Philadelphia HIV Integrated Planning Council (HIPC)
Comprehensive Planning & Needs Assessment Committees
Meeting Minutes
Thursday, May 18, 2017
2:00-4:00p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia, PA

Present: Gus Grannan, Leroy Way, Mark Coleman, Katelyn Baron, Keith Carter, David Gana, Peter Houle, Ann Ricksecker, Adam Thompson, Cheryl Dennis, Pamela Gorman, Gerry Keys, Nicole Miller, Jeanette Murdock

Absent: Karen Coleman, Lupe Diaz, Tessa Fox

Guests: Jessica Browne (AACO), Sebastian Branca (AACO)

Staff: Mari Ross-Russell, Nicole Johns, Briana Morgan, Antonio Boone, Jennifer Hayes

Call to Order/Introductions: A. Thompson called the meeting to order at 2:02p.m. Those present then introduced themselves.

Approval of Agenda: A. Thompson presented the agenda for approval. **Motion**: P. Houle moved, L. Way seconded to approve the agenda. **Motion passed**: All in favor.

Approval of Minutes *(April 20, 2017)*: A. Thompson presented the minutes for approval. **Motion**: J. Murdock moved, J. Roderick seconded to approve the April 20, 2017 minutes. **Motion passed**: All in favor.

Report of Staff: N. Johns reviewed the handouts. She said they included two packets of utilization data for Ryan White service categories, by income level (percent of the federal poverty level, or FPL) by region, and by insurance type by region. She stated that participants could reference the information when discussing the Community Conscience priority setting factor.

N. Johns reviewed the priority setting factors. She stated that they included the consumer survey, care continuum, unmet need (data from the Medical Monitoring Project, or MMP, and AACO Client Services Unit, or CSU), and essential health benefit (EHB). She noted that the 5th, newest, factor was Community Conscience.

N. Johns explained that participants had cards in front of them labelled 1, 5, and 8. She said the cards would be used in determining the 5th factor.

N. Johns said that another sheet in the packet summarized consumer survey results for question 38. She said the sheets following those listed unmet need data, and they continued on to the care continuum, as updated following the last meeting. She noted that the EHB factor was pre-populated on the priority setting spreadsheet, as each service category had a known yes-or-no value.

N. Johns stated that another handout was not included in the packets but had also been distributed. She said the sheet contained open-ended answers from the consumer survey. She

stated that key words were highlighted in yellow. She said that common issues included copays, problems accessing medication, and transportation. She added that the numbers on the left-most column were survey number, for easy reference.

N. Johns noted that the spreadsheet for priority setting was displayed on the projector. She explained that the fields were pre-populated except for the community conscience factor, which would be discussed today. She stated that the service categories were listed in alphabetical order. She noted that the percentage listed under the factor name represented the weight of each factor.

M. Ross-Russell stated that the priority setting process was designed to ensure that everyone's vote counted. She said that, as the group voted on the community conscience factor, she would be dynamically filling out the corresponding field on the priority setting scoresheet. She stated that each member would give each service category a score of 1, 5, or 8 on the community conscience factor, which would then be averaged based on everyone's responses. She stated that the results would be figured into the total score calculation, based on a weight of 15%.

M. Ross-Russell reported that there were 14 voting Planning Council members currently in the room.

A. Ricksecker stated that, in the past, participants had been able to discuss their decisions before voting. A. Thompson said comments would be welcomed before voting this year as well.

Report of Chair: A. Thompson noted that the priority setting process would be visible on the whiteboard and the projector. He suggested members who could not see these move to another part of the room.

Discussion Items:

- **Priority Setting**

A. Thompson stated that the group would go through each service category one-by-one. He said that members would be asked to speak out if they believed the first four factors did not fully capture need for the service, due to emergent needs, vulnerable populations that were not captured by data, their own knowledge about the service, or service utilization data.

A. Thompson discussed home health care as an example. He said that the service was not viewed as commonly used. However, he stated that many people living with HIV (PLWH) in Philadelphia were aging. He stated that this may be an appropriate justification for giving it a higher score (of 5 or 8).

S. Branca asked if he should interject when he knew there to be Part B funding for a given service. A. Thompson stated that he would defer to the recipient on such questions. However, he added that the group could not consider other funding in priority setting. M. Ross-Russell said it would be useful to know that a service was being provided, even without exact funding totals. N. Johns stated that the answers on the consumer survey reflected which services were being used, regardless of payers.

S. Branca asked if it would be more useful if he pointed out services that were only funded under Part B. A. Thompson said that the discussion should avoid specific funding totals. M. Ross-Russell noted that priority setting was about documented need in the community. Therefore, utilization and need were taken into account. She stated that, regardless of Part B funding, emergent need for a service should be considered as part of the discussion. M. Ross-Russell stated that the group would like feedback from the recipient. A. Thompson asked if S. Branca was referring to Part B funding in Pennsylvania only. S. Branca agreed.

AIDS Drug Assistance Program

A. Thompson stated that the first service category was the AIDS Drug Assistance Program (ADAP). He asked the group to review the category's score for the first four factors (unmet need, consumer survey, continuum, and EHB) and determine if those scores sufficiently captured the need for the service. K. Baron said that she'd thought the services on the pre-populated spreadsheet would be sorted by priority rank. A. Thompson said that he'd thought the same, but the conversation may focus on the current priority ranking rather than data if the spreadsheet was arranged this way.

A. Thompson noted that ADAP had a score of 5 for unmet need. He asked the group to consider if they felt unmet need data reflected whether or not people had access to their medications. A. Ricksecker asked if ADAP referred to the state program or local medication assistance. A. Thompson noted that local medications were no longer included in the same category as in the past. M. Ross-Russell said that 3 programs existed: ADAP, local pharmaceutical assistance program (LPAP), and emergency financial assistance (medications). M. Ross-Russell said the first service category was ADAP or the Special Pharmaceutical Benefit Program (SPBP) in PA, the statewide medication assistance program.

A. Thompson stated it was generally known who didn't have access to medications. Therefore, this information was captured in the existing data. G. Grannan noted that some people, for instance, who were homeless, may not be able to access their medications uninterrupted. He asked if this category covered adherence or just payment. A. Thompson said it concerned paying for medications only. He asked the group to consider their community conscience scores. He noted that a score of 1 was neutral (community need was represented by other factors), 5 indicated some concern (need was underrepresented by other factors), and 8 indicated great concern (the service was not covered by other factors).

Vote: 14 members voted 1 on the community conscience factor for the ADAP service category.

Ambulatory Medical Care

A. Thompson stated that ambulatory care was the second service category on the list. He asked the group if the first 4 factors' data sets adequately represented need for medical care. S. Branca said there was some Part B funding for medical care. A. Thompson said the category had a high priority ranking based on the first 4 categories. A. Ricksecker asked how the service category was designated on the unmet need handout. N. Johns said that it was called "medical care." G. Keys stated that there were many ways a person could get medical care. A. Thompson said that ambulatory care was a much needed service. He stated that, without the community conscience factor included in the scores, it was the highest scoring item. A. Thompson clarified that the category covered HIV-specific medical care only.

A. Ricksecker asked if medical care was represented in any other categories. A. Thompson replied that it wasn't. He noted that some services were needed but weren't captured in the data, due to a lack of client knowledge that they needed the service. K. Baron suggested the group thoroughly review the data in their packets prior to discussing each category. A. Thompson read off the scores for each of the first four factors in the category. P. Gorman asked for more information about the continuum scores. A. Thompson pointed out the continuum in the packets, and stated that services that extended all the way across the continuum got a score of 8. A. Thompson pointed out that all 4 factors assigned high importance to ambulatory care.

Vote: 14 members voted 1 on the community conscience factor for the outpatient/ambulatory medical care service category.

Care Outreach

A. Thompson stated that the next category was care outreach. N. Johns noted that there was no unmet need data for this category. She said that some categories had not been reported as an unmet need by any clients. A. Thompson reviewed the data points for the category under each of the first four factors. A. Ricksecker stated that care outreach was a misunderstood and underappreciated category. She said that care outreach was recently defunded. She stated that the service was often valued in terms of its outcomes rather than its importance. She said it was difficult to get consistent and measureable results from the service, but it was still needed. She stated that some people seemed to believe that the service was being provided in other ways outside Part A. She reiterated that the service was very important, despite its current lack of Part A funding.

K. Baron noted that her organization provided care outreach, though it did not receive Part A funding for it. She said it was an important and useful service for clients. A. Ricksecker added that patient navigation was frequently discussed over the past few years. She stated that the group had learned about many programs that were currently linking and retaining patients in care. She said that the group had decided that patient navigation fell under care outreach. A. Thompson stated that this service category was used to support community health workers in NJ. He noted that people who were lost to care would not be able to cite care outreach services as a need. He pointed out that there were two high scores of 8 for the category, under the continuum and EHB factors, though it scored low on the other 2 factors. He stated that care outreach had positive outcomes for cancer and other chronic illnesses. G. Grannan pointed out that need was not entirely captured by unmet need data. For instance, he said that people who needed translation services had a hard time reporting that need.

Vote: 5 members voted 8 and 10 members voted 5 on the community conscience factor for the care outreach service category.

Case Management (Non-Medical)

A. Thompson said the next category was case management (non-medical). He said there was no unmet need data for this category. He reviewed the data for the other 3 factors. G. Grannan stated that the category could help address stigma and societal issues, including injection drug use. A. Thompson reviewed the difference between medical and non-medical case management. He noted that medical case management required a direct clinical outcome and follow-up. He said that non-medical case management did not require follow-up and related to the way clients accessed a service. He said that non-medical case managers may

help clients who were referred to them to navigate their care. He explained that some organizations used non-medical case managers to control the flow of information about patients throughout a single practice. G. Grannan asked if non-medical case managers helped clients with issues related to stigma in a clinical setting. A. Thompson said they didn't.

P. Gorman stated that non-medical case managers helped clients to access needed services that may help with comorbid conditions that were not directly connected with HIV medical outcomes. She added that services like transportation could be accessed without a comprehensive medical plan through non-medical case managers. K. Baron noted that non-medical case management had a score of 5 under unmet need. N. Johns pointed out that the service category included benefits assistance. She stated that the score in the unmet need category could be changed.

A. Thompson noted that non-medical case management was a category that was undergoing redevelopment in different areas across the US. A. Ricksecker stated that the category had inspired a robust conversation, which led her to believe that it was important. A. Thompson explained that different sites had implemented the programs very differently. However, the program had critical functions in various implementations. A. Thompson said that retention in care and barriers to care may relate more to psychosocial factors than medical factors. He pointed out that medical and non-medical needs went hand-in-hand.

Vote: 10 members voted 8 and 5 members voted 5 on the community conscience factor for the case management (non-medical) service category.

Childcare

A. Thompson moved forward to childcare services. He reviewed the data that contributed to each of the factors. N. Johns noted that many respondents to the consumer survey were male and over 50, so they might not have any need for childcare. A. Thompson said the service was critical for those who needed it. G. Grannan noted that there was a gender imbalance in accessing certain programs, citing syringe exchange, because some women needed but couldn't access childcare. G. Keys stated that the City health centers were not able to provide childcare, which clients often cited as a reason for missed appointments. G. Grannan added that some men needed the service, though this was not the norm.

Vote: 5 members voted 8, 5 members voted 5, and 4 members voted 1 on the community conscience factor for the childcare service category.

Day or Respite Care

A. Thompson moved forward on to day or respite care. He reviewed data for the first 4 factors. He asked if the group had forgotten to include it on the continuum, as it was not listed. N. Johns noted that not all services were included on the continuum when it was originally created. S. Branca stated that the service was funded under Part B. He noted that it was provided for caregivers rather than PLWH. G. Grannan said that the service could give caregivers a day off. S. Branca explained that the service also assisted people who ran a household that included a PLWH. M. Ross-Russell explained that it could provide in-house help for a caretaker of a PLWH that was homebound (e.g. so they caretaker could run errands).

A. Thompson noted that respite care was a similar service category to home health care. He said he was concerned about categories that served older PLWH, given the aging epidemic in the Philadelphia EMA. He noted that HIV and medications could cause PLWH to age more quickly. He added that PLWH were now living longer than they had in the past. P. Gorman said that at least 40% of the patients at her organization were 45 and older. She stated that family members of these individuals had to ensure their loved ones were cared for and attended appointments. She stated that this need would likely increase as their family members aged, leading to more complex medical conditions and decreased mobility. She explained that caregivers were experiencing fatigue from assisting homebound family members. She encouraged the group to focus on the issue, which would probably grow more important over time.

P. Houle asked how often priority setting was completed. N. Johns stated that priority setting was done every couple years. P. Houle agreed that respite care was an emerging need. However, he said that it wasn't necessarily urgent. He stated that over half of clients at his organization were over 50. However, there was a minimal need for respite care among these clients. He acknowledged that they were likely to have an increased need for the service in the future. He encouraged the group to monitor the ongoing need for the service as clients continued to age. A. Thompson speculated that, like childcare, the service may be critical to those who needed it. He noted that the service was ranked very low right now. P. Houle asked A. Thompson to review the amount of unmet need for the service. A. Thompson said that unmet need for the service was 14%. P. Houle stated that PLWH had directly cited a lack of need for the service.

N. Johns stated that respite care was near the bottom of the list of services on the consumer survey, and sometimes respondents inconsistently marked the last items on the list. M. Ross-Russell noted that the consumer survey did not relate to the funding of services. She stated that the survey explained the services rather than referred to them by their technical names. She said that the service could be covered under home health care, though in some cases insurance did not cover home health services.

S. Branca stated that, in the Ryan White Part A system, 55 people utilized respite care. He stated that this didn't reflect the amount of homebound individuals or marketing of the service. However, the service was being provided by a large organization with substantial reach.

Vote: 4 members voted 5 and 11 members voted 1 on the community conscience factor for the day/respite care service category.

Early Intervention Services (EIS)

A. Thompson moved on to early intervention services. He reviewed the values for each of the first four factors. N. Johns noted that early intervention wasn't included in unmet need or consumer survey data. A. Thompson noted that this service was also ranked low in the priority order. J. Murdock asked for more information on early intervention services. P. Gorman stated that it included counseling, testing, and referral, and was a crossover between different categories. She said it included screening and identification, which might be covered by prevention agencies, and some that were covered by medical care agencies. A. Thompson stated that a client presenting to a clinic would use EIS in order to get labs and

early diagnostics done. P. Gorman stated that first visits were also encompassed in EIS. A. Thompson stated that clients may not know they needed or had gotten EIS. P. Gorman noted that her organization was funded for EIS by Part C.

M. Ross-Russell noted that Part A and Part C early intervention services were defined differently.

N. Johns read the definition of EIS from Policy Clarification Notice 16-02[1]. She said that elements of EIS overlapped with other service categories. However, EIS required a combination of these services rather than a standalone. She said it included testing, referral services, access to and linkage to HIV treatment services, outreach, and health education. She stated that this definition was for the service under Parts A and B. A. Thompson said that EIS was a stopgap for patients needed it in order to get into medical care. P. Gorman said testing was a key component of EIS.

Vote: 1 member voted 8, 6 members voted 5, and 8 member voted 1 on the community conscience factor for the early intervention services category.

Emergency Financial Assistance

A. Thompson moved on to the emergency financial assistance service category. He reviewed data for each of the first four factors. G. Grannan asked if the category covered mortgages. S Branca stated that it didn't. He said that the service could help with preventing eviction and first and last month's rent, as well as medications or utilities assistance.

N. Johns stated that DEFA provided limited short-term or one-time payments for clients with an emergent need. She said the service helped with paying for utilities, housing, food, medication, or transportation. A. Thompson asked if LPAP was being considered separately from DEFA medications. N. Johns stated that it was. S. Branca stated that a bulk of local medication assistance was now provided through DEFA. A. Thompson asked why DEFA and LPAP weren't counted together. He asked if providers had to differentiate between which category they were providing medications through. S. Branca noted that LPAP was provided through the health centers and was provided differently than DEFA pharmaceutical assistance. He stated that under PCN 16-02, the categories were required to be split.

A. Thompson asked if the category being considered right now included emergency medications. N. Johns said it did. S. Branca clarified that LPAP was provided only through the health centers. J. Murdock asked if clients on Section 8 housing could get utilities help through DEFA. N. Johns stated that she could look into the question. P. Houle asked if there

[1] RWHAP Parts A and B EIS services must include the following four components:

- Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be HIV-infected:
    - Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
    - HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources
- Referral services to improve HIV care and treatment services at key points of entry
- Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care
- Outreach Services and Health Education/Risk Reduction related to HIV diagnosis

were any other sources of emergency funding in the city. N. Johns said there were for utilities. G. Grannan said emergency housing assistance also existed. A. Thompson noted that outside funding should not determine priority rankings.

N. Johns stated that many responses to open-ended questions on the consumer survey cited needs that could be covered through DEFA. A. Thompson asked if the group was ranking based on HRSA service category definitions rather than Philadelphia-specific definitions. N. Johns said that the consumer survey did not use HRSA service category definitions.

M. Ross-Russell explained that emergency medications were previously provided under LPAP. She stated that this program was carried out through a pharmacy and health centers. She noted that, through PCN 16-02, LPAP could no longer provide short-term medication assistance. She stated that the emergency medications were previously being covered by LPAP. She noted that medications were then split between those covered under DEFA and those covered under LPAP. She said the same service was being provided as was before.

A. Thompson asked where someone from Camden would go to access emergency medications. N. Johns said emergency medication assistance could be accessed through their case manager. S. Branca said that someone who went to a city health center in Philadelphia would probably have their medications filled through LPAP. He said that, typically, other organizations connected clients to emergency medications through DEFA via their case manager or physician. He added that, until last year, these were both encompassed by the same category. A. Thompson asked how clients accessed medications through DEFA. S. Branca stated that clients would go through a different application process for DEFA than they would for other types of emergencies.

A. Thompson clarified to the group that the category certainly being discussed, DEFA, covered utilities, rental assistance, food, transportation, and emergency medications. He noted that the need for emergency medication had been noted among his clients. M. Ross-Russell changed the heading for the category on the spreadsheet to emergency financial assistance/medications and changed LPAP to remove DEFA from the heading.

G. Grannan said he heard from providers that medications aside from HIV meds were important to keeping people healthy in emergencies. A. Thompson said that only HIV medications could be covered under DEFA medication assistance. A. Ricksecker reminded the group that they should consider whether or not the need for the service was adequately captured by the factor scores that were already listed. A. Thompson asked if people accurately filled out their need for the service on the consumer survey. G. Grannan noted that the consumer survey measured only the need for the service, not the acuteness of the need.

Vote: 1 member voted 8, 11 members voted 5, and 2 members voted 1 on the community conscience factor for the emergency financial assistance service category.

Food Bank/Home-Delivered Meals

A. Thompson moved on to food bank/home-delivered meals. A. Thompson reviewed the data for the service on the first four factors. He noted that the unmet need factor compared CSU and MMP data, because they came from a different viewpoint. He said there was a discrepancy in this category, with 27% vs 6% on the two measures of unmet need. He noted

that the group took the highest value for the unmet need calculation. S. Branca explained that CSU data reflected needs that were expressed by clients when first accessing case management services. He noted that the CSU clients were a population who needed to access case management. He pointed out that food bank was also funded under Part B.

Vote: 4 members voted 5 and 10 members voted 1 on the community conscience factor for the food bank/home-delivered meals service category.

Health Education/Risk Reduction
A. Thompson moved forward to health education/risk reduction. He reviewed data points for the first four factors. S. Branca noted that the category was funded under Part B. A. Thompson said it was also funded by the CDC. A. Ricksecker stated that risk- and harm-reduction were important and underappreciated categories in the EMA. She argued that the category should be highly-ranked in the priority order. A. Thompson pointed out that health education and risk reduction were both very important parts of the category. G. Grannan said this category was one realm where prevention had worked well. However, it was underrepresented when asking people who were HIV-positive to cite their need.

N. Johns said that there was a question on the survey about prevention services. She stated that many respondents had talked about PrEP, along with receiving information about HIV disclosure, safer sex, and safer injection practices. P. Houle asked if the health education/risk reduction service category included PrEP. N. Johns stated that it did. She read the definition of the service category from PCN 16-02[2]. A. Thompson agreed that the service was underrepresented in the priorities.

P. Gorman asked if the group should view this service as it existed under Part A only. A. Thompson said they should consider the importance of this type of service overall. He clarified that the priorities encompassed people who were HIV-positive or affected by HIV. P. Gorman said that health education/risk reduction was supposed to be provided at every medical care visit. A. Thompson noted that priorities delivered a statement. He said that organizations could be held accountable for failing to provide this service.

Vote: 12 members voted 8, 2 members voted 5, and 1 member voted 1 on the community conscience factor for the health education/risk reduction service category.

Health Insurance Premium/Cost-Sharing Assistance (HIPCSA)
A. Thompson said the next category was health insurance premium/cost-sharing assistance. He reviewed the data for each of the first four factors. He noted that no MMP data was

[2] Health Education/Risk Reduction is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics covered may include:

- Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
- Health literacy
- Treatment adherence education

available for the category. He encouraged the group to look at the qualitative answers to the consumer survey that were included in their packets. A. Ricksecker reiterated that priority setting was an expression of the Planning Council's values. She noted that they'd spent a great deal of time discussing HIPCSA. A. Thompson noted that many respondents to the consumer survey said they had problems with copays and other medical costs. P. Houle stated that HIPCSA was a cost-effective and successful program in his experience. He said that it saved money for other programs. He encouraged the group to make HIPCSA a priority. He stated that money had been allocated for the category but was found insufficient to support a HIPCSA program. He said the program may become even more important moving forward in light of proposed policy changes. K. Baron noted that the group had decided to retain the EHB factor in the priority setting process. However, she stated that proposed policy changes may affect the EHB and implementation of the ACA.

A. Thompson stated that some clients may not understand that Ryan White was not health insurance. N. Johns said that she believed respondents to the consumer survey knew what health insurance they had. M. Ross-Russell said that, in the past, individuals who had Medicaid would list it as private insurance due to the name. She noted that the group had received data from S. Branca about the insurance status of PLWH in the EMA. She stated that proposed changes in healthcare policy may change the numbers of insured people.

A. Ricksecker reiterated that HIPCSA should be ranked based on need rather than funding. She noted that the Comprehensive Planning Committee had asked the state to help pay for HIPCSA. She stated that prioritizing the program highly would send a message to the state about its importance. A. Thompson stated that, if HIPCSA moved up or down 3 spaces in the priority order, the group had to justify why. Therefore, there would be an opportunity to bring up the points that had been made in their discussions in the process of justifying the change.

M. Ross-Russell noted that HIPCSA category had been ranked highly during priority setting in previous years. She stated that the Planning Council would already be making statements about HIPCSA when describing the work they'd done throughout the year, including in grant applications.

Vote: 15 members voted 8 on the community conscience factor for the health insurance premium/cost-sharing assistance service category.

A. Thompson asked the group for feedback about the priority setting process thus far. P. Houle said he appreciated the discussion. He stated that the group had taken time to define categories as necessary. The group agreed they had adequate time to make decisions about their votes.

Old Business: None.

New Business: None.

Next Steps: N. Johns stated that, at their next meeting, the group would continue the priority setting process, rank the priorities, and then carry out their final discussion on the rankings.

Announcements: D. Gana stated that, on June 3rd from 10am-5pm, The Reunion Project, an event for long-term survivors, would take place at St. Luke's Church on 13th Street. A. Thompson asked how long-term survivor was defined. D. Gana said that anyone could attend the event. A. Thompson said he'd heard long-term survivors generally defined as PLWHA for 10 years or more. K. Carter reiterated that anyone was welcome. D. Gana asked anyone who was interested in attending the event to RSVP.

Adjournment: The meeting was adjourned by general consensus at 3:57p.m.

Respectfully submitted by,

Jennifer Hayes, Staff

Handouts distributed at the meeting:

- Meeting Agenda
- April 20, 2017 Meeting Minutes
- Insurance Status by Service Category from 2016 PDE Data
- Priority Setting Worksheet 2017
- Consumer Survey Question 38
- Unmet need data for Priority Setting 2017
- Care Continuum
- Consumer Survey Question 57
- OHP Calendar