

NOTICE OF AVAILABILITY OF STATE AND FEDERAL FUNDS

Division of Criminal Justice Services

Four Tower Place
Albany, NY 12203

LOCAL GOVERNMENT AGENCIES

Alternatives to Incarceration Programs

The NYS Division of Criminal Justice Services' (DCJS), Office of Probation and Correctional Alternatives (OPCA) is issuing a Request for Applications (RFA) in the Annual 13A Alternatives to Incarceration (ATI) Performance-Based Service Plan pursuant to article 13-A of the Executive Law. Approximately \$3.6 million will be available in 2011 to New York counties (outside of New York City) through county ATI Advisory Boards consistent with funding allocations provided in 2010, unless otherwise effected with the enactment of the 2011/12 State FY Budget. The funding is available to provide continued support for ATI programs. The Office of Probation and Correctional Alternatives' goal for all ATI programs is to reduce recidivism, promote public safety, and enhance defendant/offender accountability through effective community corrections programming. The Application is available on the DCJS website at <http://criminaljustice.state.ny.us/ofpa/newrpf.htm>.

Applications must be submitted by February 15, 2011 using the DCJS Grants Management System (GMS). In order to complete an application using GMS, counties must first register with DCJS' Office of Program Development and Funding (OPDF). For information about how to register for GMS, a tutorial and user's manual, please visit: <http://criminaljustice.state.ny.us/ofpa/gms.htm>.

Department of Health

Office of Minority Health

Empire State Plaza, Corning Tower – Rm. 780
Albany, New York 12237

VARIOUS NOT-FOR-PROFIT 501C(3) HEALTH & HUMAN SERVICE ORGANIZATIONS

Health Equity Initiative

The New York State Department of Health (NYSDOH), Office of Minority Health (OMH) announces the availability of funds to support a health equity initiative. The purpose of this funding is to reduce barriers and improve health care system access for minority males, Latinos and poor and underrepresented minority students pursuing (or interested in pursuing) careers in medicine or the health professions. The services provided through this Request for Applications (RFA) are in partial fulfillment of § 241 numbers 1 and 2 of the Public Health Law, which indicate that OMH has a responsibility to: (1) Integrate and coordinate selected state health care grant and loan programs established specifically for minority health care providers and residents; and (2) Assist medical schools and state agencies to develop comprehensive programs to improve minority health personnel supply by promoting minority clinical training and curriculum improvement, and disseminating minority health career information to high school and college students. The services being proposed under this RFA are also in alignment with the goals of NYSDOH's Prevention Agenda toward the Healthiest State: to increase the length and quality of life,

and decrease gaps in health status. The priority area of focus is access to high quality health care.

This RFA contains the following three distinct components:

Component A: Minority Male Wellness and Screening

Component B: Latino Health Outreach

Component C: Mentorship Program in Medicine and the Health Professions

Eligibility Requirements

There are three components to this RFA. Eligibility requirements vary by component. If applying for all three components, the applicant must meet the eligibility requirements for each component.

Component A: Minority Male Wellness and Screening

Applicants must meet the following eligibility requirement:

Be a not-for-profit 501c(3) health organization, community based organization or other not-for-profit organization that currently provides comprehensive health services to the target population or a not-for-profit academic institution that provides health services through community-based organizations or other entity to minority males. Outreach and education providers collaborating with a health care provider are also eligible.

Component B: Latino Health Outreach

Applicants must meet the following eligibility requirement:

Be a not-for-profit 501c(3) health and human service organization whose target population is at least 50 percent Latino

Component C: Mentorship Program in Medicine and the Health Professions

Applicants must meet the following eligibility requirement:

Be a medical academic institution currently implementing a mentorship program or a not-for-profit 501c(3) health and human service organization that is affiliated with one or more academic medical institutions and currently implementing a mentorship program

Preferred Eligibility Requirements

Preference for all three components will be given to applicants with a minimum of:

- three (3) years experience working with the targeted minority population
- three (3) years experience in oversight of administrative, fiscal and programmatic aspects of government, foundation or other grant-makers in health contracts, including timely and accurate submission of fiscal and program reports.

Problem/Issue:

1. Component A: Minority Male Wellness and Screening

Minority males, defined as men who are Latino, American Indian/Alaska Native, Asian American, African American, and Native Hawaiian/Other Pacific Islander, represent approximately 30 percent (more than 40 million) of all American men. The largest sub-populations among minority males are Latinos and African Americans. Alarming statistics show that men's health is at great risk. Men suffer more severe chronic conditions, have higher death rates for the leading causes of death, and die nearly 7 years younger than women.^{4, 5} As they relate to minority males; the statistics are even more dismal. Minority males experience a disproportionate rate of disease, disability, and premature death compared to White men. For example, diabetes mellitus, often associated with obesity in adults, is found in one

out of six American Indian/Alaska Native men and in one out of nine African American men. In 2002, the death rate for suicide among young American Indian males 15-24 years of age was almost 60 percent higher than their White male counterparts. The age-adjusted death rate for stroke among Asian American men ages 45-54 and 55-64 years was about 15 percent higher than for White males of the same ages. Data released by the Centers for Disease Control and Prevention in 2009 show that African American males, in 2007, had a life expectancy of 70.2 years compared with a 75.3 life expectancy of all males. As a group, minority males tend to be younger than White men. Nearly 40 percent of minority males are under age 20, compared to the 27 percent of White men and 29 percent of Asian American men this age. By contrast, men over 65 make up 13 percent of White men but less than 8 percent of each group of minority males. These differences in age distribution in themselves are suggestive of distinct health care needs.⁶

Gender identity is a key variable in decisions about health behaviors, including how to engage with the healthcare system. The differences between men and women go beyond anatomy and physiology. The rules that guide gender behavior, in particular masculinity (a shared understanding of what it means to be a man, what one looks like, and how one should behave, for example) are culturally created and shift over time and place. According to the Blueprint for Men's Health: A Guide to a Healthy Lifestyle, there are many reasons for the gender health gap. These reasons include: men do not take care of themselves as well as women do; men are more likely to engage in unhealthy behavior and less likely than women to adopt preventive health measures; men are also less likely to have health insurance, more likely to work in dangerous occupations, and often put off going to the doctor. More than half of premature deaths among men are preventable.⁷ Given the lack of awareness and a scarcity of minority male-specific health programs, the health and well-being of minority males will continue to worsen.

2. Component B: Poor Health Care Access of Latinos

The 2007 New York State Minority Health Surveillance Report⁸ indicates that the Latino population in New York State grew by 30% in the last decade and is more likely to live in poverty than non-Latino White, Black or Asian/Pacific Islanders. Latinos in New York fared worse on 12 of the 49 health indicators featured in this report, particularly in health care access measures. Specifically, relative to health outcomes among racial/ethnic groups in New York State, Latinos were more likely to report being in poor or fair physical and mental health in the past month, to have current asthma, and to experience premature death (death at younger than 75 years of age). For both men and women, the Latino population is least likely to have early stage diagnoses of prostate cancer and colorectal cancer. Latino adults most often experience cost as a barrier to doctor visits, have no regular health care providers, and lack health insurance at rates higher than other populations. Additionally, Latino high school students and young children also fared worst on three of ten obesity behavioral/risk measures. These data draw attention to the unique health care access needs of Latinos.

3. Component C: Underrepresentation of Minorities in Medicine and the Health Professions

As racial and ethnic minorities continue to grow as a percentage of the population, requirements for health care services by groups and sub-groups within this population will also increase. African Americans, Latinos, and Native Americans represent one-fourth of the U.S. population yet they make up only 9.9 percent of pharmacists, 8.7 percent of physicians, 8.0 percent of physician assistants, 6.2 percent of nurses, and 5.4 percent of dentists.⁹ A study by the Center for Health Workforce Studies confirms the value of workforce diversity among primary care physicians in New York State. Analysis of data derived from the New York Physician Survey (2005-2006) and the 2007 New York Resident Exit Survey revealed that New York's physicians are less diverse than the State's population, that underrepresented minority physicians, compared to all other physicians, were more likely to: report a principal specialty in primary care or obstetrics/gynecology; practice in hospitals and clinics; work in downstate New York and in urban areas; were more likely to serve a higher percentage of Medicaid patients in their practices; practice in federally

designated primary care shortage areas; and begin their professional careers with higher levels of educational debt compared to all other newly-trained physicians.¹⁰

A racially and ethnically diverse physician workforce is important for increasing access to care for underserved populations, improving the cultural competence of the workforce, and enhancing the educational experience of all medical students. However, as noted, many racial-ethnic groups remain underrepresented among physicians in the United States. Moreover, students from underrepresented minority groups constitute a decreasing proportion of United States medical students. In 1994, underrepresented minorities comprised 15.5% of students matriculating into the Liaison Committee on Medical Education-accredited medical schools, but by 2000 this proportion had decreased to 13.8%. Students from lower-income families are also much less likely than those from higher-income families to matriculate into medical school. Sixty percent of US medical students come from families in the top quintile of household income.¹¹ The situation is similarly bleak for other critical health professions.

The U.S. Institute of Medicine and the National Institutes of Health suggest improved mentoring as an important tool for helping to reverse these trends. There is a growing interest on the part of physicians and health care officials in finding effective ways to mentor economically disadvantaged and underrepresented minority students toward academic success and, ultimately toward careers in medicine and the health professions.

There will be one award per component (total of 3 awards). It is anticipated that each component will be funded at an amount not to exceed \$100,000 for one year; renewable annually for up to 4 additional years for a total of up to five (5) years, contingent upon satisfactory performance and availability of funds.

Applications will be accepted through 5:00 p.m., February 16, 2011.

The anticipated first year grant period is April 1, 2011 through March 31, 2014. The option to continue funding for two additional years, beyond the initial three years, may be available and is contingent upon the satisfactory performance and continued availability of funds.

For an application, contact: Dina M. Addario, Contract Manager, Department of Health, Office of Minority Health, Empire State Plaza, Corning Tower – Rm. 780, Albany, NY 12237, (518) 474-2180, or send an email request to somh@notes.health.state.ny.us, or visit the Department's website at www.nyhealth.gov

⁴ Courtenay, W.H. (2000). Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Social Science & Medicine*, 50: 1385-1401.

⁵ Pinkhasov, R.M., Wong, J., Kashanian, J., Lee, M., Samadi, D.B., Pinkhasov, M.M., & Shabsigh, R. (2010). Are men shortchanged in health? Perspective on health care utilization and health risk behavior in men and women in the United States. *Int J Clin Pract*. 64(4):475-487.

⁶ Leigh, W.A. (2004). Factors affecting health of men of color in the United States: An overview. Joint Center for Political and Economic Studies, Washington, DC.

⁷ Brott, A., and the Blueprint for Men's Health Advisory Board. (2009). *Blueprint for Men's Health: A guide to a Healthy Lifestyle*. Second Edition. Men's Health Network.

⁸ New York State Department of Health. *The New York State Minority Health Surveillance Report*, September 2007.

⁹ Bodenheimer, T., Chen, E., & Bennett, H.D. (2009). Confronting the growing burden of chronic disease: Can the U.S. health care workforce do the job? *Health Affairs*, 28(1):64-74.

¹⁰ Center for Workforce Studies, School of Public Health, University at Albany, State University of New York. *A profile of New York's underrepresented minority physicians July 2008*.

¹¹ Grumbach, K., & Chen, E. (2006). Effectiveness of University of California post-baccalaureate premedical programs in increasing medical school matriculation for minority and disadvantaged students. *JAMA*, 296:1079-1085.