



ReachOut e-Diversity News

An Electronic Publication of the Ohio Developmental Disabilities Council

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June 2015 Edition | Volume 9, Issue 3
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Read, Pass on to Friends, Family Members, Colleagues & Constituents



Culturally and Linguistically Appropriate Services

The United States continues to grow more diverse. Currently, about 20% of the U.S. population speaks a language other than English at home, and 9% has limited English proficiency. By 2050, the United States will be a “majority minority” nation, with more than half the population coming from racial or ethnic minority backgrounds.

5 Things You Need to Know about Mental Health



1. Fighting Stigma
2. Children and Youth
3. Keeping Sharp While Aging
4. Treating and Coping...
5. Managing PTSD



Men's Health Facts

A helpful and printable Fact Sheet to assist in life management.

White House Appoints Town as New Disability Policy Coordinator



There is a new staffer at the White House tasked with addressing the needs of the disability community.

[CLICK HERE](#)

The ODDC Needs your help!

[CLICK HERE](#)

Please, take a few minutes and let us know how our outreach effort enhances your understanding of the The Ohio Developmental Disabilities Council's work. The Council uses the ReachOut e-Diversity Newsletter as a means of outreach and education. We are engaged in a consolidated planning process and need your feedback. Your help is very much appreciated and essential to ensure ODDC's continued success!

The purpose of "Reach Out" e-Diversity newsletter is to promote interagency collaboration and coordination that result in agencies providing culturally competent services to the unserved/underserved populations in Ohio



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Culturally and Linguistically Appropriate Services — Advancing Health with CLAS

Howard K. Koh, M.D., M.P.H., J. Nadine Gracia, M.D., M.S.C.E., and Mayra E. Alvarez, M.H.A.



The United States continues to grow more diverse. Currently, about 20% of the U.S. population speaks a language other than English at home, and 9% has limited English proficiency. By 2050, the United States will be a “majority minority” nation, with more than half the population coming from racial or ethnic minority backgrounds. Diversity is even greater when dimensions such as geography, socioeconomic status, disability status, sexual orientation, and gender identity are considered. Attention to these trends is critical for ensuring that health disparities narrow, rather than widen, in the future.

The U.S. Department of Health and Human Services (HHS) has long promoted

cultural and linguistic competence as one way to address health disparities. Boosting such competence among health care providers and organizations could not only help them improve

health equity but also increase client satisfaction, improve quality and safety, gain a market advantage, and meet legislative and regulatory standards. Although many providers are personally committed to improving cultural and linguistic competence, their organizations may remain uncertain about how best to become welcoming to all.

To address this need, in 2013, the HHS Office of Minority Health (OMH) released the enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (see National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care). These standards provide a framework

for organizations seeking to offer services responsive to individual cultural health beliefs and practices, preferred languages, health-literacy levels, and communication needs. Building on standards released in 2000, the enhanced standards employ broader definitions of culture (beyond traditional considerations of race and ethnicity) and health (including mental health as well as physical health, for example). They apply to organizations focused on prevention and public health as well as health care organizations. To guide and encourage adoption, the OMH released a blueprint highlighting promising practices and exemplary programs.

Although adherence is voluntary, many organizations have committed to some or all of the 15 standards, which fall under three themes. The first, “**Governance, Leadership, and Workforce**,” emphasizes that the responsibility for CLAS implementation rests at the highest levels of organizational

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leadership. Prominent groups have endorsed this concept. For example, the National Quality Forum identifies leadership as one of the seven primary domains for measuring and reporting cultural competence. National public health organizations such as the American Public Health Association and the Society for Public Health Education promote CLAS and health equity policies through their mission, vision, or values statements. The Health Research and Educational Trust, an affiliate of the American Hospital Association, asks organizations whether their boards set cultural-competence goals in their strategic plans and whether diversity awareness and training are required for senior leadership, management, staff, and volunteers — since without culturally appropriate services, any client encounter could result in misunderstanding. Some studies have linked greater cultural competence in health settings to greater client trust and better patient-reported quality of care.

Standards under the second theme, “**Communication and Language Assistance**,” include the recommendation that language assistance should be provided as needed, in a manner appropriate to the organization’s size, scope, and mission. For example, the multifaceted language assistance at California’s Alameda Alliance for Health includes interpreters, bilingual staff, remote interpreting systems, and Braille materials. The alliance informs members of the availability of assistance in their preferred language through welcome packets, newsletters, “I speak . . .” cards with which clients indicate their language needs, and verbal contact with the member services department. Notably, health care organizations and providers that receive federal financial assistance without providing free language-assistance services could be in violation of Title VI of the Civil Rights Act of 1964 and its implementing regulations.

The third theme, “**Engagement, Continuous Improvement, and Accountability**,” underscores the importance of quality improvement, community engagement, and evaluation. Organizations can assess whether their CLAS activities meet their community’s needs and communicate implementation progress to interested parties. For example, in its resource manual for stakeholders, “Making CLAS Happen,” the Massachusetts Department of Public Health recommends using “cultural brokers,” such as community health workers or *promotores de salud*, as bridges to people of various cultural backgrounds.

Embracing systemic change, a growing number of national programs, states, and institutions have committed to adopting the CLAS standards comprehensively. For example, the Joint Commission has established accreditation standards targeting improved communication, cultural competence, patient-centered

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care, and provision of language-assistance services. Its **“Comprehensive Accreditation Manual for Hospitals”** addresses the importance of collecting data on patients’ race and ethnic background, meeting patients’ communication needs, establishing qualifications for interpreters and translators, and ensuring nondiscrimination in care delivery.

National health care groups have also leveraged the CLAS standards to move toward health equity (www.equityofcare.org). In 2011, the American College of Healthcare Executives, the American Hospital Association, the Association of American Medical Colleges, the Catholic Health Association of the United States, and the National Association of Public Hospitals and Health Systems (now known as America’s Essential Hospitals) issued a call to eliminate health care disparities by improving the collection of race, ethnicity, and language-preference data;

increasing cultural-competence training; and increasing diversity in governance and leadership. Moreover, at least six states have laws requiring or strongly recommending cultural-competence training for providers that includes the CLAS standards.

Kaiser Permanente, a nonprofit health plan with 9.3 million members, has adopted the CLAS standards and committed to myriad initiatives to support them. The company’s National Diversity and Inclusion function provides oversight, technical expertise, and consultation to promote the standards throughout its facilities in eight states and the District of Columbia. Its Qualified Bilingual Staff Model and Program trains bilingual staff who can serve members and patients in their preferred language. Its Clinician Cultural and Linguistic Assessment Initiative supports language concordance programs that enable provider–patient matching based on linguistic preferences. And a Lesbian, Gay,

Bisexual, Transgender Health Equity Initiative and a Member Demographic Data Collection Initiative for race, ethnicity, language preference, sexual orientation, and gender identity have earned recognition by the National Committee for Quality Assurance and the Institute of Medicine.

Future efforts should promote evaluation of the CLAS standards to build a robust evidence base about their impact. Some studies have proposed tools for assessing cultural competence within health organizations. Adopters of the standards can contribute to evolving knowledge about their dissemination and effect on quality of care, health literacy, and health disparities, among other critical areas. It would also be useful to study the standards’ application in addressing specific health issues, such as cardiovascular disease, HIV/AIDS, mental health, and multiple coexisting conditions, as well as in health-promotion and

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disease-prevention initiatives. Furthermore, research should clarify the standards' potential effects on new models of care, including patient-centered health homes and accountable care organizations, as well as community health improvement activities. Understanding how meeting the standards ultimately changes health and economic outcomes would help

organizations in weighing practice and business decisions.

Many observers today are asking how our health system can best meet our country's future needs. Achieving health equity for all remains a critical goal. Advancing health with CLAS can help us attain the high-quality system of care and prevention that all people, regardless of background,

need and deserve.

Reprinted from *New England Journal of Medicine* 371:198-201, July 17, 2014

Read the National CLAS Standards below.

[CLICK THE CLAS LOGO](#) to view the The Blueprint with guidance and implementation strategies

NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) IN HEALTH AND HEALTH CARE.

The CLAS standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations:

Principal Standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance,

leadership, and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, orally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the

languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability and infuse them throughout the organization's planning and operations.

10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality-improvement activities.

11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.



13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Create processes for conflict and grievance resolution that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

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5 Things You Need to Know about Mental Health

1. Fighting Stigma. Many people living with a mental health condition unfortunately experience stigma and misunderstanding. In fact, a nationwide survey found that only 25 percent of adults with mental health symptoms believed that people are sympathetic towards those with mental illness. Some people mistakenly believe that mental illness always leads to violent and unpredictable behavior. Based on fear, misunderstanding or a lack of information about mental illness, stigma may cause people to delay treatment or to experience discrimination in employment, housing and other areas of their lives.

2. Children and Youth. Young people's mental health is just as important as their physical health as they grow and age. Youth are more affected by mental health issues and millions of American children live with depression, mood and anxiety disorders and other mental health issues. It's not unusual for youth to experience phases of anxiety, for example, but it may be time to seek help if symptoms continue.

3. Keeping Sharp While Aging. As people age, their brains change and communicate differently. As these natural changes occur, people may notice differences in their ability to learn new tasks or recall information. If all this is upsetting, don't worry – learn the difference between being forgetful and experiencing more serious memory loss. Aging does make people more susceptible to conditions such as dementia, including Alzheimer's. There are signs and symptoms to keep an eye on if you or an older adult you know seems to experience more than simple memory decline.

4. Treating and Coping with Depression. It's estimated that more than 20 million people in the United States have depression. Depression is not just feeling down or sad for a few days – it is a serious medical illness with a broad spectrum of symptoms that persist and interfere with everyday life. These symptoms may include feelings of sadness, loss of interest or pleasure in activities and changes in weight.



5. Managing PTSD. Almost eight percent of Americans will experience post-traumatic stress disorder (PTSD) at some point in their lives. PTSD can be difficult to manage, but with proper treatment and care, recovery is possible. There are many effective ways to treat PTSD, including cognitive therapy, group therapy and medication. The U.S. Department of Veterans Affairs is committed to helping veterans coping with PTSD with online resources for managing and recovering from this complex condition that can be used by non-veterans as well.

For additional information Visit:

<https://www.disability.gov/disability-connection-newsletter-may-2015/>

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June is Men's Health Month

The purpose of Men's Health Month is to heighten the awareness of preventable health problems and encourage early detection and treatment of disease among men and boys

The average life expectancy of a man born in the United State in 2007 is 75 years and 5 months. The life expectancy for a man has increased dramatically in the past 50 years. How long we live is important; however, the quality of life is equally important. The ability to enjoy life to its fullest requires investing time and effort into health maintenance and disease prevention. This investment pays dividends almost immediately and it is never too late to begin. A person who was 65 years old in 2007 could expect to live to age 82, and a 75 year old could expect 10 more years of life

Most of the common diseases that affect men are potentially preventable, but one needs to know their enemy. Interestingly, the presence of some diseases increases the likelihood that another will occur. Heart disease, stroke, peripheral vascular disease, and dementia all share

the same risk factors: smoking, high blood pressure, high cholesterol, and family history. Top 10 Diseases that kill men are:

- Heart Disease
- Cancers
- Accidents (unintentional Injuries)
- Stroke
- COPD
- Diabetes
- Influenza and Pneumonia
- Suicide
- Kidney Disease
- Alzheimer's Disease

Different races have different rankings. For example, homicide is the fourth highest cause of death for black men and HIV/AIDS is the seventh, neither of which is in the top ten for all races. For Hispanic men, homicide is sixth, followed by chronic liver disease. The following are examples of certain health issues impacting Minority men.



- **African-American and Hispanic-American/Latino men** are less likely than white men to see a doctor.
- **Minority men** are less likely to get timely preventive care, such as flu shots and colonoscopies.
- **African-American men** are 30 percent more likely to die from heart disease compared to non-Hispanic white men.
- Even though **African-Americans** account for about 13 percent of the U.S. population, they account for about half of the people who get HIV/AIDS.
- **American Indians and Alaska Natives** have especially high rates of depression, suicide, and substance abuse.

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- **African-Americans who get skin cancer** are more likely to die from it than whites.
- Type 2 diabetes is more common among **African-Americans, Hispanic-Americans/Latinos, and American Indians** than among whites.
- **Asians and Pacific Islanders** make up 4.5 percent of the U.S. population but have more than half of the chronic cases of hepatitis B.

The reasons for these health disparities are not directly related to race and ethnicity. Instead, low income, lack of access to care, language and cultural differences, and other barriers often make good health hard to achieve for many minority groups.

Our bodies are incredibly complex

machines that require fuel components (food, water, and air) to grow, function, and repair itself. Like any machine, the body requires routine maintenance to make it last a long time and to function well throughout a person's life expectancy. Using the body as it was intended and minimizing abuse also increases its ability to perform. When we buy a car, we expect to routinely change the oil, filters, rotate the tires, and avoid driving too aggressively to keep the car running smoothly and last a certain length of time. As in life, accidents happen and cosmetic injuries occur, but it is the "guts" of a car, the engine, transmission, and brakes that will decide if it will be happily driving down the road or sitting in the junkyard.

Our bodies suffer through illnesses and accidents and many are unavoidable. Taking care of your body also includes

scheduled maintenance and screening examinations to detect illnesses at an early stage, which increases the potential for cure and a return to health. Learning to listen to the body's warning signs and symptoms is the same as paying attention to the check engine light in your car, neither should not be ignored.

A healthy lifestyle is not just an absence of disease, but an opportunity to enjoy the years of life available to each person. Medical care can help the body maintain its performance as it ages.

This information was reprinted from Men's Health Newsletter, William Shiel Jr., M.D., F.A.C.P. Chief Medical Editor, MedicineNet.com and Minority Men's Health @ <http://www.womenshealth.gov/mens-health/index.html>

Did You Know?

Depression is under-diagnosed in men. Men are over four times more likely than women to commit suicide.

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Men's Health Facts



Health Facts:

Men die at higher rates than women from the top 10 causes of death and are the victims of over 92% of workplace deaths. (BLS)
In 1920, women lived, on average, one year longer than men. Now, men, on average, die almost five years earlier than women. (CDC)

Silent Health Crisis

There is a silent health crisis in America...it's that fact that, on average, American men live sicker and die younger than American women."
Dr. David Gremillion
Men's Health Network

Prevention:

Women are 100% more likely to visit the doctor for annual examinations and preventive services than men. (CDC 2001)

Cause & Rate¹ Men Women

Cause	Men	Women
Heart Disease	228.6	143.0
Cancer	211.6	146.8
Injuries	51.1	24.6
Stroke	39.7	37.8
Suicide	19.2	4.9
HIV/AIDS	4.4	1.7



Men as Victims of Homicide

The chance of being a homicide victim places African-American men at unusually high risk.

Chance of being a Homicide Victim*

1 in 30 for black males 1 in 179 for white males
1 in 132 for black females 1 in 495 for white females

*BJS DATA REPORT, 1989

Who is the Weaker Sex?

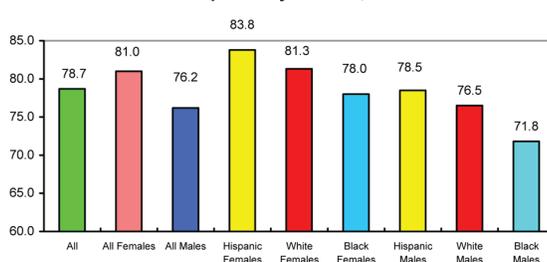
- ◆ 115 males are conceived for every 100 females.
- ◆ The male fetus is at greater risk of miscarriage and stillbirth.
- ◆ 25% more newborn males die than females.
- ◆ 3/5 of AIDS victims are boys.
- ◆ Men suffer hearing loss at 2x the rate of women.
- ◆ Testosterone is linked to elevations of LDL, the bad cholesterol, and declines in HDL, the good cholesterol.
- ◆ Men have fewer infection-fighting T-cells and are thought to have weaker immune systems than women.
- ◆ By the age of 100, women outnumber men eight to one. (NYT Magazine 3-16-03)

Depression and Suicide¹

Depression in men is undiagnosed contributing to the fact that men are 4 x as likely to commit suicide.

- ◆ Among 15- to 19-year-olds, boys were 4 x as likely as girls to commit suicide.
- ◆ Among 20- to 24-year-olds, males were 6 x as likely to commit suicide as females
- ◆ The suicide rate for persons age 65 and above: men...28.5 – women...3.9.

Life Expectancy At Birth, 2010



To learn more, call:

Men's Health Network
P.O. Box 75972
Washington D.C. 20013
202.543.MHN.1 (6461) x 101
info@menshealthnetwork.org
www.menshealthnetwork.org

¹ Centers for Disease Control and Prevention and the National Center for Health Statistics 2011. Retrieved from <http://205.207.175.93/HDI/TableViewer/tableView.aspx?ReportId=166>

² Life Expectancy data is from CDC/NCHS, Health, United States, 2013

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White House Appoints Town as New Disability Policy Coordinator

There is a new staffer at the White House tasked with addressing the needs of the disability community. In May, Maria Town took over as an associate director in the White House's Office of Public Engagement. In the post, she will focus on incorporating the needs of people with disabilities in Obama administration activities. The new hire comes just over a month after Taryn Mackenzie Williams left the role. Williams was in the position temporarily and has since returned to the U.S. Department of Labor where she was stationed previously.

Maria, who has cerebral palsy, is a full-time, permanent hire, White House officials said. Before joining the president's staff, Town worked as an adviser in the Labor Department's Office of Disability Employment Policy. In that role, she focused on improving employment among youth and young adults with disabilities. At ODEP, her work focuses on issues related to youth with disabilities as they transition into the workforce. Maria's portfolio includes creating career

development opportunities in the classroom, developing leadership in young people with disabilities, and building opportunities for inclusive volunteerism. She has spoken at a variety of national and international venues on disability topics, including: the national conferences on youth leadership and transition to work, the Society for Disability Studies, Mobility International USA professional Exchange in Jordan and the American Councils for International Education. In 2014, Maria was selected a National Leaders Council Fellow. She has co-lead a networking group for young professionals called The Hidden Army and volunteers on the Inclusion Task Force of the Girl Scouts of the Nation's Capital. She also writes about fashion, disability, and design on her blog CP Shoes. <http://cpshoes.tumblr.com>.

Before coming to Washington DC, Maria worked for her alma mater Emory University in the Vice Provost's Office of Community and Diversity where she helped to develop programming and policies to improve access, equity,

and inclusion on Emory's campus. While a student at Emory University, she majored in Anthropology and served as the University-wide Student Government Association President. Maria hails from Louisiana, where her family resides.



Maria Town

"Maria's track record on bolstering youth with disabilities as they transition into the workforce and her demonstrated skill crafting career development opportunities in classrooms, fostering leadership for young people with disabilities and building opportunities for inclusive volunteerism will serve the existing efforts of the White House on behalf of Americans with disabilities well," said Rebecca Cokley, executive director of the National Council on Disability, a federal agency that advises the president on disability issues.

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