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U.S. Department of Health and Human Services  
Office of the Assistant Secretary for Planning and Evaluation  
Strategic Planning Team  
200 Independence Avenue, SW, Room 415F  
Washington, DC 20201

**VIA ELECTRONIC MAIL – [HHSPlan@hhs.gov](mailto:HHSPlan@hhs.gov)**

Attn: Strategic Plan Comments

The National Council of Asian Pacific Americans (NCAPA) thanks the Department of Health and Human Services (HHS) for the opportunity to comment on the *HHS Draft Strategic Plan (2018-2022)*.

NCAPA is a coalition of thirty-four national Asian American, Native Hawaiian and Pacific Islander organizations around the country. NCAPA, located in Washington, D.C., serves to represent the interests of the greater Asian American, Native Hawaiian, and Pacific Islander (AA&NHPI) communities and to provide a national voice for AA and NHPI issues.

We want to note the importance of the Affordable Care Act (ACA) for AA&NHPI communities and particularly the importance of its consumer protections. Since 2010, the uninsured rate has fallen from 15.1 percent to 6.5 percent in 2016 for AAs and from 14.5 percent to 7.7 percent for NHPs, higher than any other racial group.<sup>1</sup> All consumers will be best served by maintaining and continuing to implement the ACA, which includes a strong enforcement of consumer protections in regulation and in statute. Since the ACA was

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<sup>1</sup> American Community Survey Table S0201, 2010 and 2016 1 year estimates.

implemented, community health centers have seen a 9% increase in patients.<sup>2</sup> As such, we note our concerns about the complete absence of the ACA in the Draft Strategic Plan and recommend the plan be revised to incorporate the ACA across numerous objectives and strategies.

The core principles of Medicaid need to be retained such that there are the same benefits and cost-sharing protections, opportunities for notice and appeal, and adequate networks of plan providers, including Essential Community Providers, for Medicaid expansion beneficiaries in the states' respective Health Insurance Marketplaces.

The AA and NHPI populations are the fastest growing racial group in the United States with dozens of different cultures and languages.<sup>3</sup> While the majority of AA and NHPIs speak English well, approximately 32% of Asian Americans are Limited English Proficient (LEP) and experience some difficulty communicating in English.<sup>4</sup> Census data also shows that 21% of Asian American households are linguistically isolated, meaning that all members 14 years old and older speak English less than "very well."<sup>5</sup> When more closely examining AA and NHPI ethnic communities, some communities have a large share of households that are linguistically isolated. Twenty percent or more of Vietnamese, Korean, Chinese, Bangladeshi, Laotian, Thai, Hmong, Indonesian, and Cambodian households are linguistically isolated.<sup>6</sup>

HHS' overarching mission and function is "to enhance and protect the health and well-being of all Americans." Accordingly, HHS establishes the goal of improving patients' access to the health care they need in the Draft Strategic Plan. We support Department of Health and Human Services (HHS) program and initiatives that serve and protect all individuals across the lifespan. However, the Plan also states that HHS will "promote equal and nondiscriminatory participation by faith-based organizations in HHS-funded or conducted activities," and HHS will "affirmatively accommodate" burdens imposed on the exercise of religious beliefs and "moral convictions" by persons and entities partnering with HHS (Objective 1.3).

Public health programs and policies must be based on research, evidence, and medical and health-related facts, and must be responsive to individual patient and consumer needs and wishes. However, we note that religion and conscience are not limited to those who support the idea of life beginning at conception. In fact, the vast majority of patients have

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<sup>2</sup> Hatch et al. Impacts of the Affordable Care Act on Community Health Centers: Characteristics of New Patients and Early Changes in Delivery and Utilization of Care. *Medical Care*, submitted for publication, October 2016.

<sup>3</sup> Between 2000 and 2010, the Asian American population grew faster than another racial group, at a rate of 46%." Karthick Ramakrishnan, University of California Riverside & Taeku Lee, University of California Berkeley, *Public Opinion of a Growing Electorate: Asian Americans and Pacific Islanders in 2012*, *National Asian American Survey* 3 (2012), <http://naasurvey.com/resources/Home/NAAS12-sep25-election.pdf>.

<sup>4</sup> Asian Americans Advancing Justice | Los Angeles and Asian Americans Advancing Justice | AAJC (formerly Asian Pacific American Legal Ctr. (APALC) & Asian American Justice Ctr. (AAJC), Members of Asian American Ctr. for Advancing Justice), *A Community of Contrasts Asian Americans in the United States: 2011*, at 25 (2011), available at [http://www.advancingjustice.org/pdf/Community\\_of\\_Contrast.pdf](http://www.advancingjustice.org/pdf/Community_of_Contrast.pdf).

<sup>5</sup> *Id.* at 29.

<sup>6</sup> *Id.*

religious and conscience needs and wishes that are not served using that limited framework. In order to fulfill the person-centered strategy laid out by HHS, consumers require medically accurate, evidence-based, unbiased comprehensive health care services so that they can use their own decision making capacity to choose health care services that comport with their individual morality and circumstances. This means that reproductive health care services, including hormonal contraception, sterilization, and pregnancy termination, must be available to all who desire those services in accordance with their own individual beliefs.

However, one individual's personal religious belief should never determine or limit the healthcare services that another individual can receive. When hospitals, clinics, and individual health care providers have the ability to refuse patient care based on religious or moral beliefs, patients may suffer devastating health consequences.<sup>7</sup> The harms caused by refusals to provide care have a disproportionate impact on AAPI women, immigrants, and LGBTQ and gender non-conforming individuals, who already face multiple barriers to care. Requirements that all organizations including those that are faith-based provide unbiased, non-discriminatory, evidence-based information and services is not a "barrier" to be removed, but is a consumer and patient protection to be upheld. Any deviation from these standards should not be allowed.

HHS should be committed to putting measurable goals toward improving individual patient care at the center of any strategic plan, and should work to ensure medical standards of care and individual patient circumstances determine patient care, not politicians or providers' and insurance companies' religious beliefs. The Draft Strategic Plan's repeated commitment to accommodating faith-based entities signals that HHS may prioritize personal opinion and belief over access and care. This is completely inappropriate for HHS' strategic plan. Additionally, this strategic plan fails to acknowledge that many health care providers have moral convictions telling them that they must provide services that patients need, including abortions. HHS is responsible for enforcing federal law that protects individual health care providers from employment discrimination due to their providing abortions and other care. If HHS cares about protecting individual health care providers' conscience beliefs, as it claims, then it should acknowledge its responsibilities under federal law and articulate a commitment to protecting doctors and nurses who are committed to providing abortions and other services that patients need. We urge HHS to redact the broad language promoting open-ended deference to religious health care providers, and to commit to truly putting patient health first.

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<sup>7</sup> For documented examples of religious healthcare providers denying care to patients on the basis of religious beliefs, see Compl. 2, *ACLU of Mich. v. Trinity Health Corp.*, 2016 U.S. Dist. LEXIS 30690 (E.D. Mich. Mar. 10, 2016); Freedman et al., *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 AM. J. PUBLIC HEALTH 1774 (2008), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636458/>; National Women's Law Center, *Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide*, <https://nwlc.org/resources/refusals-to-provide-health-care-threaten-the-health-and-lives-of-patients-nationwide/> (last visited Oct. 20, 2017).

## **STRATEGIC GOAL 1: REFORM, STRENGTHEN, AND MODERNIZE THE NATION'S HEALTH CARE**

### **Objective 1.1**

We agree with HHS's strategy to "promote preventive care to reduce future medical costs" by "reduc[ing] downstream costs by implementing high-value, evidence-based prevention interventions to achieve better health outcomes." We note that alternative payment models must not be implemented in such a way that they create incentives to stint on needed care or avoid costlier patients, and believe that HHS should focus on models that prioritize primary care. Furthermore, we recommend that if HHS uses financial incentives, those incentives should be focused on improving outcomes and not to reducing costs.

We greatly appreciate HHS' recognition of the importance of consumer-driven preventive care, and we fully agree with the initiative to work towards implementing evidence-based prevention programs in order to achieve better health outcomes. That being said, we would like to see the plan acknowledge that health disparities specifically exist among racial and ethnic minorities, language, age, sex, sexual orientation, gender identity, and disability, as mentioned in the HHS 2014-2018 plan, and that programs that improve the quality of care and increase access be developed and implemented in a culturally and linguistically appropriate manner.

Furthermore, contraception and family planning are some of the most well-researched and proven effective methods of preventive care.<sup>8</sup> They are particularly important in achieving Healthy People 2020's goal to "improve pregnancy planning and spacing, and prevent unintended pregnancy."<sup>9</sup> Yet, AAPI women still lack access to contraceptive care: only 57 percent of AAPI women have reported ever using birth control pills, a more effective pregnancy prevention method, as compared to 68 percent of Hispanic or Latina women, 78 percent of black women, and 89 percent of white women.<sup>10</sup> Access to contraception and preventive care is vital to ending health disparities that women of color face, including unintended pregnancy and high rates of cervical cancer incidence and mortality, which is especially common among AAPI women and even higher for certain AAPI ethnicities.<sup>11</sup> The medical and health-related standard of care for some women with chronic medical conditions or taking certain medications is to use contraception to prevent pregnancy until their conditions are under control to improve maternal health and birth outcomes. For

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<sup>8</sup> INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS (2011), [http://nationalacademies.org/hmd/~media/files/report%20files/2011/clinical-preventive-services-for-women-closing-the-gaps/preventiveservicesforwomenreportbrief\\_updated2.pdf](http://nationalacademies.org/hmd/~media/files/report%20files/2011/clinical-preventive-services-for-women-closing-the-gaps/preventiveservicesforwomenreportbrief_updated2.pdf).

<sup>9</sup> OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION, HEALTHY PEOPLE 2020 TOPICS & OBJECTIVES: FAMILY PLANNING, <https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning>.

<sup>10</sup> Kimberly Daniels et al., "Contraceptive Methods Women Have Ever Used: United States, 1982-2010." U.S. Department of Health and Human Services (Feb 14, 2013). <http://www.cdc.gov/nchs/data/nhsr/nhsr062.pdf> (last visited Aug 15, 2017).

<sup>11</sup> American Cancer Society, *Special Section: Cancer in Asian Americans, Native Hawaiians, and Pacific Islanders* at 26 (2016). [www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2016/special-section-in-asian-americans-native-hawaiians-and-pacific-islanders-cancer-facts-and-figures-2016.pdf](http://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2016/special-section-in-asian-americans-native-hawaiians-and-pacific-islanders-cancer-facts-and-figures-2016.pdf).

example, women taking accutane for severe acne are advised to use two forms of contraception.<sup>12</sup> Barriers to post-partum contraception are strongly associated with poor health outcomes including very low birth weight, infant mortality, and maternal mortality when women cannot ensure safe intervals between pregnancies.<sup>13</sup> Moreover, we believe that recent administrative actions, including those that undermine the marketplaces, stopped payment of cost-sharing reductions of the Affordable Care Act, and the released interim final rules regarding the contraceptive coverage benefit, are inconsistent with promoting preventive care and strengthening the economic and social well-being of individuals across the lifespan.

We support HHS' recognition of the need for health literacy tools. We suggest HHS specifically recognize the need to provide linguistically and culturally specific tools such that all individuals, regardless of their background, can benefit from these tools. We are generally supportive of the HHS Language Access Plan, and recommend HHS ensure they are implemented consistent with the best practice standards for translation and oral interpretation services found in the enhanced National CLAS Standards.<sup>14</sup>

Culturally competent language assistance services are necessary for individuals with LEP to access the numerous programs supported by HHS in its goal to decrease racial and ethnic health disparities and improve health equity. Without language assistance services that ensure meaningful access to the ACA's new insurance programs, discrete communities such as those with a large number of LEP individuals will be systematically excluded from opportunities to achieve better health.

A lack of language services limits the amount and quality of care that LEP individuals receive.<sup>15</sup> Visiting health care facilities and agencies that administer health programs and activities are often unfamiliar experiences for individuals with LEP who do not know the system's norms and vocabulary. Standard 1 of the enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care ("enhanced National CLAS Standards") explains how providing "effective, equitable, understandable, and respectful quality care and services" requires incorporating cultural health beliefs into the delivery of medical care. Language assistance services are more effective when

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<sup>12</sup> U.S. FOOD AND DRUG ADMINISTRATION, INFORMATION FOR HEALTHCARE PROFESSIONALS: ISOTRETINOIN (MARKETED AS ACCUTANE) (2005), <https://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/DrugSafetyInformationforHealthcareProfessionals/ucm085227.htm>.

<sup>13</sup> Agustín Conde-Agudelo et al, *Effects of Birth Spacing on Maternal, Perinatal, Infant, and Child Health: A Systematic Review of Causal Mechanisms*, 43 STUD. FAM. PLAN. 93 (2012), available at [https://www.k4health.org/sites/default/files/conde-agudelo\\_2012.pdf](https://www.k4health.org/sites/default/files/conde-agudelo_2012.pdf).

<sup>14</sup> Office of Minority Health, U.S. Dep't of Health & Human Servs., *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice* (2013).

<sup>15</sup> See, e.g., G. Flores et al., *Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters*, 111 PEDIATRICS 6–14 (2003); T.K. Ghandi et al. *Drug Complications in Outpatients*, 15 J. OF GEN. INTERNAL MED. 149–54 (2000); D. K Pitkin et al., *Limited English Proficiency and Latinos' Use of Physician Services*, 57 MEDICAL CARE RESEARCH AND REVIEW 76–91 (2000).

delivered within cultural context, since communities have different perceptions of health, wellness, illness, disease, and health care.<sup>16</sup>

AA and NHPI communities are incredibly diverse. The lack of disaggregated data for AA and NHPI subgroups masks disparities in health status and access that may be present for specific subgroups. We recommend additional requirements to specifically address collecting, analyzing and applying **demographic** data, ideally disaggregated by race/ethnicity for AA&NHPIs. Accurate and robust data collection is extremely important to help us understand diseases and health issues that specifically and disproportionately affect AA and NHPI communities. Data on our communities continues to be inadequate or missing due to small sample sizes and aggregated race/ethnicity categories.

Data and research should strive to capture the similarities and differences across ethnic groups and/or nations of origin. Other key subgroups in need of new data and research include, but are not limited to, immigrant and refugee status, language(s) spoken, gender identity, sexual orientation, socioeconomic class, religion, and geographic location (especially in the case of Hawaii and the Pacific Island territories).

In order to improve data collection and research of the AA and NHPI community, we recommend HHS implement the best practices developed by the National Council of Asian Pacific Americans (NCAPA):

- **Best Practice: HHS should ground its research with community-based knowledge of the AA and NHPI community.**

HHS should design its research to collect accurate data on racial and ethnic groups. HHS should ground its research and data collection in the expertise and knowledge of community-based organizations, whose experience and work often defy popular misconceptions that stem from traditional research that lumps AA and NHPIs into one monolithic community and/or neglects to collect enough data to produce reliable findings on many smaller or medium-sized ethnic populations. This grounding should come at a minimum from a literature review of some community-based research and the active participation of appropriate AA and NHPI advisory committee members, and at a maximum, from a Community-Based Participatory Research Model.

Collecting accurate, detailed data that can capture the unparalleled ethnic and linguistic diversity of the AA and NHPI community depends on (a) the demographic questions asked, (b) the sample design, and (c) the extent of Asian-language support.

- (a) **Demographic question design:** When collecting demographic information, researchers should include separate race categories for AA and NHPIs as two distinct groups, as well as ethnic categories that capture both large and small AA

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<sup>16</sup> Lisa C. Ikemoto, *Symposium: Racial Disparities in Health Care and Cultural Competency*, 48 ST. LOUIS L.J. 75, 86 (2003).

and NHPI ethnic groups.<sup>17</sup> Data collection efforts should also provide write-in categories that allow respondents to self-identify as a racial or ethnic group not captured by existing categories.

**(b) Sample design:** To ensure meaningful disaggregated analysis, research should also oversample AA and NHPI ethnic groups.

**(c) Language support:** Since 32 percent of AAs and 8 percent of NHPs nationwide are limited English proficient, research should translate questionnaire instruments into as many AA and NHPI languages as possible.

- **Best Practice: HHS must provide disaggregated data for the AA and NHPI community.**

Findings for the “average” or “median” Asian American are rarely useful. This is particularly true when such average data lack accompanying results that have been separated into ethnic subgroups, geographic location, class groupings, gender, sexual identity, and/or other instructive categories.

To avoid producing research that masks the critically important differences in experiences and conditions that exist within AA and NHPI communities, HHS should provide disaggregated results of their data by ancestry, nationality, language access, etc., whenever possible. In order to achieve this, researchers should strive to provide resources that will allow for disaggregated data collection by ethnicity, locality, and socioeconomic status.

Whenever possible, we also recommend oversampling on ethnic subgroups and/or other categories, and reporting out data where the margins of error for each group reach up to 10 percent.

When oversampling is not possible due to the absence of a statistically significant sample size for all of the represented groups, researchers should explicitly state this, and should actively work to support improved data collection, while also citing existing research from community-based organizations that reveal sub-community attitudes, experiences and contexts.

We also emphasize the importance of particularly oversampling NHPs, who are among the most vulnerable and underrepresented racial groups in the United States. To date, health data on NHPs have been collected mostly in the two states with the largest NHPI populations—Hawaii and California—or in localized surveys. Oversampling of NHPI populations will lead to a better understanding of the health and health care access needs of NHPs.

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<sup>17</sup> Following Institute of Medicine (IOM) recommendations, questions capturing a respondent’s racial or ethnic background should use existing Office of Management and Budget (OMB) race and Hispanic ethnicity categories as well as more fine-grained categories of ethnicity and language need. *See* The Office of Minority Health, OMB STANDARDS FOR DATA ON RACE AND ETHNICITY, <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=172> (last visited Oct. 14, 2013).

As a population that experiences the significant disparities related to health care access, essential services, and economic security described above, LGBTQ individuals should be specifically mentioned in relevant portions of the Strategic Plan. In previous strategic plans, HHS included explicit references to the LGBTQ population when discussing goals related to providing access to quality, competent care, improving data collection, supporting the healthy development of youth, and expanding access to culturally competent services, among other goals.

#### **Objective 1.4**

We appreciate HHS' desire to strengthen and expand the healthcare workforce. However, we believe that the National Health Service Corps is a key model across the country, and prefer that HHS works to bolster that model rather than create 50 different models based on state choice. Additionally, federal law provides ample protections and religious exemptions, such as the Church Amendments, for health care entities and individuals who object to providing certain services based on their religious beliefs. The Strategic Plan cites no evidence that further protections are needed, and we note that additional provisions to shield these providers from delivering evidence-based, quality medical and health-related services that meet the standard of care would be unnecessary and restrictive.

We recommend HHS to borrow implementation strategies from the enhanced the Enhanced CLAS Standards in furthering the agency's Strategic Plan to "strengthen and expand the healthcare workforce to meet America's diverse needs." We direct HHS to Standard 2: Advance and Sustain Governance and Leadership that Promotes CLAS and Health Equity; Standard 3: Recruit, Promote, and Support a Diverse Governance, Leadership, and Workforce; and Standard 4: Educate and Train Governance, Leadership, and Workforce in CLAS. The Enhanced CLAS Standards provide guidance on how to reach diverse candidates for positions within an organization and how to ensure that diversity is present throughout the hierarchy of an organization. Meeting America's health and human services needs requires a workforce within HHS that is responsive to America's diversity in racial and ethnic makeup, sexual orientation and gender identity, and disability.

### **STRATEGIC GOAL 2: PROTECT THE HEALTH OF AMERICANS WHERE THEY LIVE, LEARN, WORK, AND PLAY**

#### **Objective 2.1**

Community-based organizations and community health centers can help ensure that people have what they need to make healthier living choices. Examples of community-based prevention programs include the CDC's Racial and Ethnic Approaches to Community Health (REACH) initiative. REACH programs have documented continued success in engaging impacted communities in addressing the underlying conditions of chronic



disease.<sup>18,19,20</sup> The achievements of REACH grantees in preventing the widening of racial and ethnic health disparities serve as a model and critical complement to general public health promotion programs. These separate and distinct programs work together to promote community-based best practices and develop evidence-based interventions that have resulted in sustained positive results. Several REACH programs have been key in reaching communities, such as hard-to-reach AA and NHPI communities, that federal funding has previously not been able to support. We therefore caution HHS against eliminating the REACH program and sacrificing long-term investments in ending health disparities for short-term financial gains—gains that will end up costing us more down the road.

HHS makes specific mentions of the necessity for community integration and inclusion in numerous sections of the strategic plan. While we encourage the development of additional community supports to enhance community integration, we caution against relying on such supports in place of paid supports.

## **Objective 2.2**

AAs and NHPs are the fastest growing racial group in the United States with dozens of different cultures and languages.<sup>21</sup> Not mentioning racial and ethnic populations has implications in tailoring preventive programs to address health disparities, including chronic conditions, that exist among AA and NHPs. AA and NHPI communities suffer disproportionately higher rates of many chronic diseases like hepatitis B, cervical cancer, and diabetes.<sup>22,23</sup>

Racial and ethnic minorities, including AA&NHPs, disproportionately experience a number of chronic conditions due to factors including poverty, inability to afford quality coverage, and challenges accessing culturally competent care, among others. Specific culturally and linguistically specific interventions need to be made to address chronic disease in AA&NHPs. AA&NHPs have a higher likelihood of suffering from a number of chronic conditions requiring routine access to care and underscoring the importance of early

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<sup>18</sup> Two Feathers J, Kieffer EC, et al. Racial and Ethnic Approaches to Community Health (REACH) Detroit partnership: improving diabetes-related outcomes among African American and Latino adults. *Am J Public Health* 2005; 95(9): 1552-60.

<sup>19</sup> Special Issue: Centers for Disease Control and Prevention Racial and Ethnic Approaches to Community Health (REACH). *Journal of Health Care for the Poor and Underserved* 2006; 17(2) Supp.

<sup>20</sup> Racial and Ethnic Approaches to Community Health (REACH): Translating Processes of Change and Attributing Improved Health Outcomes to Social Determinants of Health Programs. *Family and Community Health* 2011; 34(S1).

<sup>21</sup> “Between 2000 and 2010, the Asian American population grew faster than another other racial group, at a rate of 46%.” Karthick Ramakrishnan, University of California Riverside & Taeku Lee, University of California Berkeley, *Public Opinion of a Growing Electorate: Asian Americans and Pacific Islanders in 2012*, *National Asian American Survey* 3 (2012), <http://naasurvey.com/resources/Home/NAAS12-sep25-election.pdf>.

<sup>22</sup> See Dr. Alka Kanaya, University of California San Francisco, Pacific Islanders, South Asians and Filipinos Have Higher Rates of Diabetes Than All Other Ethnic Groups, October 15, 2012,

<sup>23</sup> See National Institutes of Health, Office of Research on Women’s Health Women of Color Health Information Collection: Diabetes Mellitus (Apr. 2011), available at <http://orwh.od.nih.gov/resources/policyreports/pdf/ORWH-HIC-Diabetes-Mellitus.pdf>.

prevention. Native Hawaiians and Pacific Islanders have proven to be some of the highest risk populations for cardiometabolic diseases (i.e. diabetes, obesity, and CVD) in the United States.<sup>24</sup> Of the statistics that we know of subsections of AA&NHPI populations, we realize that many conditions are severely undertreated.

AA and NHPI communities who face cultural and linguistic barriers to care have difficulty accessing needed health services, including routine screenings. Currently, there is a lack of hepatitis B and C screenings in high-risk foreign-born populations including AA and NHPI and African immigrant communities. Therefore, it is vital that these communities in question are made aware of screenings for high-risk diseases such as HIV/AIDS, hepatitis B, and hepatitis C. Targeted screening for HBV that focus on highly-burdened communities is a recognized key to reducing negative health outcomes and eliminating hepatocellular carcinoma (HCC)-related disparities.<sup>25,26</sup> Additionally, screening with appropriate follow-up and referral to care has shown to be cost-effective, particularly when targeting Asian American and Pacific Islander (AA and PI) communities.<sup>27,28,29,30</sup> However, despite indications, screening rates for HBV in the United States remain low, leading to vast under-diagnosis of chronic hepatitis B infections. Large surveys in AA and PI communities indicate self-awareness of chronic HBV infection status that hovers between 30% and 40%, although some surveys have found screening rates in API immigrant communities to be as low as 8%, or as high as 60%.<sup>31,32,33,34</sup> As hepatitis B has a prevalence rate of about 2 million individuals in the United States, these screening rates indicate that up to 1.4 million Americans are unaware of their HBV infection. Individuals that are unaware of their infection status are not receiving appropriate medical management, treatment and HCC

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<sup>24</sup> Mau MK, Sinclair K, Saito EP, Baumhofer KN, Kaholokula JK. Cardiometabolic Health Disparities in Native Hawaiians and Other Pacific Islanders. *Epidemiologic Reviews*. 2009; 3(1): 113-129.

<sup>25</sup> IOM. Hepatitis and Liver Cancer: A National Strategy for the Prevention and Control of Hepatitis B and C. Washington, D.C.: Institute of Medicine; 2010.

<sup>26</sup> Weinbaum CM, Williams I, Mast EE, Wang SA, Finelli L, Wasley A, et al. Recommendations for identification and public health management of persons with chronic hepatitis B virus infection. *MMWR Recomm Rep* 2008; 57(RR-8):1-20.

<sup>27</sup> Armbruster B, Brandeau ML. Cost-effective control of chronic viral diseases: finding the optimal level of testing and contact tracing. *Math Biosci* 2010; 224(1):35-42.

<sup>28</sup> Hutton DW, Tan D, So SK, Brandeau ML. Cost-effectiveness of testing and vaccinating Asian and Pacific Islander adults for hepatitis B. *Ann Intern Med* 2007; 147(7):460-9.

<sup>29</sup> Post SE, Sodhi NK, Peng CH, Wan K, Pollack HJ. A simulation shows that early treatment of chronic hepatitis B infection can cut deaths and be cost-effective. *Health Aff (Millwood)* 2011; 30(2):340-8.

<sup>30</sup> Veldhuijzen IK, Toy M, Hahne SJ, De Wit GA, Schalm SW, de Man RA, et al. Testing and early treatment of migrants for chronic hepatitis B virus infection is cost-effective. *Gastroenterology* 2010; 138(2):522-30.

<sup>31</sup> Lin SY, Chang ET, So SK. Why we should routinely screen Asian American adults for hepatitis B: a cross-sectional study of Asians in California. *Hepatology* 2007; 46(4):1034-40.

<sup>32</sup> Ma GX, Fang CY, Shive SE, Toubbeh J, Tan Y, Siu P. Risk perceptions and barriers to Hepatitis B testing and vaccination among Vietnamese immigrants. *J Immigr Minor Health* 2007; 9(3): 213-20.

<sup>33</sup> Thompson MJ, Taylor VM, Jackson JC, Yasui Y, Kuniyuki A, Tu SP, et al. Hepatitis B knowledge and practices among Chinese American women in Seattle, Washington. *J Cancer Educ* 2002;17(4):222-6.

<sup>34</sup> Wan KJ MT, Fryer G et al. Testing for hepatitis B virus infection by primary care physicians in New York City: are testing recommendations for persons born in endemic countries being followed? [abstract 1454]. *Hepatology* 2007;46(Suppl)(889A-890A.).

screening, and are at greater risk of developing serious liver disease leading to premature death.<sup>42,35</sup>

Clinics that take care of refugees do not have to adhere to screening requirements. Health providers and case managers who care for refugees need to be better educated about chronic diseases that AA and NHPI populations are at high-risk for acquiring, including hepatitis B. When refugees arrive, patients are unaware of whether they may or may not have been tested, and even when they are tested, they are not educated about what they need to do after receiving their results. We recommend that HHS collaborate with the federal Office of Refugee Resettlement, as well as state offices, to help alleviate these barriers to care.

Within disease states such as hepatitis B that disproportionately affect immigrant populations, there is a severe lack of vaccine awareness and education, potentially fueling the spread of disease. HHS agencies should work with community-based organizations with links to at-risk communities to share resources and collaborate to increase vaccination education and awareness. Reflecting recent updates to Section 317 of the Public Health Service Act, it is imperative that high-risk communities understand how to obtain hepatitis B vaccinations.<sup>36</sup> Actions must be made towards vaccinating household contacts of non-pregnant infected individuals, and linking them to care if needed.

Many individuals who are aware of their infection status do not or cannot obtain appropriate follow-up care (as defined by professional practice guidelines). Only a minority of those diagnosed as chronically infected are able to access care.<sup>37,38</sup> When persons are screened in the hospital or as a part of a targeted screening and intervention effort, up to 66% of those found to be infected are evaluated and referred to appropriate care.<sup>39,40</sup> However, it is estimated that only 40% of those screened in community clinics and medical offices are referred and linked to appropriate care.<sup>55,41</sup>

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<sup>35</sup> Lok AS, McMahon BJ. Chronic hepatitis B. *Hepatology* 2001; 34(6):1225-41.

<sup>36</sup> On October 1, 2012, guidelines for the distribution of vaccines under Section 317 changed to reflect new provisions under the ACA. <http://www.cdc.gov/vaccines/spec-grps/prog-mgrs/317-QandA.htm#Vaccines> (last visited Oct. 15, 2013).

<sup>37</sup> Cohen C, Evans AA, London WT, Block J, Conti M, Block T. Underestimation of chronic hepatitis B virus infection in the United States of America. *J Viral Hepat* 2008; 15(1):12-3.

<sup>38</sup> Cohen C, Chen G, Block J, et al. Chronic Hepatitis B in Chinese Immigrants: Assessing Barriers to Care. [Abstract 199792]. American Public Health Association Annual Meeting, Philadelphia, PA. November, 2009.

<sup>39</sup> Pollack H, Wan K, Miyoshi T, et al. Management of chronic hepatitis B virus (HBV) infection by primary care physicians in urban hospitals and clinics in New York City. [Abstract 984]. *Hepatology* 2007; 46(Suppl): 676A.

<sup>40</sup> Chao SD, Chang ET, Le PA, Prapong W, Kiernan M, So SKS. The Jade Ribbon Campaign: a model program for community outreach and education to prevent liver cancer in Asian Americans. *J Immigrant & Minority Health* 2007; 11(4): 281-290.

<sup>41</sup> Nishimura A, Shiono P, Stier D et al. Enhanced Surveillance for Chronic Hepatitis B- San Francisco, 2008. [Abstract OP-57]. Presented at the 13<sup>th</sup> International Symposium on Viral Hepatitis and Liver Disease. Washington, DC. March 22, 2009.

Without adequate data, we are presented with an inaccurate picture of hepatitis B and other diseases in at-risk communities. Therefore, we recommend HHS implement a more comprehensive system of surveillance and intervention, with data collection that includes race and ethnicity, to better understand and address the complexities of health disparities that affect high-risk populations, such as hepatitis B prevalence in AA and NHPI and African immigrant populations.

### **Objective 2.3**

HHS's strategic plan appropriately addresses issues related to individuals with disabilities throughout the entire plan. Recognizing that accessibility, community-integration and self-determination are implicated in almost every aspect of health care. Our comments below seek to clarify and strengthen HHS' strategies to promote the following four goals: expansion of access to services in the context of behavioral and physical health collaborative models; promotion of community-integration and inclusion; and protection all other individual rights.

We appreciate HHS' commitment to promoting collaborative models of behavioral and physical health care. Such collaboration has the potential to both address shortages of behavioral health professionals via consultative models, and to address unmet physical health care needs of individuals receiving behavioral health care services. To the extent these models focus on the former by expanding the reach of behavioral health professionals via screening, telemedicine, and/or other consultative models, HHS should ensure that such approaches are coupled with an explicit commitment to expanding and integrating essential community-based behavioral health support services, and provide those services in a culturally and linguistically appropriate manner. Essential community-based services include, but are not limited to, Peer Support Services, Assertive Community Treatment, Mobile Crisis Intervention, and various other intensive community-based services.

Strategic goal 2 potentially provides important resources to meet the needs of AA and NHPI children and youth. We are especially encouraged by the focus on preventing interpersonal violence, promoting healthy relationships, and implementing trauma-informed approaches. This focus on violence and trauma is especially important for Southeast Asian American youth (i.e. Cambodian, Laotian, Hmong, and Vietnamese Americans) who experience compounded mental health trauma from their experience as refugees of war and violence and living in extreme poverty. For example, research indicates that 62% of the Cambodian population suffers from post-traumatic stress disorder, the highest level diagnosed amongst any group ever studied.<sup>42</sup> Additionally, Southeast Asian refugees were often resettled in blighted neighborhoods with high exposure to violence and lack of support services. Finally, mental health is also stigmatized within these communities, leading to low

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<sup>42</sup> Rand Corporation, Cambodian Refugees Suffer from Psychiatric Illness at High Rates Two Decades After Escaping Homeland Terror.

rates of treatment.<sup>43</sup> HHS's strategy to treat violence and trauma is therefore a critical strategy that will serve the needs of Southeast Asian American communities.

We appreciate that HHS has included a section regarding improving Home and Community-Based Services (HCBS), and that HHS makes explicit mention of the well-established and crucial right to community integration and inclusion in numerous sections of the strategic plan. While we encourage the development of additional community supports to enhance community integration, we caution against relying on such supports in place of paid supports.

The choice of providers for mental health and substance use treatment services is often quite limited. Care must be taken to ensure that all individuals are able to access care free of discrimination.

We appreciate the role HHS has in preparing for and responding to public health emergencies. We believe that much of this work, especially in the provision of tools to states and providing public health communications must be done in a culturally competent manner. Protection from abuse and neglect must be built into emergency planning. People with disabilities and older adults too often bear the brunt of poor disaster planning, and may need additional assistance to safely survive emergencies.

### **STRATEGIC GOAL 3: STRENGTHEN THE ECONOMIC AND SOCIAL WELL-BEING OF AMERICANS ACROSS THE LIFESPAN**

LGBTQ people are considered a vulnerable population as it concerns their health. LGBTQ people face higher rates of HIV/AIDS, depression, an increased risk of some cancers, and are twice as likely as their heterosexual peers to have a substance use disorder.<sup>[2]</sup> The medical community and scientific research has repeatedly demonstrated that the poor health outcomes that LGBTQ people face are not associated with any inherent pathology, but rather high rates of poverty, discrimination in the workplace, schools, and other areas, and barriers to nondiscriminatory health care that meets their needs. Recognizing these disparities and the impact they have on LGBTQ people, improving the health, safety, and well-being of LGBTQ people was made a goal of Healthy People 2020, LGBTQ people were included in a number of other health objectives including mental health and mental illness, tobacco use, usual source of care, and health insurance coverage, and the National Institute

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<sup>43</sup> McGale, Nadine (2011) *Alternative interventions for young men's mental health*. PhD thesis, Dublin City University.

of Health (NIH) formally designated sexual and gender minorities as a health disparity population in 2011 for NIH research.<sup>44</sup>

A major factor in these health disparities is the discrimination that LGBTQ people face when trying to access health care. While the Affordable Care Act has significantly increased the percentage of LGBTQ people with insurance and has helped prohibit discrimination against LGBTQ people in coverage and care, LGBTQ people are still more likely than non-LGBTQ adults to lack insurance and LGBTQ people still face discrimination.<sup>[4]</sup> We expect HHS to continue serving LGBTQ people and believe the strategic plan is an ideal opportunity for HHS to show that it plans to engage in targeted efforts to ensure that vulnerable populations like LGBT communities get the healthcare they need.

As a population that experiences the significant disparities related to health care access, essential services, and economic security described above, LGBTQ individuals should be specifically mentioned in relevant portions of the Strategic Plan. In previous strategic plans, HHS included explicit references to the LGBTQ population when discussing goals related to providing access to quality, competent care, improving data collection, supporting the healthy development of youth, and expanding access to culturally competent services, among other goals.

### **Overall: Implications for Health Equity**

While we appreciate the numerous references to addressing health and health care disparities, including those experienced by limited English proficient persons, we note that there is a concerning lack of reference to the distinct disparities that racial and ethnic minorities, in particular, experience. Each year, approximately 83,000 African Americans alone die as a result of health disparities.<sup>45</sup> Health disparities are caused by a multitude of factors and impacted by race, ethnicity, sex, immigration and primary language, among others. This is one reason the HHS Office of Minority Health (OMH), Centers for Medicare & Medicaid Services Office of Minority Health and numerous other OMH divisions within HHS serve critical roles in supporting HHS' Strategic Plan.

The AA&NHPI community speaks over 100 different languages and traces their heritage to more than 50 different countries. As of 2016, 11% of AAs and 23% of NHPI families live below the poverty line.<sup>46</sup> Language barriers, lack of cultural competency, poverty, and immigration status all affect the ability of AAs and NHPIs to access coverage and care.

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<sup>44</sup> Kellan Baker, "Open Doors for All" (Washington: Center for American Progress, 2015), available at <https://www.americanprogress.org/issues/lgbt/reports/2015/04/30/112169/open-doors-for-all/>.

<sup>45</sup> Satcher et al, *What If We Were Equal? A Comparison Of The Black-White Mortality Gap In 1960 And 2000*, Health Affairs March 2005 vol. 24 no. 2 459-464, <http://content.healthaffairs.org/content/24/2/459.long>

<sup>46</sup> Samantha Artiga, et al., *Key Facts on Health and Health Care by Race and Ethnicity, Section 1: Demographics*, Kaiser Family Foundation, June 7, 2016, available at: <http://kff.org/report-section/key-facts-on-health-and-health-care-by-race-and-ethnicity-section-1-demographics/>.

HHS must continue to undertake activities to identify and address health disparities with the ultimate goal of eliminating them. In activities spanning the Office for Civil Rights, Office of Minority Health, Office of Women's Health as well as the Centers for Medicare & Medicaid Services, all of HHS' endeavors must ensure that disparities are prevented. We appreciate recognition of the need to address disparities within the Strategic Plan but believe that HHS must strengthen these sections to ensure all individuals can achieve their health equity.

Further, the Strategic Plan should ensure that all of HHS' activities are undertaken in a culturally competent manner. Providing culturally competent services is critical to ensure that services are client/patient centered and are appropriate for not just the particular program at issue but also for the clients/enrollees served. We urge HHS to include more specific and measurable goals and strategies to address cultural competency in a holistic manner including race, ethnicity, language, immigration status, age, disability, sex, gender identity and sexual orientation.

### **Additional Comments**

We believe HHS' strategic plan must specifically mention and address HHS' legal responsibility to uphold the laws of the United States, including the Affordable Care Act and Medicaid. Without robust implementation of the ACA and adherence to Medicaid's governing statute and regulations, many of the goals and strategies outlined in this plan will be unobtainable. Further, we appreciate the recognition that consumers and enrollees should have choice but that choice must come with sufficient knowledge and information to make informed choices. The recent actions by the Administration to cut funding for navigators and open enrollment outreach are contrary to the stated ability to provide consumers with choices that they actually can understand. Navigators in particular play a critical role in informing consumers about their eligibility for health insurance, helping them enroll, explaining how to use health insurance, and connecting them with health care.

We thus suggest adding a new "strategy" bullet that would read as follows:

#### ***Implement and enforce the ACA***

- ***Ensure sufficient resources to maintain and improve healthcare.gov and its Call Center, and provide information in-language.***
- ***Provide sufficient financial support to FFM navigators to ensure they can operate in all counties in all FFM states and throughout the entire calendar year.***
- ***Conduct outreach activities commensurate with the need to educate and inform individuals about the marketplaces, public health insurance programs (including Medicaid, CHIP and Medicare), their health insurance options, and how to enroll.***
- ***Ensure compliance with all statutory and regulatory requirements regarding the Affordable Care Act and Medicaid.***

We appreciate the opportunity to comment on the HHS Strategic Plan which is critically important for the AA and NHPI communities. If you have any questions regarding our comments, please contact Nisha Ramachandran, Policy Director, at [nisha@ncapaonline.org](mailto:nisha@ncapaonline.org) or Isha Weerasinghe, Director of Policy and Advocacy at AAPCHO, at [isha@aapcho.org](mailto:isha@aapcho.org).

Sincerely,

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