2016 OHPB CCO Listening Session
Summary Report & Policy Option Areas

Oregon Health Authority
HEALTH POLICY & ANALYTICS
The Oregon Health Policy Board is charged with policy oversight of Oregon’s Health system. The Board conducted targeted listening sessions in the fall of 2016 to revisit the state’s vision for health system transformation and consider recommendations to improve coordinated care in Oregon’s coordinated care organizations. To inform transformation progress and potential recommendations, the Board sought out community input around targeted policy areas from primary care providers, Oregon Health Plan members, health advocates and other stakeholders. Qualitative data from the listening sessions reviewed in this report demonstrates meaningful progress transforming Oregon’s delivery system to meet the triple aim: Coordinated care organizations are improving health, delivering better care and bending the cost curve. That said, communities indicate the urgent need to build on and accelerate progress. Health should be better coordinated with the community to meet non-medical social determinants of health and confront health disparities. Coordinated care organizations should continue to strive to be more transparent and community voices must be heard to ensure community centered health. Integration of behavioral, physical and oral health care can be further improved to realize the vision of an integrated and coordinated system.
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This report contains information regarding the Oregon Health Policy Board’s 2016 CCO Listening Session process, thematic outcomes and draft policy option areas regarding the future of Oregon’s Coordinated Care Model.

Oregon’s Coordinated Care Organizations were statutorily designed in 2011 through House Bill 3650 and launched in 2012 through Senate Bill 1580 after receiving approval through the Centers for Medicare and Medicaid Services with an updated waiver. Since their launch at that time 16 CCOs, the state and stakeholders have worked tirelessly to transform Oregon’s health delivery system to better meet Oregon’s triple aim of better care, better health and lower costs through the coordinated care model.

As the state nears the end of the first five year period with CCOs delivering care to over 1.1 million Oregonians, the Oregon Health Policy Board (the Board, OHPB) has been asked to review the vision for coordinated care and make recommendations to build on the promise and progress achieved by health system transformation and Coordinated Care Organizations thus far.

To meet this charge the Board reviewed quantitative system data at several Board meetings from July through December and appointed a sub-committee made up of Chair Zeke Smith, Chief Impact Officer of United Way Columbia Willamette, Dr. Joe Robertson, President Oregon Health & Science University, and Brenda Johnson, CEO of La Clinica, to tour the state from September to October seeking...
qualitative input from all stakeholders including health care advocates, Oregon Health Plan members and primary care providers. In addition to the six listening sessions the Board fielded an online survey consistent with the questions asked at listening sessions. The survey was posted online for more than 45 days. The online survey was available in Spanish and English and was distributed through electronic newsletters, social media and via community outreach.

The questions asked by the Board are a synthesis of legislative direction, Board input, stakeholder feedback and OHA analysis. Criteria for choosing questions were based on Oregon’s identified levers and drivers for health system transformation as articulated by Oregon’s 1115 Waiver, State Innovation Model grant and Coordinated Care Model Alignment Workgroup. Questions chosen were prioritized and the most impactful and potentially actionable were chosen.

Themes heard during the listening session were wide ranging. The majority of responses fall into the five broad policy areas targeted by the Board’s questions regarding, coordination to meet community needs and better deliver services to address the social determinants of health, system integration of behavioral, physical and oral health, addressing health inequity, payment reform for value-based purchasing and flexible services and CCO governance and structure.

The Board is working to update its Action Plan for Health by the spring of 2017 to encompass a comprehensive update to health system improvement strategies, including opportunities and recommendations identified and developed for this report. Potential Action Plan foundational strategies and actions are used to align themes heard during the listening session. see Table 1.

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1 See https://www.oregon.gov/oha/OHPR/Pages/sim/index.aspx for more info regarding Oregon’s SIM grant.
3 The Department of Consumer & Business Affairs and the Market Place Advisory Committee administer and guide policy regarding insurance access, OHA/DHS implement Medicaid policy.
Table 1: OHPB CCO Listening session themes to action plan matrix

<table>
<thead>
<tr>
<th>Action plan for health 2017 DRAFT foundational strategies</th>
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<tbody>
<tr>
<td>CCO Listening Session policy area</td>
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<tr>
<td>Change how care is paid for</td>
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<tr>
<td>Shift focus upstream to address the social determinants of health</td>
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<tr>
<td>Improve health equity</td>
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<tr>
<td>Ensure access to health insurance³</td>
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<tr>
<td>Reduce barriers to care</td>
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<tr>
<td>Set standards for safe &amp; effective care</td>
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<tr>
<td>Involve everyone in improvements</td>
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<tr>
<td>Measure progress</td>
</tr>
</tbody>
</table>

| CCO Coordination | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |
| CCO Integration  | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |
| Health equity    | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |
| Value based payment | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |
| CCO governance & structure | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |

Thematic feedback is formed into the five broad DRAFT statements below based on analysis of listening session notes and survey responses.

1. **CCO coordination**: CCO community coordination to address the social determinants of health has begun but must be accelerated and strengthened to link Oregonians with the right kind of care at the right place at the right time.

2. **CCO integration**: The integration of physical, behavioral and oral healthcare services has improved but should be accelerated to realize the vision of an integrated delivery system.

3. **Health equity**: Health care delivery system disparities persist; strategies that address cultural competency, social stigmas, and equitable access should continue to be prioritized.

4. **Value-based payment**: Payment reform is in progress but needs more clarity, coordination and technical assistance to achieve critical mass.

5. **CCO governance & structure**: CCO’s have implemented community feedback mechanisms but the community’s voice should be strengthened. Governance structures should reflect local community and public needs and be transparent and accountable; CCOs should invest savings in community needed services.
**OHPB coordinated care assessment timeline**

**July 2016**
- OHPB directed by Legislature and Governor’s Office to analyze and consider recommendations regarding Coordinated Care and the vision of Health System Transformation
- Regular System Oversight and Monitoring

**August 2016**
- Board Plans CCO listening sessions and begins reviewing data
- Oregon Health Insurance Survey
- Oregon Health System Transformation Metris 2015 Final Report
- Hospital Transformation Performance Project Report

**September 2016**
- Listening Sessions begin, online survey activated, data analysis continues
- CCO Quarterly Report
- SB 440 Data Report

**October 2016**
- Listening sessions continue and Board continues quantitative analysis
- Primary Care Payment Reform Recommendations Discussion
- Behavioral Health Discussion
- Workforce Recommendations
- Health Information Technology Discussion and Recommendations
- Medicaid Advisory Committee Discussion

**November 2016**
- Listening sessions complete, survey closes, data analysis continues
- Listening session themes review and potential policy option areas focus discussion
- High Cost Drugs Recommendations Discussion
- Public Health Modernization Discussion
- Medicaid Advisory Committee Analysis

**December 2016**
- OHPB recommendations for the Future of Coordinated Care Work Session
- Recommendations approved by the Board
- Primary Care Payment Reform Recommendations Presented
- Behavioral Health Improvement Recommendations Presented
- Medicaid Advisory Committee Recommendations Developed

**January 2016**
- Board Retreat
- Action Plan for Health Refresh
- OHPB Recommendations for the Future of Coordinated Care submitted to Legislature
Feedback from listening sessions was collected at small group discussion tables by OHA staff and combined with feedback given through the Board’s online survey. The survey was available in Spanish and any content or publication that was part of the listening session was available in another format or language as requested. Spanish translators and American Sign Language translators were on hand for each listening session. Criteria for choosing questions were based on Oregon’s identified levers and drivers for health system transformation as articulated by Oregon’s waiver, State Innovation Model grant and Coordinated Care Model Alignment Workgroup. Questions chosen were prioritized and the most impactful and potentially actionable were chosen.

1. Thinking about your local Coordinated Care Organization (CCO), what health care services are working for you, your family and your community? What could your CCO do to improve the health and well-being of families and the community? For example, are there specific services outside of a typical health plan benefit or resources that your CCO is providing or could help provide that would make a difference? Is health care connecting you with community resources to help with employment, housing, education, finances, and access to healthy foods and other essentials?

Sustain and Accelerate Community Coordination to Address the Social Determinates of Health

“Housing is cornerstone to health. Putting Community Health Workers in housing (especially those trained in trauma informed care/peer support services) is critical.”

“Systems don’t talk to each other. Lots of Electronic Health Records- Especially between mental health, dental and programs health.”

“For its part, OHA also needs to be more accountable to members and provide support when CCOs are not providing necessary support. OHA also needs to re-evaluate how CCOs are incentivized to improve coordination and care”

“organizations, particularly health-related, seem to be talking to each other more over the past 3-4 years. (hospitals, clinics, etc) There is a sense that the CCO has helped to break down silos”

“…needs more help with housing and resources for homeless persons”

“I love the small town feel”

“CCOs need to “get credit” for good deeds/savings, e.g. high school grad and recidivism.”
2. When reflecting on care received from a CCO, do dental care and mental health care feel connected with primary care? If they feel connected, please tell us why. If they don’t feel connected, why is that the case? For example, do primary care providers ask about overall health, including oral and behavioral health?

“CCOs are not sufficiently connected with mental health services – there is no process to provide referrals for behavioral health treatment and there is limited colocation of services.”

“Neither dental nor mental health aren’t connected. Not even on the board of our CCO. Cannot have a CCO who doesn’t have those players at the table.”

“Still silos”

“OHP population is not connected – the docs punt client from CCO to local providers.”

“…some integration of mental health and physical health, but no evidence of dental integration.”

“Confusion on the part of members about dental benefits under their OHP”

“Primary care providers are asking about mental health but the referral process for the local mental health is a barrier to receiving services.”
3. For Oregon Health Plan Members and Advocates: Do you feel your needs are understood by others? Do you believe culturally appropriate services are available when needed? (This may include language interpreter and translation services, culturally competent clinical medical staff, access to a Traditional Health Worker, etc.). What barriers, if any, prevent you from getting the health or health care services that you need? (This may include language barriers, physical access, cultural differences, lack of cultural understanding, stereotyping etc.).

"Yes my Primary Care Physician’s Medical Assistant asks about my oral and mental health. They even connected me to the Dental Clinic for dental cleanings."

"I cannot answer for dental or BH in regards to how they feel. As a PCP, I am connected to the resources to ensure our patients get the care they need. As a PCP, we screen for BH as part of our check in process...built into the work flow."

"Behavioral health is integrated with physical health at the pain clinic– members accessing services like yoga - into idea of alternative medicine."

"Shortage of MH providers, in rural areas lucky if you get to see a psychiatrist in 1 years’ time. this is dangerous. Since members are using meds for that entire time without having the time to check in."

"Member expressed a huge disconnect between her primary care not asking her about MH or dental."

"Leave flexibility to meet outcomes, don’t define process steps"

"…our mental health services are very hard to access for Latino parents and they provided my family with interpretation from a staff! Not a professional the information she translated was not accurate and I had to sit down with my family to explain the information properly. Primary care providers never talk to be about oral or behavioral health and often times I have to educate them."

"Dental services for those restricted to wheelchairs not accessible. Just because you are not in a chair doesn’t mean you don’t have a disability."

"More language interpretation is needed, shortage of medical interpreters for all interpretation needs including spoken and sign language."

"There is a lack of culturally-specific mental health services, especially for Spanish speakers."

"Why do people think that culturally appropriate is limited to the color of your skin or where you were born? There is a culture of poverty, a culture of people with disabilities, and a culture of those who have experienced trauma."
4. For Primary Care Providers: What’s been your experience with your local CCO around payment for providing high-quality care to your patients (i.e., alternative payment methodologies (APMs) or value-based payments (VBPs))? What’s working and what’s not? How can your CCO help spread APMs and VBPs in a way that works for you?

“Value based may work for the CCO but not providers and consumers
Increases administrative level for everyone.”

“It has been horrific. Our CCO refuses to offer APM, or VBPs”

“Scale in small communities? Primary care standards are variant, conflicting, burdensome (e.g. 86 metrics for primary care clinics in rural) standardize/streamline metrics, metrics changes hit primary care. Primary care physicians are burning out.”

“Both APM and VBP are being utilized. I feel these incentives are working to an extent; however, our board seems controlled by specialists and we primary care are getting less incentives each year.”

“we participate successfully in an apm takes a long time to gather the data they want to validate our “touches””

“APMs do not work when the hospital remains a small part of the CCO. VBPs may work, but again numbers (the volume) remain small and one adverse event can destroy a provider’s quality number.”
5. Regarding CCO decision making -- do you know who’s “at the table” to make decisions? Who should be? What kind of decision-making structure would best reflect community needs and priorities? Should CCO decision makers be locally-based and part of the community?

“Need more transparency; need stronger definition for who should be at the table (OHP member or CAC member should be on the board); unclear about governance – really need a way to ensure they care. In a small community, if you complain you’re labeled as a troublemaker.”

“Lawsuits between community partners and CCO, creating major issues.”

“When we’ve inquired about anything at our CCO, the response has been that its proprietary info and not available to the public. CCOs were designed to serve the public with public funds, then the public has the right to know. This is a PUBLIC concern, not a business concern.”

“Finger is at the state, how could we allow this to happen”

“What is the healthcare of the community is more important than looking at the structure”

“Decision making processes of CCOS needs to locally based rather than use other external plans developed from other communities which doesn’t reflect the local reality”

“There is a need to have local flexibility instead of operating on one size fits all.”

“CAC’s are great things to have with within CCO. It enable consumer’s voice and some ability to work on projects in community.”

“Alternative payment allows an increase in team based care team and creative appointment types. This is critical to changing how primary care is carried out.”

“Our experience at our small rural health clinic has been that our CCO, pays us far below our actual costs of providing service. Their payment model is driving us out of business. We have not had any help from them in understanding their payment systems. I am not aware that we are getting any APMs or VBPs.”

“There is confusion about what VBPs actually are and what strategies can be used to pay differently.”

“The difference in metrics across payers (e.g., Medicaid, Medicare, commercial) make it difficult to align payment strategies because there are so many reporting requirements. Reporting requirements across payers make it difficult for individual practices to pay differently since it places an increased administrative burden on the practice.”

“Coordination is not being paid for under APMs/VBPs especially for behavioral health services. The case rate that has been negotiated does not necessarily compare to FFS.”
“Headstart is not represented. Children/families who could be identified when child is four or five suddenly burst on the scene at seven or eight.”

“Should have open board meetings, published so clients can attend”

“Chaos from OHA leadership changes was burdensome; need stable agency infrastructure”

“Stay focused on triple aim on all policy areas”

“I know CCO was sold at an obscene profit to its shareholders at a time when many still struggle to get quality primary care. Shameful.”

“CCO decision-making should be limited to local (county) stakeholders, including the people giving and receiving services. Private, out-of-state ownership is not compatible with fairly reflecting the needs and priorities of the local community.”

“If you are not part of one of their “wholly owned subsidiary companies” then you are not defined as being a major component of the health care system here. I would like the CCO model to be opened up, public, and allow for more community input. The money to fund this model (the Medicaid waiver) should demand that the model be public”
## Policy Option Areas Identified

### Potential draft focus areas regarding CCO coordination

<table>
<thead>
<tr>
<th>Coordination Policy Issue Area</th>
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<tr>
<td><strong>Coordinated Health Partnerships:</strong> Support and develop 1115 Waiver demonstration concept which creates a five-year pilot program that seeks to address the social determinates of health and funds homelessness prevention, care coordination, and supportive housing services to at-risk adults and families. This work is underway, an advisory committee is being formed.</td>
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<tr>
<td><strong>Early Childhood:</strong> Consider strategies and policies which ensure better coordination and integration of resources devoted to early childhood health to address adverse childhood experiences and the social determinates of health.</td>
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<td><strong>Community Benefit:</strong> Consider defining and setting standards and procedures for hospital and CCO community benefit to align with health system transformation goals, improved community coordination and Coordinated Care Organization improvement plans.</td>
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<tr>
<td><strong>Social Determinates of Health:</strong> Consider defining a targeted percentage of budget that must be invested in addressing those social determinates that have a proven and direct impact on the health of CCO members.</td>
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<tr>
<td><strong>Community Health Improvement Plan:</strong> Consider mechanisms to include important community stakeholders in community health assessment and improvement plan development who may not currently be at the table and related accountability mechanisms. Consider emphasis on prevention and addressing the social determinates of health in these plans.</td>
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<tr>
<td><strong>Public Health Modernization:</strong> Public Health Modernization will ensure basic public protections critical to the health of all in Oregon and future generations by working to address the social determinates of health including clean air, safe food and water, health promotion and prevention of diseases, and responding to new health threats. This work is underway, legislation is prepared for the 2017 session.</td>
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<tr>
<td><strong>Member Experience:</strong> Consider improving member experience with Oregon’s Eligibility system (ONE) in the next phase of system build-out. Identify opportunities to improve processes regarding correspondence, renewals, cancellations and timely communication.</td>
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## Potential draft focus areas regarding CCO delivery system integration

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<th>Integration Policy Issue Area</th>
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<tr>
<td><strong>Oral Health:</strong> Consider meaningful integration of oral health by allowing CCOs to procure oral health services outside of local Dental Care Organizations (DCOs). Consider dropping the requirement that CCOs must contract with all DCOs located in their geographic area, some areas have as many as 9 local DCOs. Consider strengthening CCO contract language regarding oral health integration so that it reflects a level of integration emphasis similar to that of behavioral health integration.</td>
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<tr>
<td><strong>Behavioral Health:</strong> Consider recommendations from Oregon’s Behavioral Health Collaborative being presented in December as well as enhanced opportunities which increase accountability and flexibility for communities to find solutions that work.</td>
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<tr>
<td><strong>Primary Care:</strong> Consider primary care multipayer alignment and informing guidance for Patient Centered Primary Care Home standards regarding upstream investment and shared responsibility for prevention. Consider the development and oversight of a plan to reduce administrative burden for all providers, especially primary care providers.</td>
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<tr>
<td><strong>Prescription Drugs:</strong> Consider tasking the Oregon Health Plan Pharmacy and Therapeutic Committee to study and recommend a process to standardize formularies and reduce administrative burden. Consider researching and pursuing a west coast drug purchasing consortium made up of different states to better unify and take advantage of purchasing power.</td>
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## Potential draft focus areas regarding improved health equity

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<thead>
<tr>
<th>Health Equity Policy Issue Area</th>
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<tr>
<td><strong>Policy Development:</strong> Consider developing an equity policy body charged with considering the social determinants of health and addressing health equity to advise OHPB which may develop an equity agenda to inform a refreshed action plan for health.</td>
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<tr>
<td><strong>Diversity:</strong> Ensure communities with health disparities have a voice, consider mechanisms to ensure some proportion of Community Advisory Councils be made up of these voices based on local population race, ethnicity, age, disability and native language status.</td>
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<tr>
<td><strong>Programs:</strong> Continue to develop strategies and mechanisms to spread traditional health worker model, including peer delivered services and health navigators.</td>
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<tr>
<td><strong>Cultural Competency:</strong> Design and develop improved cultural competency strategies regarding improved translation services, disability access and metric(s) which may measure baseline and benchmark improvement in cultural competency.</td>
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### Potential draft focus areas regarding Paying for Value

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<th>Paying for Value Policy Issue Area</th>
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<tr>
<td>CCO Value Based Payments: Consider alignment with other value based purchasing initiatives like Medicare’s alternative payment methodology effort. Consider setting a minimum ratio of spend which must be through VBP.</td>
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<tr>
<td>Primary Care Payment Reform: Consider alignment with CMS’ Comprehensive Primary Care Plus program and Primary Care Payment Reform Workgroup recommendations.</td>
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<tr>
<td>Local Governments: Consider developing procedures and technical assistance for pilots which incent and spread integrated budgets aimed at addressing the social determinates of health and further coordination to deliver care amongst risk baring entities already responsible for care, e.g. local public and mental health efforts.</td>
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<tr>
<td>Global Budgets: Continue to lead the nation in the development of a global budget methodology which supports flexibility, integration and flexible services.</td>
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### Potential draft focus areas regarding CCO structure

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<tr>
<th>CCO Structure &amp; Governance Policy Issue Area</th>
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<tr>
<td>CCO Mission: Oregon’s Triple Aim (better health, better care, lower costs) should be the top business priority of any entity delivering or responsible for delivering CCO services in Oregon.</td>
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<tr>
<td>CCO Governing Board &amp; Community Voice: Consider mechanisms which increase community and Oregon Health Plan voice to help build on CCO community based governance. Consider meta-analysis and significant best-practices review.</td>
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<tr>
<td>CCO Investments: Consider mechanisms and strategies which ensure CCOs transparently and collaboratively re-invest in their local communities.</td>
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<tr>
<td>Accountability: Consider developing a more rigorous CCO contract accountability system including the establishment of a set of clear criteria defining the common elements of a CCO by which each CCO must adhere. Re-develop and clarify policies and procedures regarding complaints and grievances for community members regarding CCO and OHA delivered services.</td>
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Community Input: Consider mechanisms to ensure CCO decisions are aligned with community need such as the CACs ability to transparently review CCO decisions related to community health and provide a non-legally binding vote of community support or denial when appropriate.

Community Advisory Councils: Develop annual Community Advisory Learning Collaborative Summit to spread best practices; ensure each CCO CAC is represented and can participate in shared learning throughout the year.

Transparency: Consider mechanisms which guarantee that at least once a year CCO Board meetings take place in the local community open to the public and all CAC meetings comply with public meetings laws. Consider requiring all CCOs to have an annual community meeting outlining core strategies and activities to deliver on Triple Aim.
The Board’s CCO Listening Session Sub-Committee visited six locations across Oregon as shown in the table below.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Region</th>
<th>Location</th>
<th>Attendance</th>
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| 9/1/2016   | 11:00-1:30 | Bend               | Deschutes National Forest Supervisor’s Office
Aspen Ponderosa Conference Room
63095 Deschutes Market Road
Bend, OR 97701                                | 50         |
| 9/9/2016   | 4:00-6:30  | Tillamook          | Port of Tillamook Bay
Officers’ Mess Hall
6825 Officers Row
Tillamook                                      | 30         |
| 9/21/2016  | 5:30-8:00  | Rogue Valley (Medford) | Inn at Commons
Crater Lake and Rogue River Rooms
200 North Riverside Avenue
Medford                                        | 80         |
| 9/26/2016  | 12:00-2:30 | Eugene             | Unitarian Universalist Church
1685 West 13th Avenue
Eugene                                          | 120        |
| 10/7/2016  | 12:00-2:30 | Pendleton - Hermiston | Eastern Oregon Trade and Event Center
1705 East Airport Road
Hermiston                                       | 60         |
| 10/18/2016 | 4:30-7:00  | Portland           | Ambridge Event Center Ballroom
1333 NE MLK Boulevard
Portland                                        | 120        |
The Board received nearly 171 survey responses from September through November.
Survey ethnicity self-identification

Answered: 169  Skipped: 2

- African American/Black: 1.18%
- American Indian/Alaskan: 4.14%
- Asian: 2.96%
- Hawaiian/Pacific Islander: 7.10%
- Hispanic/Latino: 3.55%
- Caucasian/White: 84.02%
- None of the above/Other: 3.55%
- Other (please specify): 3.55%

Survey stakeholder self-identification

Answered: 168  Skipped: 3

- Primary care provider: 4.14%
- Healthcare advocate: 29.6%
- Oregon Health Plan member: 29.6%
- CCO Stakeholder: 7.10%
- Community advisory: 3.55%
- Regional health equity: 3.55%
- Other: 1.18%
Survey disability self-identification
Answered: 168   Skipped: 3

- Yes
- No

Survey gender self-identification

- Man
- Woman
- Transgender
- Other (please specify)