The Connecticut State Conference of
NAACP Branches-Health Committee

A Health Status Report of African Americans In Connecticut

2008



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A Health Status Report on African Americans in Connecticut

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."

Dr. Martin Luther King, Jr.

"Improving the health of communities of color is one of the greatest challenges facing America. Despite improvements in health and healthcare across the board, African Americans continue to suffer significantly worse health outcomes than their white counterparts in many disease areas."

Julian Bond, Chairman

National Board of Directors, NAACP

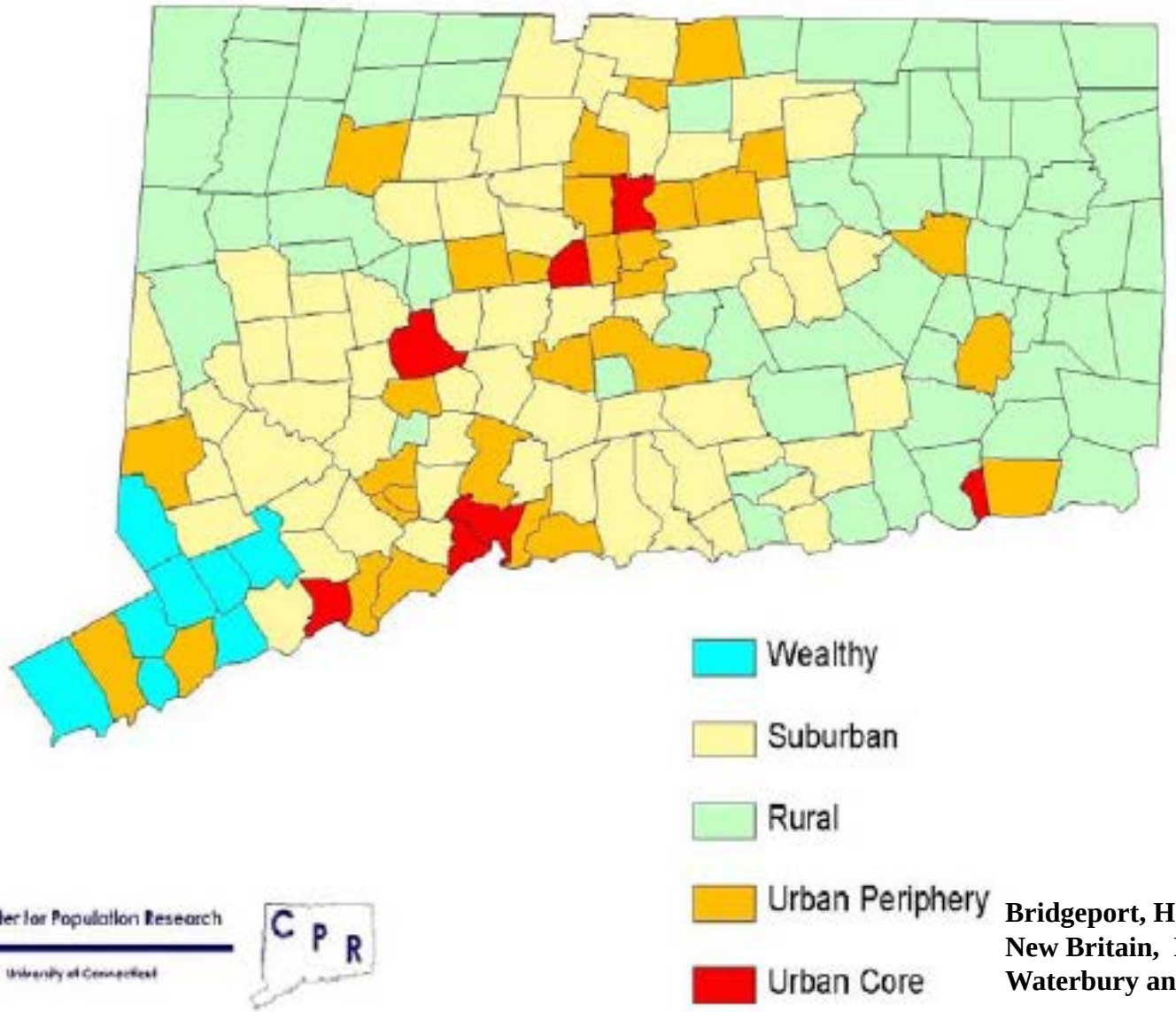
A Health Status Report on African Americans in Connecticut Project Overview

- The NAACP Health Committee was First established in 1940s.
- Connecticut State Conference of NAACP Branches has had a fairly active Health Committee for over the last 25 years.
- The Health Committee of the New Haven Branch host the largest Health and Career Fairs in New England Annually.
- The Connecticut State Conference of NAACP Branches realized that events such as Health Fair and other events could do little in short term to address the mayor health disparities prevalence among Connecticut's African American population. It became obvious that something more was needed.
- Sought a grant from the Connecticut Health Foundation to better understand and to the extend possible quantify the impact of health disparities among African Americans in Connecticut.

This Health Status Report should not be viewed as a strategic plan, but rather as a tool that indicates the need for the State of Connecticut to develop a comprehensive, time –phased, strategic plan to address healthcare disparities within Connecticut's African American population.

A plan with clear goals, objectives, and timetables is necessary to address this complex problem.

2000 Town Groups



Center for Population Research

University of Connecticut

C P R

Bridgeport, Hartford, New Haven, New Britain, New London, Waterbury and West Haven

What are “Racial and Ethnic Health Disparities”?

- Differences in rates of diseases
- Differences in health outcomes

affecting the health status of certain racial or ethnic groups

What are “Racial and Ethnic Health Disparities”? Cont.

Differences in

health care access

and

medical treatment

What are “Racial and Ethnic Health Disparities”? Cont.

Racial minorities are less likely than Whites to receive certain diagnostic and life saver procedures

Differences in outcomes of disease

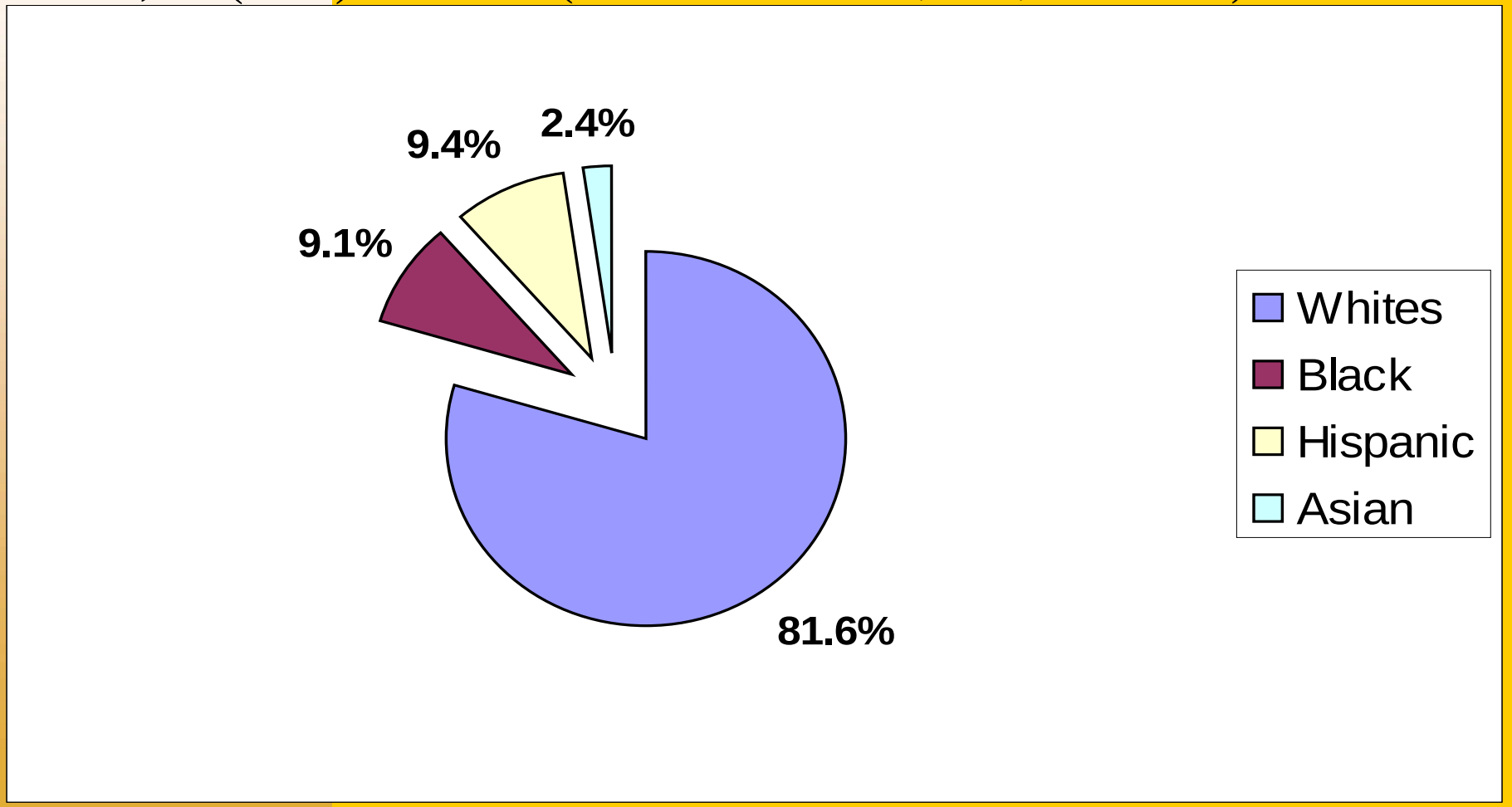
Black women die of cervical cancer at twice the rate of White women

Differences in outcomes of disease

Compared to Whites, a higher percentage of Black babies die in the first year of life

Background

The 2000 census information indicates that Connecticut's overall population is 3,405,565, of which 2,780,355 (81.6%) are classified as White, 309,843 (9.1%) as Black or African American, 320,323 (9.4%) as Hispanic or Latino, and 82,313 (2.4%) as Asians. (**Source:** U. S. Census, 2000, Connecticut)



Cancer

Table 2: Rates of various cancers in CT residents in number of cases per 100,000, 1998–2002				
Site of Cancer	**White Male**	**White Female**	**Black Male**	**Black Female**
All sites	**593.3**	**456.0**	**636.1**	**382.4**
Digestive System	**119.5**	**78.3**	**135.9**	**94.2**
Colon and Rectum	**70.6**	**51.1**	**61.5**	**58.9**
Liver	**6.1**	**2.0**	**11.2**	**2.2**
Pancreas	**13.5**	**10.0**	**16.9**	**12.4**
Respiratory system	**94.2**	**60.2**	**115.8**	**52.9**
Lung and bronchus	**85.6**	**57.7**	**100.8**	**50.5**
Skin	**30.7**	**20.5**	**1.8**	**1.6**
Breast	**1.7**	**145.5**	**3.1**	**116.7**
Cervix	--	**7.0**	--	**11.0**
Uterus	--	**29.3**	--	**18.3**
Prostate	**171.2**	--	**248.6**	--
Brain and Nervous system	**9.2**	**6.1**	**4.3**	**3.8**
Lymphoma	**28.8**	**20.6**	**19.9**	**14.8**
Leukemia	**15.9**	**9.6**	**11.5**	**7.2**

Source: Surveillance, Epidemiology and End Results (SEER) database (cancer registry) 2003

Prostate Cancer

The average age-adjusted death rates for prostate cancer per 100,000, during the period 1997–2001, was 66.3 for Blacks, 27.3 for Whites, and 23.7 for Hispanics

Breast Cancer

The average annual age-adjusted breast cancer mortality rates for women, during the period 1996–2000, was 33.1 for Blacks, 27.5 for Whites, and 12.4 for Hispanics

Cervical Cancer

During the period 1990–1994, the crude incidence rates for invasive cervical cancer per 100,000 women were 12.8 (97 cases) for Blacks, and 8.8 (667 cases) for Whites.

Lung Cancer

The average age-adjusted death rates for lung cancer per 100,000 persons, during the period 1997–2001 was 55.9 for Blacks, 50.5 for Whites, and 21.4 for Hispanics.

Prevalence and Health Conditions in Connecticut for residents age 18 and over

General Health Status

White 28
Black 23.3

Asthma Prevalence

White 13
Black 14

Diabetes

White 6.0
Black 8.7
Delta 45%

Prostate

White 3.8
Black 3.7

Hypertension

White 26.3
Black 32

Source: Center of Disease Control BRFSS 2005

Table 5: Health conditions in CT residents age 18 and over, 2000–2004 (% yes)

	Black/African American N (%) N = 1,189	**White/Caucasian** N (%) N = 20,898	**Hispanic** N (%) N = 4,085	**Other Groups** N (%) N = 808
General health status				
Excellent	261 (23.3)	5803 (28.0)	290 (21.3)	235 (29.0)
Very good	320 (26.2)	7543 (36.5)	336 (20.1)	241 (29.2)
Good	403 (36.0)	5140 (24.6)	504 (34.7)	240 (30.2)
Fair	146 (10.4)	1719 (7.9)	282 (20.0)	63 (8.5)
Poor	51 (3.7)	627 (2.7)	70 (3.9)	24 (2.4)
Asthma	182 (14.0)	2691 (13.0)	279 (16.0)	109 (12.6)
Diabetes	94 (8.7)	968 (6.0)	74 (4.5)	36 (5.0)
Gestational diabetes (during any pregnancy)	14 (1.4)	202 (1.1)	27 (1.6)	14 (1.9)
Prostate Cancer	11 (3.7)	185 (3.8)	4 (1.8)	6 (2.0)
Hysterectomy	51 (12.6)	1040 (16.5)	42 (10.4)	10 (6.2)
Hypertension	178 (32.0)	2678 (26.3)	122 (15.4)	50 (14.0)
Ever had heart attack	5 (2.0)	135 (3.1)	5 (1.0)	4 (1.8)
Had stroke	6 (1.9)	70 (1.5)	3 (0.8)	4 (2.0)
Angina or CHD	5 (1.9)	176 (4.2)	7 (2.4)	7 (4.2)
Arthritis	187 (21.4)	4323 (27.4)	183 (13.9)	75 (13.1)
High Cholesterol	128 (23.4)	2992 (31.1)	141 (24.6)	92 (24.1)

Not all questions were asked in all years of the survey or of all age/sex groups.
Not adjusted for age or other potential confounders.

Healthcare Coverage and Utilization

Have personal doctor/provider

White 80.5
Black 71.0

Where one goes when sick or in need of health advice (Doctor's office)

White 84.6
Black 63.2

Hospital ED or ER

White 2.2
Black 14.2

Needed care but couldn't get it because of cost

White 7.1
Black 15.5

Source: Center of Disease Control BRFSS 2005

Preventable Hospitalizations

A high percentage of African Americans use hospital emergency rooms for healthcare needs. Imbedded in the concept of Ambulatory Care sensitive conditions is the theory that timely primary care and strong disease management programs are critical. The latter two programs impact the severity of ACSCs and therefore "prevent" or at least reduce the need for Hospitalizations.

Therefore, preventable hospitalization volume highlights the possibility of gaps in the primary care health system, and lack of access to health services have led to the escalation in disease severity and, ultimately, hospitalization. In FY 2004, there were more than 50,000 "preventable hospitalizations" of Connecticut residents with nearly 300,000 total patient days and total associated charges of approximately 1 billion dollars.

- During FY 2000-2004 the charges increased 46.2%.
- Minorities accounted for over half of the recent increase (FY00- FY04) in ACSC hospitalizations.
- Compared with all races combined, Blacks had higher rates for 11 of the 16 ACSCs, meaning they were more likely to be hospitalized for these conditions.

Source: Agency for Healthcare Research and Quality, National Healthcare Disparities Report: Differential access may lead to disparities in quality, 2003,

Further analysis of ACSC across both the state and local level by urban, suburban and rural areas confirmed the severity of the issues.

• In many cases not only did the incidence of admissions reflect to a threefold difference compared to the general population.

• Also in many cases the average age of hospitalization for the same condition reflected a 5 years delta and in many cases a 10 years delta on average for African Americans for the same condition compared to the general population.

Of particular interests are:

• Diabetes conditions

• Low extremity amputations

• Asthma (Both Adult and Pediatric)

• Issues related to hypertension and low birth weight babies

Further analysis also revealed that the sequela of diabetes impact on the community is formidable. For example complication of the severities as ESRD, cardiovascular disease, eye problems, strokes, renal failure and lower extremity amputation.

Although African Americans represent 9.19% of the population. They accounted for over 30% of patients suffering from ESRD at a approximate cost of $ 100,000 per patients.

- The full impact of chronic diseases in this study is yet to be documented.

Obesity

According to the Centers of Disease Control (CDC) and Prevention, 77% of African-American women and 62% of African-American men are overweight while only 47% of White women and 62% of White men are overweight which explains why African Americans lead in many statistics for obesity related conditions

Diabetes

Considered a world-wide epidemic

- **Black men will be facing an epidemic of diabetes by the year 2050.**
- Most diabetics can control their illness through diet and lifestyle changes; but left untreated can progress to a more serious state.
- Approximately 12% of all African American men age 20 years or older have diabetes, however, more than 30% do not know it.
- The average African American born today has over a 50% chance of developing diabetes in his or her lifetime.
- With it's complications – blindness, amputations, heart attack, stroke, kidney failure and impotence – diabetes is the 5th leading cause of death in America.
- **African Americans are 1.5 to 2.5 times more likely to have a limb amputated than are others with diabetes.**

High Blood Pressure (Hypertension)

The silent assassin

African Americans are twice as likely to have high blood pressure and four times as likely to die from it.

If you have high blood pressure, odds are you have essential hypertension; which only means doctors have no idea what caused it, although heredity and age likely played a large role.

Since hypertension rarely has any symptoms, you must have your blood pressure checked regularly. Be sure to ask what your reading is every time, so that you know if you're straying away from your norm. Your blood pressure will vary throughout the day and can be affected by emotions, activity, and even eating.

High blood pressure is never diagnosed from a single reading.
Untreated high blood pressure can lead to: heart disease, heart attack, stroke, kidney failure, artery disease and eye damage.

Preventable Hospitalization

ACSC Conditions	FY 2004 total charges ($)	Total charge change (%) FY 2000 - 2004	Average charge ($)	Average charge change (%) FY 2000 - 2004
Adult Asthma	34,596,494	56.3	11,524	30.5
Angina	8,629,143	-23.8	10,116	35.7
Bacterial Pneumonia	196,722,535	41.8	16,077	28.8
Chronic Obstructive Pulmonary Disease	69,813,556	3.2	15,300	18.4
Congestive Heart Failure	212,320,641	56.9	19,218	48.4
Dehydration	42,764,095	47.4	10,240	23.0
Diabetes Long Term Complication	69,046,896	58.5	24,633	42.0
Diabetes Short Term Complication	14,835,993	25.2	13,176	8.3
Diabetes Uncontrolled	1,771,198	23.8	9,037	27.0
Hypertension	6,815,085	75.6	10,421	24.9
Low Birth Weight	132,536,199	61.3	48,125	54.8
Lower Extremity Amputation	44,507,518	46.6	44,154	57.8
Pediatric Asthma	8,580,327	40.3	6,103	37.7
Pediatric Gastroenteritis	2,989,681	72.8	6,152	49.7
Perforated Appendix	21,231,981	60.7	21,889	36.3
Urinary Tract Infection	53,188,423	78.9	12,433	35.8
Total	**$892,882,657** [1]	**46.2**	-	-

Source: CT Office of Health Care Access, September 2005

[1]Total charges are presented without double counting patients with more than one ACSC. They are, however, included within the total charges of each condition.

Table 8: Average age for Blacks hospitalized for an ACSC by hospital, FYs 2000 - 2004

Hospital	Diabetes Short Trm Comp	Perforated Appendix	Diabetes Long Term Comp	Pediatric Asthma	COPD	Pediatric Gastroenteritis	Hypertension	Congestive Heart Failure	Dehydration	Bacterial Pneumonia	Urinary Infection	Angina	Diabetes Uncontrolled	Adult Asthma	Lower Extremity Amp
Bradley	.	.	.	.	.	.	.	71.8	75.7	68.0	38.8	49.3	51.0	38.5	.
Bridgeport		29.1	59.4	5.7	67.6	3.6	53.4	61.0	41.5	47.7	38.6	62.0	49.3	43.7	65.4
Bristol	41.0	40.0	65.2	17.0	83.1	.	67.5	61.3	68.7	50.5	60.6	56.0	59.8	43.3	64.3
CCMC	18.0	10.4	.	6.0	.	2.1	.	.	4.3	5.8	5.0	.	.	.	.
C.Hungerford	48.3	.	57.0	3.8	61.0	.	.	59.3	27.0	46.8	77.2	.	37.5	46.0	.
Danbury	47.5	47.9	49.6	8.5	68.5	0.3	58.7	61.9	55.0	49.2	63.7	59.5	50.5	37.5	63.5
Day Kimball	51.0	.	64.0	7.3	61.1	.	39.0	.	53.0	50.4	83.0	50.0	52.0	40.0	.
Greenwich	44.8	34.0	64.5	7.5	75.4	5.7	52.6	66.9	48.7	39.6	66.5	68.8	63.3	51.1	59.0
Griffin	40.2	.	65.2	.	71.8	.	42.1	63.3	64.6	54.4	42.2	60.2	.	38.3	72.7
Hartford	49.9	49.6	58.2	17.0	63.3	17.0	55.0	63.8	60.8	56.7	58.4	61.5	56.5	46.8	62.8
John Dempsey	33.2	29.3	62.2	.	59.4	.	47.8	57.9	50.9	52.2	48.5	46.3	54.7	42.2	59.5
Johnson	53.0	.	58.0	.	63.3	.	.	63.7	0.0	44.5	54.3	55.3	55.5	22.5	.
L & M	42.9	25.2	58.0	4.4	66.4	4.0	52.2	60.0	48.4	50.8	62.9	58.6	50.8	48.6	62.4
Manchester	39.5	39.0	50.8	10.5	67.7	0.0	49.0	59.7	54.1	51.4	55.8	54.6	51.9	48.7	41.0
Middlesex	55.5	23.0	64.4	0.0	64.0	.	52.5	62.0	55.1	55.1	65.7	61.9	55.7	42.5	66.4
MidState	43.4	40.0	61.1	10.0	57.0	.	48.9	60.7	59.7	53.0	42.5	63.8	18.0	42.7	56.0
Milford	34.0	83.0	54.6	.	72.5	13.0	55.5	78.3	92.0	69.8	76.7	59.8	46.0	63.8	42.0
New Britain	42.8	33.2	58.7	5.9	67.1	4.8	53.2	65.0	50.5	49.5	57.4	60.5	46.1	43.3	59.0
New Milford	46.5	45.0	64.0	6.0	70.5	.	.	64.5	65.0	49.7	.	65.0	43.0	51.0	.
Nowalk	48.4	36.9	60.5	5.3	66.7	2.8	55.8	66.3	46.4	51.9	57.1	58.4	55.9	52.9	66.6
Rockville	32.0	37.0	63.8	10.0	81.5	.	59.5	64.4	63.0	60.6	55.5	68.7	60.5	47.5	66.5
Sharon	69.3	.	68.0	5.1	.	.	.	68.1	70.0	46.1	.	71.5	.	.	.
St. Francis	45.4	40.4	59.2	5.1	67.1	3.6	50.6	64.8	53.7	55.7	57.5	60.9	57.1	49.4	66.2
St. Mary's	42.8	29.0	62.3	5.5	66.7	1.7	54.1	67.5	39.9	50.6	54.8	53.5	64.7	43.0	68.1
St. Raphael's	55.8	48.7	67.8	8.1	72.9	9.6	68.5	78.4	72.4	76.7	76.5	64.9	67.5	58.1	68.7
St. Vincent's	46.4	31.8	56.2	6.6	64.6	6.5	54.7	63.2	65.9	60.3	62.0	57.7	55.1	45.8	65.1
Stamford	51.6	33.2	62.0	6.2	69.7	5.8	50.6	67.1	44.8	49.8	56.6	62.4	55.1	56.5	64.3
Waterbury	43.8	33.7	52.9	6.1	64.6	4.6	49.0	61.8	40.6	50.6	43.5	52.1	47.4	47.3	67.7
William Backus	45.0	30.3	52.3	7.2	64.9	3.7	45.6	60.3	45.6	43.0	58.0	57.3	53.7	36.5	52.1
Windham	21.2	17.0	45.0	4.2	60.7	5.7	38.5	59.8	37.1	52.3	44.5	67.0	46.7	42.3	.
Yale	41.4	31.7	57.8	7.1	65.3	3.4	52.6	61.0	42.2	45.8	49.0	57.7	51.6	43.5	59.9

Source: CT Office of Health Care Access Inpatient Acute Care Hospital Discharge Database.

Average age difference between Blacks and Whites Hospitalized within the same ACSC.

Color Code	
5 -10 years	
10 + years	

SOCIO-ECONOMIC DYNAMICS

The ability to pay does not necessarily translate into adequate health care in Connecticut.

A Short History of Discrimination in Health Care

- **Tuskegee experiment**
- **Segregation of medical facilities and health care providers**

LEGACY: DISTRUST AND RELUCTANCE TO SEEK CARE

Discrimination vs. Other Factors Contributing to Disparities

What causes differences

in health status?

CULTURAL EXPERIENCE

Culture is broadly defined as a common heritage or set of beliefs, norms, and values (DHHS, 1999). Sociocultural factors are a root cause of healthcare disparities because they have an impact on health beliefs, behaviors, and treatment

These factors affect:

- variation in symptom presentation

- expectations of care

- bias

- mistrust

- prejudice

- stereotyping and

- ability to maneuver within the system.

CULTURAL EXPERIENCE- cont.

Health Professions

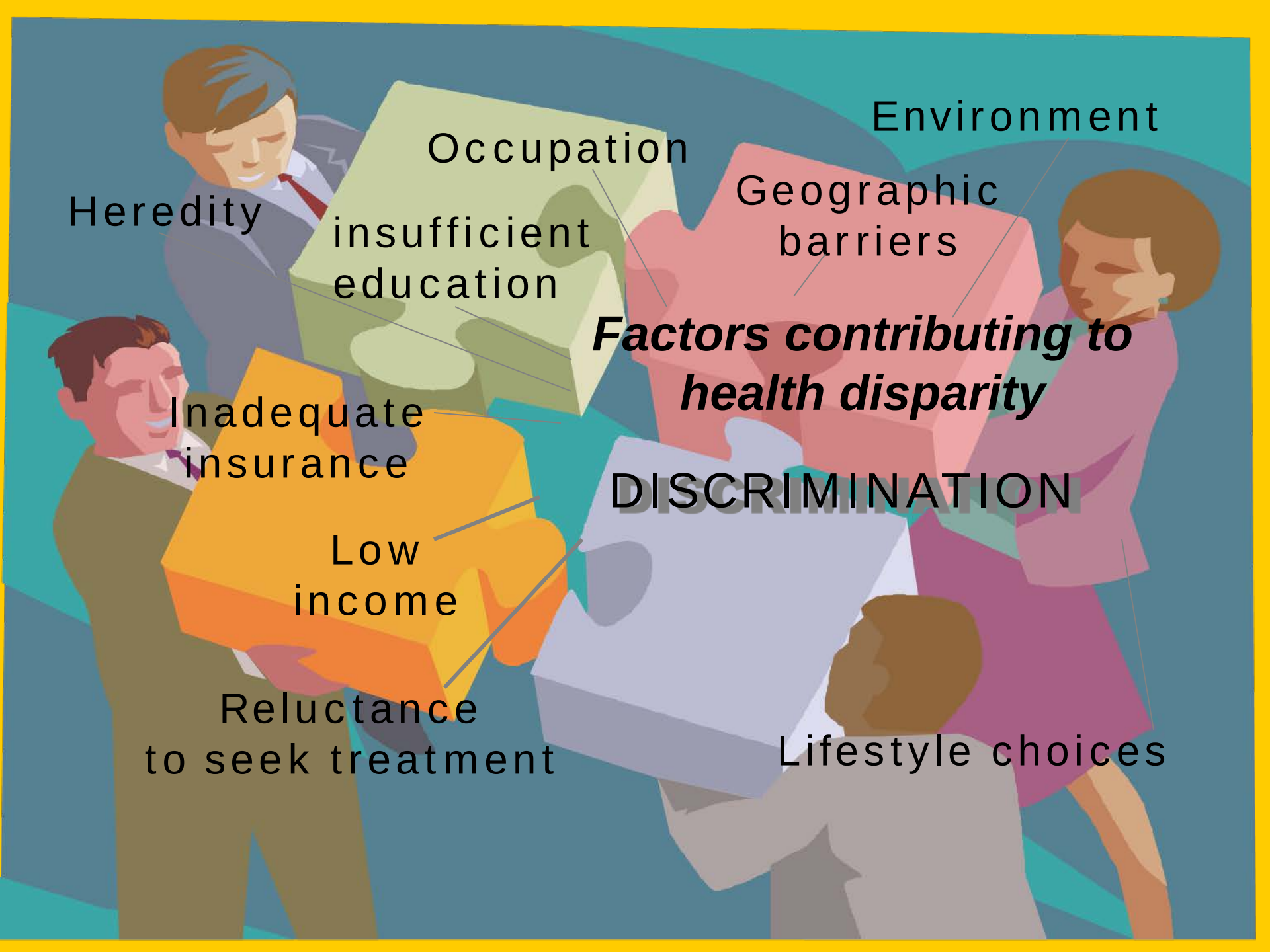
Culture is a concept not understood by patients. It also factors as a root cause of healthcare disparities because it has an impact on health beliefs, behaviors, and treatments.

Clinicians view symptoms, diagnoses, and treatments in ways that sometimes differ from the clients' views, especially when the cultural backgrounds of the consumer and provider are dissimilar.

African American Community

How healthcare is delivered and by whom it is delivered are important factors, given the historical cultural experience of Connecticut's African American population.

The Tuskegee experiment of the 1930s has lingered in the consciousness of African Americans and, consequently, a fear factor is etched in the subconsciousness of Connecticut's African Americans relative to health matters.


Environment
Occupation
Heredity
Geographic barriers
insufficient education
Factors contributing to health disparity
Inadequate insurance
DISCRIMINATION
Low income
Reluctance to seek treatment
Lifestyle choices

RECOMMENDATIONS

This Health Status Report should not be viewed as a strategic plan, but rather as a tool that indicates the need for the State of Connecticut to develop a comprehensive, time –phased, strategic plan to address healthcare disparities within Connecticut's African American population. A plan with clear goals, objectives, and timetables is necessary to address this complex problem.

RECOMMENDATIONS

The Connecticut State Conference of NAACP Branches, with over 10,000 members statewide will become the **“health care voice”** and is assuming the leadership role in advocating to Connecticut's General Assembly to enact comprehensive health care legislation.

“This advocacy will be in the form of a state wide proactive campaign to include an aggressive effort to educate the state’s African Americans community relative to the existing level of health disparities in Connecticut and the role each individual can play to eliminate health care disparities in the richest state in the Nation.“

RECOMMENDATIONS

I. LEGISLATIVE POLICY

Institutive Legislative and Policy Review Initiatives

Legislative policies and bills are currently not reviewed by an independent entity to determine their potential disproportionate impact on all citizens. An example of this would have been the significant impact on lower body amputations caused by limiting podiatric access to SAGA recipients at risk for diabetes complications.
All legislative policies and bills should be vetted through the proposed Office of Minority Health in order to prevent any disproportionate impact on any minority group, thereby avoiding and or minimizing any future health inequity legislation.

Merge the Departments of Public Health and Social Services

Each year the Department of Public Health reports on the health status of Connecticut citizens and the health inequities that exist within the state. It is clear that there is little coordination with the agency charged with providing access and programs (Department of Social Services) and the agency charged with monitoring and safeguarding health status (Department of Public Health). These departments should be consolidated to improve delivery of services and reduce current and long-term healthcare costs to this State.

RECOMMENDATIONS

II. ACCESS

Create an Office of Minority Health

There is a significant lack of coordination, accountability, and a cohesive plan for coordinating the various public and private initiatives to address the myriad concerns facing minority health. An Office of Minority Health must be established to address minority health issues and healthcare inequities and launch many of the recommendations cited in this report.

Establish Academic Medical Center Accountability

The IOM report states that the lack of inclusion of minorities in teaching settings directly impacts inequities within the healthcare system. Currently, accountability for minority inclusion, within this state, does not reside within any office of our state government. Academic medical centers and other teaching facilities must be fully engaged in developing a diverse workforce in this state, with a strong emphasis on the training of future doctors and other care providers. The issue of minority clinical staff must be included in any effort to reduce and/or eliminate inequities in health care.

RECOMMENDATIONS

III. PUBLIC POLICY

Healthcare Licensing and Approvals with Disparity Objectives

Licenses and approvals are not linked to impact programs that address disparity objectives. The State of Connecticut should use its power and influence to establish quantifiable goals that address disparity objectives in health care.

Develop Private and Public Programs With State Plans

Currently, licenses are approved are not tied to any state plan. Two examples where access is a significant state issue are childhood obesity and the emerging adult sickle cell crisis. The State of Connecticut should incorporate accountability within new/expansion programs in order to address this well documented and emerging disparities issue

Change Collection of Ethnic and Racial Demographic Data

Currently, the Department of Public Health does not collect ethnic and racial demographics beyond the broad African American and Hispanic categories. The absence of subgroup data may adversely impact demographic analyses and assessments. Change the data collection procedures to include subgroup data.

RECOMMENDATIONS

Establish New Local Level Partnerships

The absence of health partnerships at the local level reduces healthcare effectiveness. Establish new partnerships with local governing bodies and local NAACP branches in order to reduce healthcare inequities. Individuals, families, and neighborhoods have to be held accountable to close the gaps noted in this Health Status Report.

IV. INSURANCE

Invest in Health Prevention and Promotion

Currently, the cost of certain health care that is avoidable and preventable often is caused by health inequities. The cost of "loss of productive days" is enormous and creates an unnecessary expense for many employers. The Connecticut Business & Industry Association (CBIA) should invest in health prevention and promotion in order to reduce costs and increase economic profitability and development. This would also help CT realize the full economic potential of its workforce.

Establish Pay-for-Performance Requirement in MCO Contracts

Currently MCO contracts do not include a "pay-for-performance" provision, which will impact asthma care and childhood obesity situations.

Establish a "pay-for-performance" provision in MCO contracts.

Proposed Legislation: Office of Minority Health

What is needed is a comprehensive healthcare bill with specific purposes, goals, objectives, strategies, timelines, and funding. The climate appears to be right at this time for a concerted effort to make this the number one priority of the state's policy makers, i.e., health care equity in Connecticut.

What will be the Office of Minority Health's Role in Connecticut?

OMH's responsibility will be to:

- *Drive accountability across all department and governmental sectors,*
- *Staffed consistent with the mission and goals of the office,*
- *Seek funds from the federal office of Minority Health and other granting agencies, and*
- *Report annually to the House and Senate's appropriate committees relative to improvements and challenges across both the public and private sectors.*

What can you do?

“Act locally”

- Review data specific to your catchment
- Bring together stake holders who share your vision
- Develop a process to prioritize issues within your control directly or indirectly
- Initiate new programs with new partners. Remember doing the same old time and expecting different results is really insane
- Think bold, audacious, aggressive and hairy
- Set goals and use data in this report to measure results over time

"Raised Bill No. 681 An Act Establishing a Minority Health Commission"

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (a) There is established a Minority Health Commission that shall work to eliminate the disparities in health status among the state's multicultural, multilingual and multiethnic communities. Additionally, such Commission shall work for an overall improvement of the quality of health for state residents. Such Commission shall consist of the following commissioners, or their designees, and public members: (1) The Commissioners of Public Health, Mental Health and Addiction Services, Developmental Services, Social Services, Correction, Children and Families, and Education; (2) The Co-directors of the University of Connecticut Health Center and Center for Public Health and Health Policy; (3) three members appointed by the speaker of the House of Representatives who shall be a members of the NAACP; (4) one member appointed by the majority leader of the House of Representatives, who shall be a member of the Black and Puerto Rican Caucus of the General Assembly; (5) the chairperson of the African-American Affairs commission or his or her designee; (6) the chairperson of the Latino and Puerto Rican Affairs Commission or his or her designee; (7) director or designee of the Commission on Children; (8) director or designee of the Commission on Aging; (9) the Office of the Health Care Advocate; and (10) the Dean of the School of Epidemiology and Public Health at Yale University.

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To achieve systemic change requires

Advocacy, advocacy, advocacy…..