PREVENTION AND PRACTICE: BEHAVIORAL HEALTH AMONGST INDIVIDUALS WITH DISABILITIES

SESSION 3: Improving access to behavioral healthcare for veterans with disability

National Center for Health in Public Housing

MAY 20, 2026

Housekeeping Items

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- Raise virtual hand if you would like to unmute
- Meeting is being recorded
- Slides and recording link will be sent via email
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Moderators

Kevin Lombardi, MD, MPH
Director of Research

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Technical Assistance Manager, NCHPH

Prevention and Practice: Behavioral Health Amongst Individuals with Disabilities

Session 3: Improving access to behavioral healthcare for veterans with disability

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Director of Research
The National Center for Health in Public Housing
North American Management

By the Numbers: Disabled Vets with Mental Health Diagnoses

RESEARCH AND PRACTICE

Prevalence, Comorbidity, and Prognosis of Mental Health Among US Veterans

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Objectives. We evaluated the association of mental illnesses with clinical outcomes among US veterans and evaluated the effects of Primary Care–Mental Health Integration (PCMHI).

Methods. A total of 4 461 208 veterans were seen in the Veterans Health Administration's patient-centered medical homes called Patient Aligned Care Teams (PACT) in 2010 and 2011, of whom 1 147 022 had at least 1 diagnosis of depression, posttraumatic stress disorder (PTSD), substance use disorder (SUD), anxiety disorder, or serious mental illness (SMI; i.e., schizophrenia or bipolar disorder). We estimated 1-year risk of emergency department (ED) visits, hospitalizations, and mortality by mental illness category and by PCMHI involvement.

Results. A quarter of all PACT patients reported 1 or more mental illnesses. Depression, SMI, and SUD were associated with increased risk of hospitalization or death. PTSD was associated with lower odds of ED visits and mortality. Having 1 or more contact with PCMHI was associated with better outcomes.

Conclusions. Mental illnesses are associated with poor outcomes, but integrating mental health treatment in primary care may be associated with lower risk of those outcomes. (*Am J Public Health.* 2015;105:2564–2569. doi:10.2105/AJPH.2015.302836)

Mental disorders are common, costly, and debilitating.[1] In 2013, nearly 1 in 5 adults aged 18 years or older (18.5%) had a mental illness; nearly half of all Americans will experience a mental illness in their lifetime.[2] In 2006, treating the 31.6 million adult patients with mental illnesses cost the United States $48.6 billion.[3] Integrating mental health in primary care settings improves screening and detection of mental illnesses,[4–8] and collaborative care models have shown improvements in both proximal and distal mental health outcomes among patients with depression and anxiety.[6,9,10]

Despite calls for the integration of mental health services into primary care, most care in the United States remains fragmented. By contrast, the Veterans Health Administration (VHA) has a well-developed system of integrated mental health assessment, treatment, and management in primary care settings. In 2007, the VHA instituted the Primary Care–Mental Health Integration (PCMHI) program.[11] This program, which colocated mental health services within primary care, has been shown to improve the screening and detection of mental illness,[4] as well as the provision of preventive medical care among patients with psychiatric disorders.[12] In 2010, the VHA implemented a patient-centered medical home model in primary care sites called the Patient Aligned Care Teams (PACT) to further increase

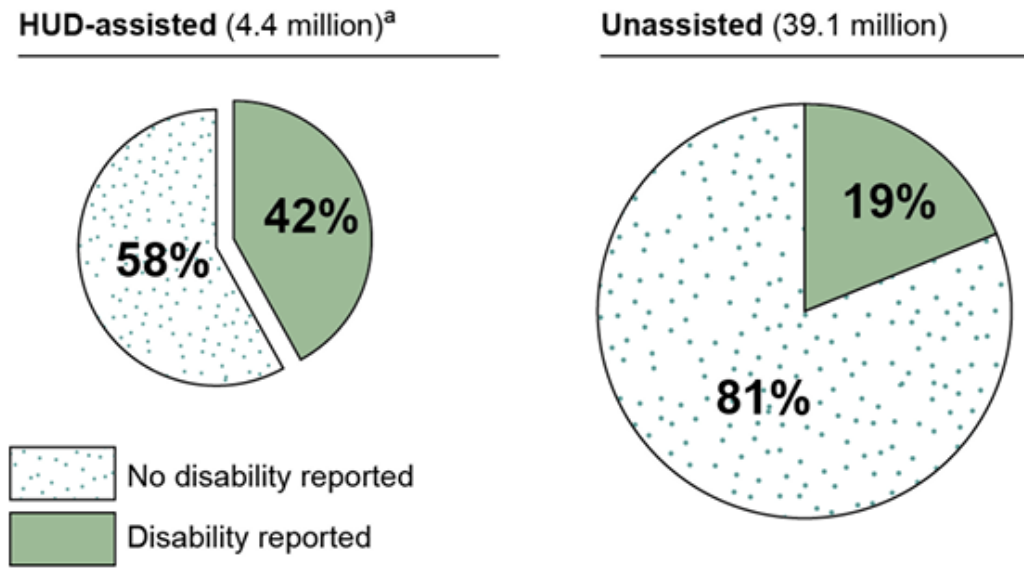
mental disorders in VHA primary care—depression, posttraumatic stress disorder (PTSD), substance use disorder (SUD), anxiety, and serious mental illness (SMI); (2) to determine the association between these mental disorders and patients' 1-year risk for emergency department (ED) visits, hospitalizations, and mortality risk; and (3) to understand whether PCMHI involvement is associated with decreased risk of ED visits, hospitalizations, and mortality among veterans with mental disorders.

2010–March 2011) to define the cohort and to obtain patients' demographics (age, gender, race/ethnicity, and marital status), service connection, clinical conditions, and *International Classification of Diseases, Ninth Revision* (*ICD-9*)[14] codes. We abstracted inpatient *ICD-9* diagnosis codes from the National Patient Care Database Medical SAS Patient Treatment File.[15] VHA eligibility is defined by enrollment in priority groups based on service-connected conditions, length of military service, disability, and income. Veterans with a service-connected

[Link to resource]

By the Numbers: HUD-Supported Residents with Disability

Figure 1: Proportion of Renter Households Assisted and Unassisted by the Department of Housing and Urban Development (HUD) That Reported a Disability, 2019



Source: GAO analysis of 2019 American Housing Survey. | GAO-23-106339

Note: Estimates in this figure have a relative margin of error of plus or minus 1–4 percent of the estimate at the 95 percent confidence level.

Link to resource: [GAO report]

Case Study: Disabled vets and mental health access

Mr. Jones is a 57 year-old man who presents for a wellness exam. He has a past medical history of T2DM, and hypertension. The patient has a behavioral health history of Major Depressive Disorder (MDD), post-traumatic stress disorder (PTSD), Generalized Anxiety Disorder (GAD) and Tobacco Use Disorder (remission for 1 years as of 2018).

Mr. Jones is a 50% service-disabled Desert Storm Navy veteran with severe lumbar degenerative disc disease with associated lumbosacral radiculopathy (sciatica) .

Your health center has a large veteran population and is in the suburban area of a medium-sized city.

Case Study: Disabled vets and mental health access

Mr. Jones undergoes a standard intake, including vitals and a nonmedical needs screener. The results are as follows:

BP: 178/98
HR: 92
RR: 18

A review of Mr. Jones' medical records indicates the following:

Vitals (2020):
BP: 138/98
HR: 60
RR: 18

HbA1c: 7.0

Prescribed Medications: Metformin, Chlorothiazide, Citalopram (Celexa)
Drug Screen: Pan-negative

The results of Mr. Jones' nonmedical needs screener reveal the following:

Appendix

WellRx Questionnaire

DOB_____ Male___ Female _____

WellRx Questions

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1. In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?

☑ Yes ☐ No

2. Are you homeless or worried that you might be in the future?

☑ Yes ☐ No

3. Do you have trouble paying for your utilities (gas, electricity, phone)?

☑ Yes ☐ No

4. Do you have trouble finding or paying for a ride?

☑ Yes ☐ No

5. Do you need daycare, or better daycare, for your kids?

☐ Yes ☑ No

Link: To Resource

The results of Mr. Jones' nonmedical needs screener reveal the following:

____ Yes	____ No
6. Are you unemployed or without regular income?	
☑ ____ Yes	____ No
7. Do you need help finding a better job?	
☑ ____ Yes	____ No
8. Do you need help getting more education?	☑
____ Yes	____ No
9. Are you concerned about someone in your home using drugs or alcohol?	☑
____ Yes	____ No
10. Do you feel unsafe in your daily life?	☑
____ Yes	____ No
11. Is anyone in your home threatening or abusing you?	☑
____ Yes	____ No

Link: To Resource

Case Study: Disabled vets and mental health access

Mr. Jones is treated by his provider, who is also a combat veteran.

Upon physical examination Mr. Jones is noted to be withdrawn and to exhibit closed body language. His responses are terse, and he seems irritated.

His physical examination is positive for 1+ pitting edema and darkened skin around his neck and groin area.

New results are positive for an HbA1c of 8.2

During the examination, Mr. Jones makes several comments about “difficulty getting up in the morning” and challenges “focusing”.

Case Study: Disabled vets and mental health access

The provider, considering Mr. Jones's disability and past behavioral health history performs a depression/anxiety screen (PHQ-9 and GAD-&), noting the following results:

Depression and anxiety screening was strongly positive for clinically significant symptomatology. Veteran endorsed persistent depressed mood, excessive anxiety, sleep disturbance, impaired concentration, irritability, and reduced daily functioning. Findings were consistent with moderate to severe depressive and anxiety-related symptoms requiring ongoing clinical evaluation and treatment.

Case Study: Disabled vets and mental health access

When Questioned Regarding the Results of his nonmedical needs Screener Mr. Jones Reveals the following:

1. He worked as a part-time customer service professional until 4 months ago, when he was laid off.
2. His disability benefits only cover about 80% of his financial needs.
3. He is behind on his utilities and his car is not operable. He uses uber and walks for transportation.
4. Mr. Jones is single and does not have any family in the area.
5. Mr. Jones has been taking a half dose of his prescription medications because he can no longer afford the medication.

Case Study: Disabled vets and mental health access

Mr. Jones is asked if he is interested in treatment for his behavioral health conditions or nonmedical needs but avoids answering the question.

When questioned **he notes that he prefers to deal with his private life by himself. When asked why he notes that in the past he has had difficulty connecting with his providers and that he felt judged.**

Case Study: Disabled Vets and Mental Health Access

Intake

- *Relationship building Screening*
- *Networking.*

Goal Setting

- *Goals set during SDOH Screening.*

Follow-up engagement

- *Keeping focus on goals.*
- *Encouragement and networking.*

Navigation

- *Relationship building, Screening*
- *Networking.*

Coaching

- *Relationship building Screening*
- *Goal achievement.*

Case Closure

- *Closure when all goals are achieved.*

Case Study: Continuity of Care to Support Behavioral Health

Mr. Jones is contacted by a staff member that works for your facility via telephone. Mr. Jones is initially reluctant to receive assistance and refuses a CHW assessment. The CHW offers the following resources, which lead to Mr. Jones agreeing to an initial consultation:

1. Consultation via Telehealth

2. His pick of CHW

Mr. Jones meets his CHW via the facility telehealth mobile application. In the beginning of his appointment Mr. Jones has a short introductory session with his CHW, who uses a number of interview techniques to make Mr. Jones more comfortable during his visit:

Link to resources: Health Assessment Interview Techniques

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Addressing Learning Objective 3

Case Study: Continuity of Care to Support Behavioral Health

Please take a moment to write or type your response to the following:

If you were interviewing Mr. Jones, how would you get him to open up to questioning?

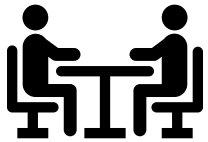
What are some interview techniques or procedures that can be used with a patient like Mr. Jones?

Case Study: Continuity of Care to Support Behavioral Health

Mr. Jones' CHW utilizes the following techniques to facilitate his interview.

Active listening: Fully comprehending the client response through verbal and nonverbal cues, including client emotional state. Complete concentration on the client

Adaptive questioning: Starting with general questions, then becoming more specific.



Nonverbal communication: Staying in-tune with client posture and body language.

Link to resources: [Health Assessment Interview Techniques]

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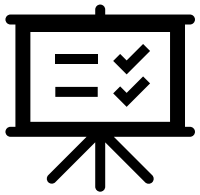
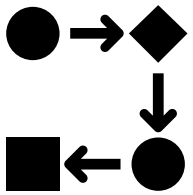
Case Study: Continuity of Care to Support Behavioral Health

Mr. Jones's CHW utilizes the following techniques to facilitate his interview (continued)



Empathy, validation, reassurance: Telling the client that their emotions are reasonable

Partnering and summarization: Playing a coach-like role with the patient, talking-back the patient responses to ensure they are and feel understood.



Transitions and empowerment: Letting the client know what steps are next can help to lower provider and client anxiety.

Link to resources: [Health Assessment Interview Techniques]

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Addressing Learning Objective 3

Case Study: Continuity of Care to Support Behavioral Health

Please take a moment to write or type your response to the following:

What types of programs are available at your organization for patients like Mr. Jones?

Which types of program interventions would be most helpful to Mr. Jones? Why?

Case Study: Continuity of Care to Support Behavioral Health

During consultation Mr. Jones' CHW utilizes a nonmedical needs framework to determine facility resources to meet his needs:

Education Access and Quality:

- *No resources identified for this client.*

Health Care Access:

- *Free transportation to health center via facility van service. Appointment reminders via facility appointment mobile application and text.*
- *Behavioral health available via local VAMC*

Neighborhood and Built Environment:

- *Utilities vouchers provided from a local community-based organization.*
- *Social worker contacts utilities for discontinuation support.*

Link to resources: [Jobs Plus Initiative]

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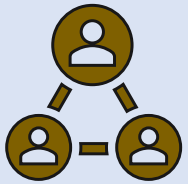
Case Study: Continuity of Care to Support Behavioral Health

During consultation Mr. Jones' CHW utilizes a nonmedical needs framework to determine facility resources to meet his needs:

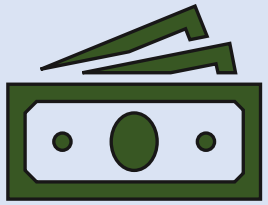
Social and Community Context:



- *Local veteran social group.*
- *Tobacco cessation literature and resource pamphlets.*
- *Regular (bi-monthly) tobacco cessation check-ins*

Economic Stability:

- *Training and support services through facility Jobs Plus Site.*
- *Veterans peer-support group at local church.*
- *Temporary medication assistance*



Link to resources: [Jobs Plus Initiative]

Addressing Learning Objective 3

Case Study: Continuity of Care to Support Behavioral Health

Please take a moment to write or type your response to the following:

Considering Mr. Jones' disability (PTSD), how was telehealth helpful in providing access to care?

How can we use telehealth to help other vulnerable patients?

Practice Recommendations: HRSA Patient Survey

Question CON27a_R (recode)

"Do you have any difficulty with self-care, such as washing all over or dressing?"

Study Results:

All FQHC* patients

10.9%

CI: 8.8-13.5

All HUD-Assisted*

22.8%

CI: 15.6-32.0

Public Housing*

22.4%

CI: 3212.8-36.2

Link to Resource: [2022 Health Center Patient Survey]

Practice Recommendations: HRSA Patient Survey

Question CON27b_R (recode)

"Do you have any difficulty with eating?"

Study Results:

All FQHC* patients

6.3%

CI: 4.9-8.1

Public Housing*

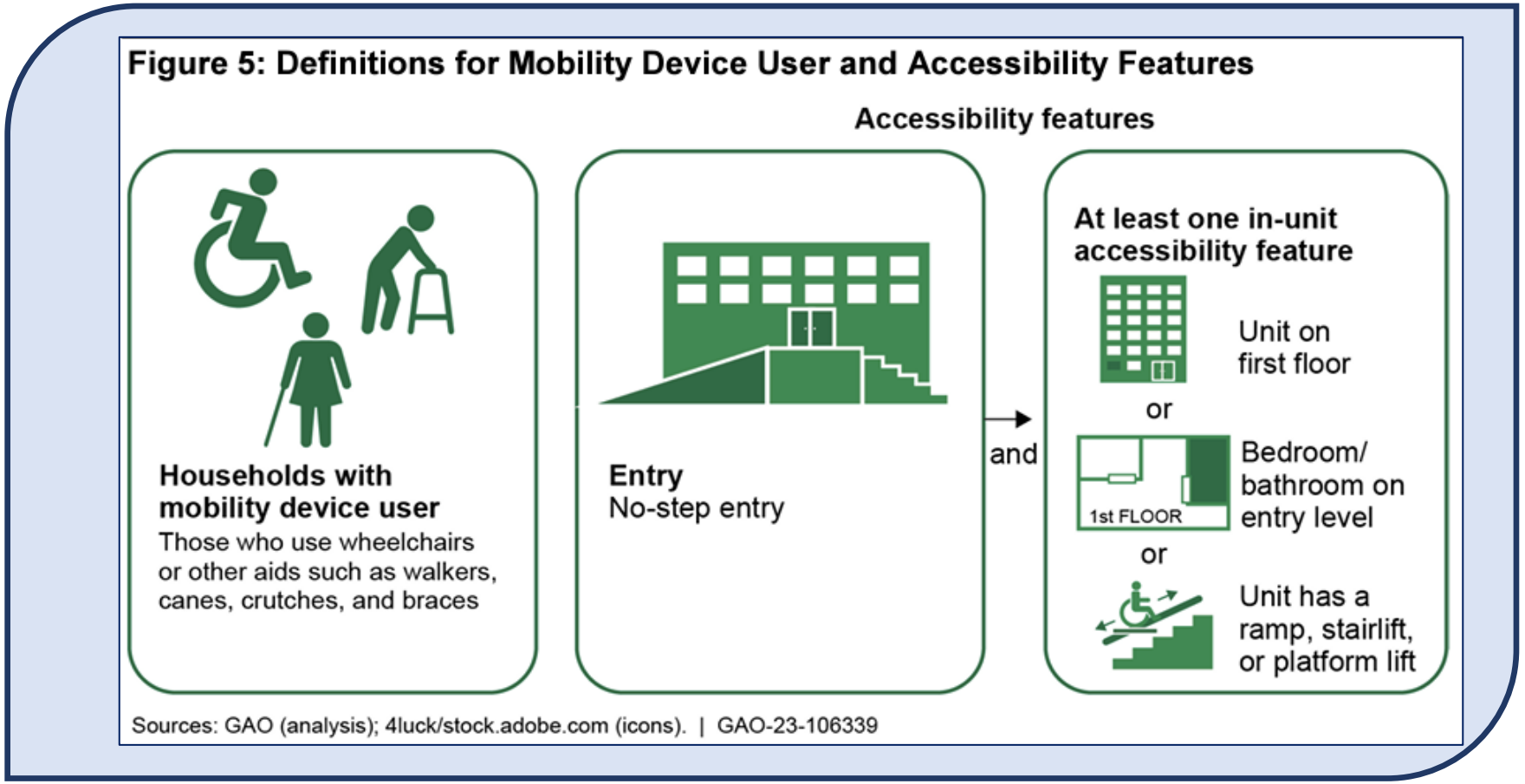
17.5%

CI: 9.1-31.2

Link to Resource: [2022 Health Center Patient Survey]

By the Numbers: HUD-Supported Residents with Disability

Properties must be updated with a variety of accessibility features to be suitable for individuals who use a mobility device.

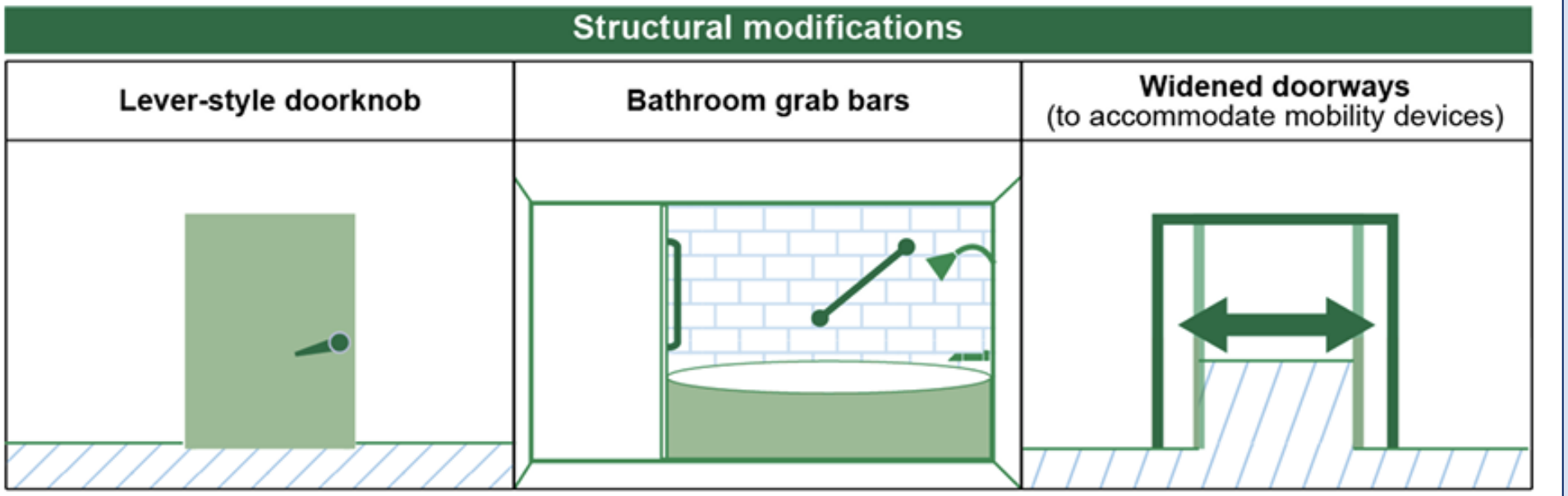


Link to resource: [GAO report]

By the Numbers: HUD-Supported Residents with Disability

Features such as bathroom-grab bars have been shown to decrease the risk of in-home injury for individuals with physical disabilities, including those utilizing mobility devices

Figure 4: Examples of Structural Modifications



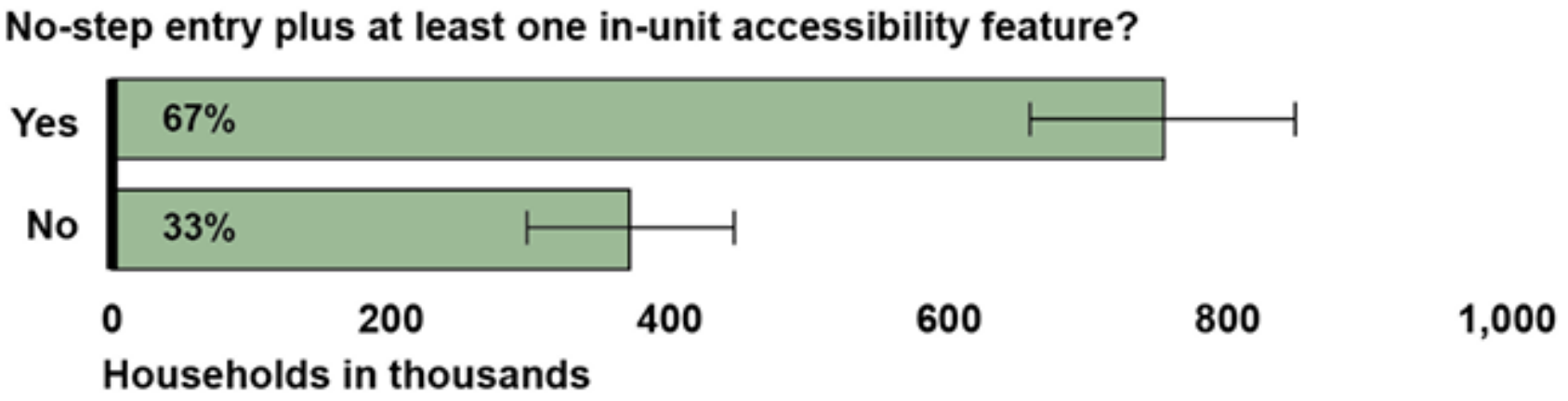
Source: GAO analysis of Department of Housing and Urban Development information. | GAO-23-106339

Link to resource: **GAO report**

By the Numbers: HUD-Supported Residents with Disability

A large proportion of HUD-Assisted Households utilizing a mobility device do not have no-step entry or at least one in-unit accessibility feature

Figure 7: Proportion of HUD-Assisted Households with a Mobility Device User That Reported a No-Step Entry and In-Unit Accessibility Features, 2019

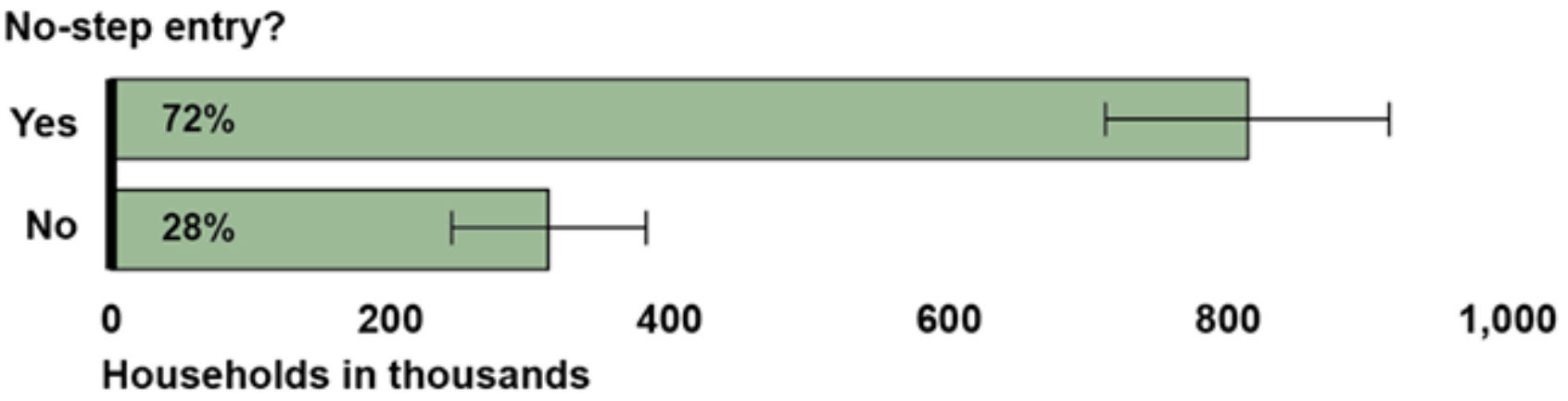


Link to resource: [GAO report]

By the Numbers: HUD-Supported Residents with Disability

A large proportion of HUD-Assisted Households utilizing a mobility device do not have no-step entry

Figure 6: Proportion of HUD-Assisted Households with a Mobility Device User That Reported a No-Step Entry, 2019



Link to resource: [GAO report]

UPCOMING SESSIONS

Preventing Substance Use Among Young Adults with Disabilities (Community of Practice)	**Session 4: 5/27/2026**	https://us06web.zoom.us/meeting/register/yYPhdbqfQNeH2XTqYUGF8Q

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