima Health: 2005 Winner of EPA's National Environmental Leadership Award in Asthma Management.

^{viii} Hsu, Joy, et al. Economic Evidence for US Asthma Self-Management Education and Home-Based Interventions. *Journal of Asthma and Clinical Immunology: In Practice*. Nov 2016; 4(6): 1126-1134.e27.

^{ix} Crocker DD, Kinyota S, Dumitru GG, Ligon CB, Herman EJ, Ferdinands JM, Hopkins DP, Lawrence, BM, Sipe TA, Task Force on Community Preventive Services. Effectiveness of home-based, multi-trigger, multicomponent interventions with an environmental focus for reducing asthma morbidity: a Community Guide systematic review *Am J Prev Med* 2011;41(2S1):S5-32.

^x *Am J Public Health*. 2016 Apr;106(4):e3-e28. doi: 10.2105/AJPH.2015.302987. Epub 2016 Feb 18. Effects of Community-Based Health Worker Interventions to Improve Chronic Disease Management and Care Among Vulnerable Populations: A Systematic Review. Kim K1, Choi JS1, Choi E1, Nieman CL1, Joo JH1, Lin FR1, Gitlin LN1, Han HR1.