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Collaboration Between State Primary Care Offices and State Offices of Minority Health

State primary care offices (PCOs) and state offices of minority health (OMHs) are federally funded programs located within state and territorial health departments. PCOs are supported by an HHS and HRSA program, Cooperative Agreements to States/Territories for the Coordination and Development of Primary Care Offices. OMHs are supported by the HHS Office of the Secretary, Office of Public Health and Science, and OMH’s State Partnership Grant Program to Improve Minority Health. The objective of the PCO program is to coordinate and oversee local, state, and federal primary care service delivery and workforce issues to meet the needs of medically underserved populations. The objective of the OMH program is to facilitate the improvement of minority health and eliminate health disparities through the development of partnerships with state and territorial offices of minority health.

In federal fiscal year 2012, PCO cooperative agreements were in place with 53 state and territorial PCOs. In fiscal year 2011, OMH partnership grants were in place with 44 state and territorial OMHs.

This issue brief explores the potential for collaboration between PCOs and OMHs. It also examines specific models of PCO/OMH collaboration. ASTHO conducted interviews with PCOs in four states with significant PCO/OMH collaborative activity. The brief includes profiles of the PCO/OMH collaborations derived from these interviews. The issue brief concludes with recommendations for PCOs about how they might collaborate with OMHs and why it is important to seek such collaboration.

State PCOs: An Overview

PCOs exist within all state health departments and in several territories, and they have operated under federal and state cooperative agreements for more than 20 years. PCOs are the state-level focal point for primary care safety net activities, with an emphasis on determining health professional shortage areas (HPSAs) and medically underserved areas or populations (MUAs/MUPs) for programs such as the National Health Service Corps (NHSC) and HRSA’s Health Center Program. These designations are also used to determine eligibility for special payment programs, including the Medicare Physician Bonus and Surgical Bonus programs, the federally qualified health center (FQHC) payment program, and the rural health clinic payment program.

PCO responsibilities strongly emphasize the assessment and development of primary care and primary care workforce in underserved areas of the state. With funding from HRSA, PCOs are responsible for several key activities, including:

- **Shortage Designation**: Routinely updating and expanding federal shortage designations, including HPSAs and MUAs/MUPs.
- **NHSC Coordination**: Supporting state-level NHSC efforts, including developing and reviewing site applications and facilitating individual participant applications.

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1 PCOs are authorized under the Public Health Service Act, 42 U.S.C. 254b, Section 330(k), 330(m) and 333(d). The PCO program is listed in the Catalog of Federal Assistance in section 93.130.

2 OMHs are authorized under the Public Health Service Act, Title XVII, Section 1707 (e)(1), 42 U.S.C. 300u et seq., Title 17, Section 1707, 42 U.S.C 300u et seq. The OMH program is listed in the Catalog of Federal Assistance in section 93.296.
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- **Health Center Expansion**: Supporting community health center expansion and development, including providing data and other technical assistance.

Since the PCO program’s inception, two of the PCO cooperative agreement’s major focuses have been shortage determinations and workforce assessment, development, and distribution. In addition to their federal responsibilities, many PCOs are also responsible for implementing state programs, including:

- **State Grant Programs**: The funds provided by this program are distributed by states to improve direct access to underserved areas by providing additional resources and tools to community health centers that serve uninsured and underinsured individuals.

- **State Primary Care Workforce Programs**: Provides a financial incentive to doctors, nurses, and other health professionals to serve in designated medically underserved locations and work with vulnerable populations.

- **NHSC State Loan Repayment Program**: Provides reimbursement of outstanding health professional education loans for clinicians who commit to practicing in eligible underserved communities. It does not reimburse administrative costs.

- **J-1 Visa Waiver Program**: Administering the State Conrad 30/J-1 Visa Waiver Program for physicians—An unfunded discretionary program under state jurisdiction that allows states to waive the federal law requiring foreign physicians who have completed their studies to return to their home country for at least two years before returning to the US if the physician commits to working with underserved populations.

Federal funding of PCOs varies significantly, with awards in federal fiscal year 2012 ranging from $112,000 to $523,000. In some states, funding can only support one or two positions. In others, larger staff sizes are supported. There is no matching requirement for federal support under the PCO program. Nevertheless, many states have additional state-funded positions assigned to their PCOs, and provide state funds to support PCO operations.

**State Offices of Minority Health: An Overview**

The 1985 *Report of the Secretary’s Task Force on Black and Minority Health* led to the development of federally-funded OMHs by publicizing the existence of health disparities for minorities in the United States and providing recommendations to decrease these health discrepancies. Federal funding was first offered to states and territories in 1987. OMHs in 44 states and territories are currently supported with federal partnership funding. In federal fiscal year 2011, partnership grants ranged from $120,000 to $175,000. There is no matching requirement for federal support under the OMH program. In the OMH program funding guidance, HHS specifies six specific areas of program expectation for grantees:

- **State Planning**: Improving state- and territory-wide planning, coordination, collaboration, and linkages among public and private entities that specifically address minority health and health disparities.

- **Program Coordination**: Improving coordination and collaboration among state and territorial public health offices that benefit minority health and contribute to eliminating health disparities.

- **Program Leadership**: Dedicating state and territorial leadership and staffing to support strategic planning and coordination; improve cultural competency; promote and implement evidence-based approaches and programs to address priority minority health problems; monitor and
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evaluate state and territorial efforts; and disseminate information focused on improving minority health and eliminating health disparities.

- **Program Expansion**: Increasing state- and territory-wide efforts to improve minority health and eliminate health disparities through the support of community programs that promote science-based health promotion and disease prevention research, or support state- or territory-level health interventions.
- **Enhanced Partnerships**: Establishing and enhancing multicultural partnerships to build efforts within communities to collaboratively address health issues impacting minority communities.
- **Diverse Workforce**: Improving diversity in the healthcare workforce through policies focused on recruiting persons capable of entering a health professions career during the grant period.

Consistent with these expectations, all OMHs conduct the following four important activities:

- Monitoring health status of racial and ethnic minority populations.
- Informing, educating, and empowering people in racial and ethnic minority communities.
- Mobilizing community partnerships and action for racial and ethnic minority communities.
- Developing policies and plans to support health efforts targeting racial and ethnic minority communities.

Some OMHs, typically those with sufficient resources, also conduct three additional activities:

- Linking people to personal health services, ensuring access for racial and ethnic minority populations.
- Ensuring a competent workforce trained and capable of meeting the needs of people in racial and ethnic minority communities.
- Evaluating effectiveness, accessibility, and quality of services, identifying ways of improving health services to meet the needs of racial and ethnic minority populations.

**PCOs and Health Disparities: Background**

The National Partnership for Action to End Health Disparities (NPA) defines health disparities as follows:

“A health disparity [is] a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”

NPA established the **National Stakeholder Strategy for Achieving Health Equity**, which provides a set of strategic goals for state, local, and national agencies working in partnership on health disparities. The **HHS Action Plan to Reduce Racial and Ethnic Health Disparities** is the HHS work plan for reducing health disparities, and it complements the national stakeholder strategy. The HHS Action Plan aims to create a nation free of health and healthcare inequalities by increasing health insurance coverage, improving quality, building data capacity, preventing disease, and strengthening cultural competency to improve the health of all populations equally. This creates an expanded focus for HHS health disparities, including both health status disparities and healthcare disparities.
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These two plans provide a framework for understanding how PCOs and OMHs may coordinate their efforts. Within NPA’s definition of health disparities, OMHs and PCOs focus their activities on different but related target populations. OMHs target their efforts on the health status disparities of racial and ethnic groups. In contrast, PCOs target their work on healthcare disparities for populations in specific geographic locations (underserved areas) and specific socioeconomic groups (low income populations).

There is significant overlap between OMHs’ and PCOs’ target populations. Many designated shortage areas, including both HPSAs and MUA/MUPs, have significant racial and ethnic minority populations. This is most clearly evident in the nationwide statistics of HRSA’s Health Center Program. Uniform Data System statistics for 2011 indicate that 62.2 percent of all health center patients are members of racial or ethnic minority groups. In addition, 23 percent of all patients are best served in a language other than English. Much of PCOs’ work is in support of health centers, making PCOs important to meeting minority communities’ health needs.

In the late 1990s, PCOs were included in a HRSA initiative establishing a new strategic target for their activities. The 100 Percent Access and Zero Disparities initiative reflected an explicit acknowledgement that health status equity and healthcare equity were equally important for HRSA’s programs. For PCOs, this initiative acknowledged existing efforts to link community-based health services in underserved areas with health department programs designed to improve health status. It is in pursuit of this broader mandate that the greatest potential exists for collaboration between PCOs and OMHs.

To explore the potential for PCO/OMH collaboration around issues of health status disparity and healthcare disparity, ASTHO conducted interviews with PCO staff in four states where there is significant collaboration between the PCO and OMH:

- New Hampshire
- Vermont
- Missouri
- Virginia

These states represent several different types of PCOs. Two of the PCOs have a small staff, while the other two have more workers. Some of the PCOs administer state-funded primary care and workforce programs, while others limit their efforts to the PCO cooperative agreement’s work. Finally, two of the PCOs are co-located or integrated with OMHs, creating a unique opportunity for program collaboration.

Profiles of the PCO/OMH collaboration in each of these states are presented below.

NEW HAMPSHIRE: Coordination with Limited Resources

Overview
New Hampshire demonstrates how a PCO and OMH can work together effectively in a state with limited staff resources. The New Hampshire PCO is managed by a single full-time equivalent staff position. In spite of limited personnel, the New Hampshire PCO works cooperatively with OMH, which amplifies the effectiveness of both offices.
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Focus
Historically, New Hampshire’s population has been predominantly white and of European and Canadian descent. Over the past two decades, there has been an increase in the population’s diversity, including significant growth in its Latino and African American populations. In addition, New Hampshire has been a resettlement location for many refugees, including those from Vietnam, Bhutan, Bosnia, Rwanda, and other African countries. These changes have challenged the state’s health infrastructure, raising questions about the health services’ cultural and linguistic competency. In addition, health status disparities in racial, ethnic, and linguistic minority populations have been identified as a major health issue for the state.

Collaboration Results
In response to these needs, the New Hampshire OMH has been restructured as the state Office of Minority Health and Refugee Affairs (OMHRA). In addition, State health partners in New Hampshire appear to understand the social and cultural determinants of the population’s health and are motivated to take action to promote health equity. Consequently, the PCO and OMHRA have multiple external partners active in addressing health and health services disparities issues, such as the state’s area health education centers (housed at Dartmouth College), the Endowment for Health, and the Bi-State Primary Care Association, which serves New Hampshire and Vermont. Given the limited resources in the state, partners collaborate in a number of different efforts, which enables them to share their knowledge and coordinate their activities for the best results.

The New Hampshire PCO and OMHRA work jointly on developing a diverse health workforce that meets the needs of the state’s racial, ethnic, and linguistic minorities. This collaboration takes several forms:

- OMHRA is the lead office in administering the New Hampshire Health Profession Opportunity Project (NHHPOP). This project, funded under the Patient Protection and Affordable Care Act, is a five-year demonstration effort designed to train low-income individuals in high-need health professions. The project is committed to ensuring that at least 25 percent of all program participants represent racial, ethnic, and linguistic minorities. This will help increase the health workforce’s diversity, and improve the delivery of health services to minority communities.

  The New Hampshire PCO is an active member of NHHPOP’s advisory group. The PCO director provides her expertise to the project, including information about health workforce needs, other health workforce programs in the state, and the health safety net system serving minority communities.

- The PCO administers the NHSC State Loan Repayment Program for eligible primary care clinicians. This federally-funded program provides reimbursement of outstanding health professional education loans for those clinicians who commit to practicing in eligible underserved communities. OMHRA is an important advisor to the PCO for this program, helping to ensure that it addresses the needs of racial, ethnic, and linguistic minorities. OMHRA provides input on program policy and operation.

- The PCO is the lead agency in a multi-year commission on primary care workforce improvement. This legislatively-authorized effort includes workforce diversity as a key consideration in deliberations. OMHRA is an important participant in the commission efforts.
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- The PCO and OMHRA are part of an advisory group for a special program, Partnership in Nursing, that is supported by the Robert Wood Johnson Foundation (RWJF). A Partnership in Nursing is part of RWJF’s effort to increase the health workforce’s diversity. The program supports an after-school program for refugee children and youth, providing them with background in nursing and other health training opportunities. Its aim is to create a pipeline from refugee communities into the health workforce.

Summary
The New Hampshire PCO and OMHRA advise and assist each other’s programs. They also work jointly on third-party projects that address their shared mission. Their collaborative relationship demonstrates what can be accomplished with limited resources and a commitment to cooperation.

VERMONT: Coordinating to Meet Special Population Needs

Overview
The Vermont PCO is a small office in the Vermont Office of Rural Health and Primary Care. The PCO staff meet regularly with the state OMH to coordinate efforts. The PCO’s and OMH’s close relationship is further bolstered by the fact that the PCO director managed OMH during a period when the OMH director’s position was vacant.

Focus
According to the census, Vermont’s population is 97 percent white and of European or Canadian descent. However, Vermont has two minority populations with significant health status disparities. The first is its substantial refugee/immigrant population, which is comprised of 20 different language or nationality groups with as many as 2,000 individuals in each group. In addition, there is a significant Hispanic population, largely from Mexico, and many of whom work in the state’s apple orchards and dairy industry.

In order to better meet the healthcare needs of these Vermont residents, eight FQHCs are located in the state, with additional satellite sites spread throughout. These centers accept patients that are uninsured and operate with a sliding scale payment to insure access for those with low and moderate incomes. However, meeting the needs of such a diverse population places a strain on the health system, particularly in rural areas.

Collaboration Results
The Vermont PCO and OMH coordinate closely in efforts to further meet the needs of both of these specific populations. To address the migrant farmworker population’s needs the PCO and OMH have worked with the Bi-State Primary Care Association and several FQHCs to create the Vermont Farm Health Connection, which conducts health outreach and screenings to migrant dairy farmworkers in several counties. Vermont dairies are large, highly mechanized operations. Migrant workers typically reside on the grounds of these farms and work as many as 70 hours in a six-day workweek. This leaves limited time for seeking access to needed health services. The Vermont Farm Health Connection is supported in part by a grant from the federal Office of Rural Health Policy. It provides work safety, nutrition education, and basic health education to farmworkers, many of whom come from rural farming communities in Mexico.
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Additionally, the PCO and OMH have coordinated with the University of Vermont to establish health outreach to seasonal farmworkers in the state’s fruit and apple orchards. This effort provides primary care, health education, and screening services to migrant farmworkers. Staff with Spanish-language skills provide the services. This effort supplements the work of FQHCs, which do not currently have the capacity to provide these targeted services.

To focus on the needs of the diverse immigrant populations the PCO and OMH have worked with Vermont’s Comprehensive Cancer Control program to arrange breast and cervical cancer screening services for immigrant women in the Burlington area. As part of this effort, an FQHC conducts community outreach to immigrant women between ages 40-65 from 12 different cultural and language groups. Promotoras—lay Hispanic or Latino community members who have received training to provide basic health education in their communities—who are familiar with the different groups conduct outreach and education activities. Where necessary, call-in translation services are utilized. Women participating in the program return repeatedly for the FQHC’s services.

Summary
Although they both have limited resources, the Vermont PCO and OMH, have been able to meet the health needs of migrant workers, refugees, and immigrants in the state by working with external partners. This is a successful model for smaller states with relatively small budgets.

MISSOURI: A Focus on Health Equity

Overview
In Missouri, the PCO and OMH co-located with the state’s Office of Rural Health and the Office of Women’s Health to form a new Center for Health Equity. The impetus for this change came from a recent ASTHO initiative, and was led by Margaret Donnelly, who was the Missouri Department of Health and Senior Services (MDHSS) director at the time. Although the offices are not integrated administratively or through their budgets, residing in a single unit with the shared mission of promoting health equity allows for greater collaboration. The center’s focus on health equity includes both health status equity and health service access equity. The new center is placed in the MDHSS department director’s office for more freedom and for greater impact on the entire department.

Focus
Although the creation of the center was an important step for the department in connecting offices with similar missions to more effectively serve the state’s specific healthcare needs, the reorganization experienced major challenges in its first year. As in many states, budget limitations prevented funding of new initiatives. In addition, the state legislature initially thought that the center was a minority health program exclusively and it was initially slated for major funding reductions. Data standardization was another major initial challenge. For example, racial and ethnic definitions are not fully standardized, and can have variations that are established in statutes, regulations, and funding guidance.

Collaboration Results
As legislative leaders learned that the center included programs for everyone in the state, funding was restored. The legislature’s positive view of the PCO and state Office of Rural Health was important to restoring the center’s funding. The PCO and OMH have played an important role in establishing shared
definitions to further effective collaboration efforts. To address the issues with data standardization, they have also helped to define a minimum data set for health equity in data collection throughout the department, which will permit results-based accountability on health equity for all department activities.

Co-locating the PCO and OMH created a fertile environment for joint efforts involving the two entities. Staff members from both offices are working together to develop a strategic plan for the center that will set out health equity targets for the entire department. The PCO’s database provides an important support for the center’s joint efforts, as well as for the individual efforts of the different offices in the center.

Summary
The PCO has gained multiple positive benefits from the co-location with the OMH. It has opened doors to underserved minority communities through the OMH network of partners. More importantly, the new collaboration has expanded the PCO mission. The PCO does not limit itself to getting providers into an underserved area, but instead has an additional focus on getting those providers to understand underserved areas and special populations. The PCO has also expanded its partners beyond the state primary care association and area health education center to include new groups representing the needs of the minority populations.

In working with the OMH, the PCO has gained an expanded understanding of how minority communities access care. Consequently, the PCO is better able to conduct its activities and ensure that healthcare is provided in a manner that is acceptable to minority communities, such as recognizing that Spanish-speaking clinicians are essential for Spanish-speaking residents of underserved areas.

VIRGINIA: Integrated Efforts to Improve Health Equity

Overview
In Virginia, the PCO and OMH are both housed within the state Office of Minority Health and Health Equity (OMHHE). This permits a unique set of cross-cutting initiatives, and helps integrate all three offices’ activities around shared health equity goals. Disparities are broadly defined, and advanced geographic information system (GIS) techniques are used to identify communities with a wide range of health disparities.

Focus
The Virginia Department of Health defines health disparities as the “differences in health status among distinct segments of the population including differences that occur by gender, race or ethnicity, education or income, disability, or living in various geographic localities.” This definition goes beyond the simple identification of minority communities and identifies communities with significant differences in health status, health service access, and socioeconomic risk factors.

OMHHE also developed a health opportunity index, a composite measure including key social determinants of health. The index combines a set of measures, including:

- Socioeconomic status.
- Hospital data.
- Years of potential life lost.
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- Health risk data.
- Housing data.
- Public support data.
- Education data.
- Distance to accessible healthcare data.

Using GIS techniques, communities that fell in the lowest index quartile were identified, including rural and inner city urban communities. These high-need communities are the targets for combined interventions from the PCO, OMH, and office of rural health. In addition, the information is provided to local and regional public health agencies to help guide their community engagement efforts to improve local health status and health services.

**Collaboration Results**

The PCO and OMH work collaboratively under the OMHHE on a number of key programs designed to improve the health status and health services in communities with significant health disparities.

- **Health System Navigator Program**: OMHHE developed and manages a program targeting foreign nationals that is designed to help them navigate the complex U.S. healthcare system, which may be quite different from healthcare in their home countries. The navigator program is designed to provide new arrivals with the information they need to effectively use the health services available in Virginia.

  The navigator program includes printed guides and instructional videos on how to use them. The guides were researched and written with culturally appropriate perspectives and explanations relevant to their target populations, and are available in English, Spanish, Arabic, Vietnamese, and Russian. The materials are designed for use by community agencies and service providers working with immigrant populations, and can also be used by community health workers and outreach specialists working with immigrant communities.

- **Congregational Health Initiative**: A Virginia Department of Health survey of religious congregations in the state identified a significant interest in health within those congregations, but a limited understanding of the public health and health safety net system currently in place. The need for health information was particularly acute in rural, underserved communities, including those with significant minority populations. Consequently, OMHHE developed a congregational health initiative to more actively engage faith-based organizations in health and health service improvement efforts.

  Under the initiative, members of participating congregations are trained as lay health promoters who can provide basic health improvement and health service utilization information to other members of their communities. The training model for these health promoters was developed for an urban, inner-city neighborhood, but has been adapted for faith-based organizations in underserved, rural communities. Through this training, faith-based organizations are integrated into the larger health system of the state.
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In addition, through the congregational health initiative, members of participating congregations are linked to EMS training. This effort significantly increased the number of trained EMS personnel in underserved communities throughout Virginia.

- **Virginia Medical Interpreter Training Grants Program**: OMHHE provides training grants to bilingual individuals to pay the cost of tuition for medical interpreter training. In exchange for a training grant, an individual must agree to provide services at a health safety net agency and be on call for public health emergencies. This expands the capacity of the state health system to communicate with limited-English-proficient individuals.

- **CLAS Act Initiative**: OMHHE has developed an extensive program to promote culturally and linguistically appropriate health services (CLAS) throughout the state. The CLAS Act program develops, compiles, and disseminates materials to health service providers seeking to meet standards of cultural and linguistic competence in their operations. Materials include:
  - Translated health/patient education materials.
  - CLAS laws, regulations, and policy guidance.
  - Health service provider CLAS self-assessments.
  - CLAS toolkits for health service providers.
  - CLAS data collection tools for health service providers.

OMHHE also links health service providers to CLAS training, including training offered through partners such as the Virginia Community Healthcare Association.

Summary
The success of OMHHE’s efforts to improve health status and health services is made possible through its network of statewide and local health partners. These partners include the following membership organizations and agencies linked with the PCO and OMH:

- Virginia Community Healthcare Association.
- Virginia Rural Health Association.
- Virginia Advisory Council on Health Disparity and Health Equity.
- Virginia Public Health Association.

Recommendations for Potential PCO/OMH Collaboration

PCO staff interviewed for this issue brief universally expressed the belief that collaboration between PCOs and OMHs is extremely beneficial for both offices. Interviewees made the following recommendations to PCOs for creating successful collaborations with OMHs:

- PCOs and OMHs should establish a regular meeting schedule to review each other’s activities and identify possibilities for cooperation.
- PCOs should solicit OMHs’ perspectives and connect with their partner networks. Multiple organization perspectives are always valuable, regardless of the organization’s size.
- PCOs and OMHs should staff each other’s grant reviews. There is no better way to learn each other’s business and concerns.
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- Understanding the social determinants of health is integral to what PCOs do. PCOs should learn the language of social determinants so they can communicate more effectively with OMHs and other public health partners.
- PCOs and OMHs should explore ways to share data, conduct joint assessment activities, and conduct joint data analysis. This will prevent duplication of effort and stretch limited budgets.
- When possible, PCOs should work jointly with OMHs to look for funding opportunities together.
- PCOs should remember that no one office can do everything, and that there is never a need to battle for turf.

In the interviews, five different types of collaboration were identified:

- **Program Advice**: PCOs and OMHs can provide advice and guidance for each other’s programs.
  
  As described by New Hampshire interviewees, PCOs and OMHs can sit on advisory committees for each other’s programs. Committees address both planning and policy decisions as well as funding decisions. Participating on these committees ensures that PCOs’ and OMHs’ perspectives can inform each other’s key program decisions. It also helps ensure that both offices address health status disparity and healthcare disparity concerns.

- **Constituent Linkage**: PCOs and OMHs can provide linkage to each other’s partner networks.
  
  As described by Missouri interviewees, PCOs and OMHs can connect to each other’s constituents, which can provide an expanded perspective for each of the two offices. OMHs can tap into the expertise and resources of primary care centers, and PCOs can tap into the expertise of leaders in communities with large populations of racial and ethnic minorities. Several states reported that this expanded linkage to communities significantly changed the direction of their programs’ decision making.

- **Data Sharing**: PCOs and OMHs can share data with one another to support each office’s mission.
  
  Both PCOs and OMHs collect compile and analyze data as part of their core activities. As described by New Hampshire interviewees, OMHs and PCOs can share the data that they have prepared separately. This can reduce the data burdens of each office and ensure that both offices have data about health status disparities and healthcare disparities.

- **Combined Assessment**: PCOs and OMHs can conduct joint data collection and assessment efforts.
  
  Virginia described its health opportunity index effort, a joint assessment approach where a new combined disparity index was developed. This new index combined health status disparity measures and healthcare disparity measures. The new indicator was used to prioritize areas of the state for interventions by both offices. This combined assessment approach permits coordinated targeting of separate OCO and OMH program interventions.
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- **Joint Projects:** PCOs and OMHs can develop joint projects or initiatives appropriate to their shared mission.

  Virginia described a joint OMH-PCO effort that used faith-based community partners to address disparities issues, including health status disparities and healthcare disparities. This type of approach maximizes the effectiveness of both programs, permitting a single community intervention to address multiple office concerns.

In conclusion, the four states profiled in this issue brief demonstrate how PCOs and OMHs can work successfully with one another. The core activities of PCOs target healthcare disparities. As resources permit, PCOs also address health status disparities. In contrast, the core activities of OMHs target health status disparities, optionally addressing health access disparities. In this way, PCOs and OMHs complement one another. Working collaboratively, PCOs and OMHs can help each other improve their programs’ effectiveness.

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i HRSA. “Cooperative Agreements to States/Territories for the Coordination and Development of Primary Care Offices.” Catalog of Federal Domestic Assistance. Available at: https://www.cfda.gov/?s=program&mode=form&tab=step1&id=fc458c5a5546894507bee284d024d4ef. Accessed 09-23-2012.

ii HHS. “State Partnership Grant Program to Improve Minority Health.” Catalog of Federal Domestic Assistance. Available at: https://www.cfda.gov/?s=program&mode=form&tab=step1&id=c984cf8e57a30c2b63a22bd9ab6c05fb. Accessed 02-25-2014.


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