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Office of the Assistance Secretary for Planning and Evaluation  
Strategic Planning Team  
Department of Health and Human Services  
200 Independence Ave. S.W.  
Room 415F  
Washington, D.C. 20201

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

**Attn: Comments on the HHS Draft Strategic Plan FY 2018-2022**

The National Latina Institute for Reproductive Health (NLIRH) is pleased to provide comments on the Department of Health and Human Services' (HHS) Draft Strategic Plan FY 2018-2022. We are deeply concerned by the Draft Strategic Plan FY 2018-2022 and have outlined these concerns by thematic area.

NLIRH is the only national reproductive justice organization dedicated to building Latina power to advance health, dignity, and justice for 28 million Latinas, their families, and communities in the United States through leadership development, community mobilization, policy advocacy, and strategic communications.

NLIRH is alarmed by several new additions and changes to the language and content of the Draft Strategic Plan FY 2018-2022 that constitute a harmful departure from past Strategic Plans, by prioritizing ideology over evidence.

The current HHS Strategic Plan for FY 2014-2018 establishes specific measurable goals to improve the health outcomes of all people living in the U.S. by specifically recognizing the health disparities that persist among populations, including communities of color, individuals with disabilities, refugees, lesbian, gay, bisexual, transgender, and queer individuals (LGBTQ).<sup>1</sup> To give just one example of stark health disparities that exist in the United States, incidence of cervical cancer for Latinas in the United States is among the highest of all racial/ethnic groups, and almost twice as high as non-Latina white women. Latinas have the second highest mortality rate from cervical cancer (after Black women), although mortality for Latina women is higher in communities along the Texas-Mexico border. These high mortality rates from cervical cancer are a result of low rates of cervical cancer screenings. Cervical cancer is preventable, but sadly, about 85% of women who die from cervical cancer never had a pap smear. The 2014-2018 Strategic Plan recognizes and highlights the need for active efforts to reduce existing disparities among specific populations and to ensure that the most vulnerable populations within the United States receive access to healthcare.

Furthermore, the 2014-2018 Strategic Plan details a data-driven agenda to support research that will increase our understanding of population subgroups, such as communities of color, the re-

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<sup>1</sup> See, E.G., HHS Strategic Plan 2014-2018, Strategic Goal 1 Objective E; HHS Action Plan To Reduce Racial And Ethnic Health Disparities (2011).

entry population, and LGBTQ populations. In contrast, while the Draft Strategic Plan promotes culturally-competent care and recognizes that health disparities exist generally, it removes all language identifying these communities and sub-populations specifically by name. At best, this makes the objectives and goals with the Draft Strategic Plan less measurable and meaningful; at worst, these omissions indicate that the agency will deprioritize work on closing gaps in healthcare services and outcomes across these groups. We strongly urge HHS to include, as it has in the past, specific objectives and goals relating to the persistent health disparities that continue to exist for communities, individuals with disabilities, refugees, LGBTQ individuals, and re-entry populations.

Our main concern is how the Draft Strategic Plan impacts the health equity and reproductive health of communities of color. We also provide additional general comments.

### **Measureable Performance Goals and Markers**

Under the Government Performance and Results Act (GPRA) of 1993 (P.L. 103-62) and the GPRA Modernization Act of 2010 (P.L. 111-352), HHS is required to submit a performance plan that expresses performance goals for each strategic objective “in an objective, quantifiable, and measurable form” unless otherwise authorized by the Office of Management and Budget.<sup>2</sup> Under § 306 of the GPRA Modernization Act of 2010, such a strategic plan must include not only general goals and objectives for the major functions and operations of the agency, but also a description of how specific performance goals contribute to achieving the general goals and objectives in the strategic plan. In previous strategic plans, including the FY 2014-2018 Strategic Plan, this requirement has resulted in concrete, measurable Performance Goals for each objective. These Performance Goals have provided benchmarks to measure progress both qualitatively and quantitatively.

Furthermore, HHS has omitted a description of how the goals and objectives incorporate views and suggestions obtained through congressional consultations. The current Draft Strategic Plan cannot be considered compliant unless and until HHS consults with the appropriate members of Congress and a public comment period is insufficient to meet these requirements.

Past Strategic Plans have included benchmarks to measure progress, such as increasing a percentage of adults who are screened for depression, or decreasing the total morphine milligram equivalents dispensed. The Draft Strategic Plan contains no specific measurable performance goals, only “strategies” expressed in vague, precatory terms, such as “promote,” “collaborate,” or “engage with.” The Draft Strategic Plan as it stands does not meet the requirements under law to create a guide and workplan that is measurable. Coupled with the unnecessary and harmful anti-abortion language as well as open-ended support for religious and moral exemptions, the overall effect is that the Draft Strategic Plan comes across as a political agenda to message support for HHS’ perceived allies under the current administration, rather than an actual plan to better the health of people living in the U.S. Further, the HHS Draft Strategic Plan diminishes, rather than ensures, government accountability, by failing to establish data-driven, evidence-based measurable goals. It is a waste of government resources to draft and try to execute against this type of plan.

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<sup>2</sup> 31 U.S.C. § 1115(B)(2), § 1115(C).

## Health Equity

Any Strategic Plan should ensure that all of HHS' activities are undertaken in a culturally competent and linguistically appropriate manner. We urge HHS to include more specific and measurable goals and strategies to address cultural competency in a holistic manner, accounting for race, ethnicity, language, immigration status, age, disability, sex, gender identity, and sexual orientation.

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 not heightened but are prevented. We appreciate recognition of the need to address disparities within the Draft Strategic Plan but believe that HHS must strengthen these sections to ensure all individuals can achieve their health equity.

Here are some additional comments related to these issues:

- We support HHS' recognition of the need for health literacy tools. We suggest HHS specifically recognize the need to provide culturally competent tools such that all individuals, regardless of their background or language, can benefit from these tools
- We recommend additional requirements to specifically address collecting, analyzing, and applying demographic data
- We appreciate HHS' mention of the need to reduce disparities. We believe this includes racial and ethnic health disparities in addition to disparities based on language, age, sex, sexual orientation, gender identity, and disability. We recommend HHS include a broad definition of healthcare disparities in its FY 2018-2022 Strategic Plan
- We note that alternative payment models must not be implemented in such a way that they create incentives to stint needed care or avoid costlier individuals. We 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 reducing costs
- We appreciate the recognition of the need to provide programs that improve the quality of care and increase access. To that end, we recommend that such programs be developed and implemented in a culturally competent and linguistically appropriate manner
- We strongly support the inclusion of the strategy "Reduce disparities in quality and safety" as it is critical to ensure that our healthcare system is accessible to all individuals, regardless of race, ethnicity, language, immigration status, sex, gender identity, sexual orientation, age, and/or disability
- To the extent HHS recognizes the need for providing materials in non-English languages, HHS should also recognize the need for providing materials in formats that will be accessible to individuals with disabilities who have communication needs. This would include large print format and audio or video recordings for those who cannot access written materials
- We are concerned that the Draft Strategic Plan fails to mention other federal civil rights laws and Executive Orders which are relevant to providing healthcare options that are

responsive to consumer demands. These include Executive Order 13166, Title VI of the Civil Rights Act of 1964, § 504 of the Rehabilitation Act, the Americans with Disabilities Act, the Age Discrimination Act, and § 1557 of the Affordable Care Act. All of these laws must be fully implemented and enforced by HHS to ensure that HHS' programs and activities, and those it supports with federal funds, are responsive to consumer demands

- 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
- We support the recognition of the need to improve collaboration with State, Local, Tribal and Territorial (SLTT) partners. We recommend that these strategies also specifically recognize the need to provide information in a culturally competent and linguistically appropriate manner

## **Reproductive Health**

The Draft Strategic Plan in Objective 2.4 defines a lifespan as from “conception” to “natural death,” and vows to respect “the inherent dignity of persons from conception to natural death.” These changes from the FY 2014-2018 Strategic Plan are an unacceptable and unconstitutional infringement on a pregnant person’s bodily autonomy, and we urge HHS to immediately remove all language that could threaten any pregnant person’s access to a broad array of healthcare services.

The explicit connotation that personhood begins at conception runs counter to well-established constitutional caselaw. *Roe v. Wade* established abortion as a fundamental right, declaring that “the word ‘person,’ as used in the Fourteenth Amendment, does not include the unborn.”<sup>3</sup> This central holding of *Roe*, protecting a pregnant person’s right to access abortion, has been consistently upheld and reaffirmed by the Supreme Court, including just last year in *Whole Woman’s Health v. Hellerstedt*. The language in the Draft Strategic Plan is an attempt to directly undermine this fundamental right by pushing an unconstitutional definition of persons and those living in the U.S. as beginning at conception, which has no basis in science. HHS’ reliance on such unscientific and non-medical terms raises serious concerns about government overreach into an individual’s autonomy to make private healthcare decisions and threatens access to crucial healthcare services, including birth control, assisted reproductive technology (ART), stem cell research, and in vitro fertilization (IVF). Perhaps most crucially, this unconstitutional non-medical definition threatens autonomous decision-making for all pregnant individuals, including those intending to carry their pregnancies to term.

Adopting policies that give health rights to fetuses would undermine a pregnant person’s constitutional right to access abortion. Furthermore, it interferes with this personal decision by limiting the information, counseling, referral, and provision of abortion services that an individual can receive. The language is overly broad, confusing, and subject to misuse and abuse by creating a federal healthcare framework that invites HHS to refuse to participate in the orderly delivery of evidence-based healthcare services.

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<sup>3</sup> *Roe v. Wade*, 410 U.S. 113, 158 (1973).

By inserting concepts such as “the unborn” and life “from conception” into the Draft Strategic Plan, HHS runs contrary to medical and health-related evidence and standards of care, and will be reflecting one particular religious point of view that has no role in advancing and protecting the public health of a diverse population. Communities of color already face additional barriers in accessing a full range of reproductive health services and adding such policies will impede the ability of HHS to cultivate and inform best practices, and in turn, interfere with the ability of providers to provide quality care.

Here are some additional comments related to reproductive health:

- We oppose all efforts to limit the provision of health information, including but not limited to when it concerns the full range of contraceptive options including sterilization, abortion, and LGBTQ-inclusive sexual health information
- We appreciate HHS’ desire to strengthen and expand the healthcare workforce. However, federal law provides ample protections and religious exemptions, such as the Church Amendments, for healthcare entities and individuals who object to providing certain services based on their religious beliefs. The Draft 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 strongly support expanding resources and information for adolescents so that they can make the best decisions for their health and well-being. However, programs and information supported under the FY 2018-2022 Draft Strategic Plan must include age, developmentally and culturally appropriate, medically accurate, evidence-based sexual and reproductive health information to ensure that adolescents have the tools they need to make informed and healthy decisions throughout their lives
- We recommend considering the importance of reproductive and sexual health in relation to preventing interpersonal violence and promoting healthy relationships

### **Implications of Religious Freedom**

The decision to obtain any health service, including reproductive healthcare, should remain with the individual. The idea that “life begins at conception” is not an evidence-based theory, but a religious one, which the vast majority of people that HHS serves do not share. The language is contrary to both the Establishment Clause and the Free Exercise Clause of the U.S. Constitution.

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 access to the healthcare they need in the Draft Strategic Plan. However, the Draft Strategic Plan in Objective 1.3 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. This language is inappropriate for any strategic plan, as it does not establish measurable goals, and further, the use of this language to qualify broader goals relating to healthcare access improperly implies that limitations on healthcare access may be appropriate based on religious or moral grounds. A religious belief should never determine or limit the healthcare services that an individual can receive. When hospitals, clinics, and individual

healthcare providers have the ability to refuse services based on religious or moral beliefs, individuals may suffer devastating health consequences. The harms caused by refusals to provide care have a disproportionate impact on those who already facing a multitude of barriers to care, including communities of color, LGBTQ individuals, those with limited English proficiency, and families and individuals with low-incomes.

HHS should be committed to putting measurable goals toward improving individual care at the center of any strategic plan, and should work to ensure medical standards of care and individual circumstances determine services, 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' FY 2018-2022 Draft Strategic Plan. Additionally, this Draft Strategic Plan fails to acknowledge that many healthcare 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 healthcare providers from employment discrimination due to their providing abortions and other care. If HHS cares about protecting individual healthcare 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 healthcare providers, and to commit to truly putting those accessing necessary healthcare first.

We do not support HHS' statement that removing barriers to and promoting participation in HHS programs by persons and organizations with religious beliefs or moral convictions is a solution to assisting targeted populations. Rather, HHS should remain religiously and morally neutral in its funding and activities to ensure that individuals do not receive a limited scope of services due to the moral or religious nature of an organization.

### **Implications for LGBTQ Individuals**

Extensive evidence demonstrates that the poor health outcomes of LGBTQ individuals are not associated with any inherent pathology. Rather, these health inequities are due to high rates of poverty, discrimination in the workplace, schools, and other areas, as well as, barriers to nondiscriminatory healthcare. Recognizing these disparities and the impact they have on LGBTQ individuals, improving the health, safety, and well-being of the community was made a goal of Healthy People 2020. LGBTQ individuals 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. The National Institute of Health (NIH) formally designated "sexual and gender minorities" as a health disparity population in 2011 for NIH research.<sup>4</sup>

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<sup>4</sup> Office of Disease Prevention and Health Promotion, "Lesbian, Gay, Bisexual, and Transgender Health: Overview," Healthypeople.gov, available at <https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health>; Eliseo J. Pérez-Stable, "Director's Message: Sexual and Gender Minorities Formally Designated as a Health Disparity Population for Research Purposes," National Institute on Minority Health and Health Disparities, October 6, 2016, available at <https://www.nimhd.nih.gov/about/directors-corner/message.html>; Office of Disease Prevention and Health Promotion, "Lesbian, Gay, Bisexual, and Transgender Health: Objectives," Healthypeople.gov, available at <https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health/objectives>

LGBTQ Latinxs are subject to a number of intersecting barriers to quality healthcare, further worsening health disparities. LGBTQ individuals face higher rates of depression, an increased risk of some cancers, HIV/AIDS, and are twice as likely as their heterosexual peers to have a substance use disorder.<sup>5</sup> The transgender community in particular is at higher risk for a range of poor health outcomes. For example, the 2015 U.S. Transgender Survey, a national study of nearly 28,000 transgender adults, found that respondents were nearly five times more likely to be living with HIV than the general population. According to the Center for Disease Control and Prevention, half of all transgender people diagnosed with HIV are Black. Transgender respondents were nearly eight times more likely than the general population to be living with serious psychological distress based on the Kessler 6 scale, with higher rates correlating with experiences of discrimination, violence, and rejection.<sup>6</sup>

A major factor in these health disparities is the discrimination that LGBTQ people face when trying to access healthcare. While the Affordable Care Act significantly increased the percentage of LGBTQ people with insurance and 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>7</sup> A recent survey found that transgender respondents were over 5 times more likely to avoid doctor's offices just to avoid the risk of experiencing discrimination than their cisgender counterparts.<sup>8</sup> Additionally, the 2015 U.S. Transgender Survey found that, just in the past year, 33% of those who saw a healthcare provider face some form of mistreatment or discrimination because of being transgender, such as being refused care, harassed, or physically or sexually assaulted, and 23% avoided seeing a doctor when needed due to fear of discrimination. We expect HHS to continue serving LGBTQ individuals and believe the FY 2018-2022 Strategic Plan is an ideal opportunity for HHS to show that it plans to engage in targeted efforts to ensure that vulnerable populations like LGBTQ communities receive essential healthcare services.

As a population that experiences the significant disparities related to healthcare access, essential services, and economic security described above, LGBTQ individuals should be specifically mentioned in relevant portions of the FY 2018-2022 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. We recommend that the needs of the LGBTQ population be explicitly mentioned in some of the following key goals:

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<sup>5</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>6</sup> K6-K10 Scales- Health Care Policy, Harvard Medical School, available at [https://www.hcp.med.harvard.edu/ncs/k6\\_scales.php](https://www.hcp.med.harvard.edu/ncs/k6_scales.php)

<sup>7</sup> Kellan Baker, Sejal Singh, Shabab Ahmed Mirza, and Laura E. Durso, "The Senate Health Care Bill Would Be Devastating for LGBTQ People" (Washington: Center for American Progress, 2017), available at <https://www.americanprogress.org/issues/lgbt/news/2017/07/06/435452/senate-health-care-bill-devastating-lgbtq-people/>.

<sup>8</sup> Sejal Singh and Laura E. Durso, "Widespread Discrimination Continues to Shape LGBT People's Lives in Both Subtle and Significant Ways" (Washington: Center for American Progress, 2017), available at <https://www.americanprogress.org/issues/lgbt/news/2017/05/02/429529/widespread-discrimination-continues-shape-lgbt-peoples-lives-subtle-significant-ways/>.

- Collect additional data, identify barriers to access, facilitate individual engagement, and promote evidence-based practices to improve access to physical and behavioral health services
- Measure and report on healthcare quality and disparities at the national, state, local, and individual provider level to facilitate improvement in the healthcare system
- Identify individuals and populations at risk for limited healthcare access and assist access to health services, including prevention, screening, linkages to care, clinical treatment, and relevant support services, including through mobilization of faith-based and community organizations
- Health promotion and wellness strategies supported by HHS should focus on specific populations at risk for poorer health outcomes, such as older adults, people with disabilities, communities of color, individuals with low-incomes, youth, and people with limited English proficiency
- Support research to identify, implement, and evaluate interventions to reduce health disparities and improve the health of populations at risk for poor health outcomes
- Support comprehensive sexual and reproductive health counseling and services from LGBTQ-competent providers, and reject faith-based partners that shame LGBTQ individuals and communities based on specific ideological beliefs

NLIRH appreciates the opportunity to comment on HHS' Draft Strategic Plan FY 2018-2022. If you require additional information about the issues raised in this letter, please contact Nina Esperanza Serriane at [nina@latinainstitute.org](mailto:nina@latinainstitute.org).

Sincerely,

National Latina Institute for Reproductive Health