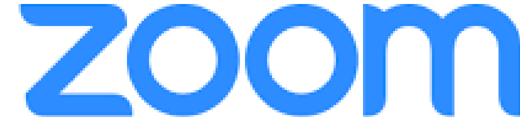
# Health for all - Increasing Inclusion for People with Disabilities

*Learning collaborative session 1:*

*The National Center for Health in Public Housing*

# Housekeeping

- All participants muted upon entry
- Engage in chat
- Raise hand if you would like to unmute
- Meeting is being recorded
- Slides and recording link will be sent via email



# National Center for Health in Public Housing

- The National Center for Health in Public Housing (NCHPH) is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U30CS09734, a National Training and Technical Assistance Partner (NTTAP) for $2,006,400 and is 100% financed by this grant. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.
- The mission of the National Center for Health in Public Housing (NCHPH) is to strengthen the capacity of federally funded Public Housing Primary Care (PHPC) health centers and other health center grantees by providing training and a range of technical assistance.

# Today's speakers

**Fide Pineda Sandoval, CHES**
Manager of Training and Technical Assistance

**Kevin Lombardi MD, MPH**
Manager of Policy, Research, and Health Promotion

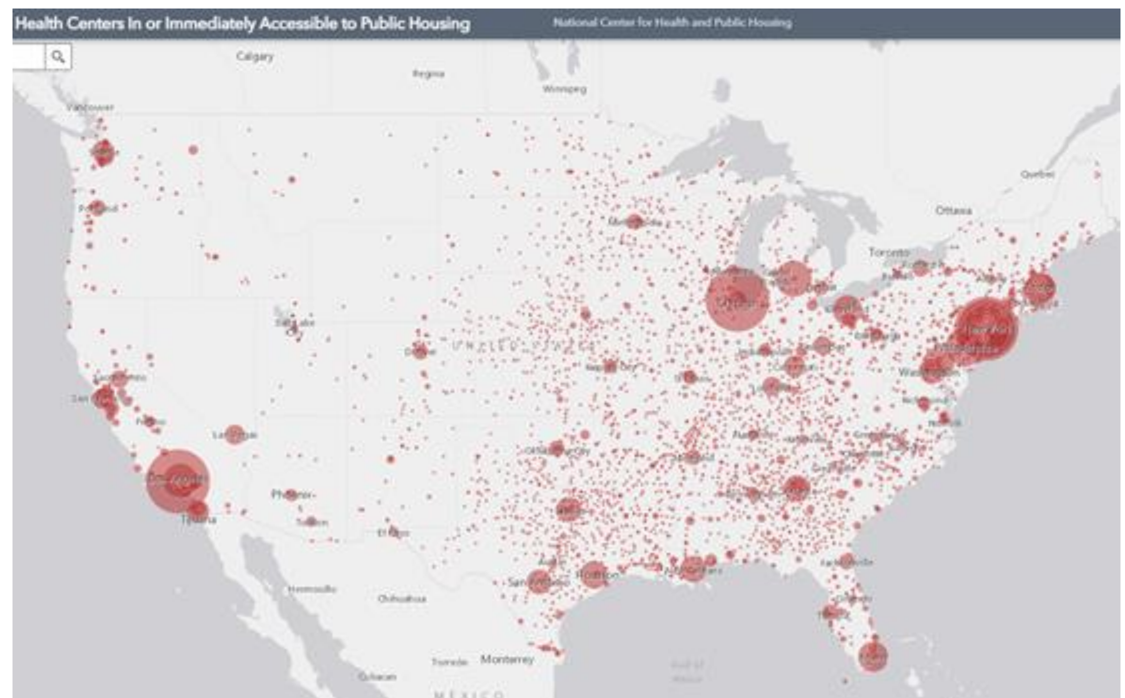
**Jose Leon MD**
Chief Medical Officer

**Chantel Moore, MA**
Communications Manager at North American Management

# Health Centers Close to Public Housing

- **1,370 Federally Qualified Health Centers (FQHC) = 30.5 million patients**
- **483 FQHCs In or Immediately Accessible to Public Housing = 6.1 million patients**
- **107 Public Housing Primary Care (PHPC) = 935,823 patients**

Source: 2022 Health Center Data




Source: Health Centers in or Immediately Accessible to Public Housing Map

# Public Housing Demographics

1.5 Million Residents

2 Persons Per Household

38% Disabled

52% White

91% Low Income

43% African-American

26% Latinx

19% Elderly

36% Children

32% Female Headed Households with Children

# Health for All LC: Curriculum Description

## Understanding the perspective of individuals experiencing disability:

***This session will include the following material (overview):***

In our first session we will engage collectively with data, research and case studies which outline the clinical and non-clinical realities faced by individuals with different types of disability. This will include:

1. Case Study Review
2. Recent Data Overview
3. Review of recent publications and resources on the topic

*This session is designed to illicit discussion, process sharing and support between colleagues. The session framework will reflect these priorities. The – Discussion – Support – Assistance model describes NCHPHs approach to Training and Technical Assistance*

## Discussion

- Two discussion questions are integrated into the session material.
- Participants are asked to please write or type their response and to be open to share.

## Support

- Participants include a range of clinical and non-clinical professionals from FQHC's, PHPCs and PHAs around the country.
- This interdisciplinary support can be an asset to better understanding the challenges your organization is facing.

## Assistance

- Discussion session format is designed to illicit the main themes in the learning objectives and are related to the resources and recommendations reviewed in this session

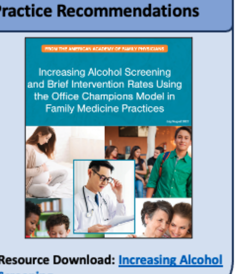
*NCHPH presentations are designed to be utilized as external resources by FQHCs PHPCs and PHAs these can be freely circulated to partners and colleagues as needed.*

## Research and Clinical Resources

- Cited resource links are located at the bottom right of the slides.
- Resources are publicly available and can shared internally or externally.
- Cited research is investigated and validated during a structured review process.

**Improving Screening for Alcohol Use Disorder**

**Practice Recommendations**



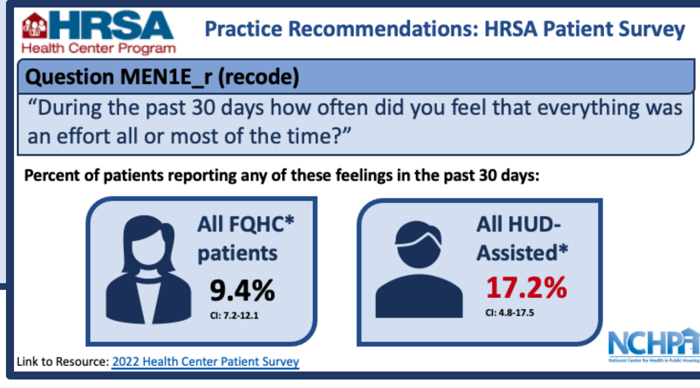
**Resource Download:** Increasing Alcohol Screening

**Practice Recommendations**

- Organizations can improve screening utilizing the "office champions" model.
- The model can be easily integrated into health center workflow.
- Integrates into existing workflow models already utilized by health centers.

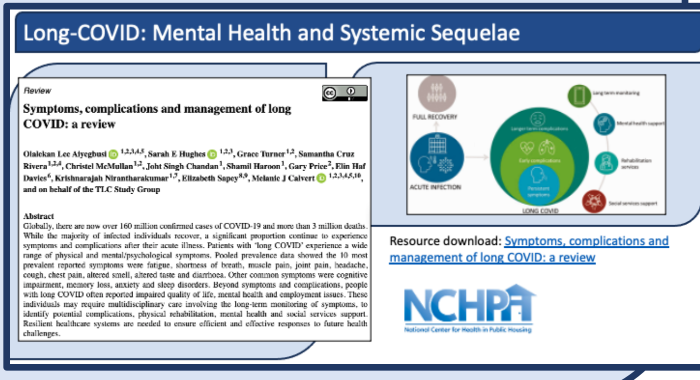
## Guidance and Recommendations

- Recommendations are based on NCHPH internal research or validated external research.
- Practice recommendations presented are reviewed and validated by the NCHPH team.




## Support and Consultation Resources

- NCHPH staff members and SMEs are available to FQHCs, PHPCs, PHAs and partner organization for consulting and advising services.

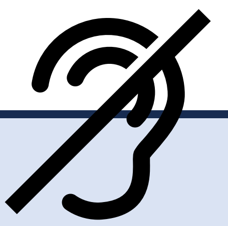



**Link to Resource: NCHPH**

# HUD Disability Classifications

*HUD divides disabilities into six main categories,  most programs do not differ benefits based on type*

## Sensory



- Blindness
- Deafness
- Sensory Processing Disorder (SPD)

## Physical

- Spinal cord injury
- Muscular dystrophy
- Cerebral palsy
- Morbid or Super Morbid Obesity

## Mental

- Schizophrenia
- Bipolar Disorder
- Neurodevelopmental Disorders

Link to resource: [HUD disability classifications]

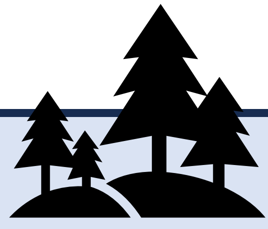
# HUD Disability Classifications

*HUD divides disabilities into six main categories, most programs do not differ benefits based on type*

## Self-care

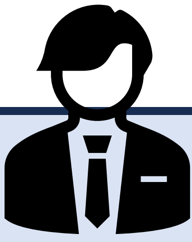
- **Severe physical and intellectual impairments can often lead to deficits in self-care.**

## Go-outside-of-home



- **Patients with certain types of anxiety disorders such as Agoraphobia find leaving their home extremely challenging.**

## Employment



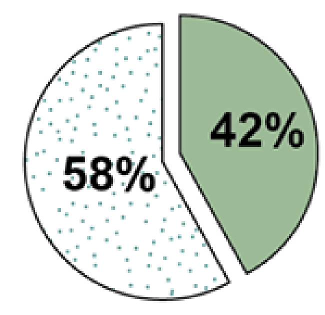
- **Certain Physical or intellectual disabilities, both congenital and acquired can create severe barriers to employment.**

Link to resource: **HUD disability classifications**

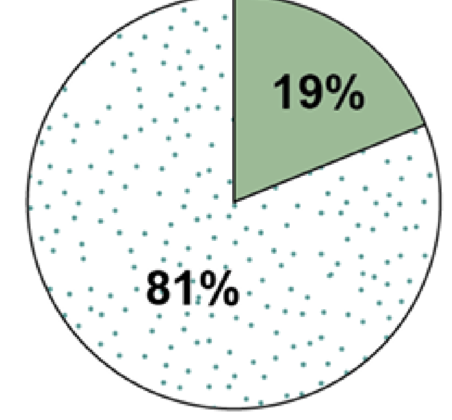
# By the Numbers: HUD-Supported Residents with Disability

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

**HUD-assisted** (4.4 million)[a]




**Unassisted** (39.1 million)



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.

Page 2 GAO-23-106339 HUD Assistance for Households with Disabilities

Link to resource: [GAO report]

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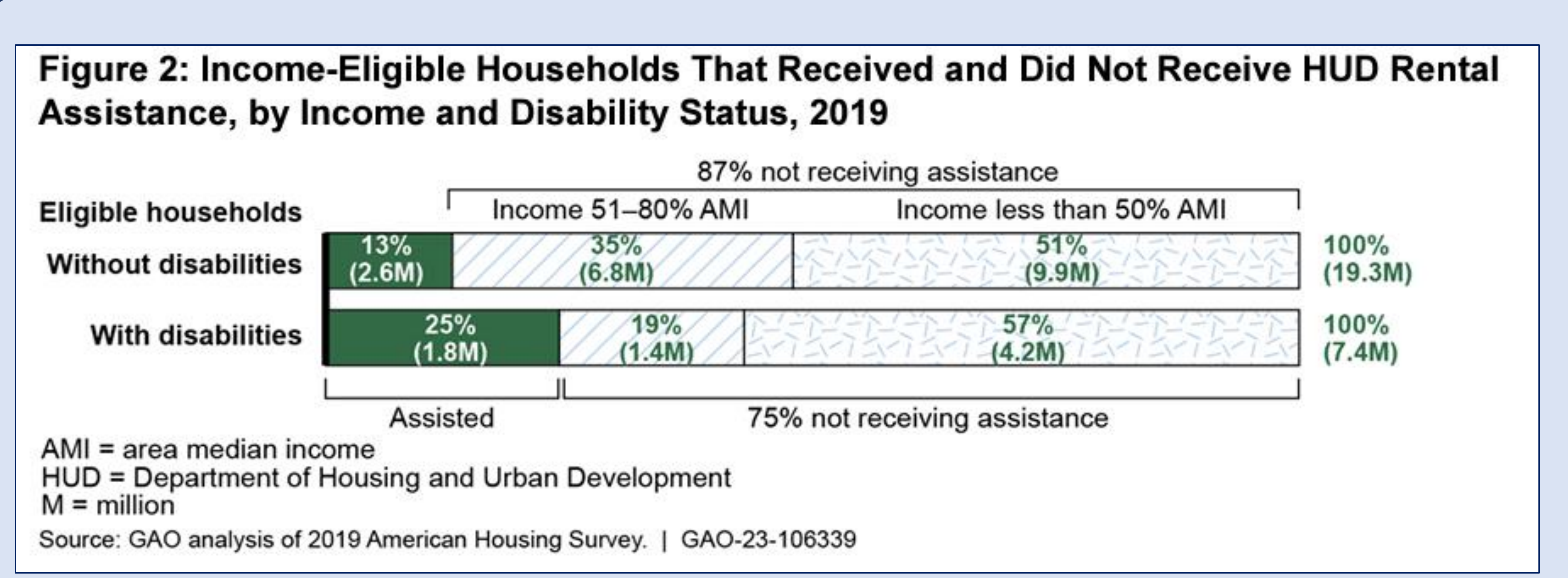


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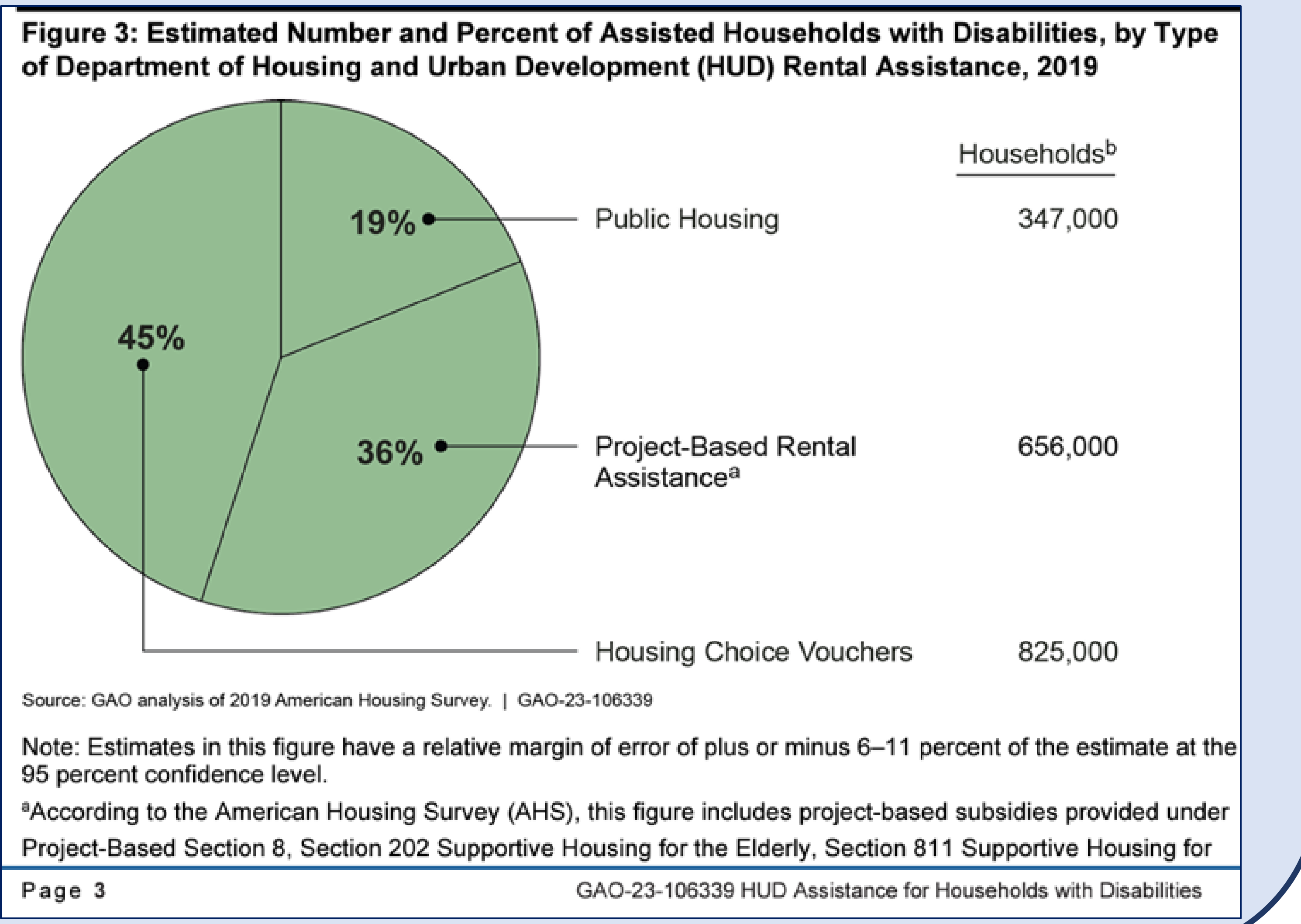
Figure 3: Estimated Number and Percent of Assisted Households with Disabilities, by Type of Department of Housing and Urban Development (HUD) Rental Assistance, 2019



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 6–11 percent of the estimate at the 95 percent confidence level.

[a]According to the American Housing Survey (AHS), this figure includes project-based subsidies provided under Project-Based Section 8, Section 202 Supportive Housing for the Elderly, Section 811 Supportive Housing for

Page 3 GAO-23-106339 HUD Assistance for Households with Disabilities

Link to resource: GAO report

# Case Study: Supporting Patients with Disabilities

**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 combat veteran. Your health center has a large veteran population and is in the suburban area of a medium-sized city. Mr. Jones identifies as African-American.

**The patient undergoes a standard intake, including vitals and an SDOH screener. The results are as follows:**

**BP: 178/98**
**HR: 92**
**RR: 18**

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

**Vitals (2018):**
**BP: 138/98**
**HR: 60**
**RR: 18**

**HbA1c: 7.0**
**Drug Screen: Pan-negative**

**Prescribed Medications: Metformin, Chlorothiazide, Citalopram (Celexa)**

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

**Appendix**

***WellRx Questionnaire***

DOB________________ Male___ Female _____

WellRx Questions

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

_____ 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

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The WellRx Toolkit was developed by Janet Page-Reeves, PhD, and Molly Bleecker, MA, at the Office for Community Health at the University of New Mexico in Albuquerque. Copyright © 2014 University of New Mexico.

[Link: To Resource]

# Case Study: Supporting Patients with Disabilities

**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**

**When Questioned Regarding the Results of His SDOH Screener Mr. Jones Reveals the following:**

1. Mr. Jones worked as a construction foreman until 6 months ago when he was laid off. His unemployment insurance ran out 3 months ago.
2. He is behind on his utilities and his car is not operable. He uses uber and walks for transportation.
3. Mr. Jones reports more frequent panic attacks in the past six months (2 x per week vs 1x per month one year ago)
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.

Mr. Jones is asked if he is interested in treatment for his behavioral health conditions or SDOH issues 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.**

# Addressing Learning Objective 3

## Case Study: Supporting Patients with Disabilities

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

*What is your assessment of Mr. Jones' clinical condition? Is it getting worse or better? Why?*

*How could a patient like Mr. Jones be encouraged to seek supportive services?*

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[Link: To Resource]

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# Self-reported disability details by housing type: HRSA Health Center patient survey (2022)

| n (weighted) = 27,224,243 | All other Housing (%) | 95% CI | All HUD-assisted* (%) | 95% CI | *p* | Public Housing (%) | 95% CI | *p* |
|---|---|---|---|---|---|---|---|---|
| Deaf or serious difficulty hearing | 7 | 5.3-9.3 | 10.1 | 5.9-16.8 | 0.3646 | 9.6 | 4.5-21[illegible] | 0.7321 |
| Blind or serious difficulty seeing | 8 | 5.9-10.2 | 13.4 | 8.9-20.5 | 0.0458 | 12.8 | 6.8-[illegible].0 | 0.1807 |
| Difficulty with self-care such as w[illegible] | 10.9 | 8.8-13.5 | 22.8 | 15.6-32.0 | 0.000[illegible] | [illegible] | [illegible].8-[illegible] | 0.0254 |
| Difficulty with eating | 6.3 | 4.9-8.1 | 10 | 5.4-18.0 | 0.197[illegible] | [illegible] | [illegible] | 0.0014 |
| Difficulty getting out of bed or chairs | 13.4 | 10.7-16.6 | 23.1 | 17.1-30.5 | 0.003[illegible] | [illegible] | [illegible] | 0.011 |
| Has fallen in the past 12 months | 20.1 | 17.1-24.6 | 25.9 | 18.4-35.2 | 0.4245 | 21 | 12.6-33.0 | 0.9536 |
| Fallen more than 4 times in past 12 months | 3.7 | 2.4-5.8 | 6.1 | 2.4-14.4 | 0.3305 | 4.7 | 1.4-14.7 | 0.7688 |
| Patient experienced any injury as the result of reported falls | 41.9 | 35.3-48.7 | 58.9 | 42.1-73.8 | 0.0585 | 58.2 | 35.7-77.7 | 0.2588 |

***95% Confidence Interval (95% range of real possibility)***

***P* – value *(statistical significance)***

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| Difficulty with self-care such as washing or dressing | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] |
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All patients (reference group)

All HUD-assisted (comparison group 1)

Public housing only (comparison group 2)

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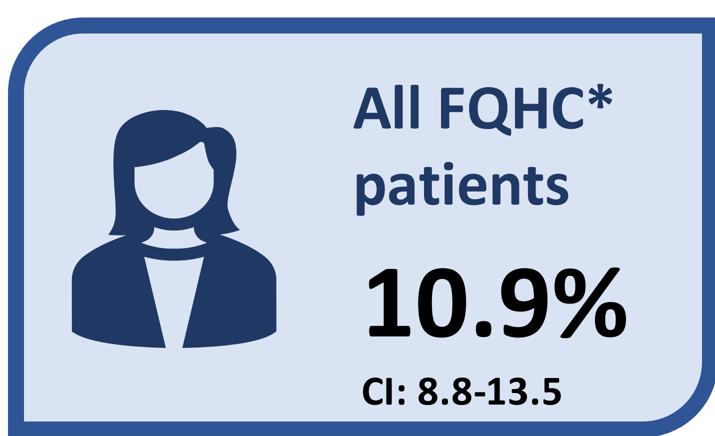
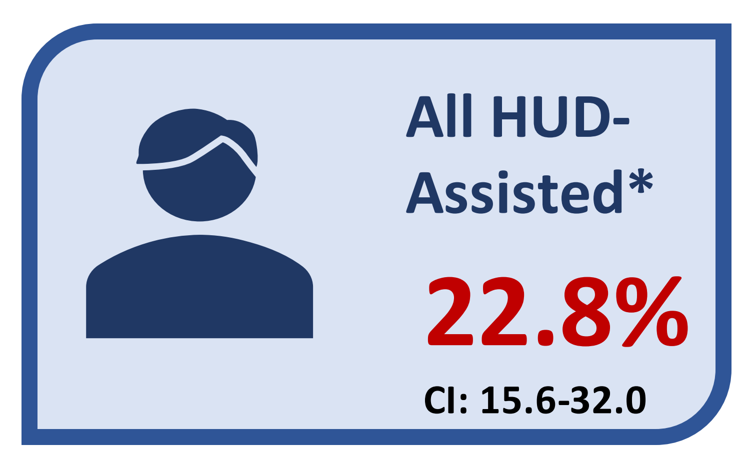
# Practice Recommendations: HRSA Patient Survey

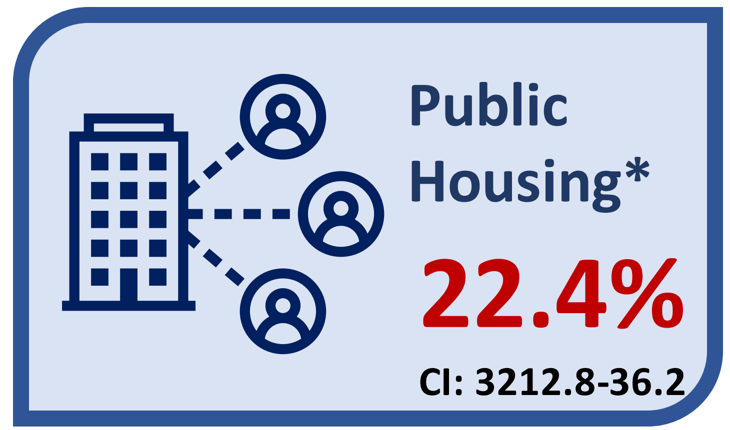
## Question CON27a_R (recode)

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

***Study Results:***




Link to Resource: [2022 Health Center Patient Survey]

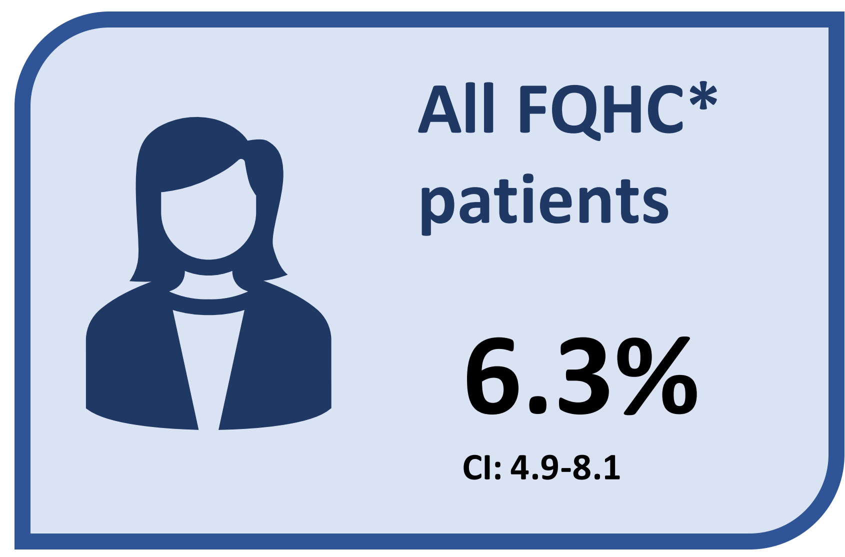
NCHPH
National Center for Health in Public Housing

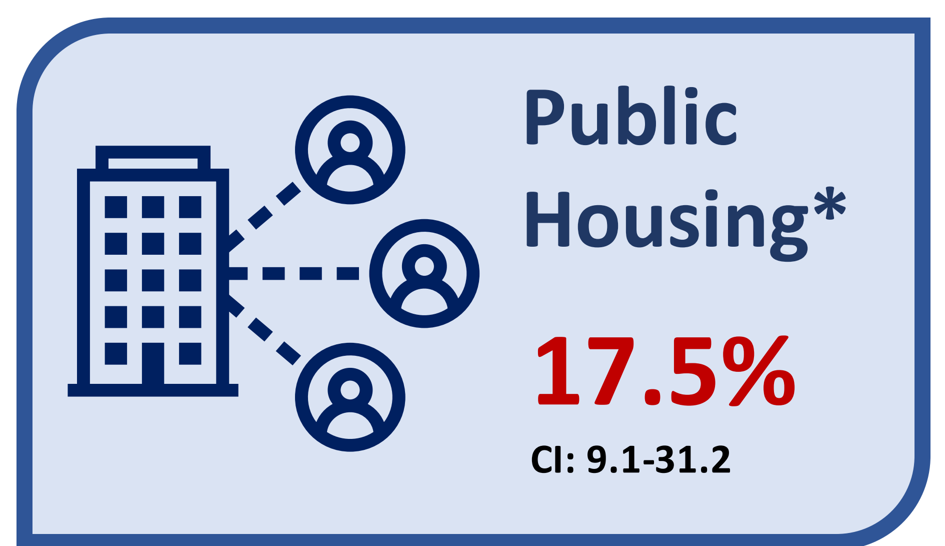
# Practice Recommendations: HRSA Patient Survey

## Question CON27b_R (recode)

"Do you have any difficulty with eating?"

***Study Results:***

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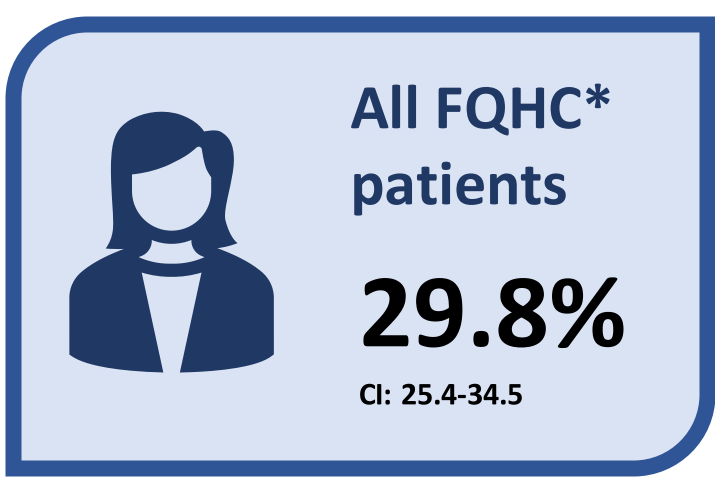
|---|---|---|---|---|---|---|---|---|
| n (weighted) = 27,224,243 | All other Housing (%) | 95% CI | All HUD-assisted* (%) | 95% CI | *p* | Public Housing (%) | 95% CI | *p* |
| Deaf or serious difficulty hearing | 7 | 5.3-9.3 | 10.1 | 5.9-16.8 | 0.3646 | 9.6 | 4.5-21.2 | 0.7321 |
| Blind or serious difficulty seeing | 8 | 5.9-10.2 | 13.4 | 8.9-20.5 | 0.0458 | 12.8 | 6.8-23.0 | 0.1807 |
| Difficulty with self-care such as washing or dressing | 10.9 | 8.8-13.5 | 22.8 | 15.6-32.0 | 0.0005 | 22.4 | 12.8-36.2 | 0.0254 |
| Difficulty with eating | 6.3 | 4.9-8.1 | 10 | 5.4-18.0 | 0.1973 | 17.5 | 9.0-31.2 | 0.0014 |
| **Difficulty getting out of bed or chairs** | **13.4** | **10.7-16.6** | **23.1** | **17.1-30.5** | **0.0037** | **27.5** | **17.0-41.2** | **0.011** |
| Has fallen in the past 12 months | 20.1 | 17.1-24.6 | 25.9 | 18.4-35.2 | 0.4245 | 21 | 12.6-33.0 | 0.9536 |
| Fallen more than 4 times in past 12 months | 3.7 | 2.4-5.8 | 6.1 | 2.4-14.4 | 0.3305 | 4.7 | 1.4-14.7 | 0.7688 |
| Patient experienced any injury as the result of reported falls | 41.9 | 35.3-48.7 | 58.9 | 42.1-73.8 | 0.0585 | 58.2 | 35.7-77.7 | 0.2588 |

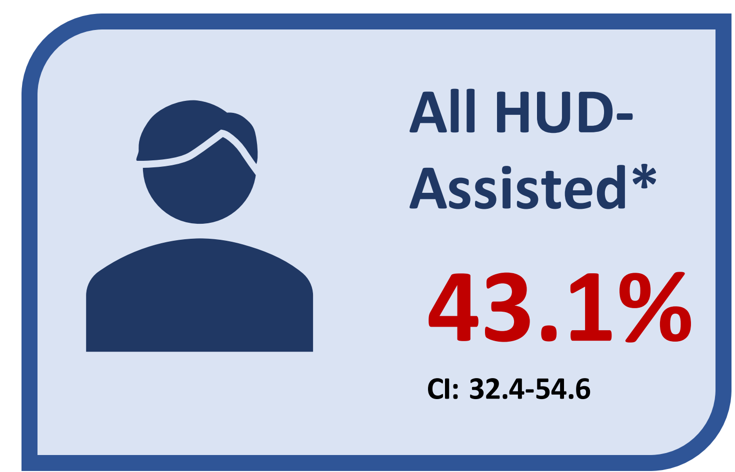
# Practice Recommendations: HRSA Patient Survey

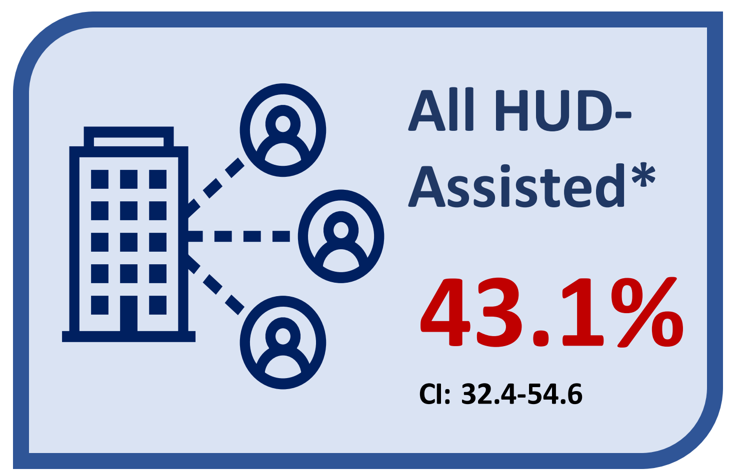
## CON27c_R (recode)

"During the past 30 days how often did you feel that everything was an effort"

***Study Results:***




Link to Resource: [2022 Health Center Patient Survey]

# Self-reported disability details by housing type: HRSA Health Center patient survey (2022)

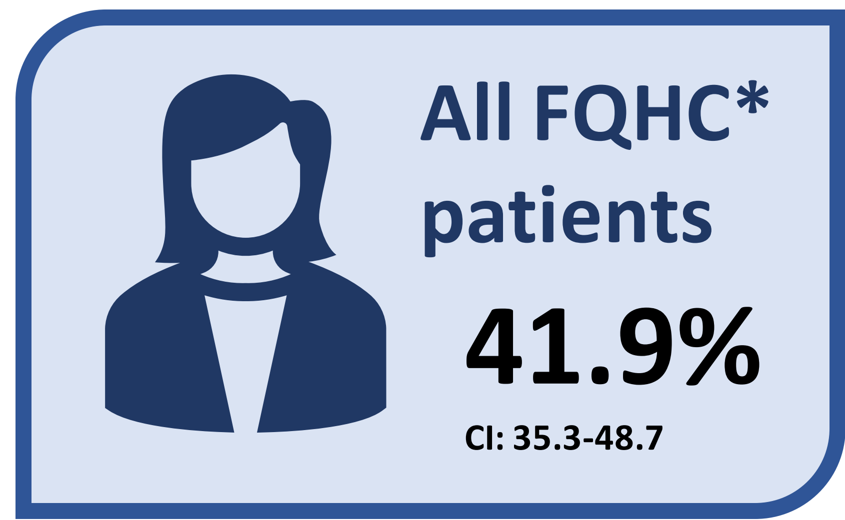
| n (weighted) = 27,224,243 | All other Housing (%) | 95% CI | All HUD-assisted* (%) | 95% CI | *p* | Public Housing (%) | 95% CI | *p* |
|---|---|---|---|---|---|---|---|---|
| Deaf or serious difficulty hearing | 7 | 5.3-9.3 | 10.1 | 5.9-16.8 | 0.3646 | 9.6 | 4.5-21.2 | 0.7321 |
| Blind or serious difficulty seeing | 8 | 5.9-10.2 | 13.4 | 8.9-20.5 | 0.0458 | 12.8 | 6.8-23.0 | 0.1807 |
| Difficulty with self-care such as washing or dressing | 10.9 | 8.8-13.5 | 22.8 | 15.6-32.0 | 0.0005 | 22.4 | 12.8-36.2 | 0.0254 |
| Difficulty with eating | 6.3 | 4.9-8.1 | 10 | 5.4-18.0 | 0.1973 | 17.5 | 9.0-31.2 | 0.0014 |
| Difficulty getting out of bed or chairs | 13.4 | 10.7-16.6 | 23.1 | 17.1-30.5 | 0.0037 | 27.5 | 17.0-41.2 | 0.011 |
| **Has fallen in the past 12 months** | **20.1** | **17.1-24.6** | **25.9** | **18.4-35.2** | **0.4245** | **21** | **12.6-33.0** | **0.9536** |
| **Fallen more than 4 times in past 12 months** | **3.7** | **2.4-5.8** | **6.1** | **2.4-14.4** | **0.3305** | **4.7** | **1.4-14.7** | **0.7688** |
| **Patient experienced any injury as the result of reported falls** | **41.9** | **35.3-48.7** | **58.9** | **42.1-73.8** | **0.0585** | **58.2** | **35.7-77.7** | **0.2588** |

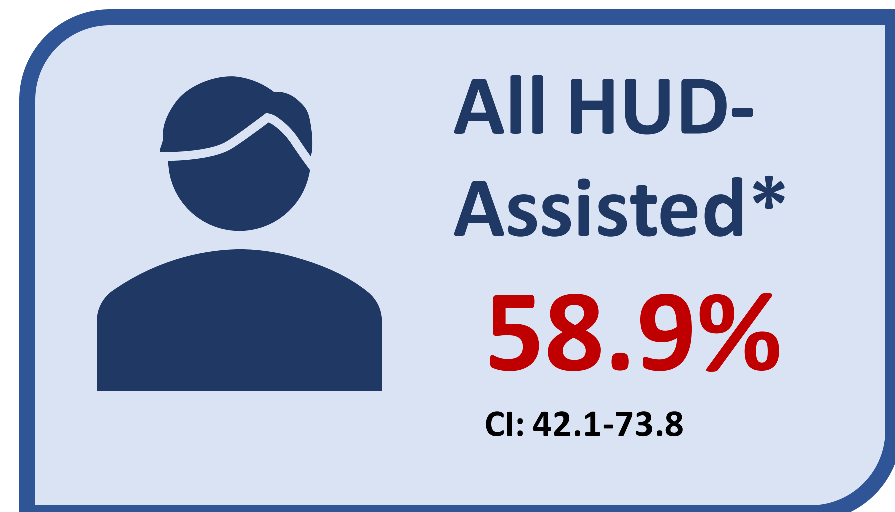
# Practice Recommendations: HRSA Patient Survey

## Question CON33_r (recode)

"How many of these falls (experienced in past 12 months)" caused an injury that limited your regular daily activities or caused you to go to see a doctor or health professional?"

***Study Results:***




Link to Resource: [2022 Health Center Patient Survey]

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# Case Study: Continuity of Care to Support Behavioral Health

**Mr. Jones is contacted by a staff member that works for your facility. He initially refuses assistance. The CHW offers the following resources, which lead to Mr. Jones agreeing to an initial consultation.**

***1. Consultation via Telehealth***
***2. A community-based, African-American veteran 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 the following techniques to make Mr. Jones more comfortable during his visit.**

**Link to resources:** Health Assessment Interview Techniques

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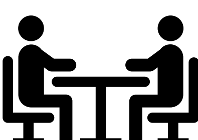
# Case Study: Continuity of Care to Support Behavioral Health

*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.

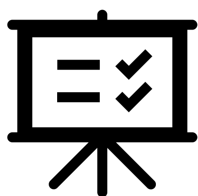


**Nonverbal communication:** Staying in-tune with client posture and body language.

**Link to resources:** Health Assessment Interview Techniques

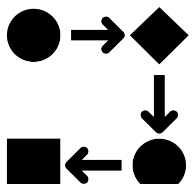
# Case Study: Continuity of Care to Support Behavioral Health

*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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The results of Mr. Jones; SDOH screener reveal the following:

# Appendix

***WellRx Questionnaire***

DOB__________________ Male___ Female _____

WellRx Questions

---

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

_____ 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

---

The WellRx Toolkit was developed by Janet Page-Reeves, PhD, and Molly Bleecker, MA, at the Office for Community Health at the University of New Mexico in Albuquerque. Copyright © 2014 University of New Mexico.

# Case Study: Continuity of Care to Support Behavioral Health

*During consultation Mr. Jones' CHW utilizes the Framework of the SDOH 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/*

***Neighborhood and Built Environment:***

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

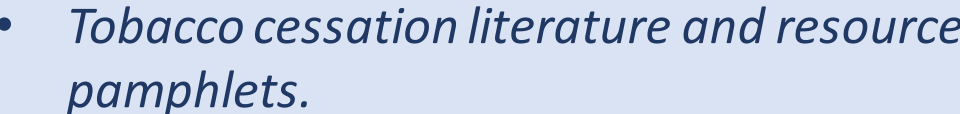
**Link to resources:** Jobs Plus Initiative

# Case Study: Continuity of Care to Support Behavioral Health

*During consultation Mr. Jones' CHW utilizes the Framework of the SDOH to determine facility resources to meet his needs:*

## *Social and Community Context:*

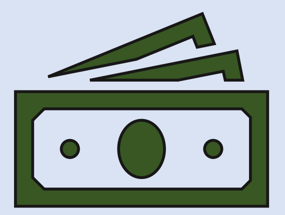
- *Local veteran social group.*



- *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:**

How could telehealth via utilized at your institution to support Mr. Jones through his TUD recovery?

# Case Study: Continuity of Care to Support Behavioral Health

*During consultation Mr. Angelo's CHW utilizes the Framework of the SDOH 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.*

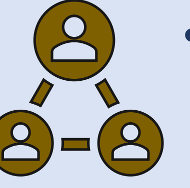
### *Neighborhood and Built Environment:*

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

**Link to resources:** Jobs Plus Initiative

# Case Study: Continuity of Care to Support Behavioral Health

*During consultation Mr. Angelo's CHW utilizes the Framework of the SDOH to determine facility resources to meet his needs:*

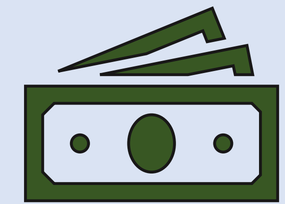


***Social and Community Context:***

- *Spanish-language Narcotics Anonymous Meetings.*
- *Drug use recovery literature and resource pamphlets for Mr. Angelo to give to his wife*

***Economic Stability:***

- *Training and support services through facility Jobs Plus Site.*
- *Spanish-language peer-support group at local church.*



**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:**

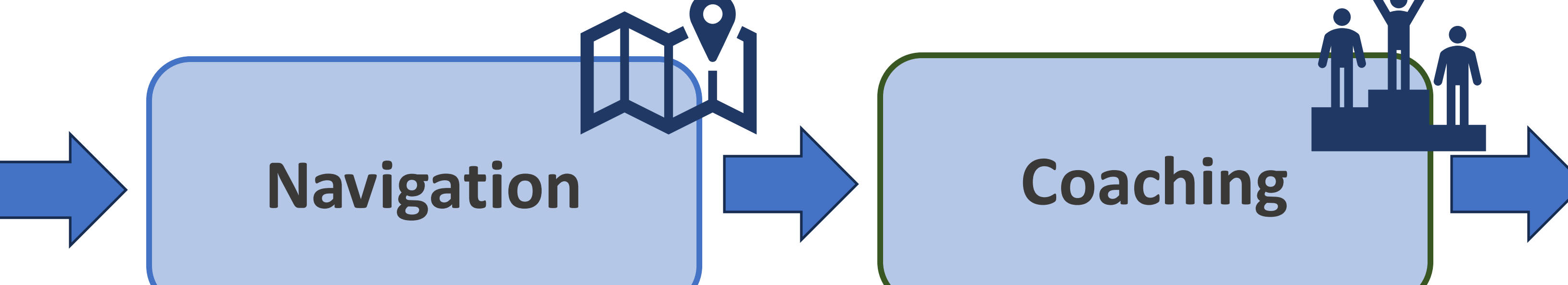
What is a program at your institution that would be helpful in supporting Mr. Jones' SDOH needs?

# Case Study: Continuity of Care to Support Behavioral Health

- *Relationship building Screening*
- *Networking.*

- *Goals set during SDOH Screening.*

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



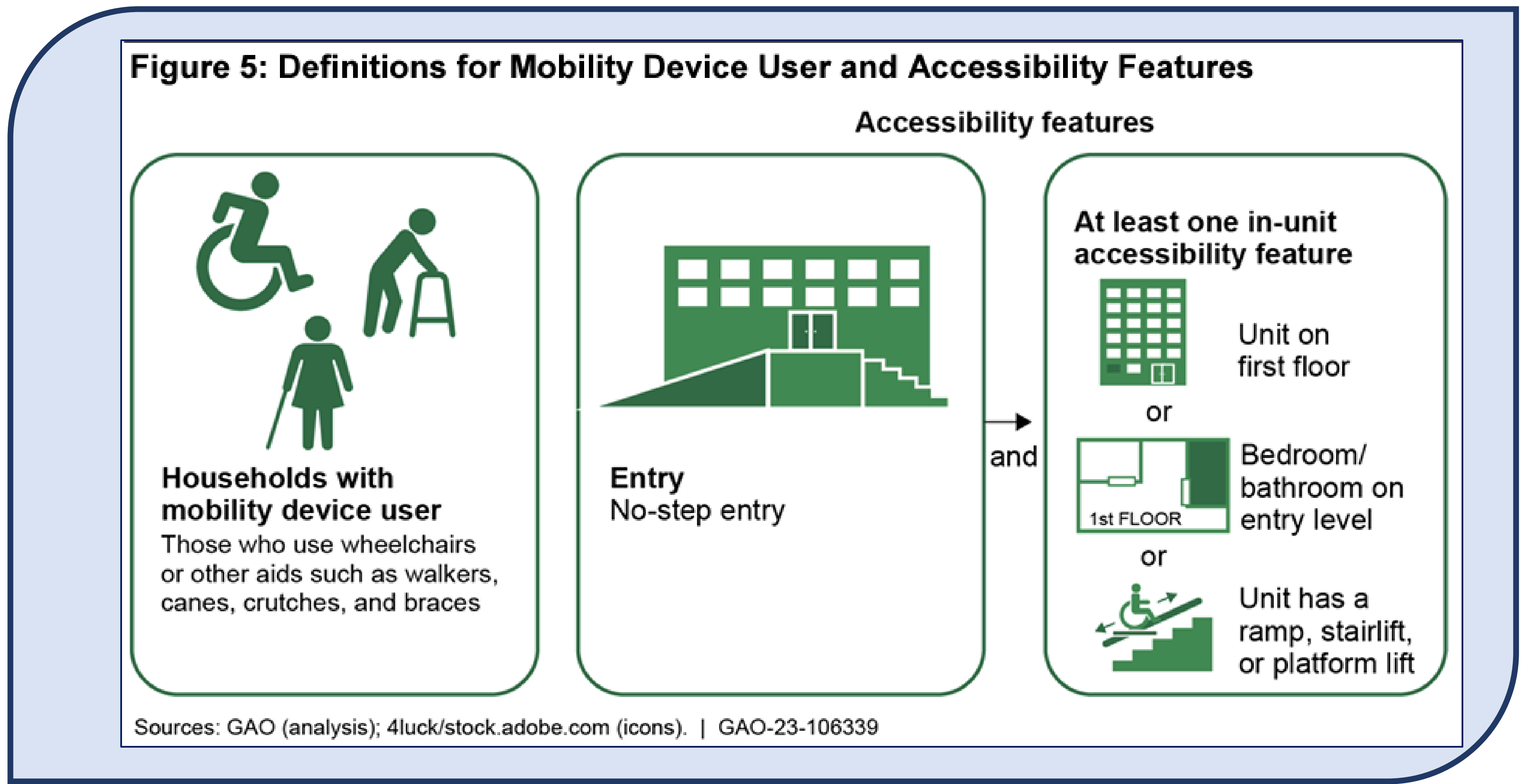
- *Relationship building, Screening*
- *Networking.*

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

- *Closure when all goals are achieved.*

# 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.*

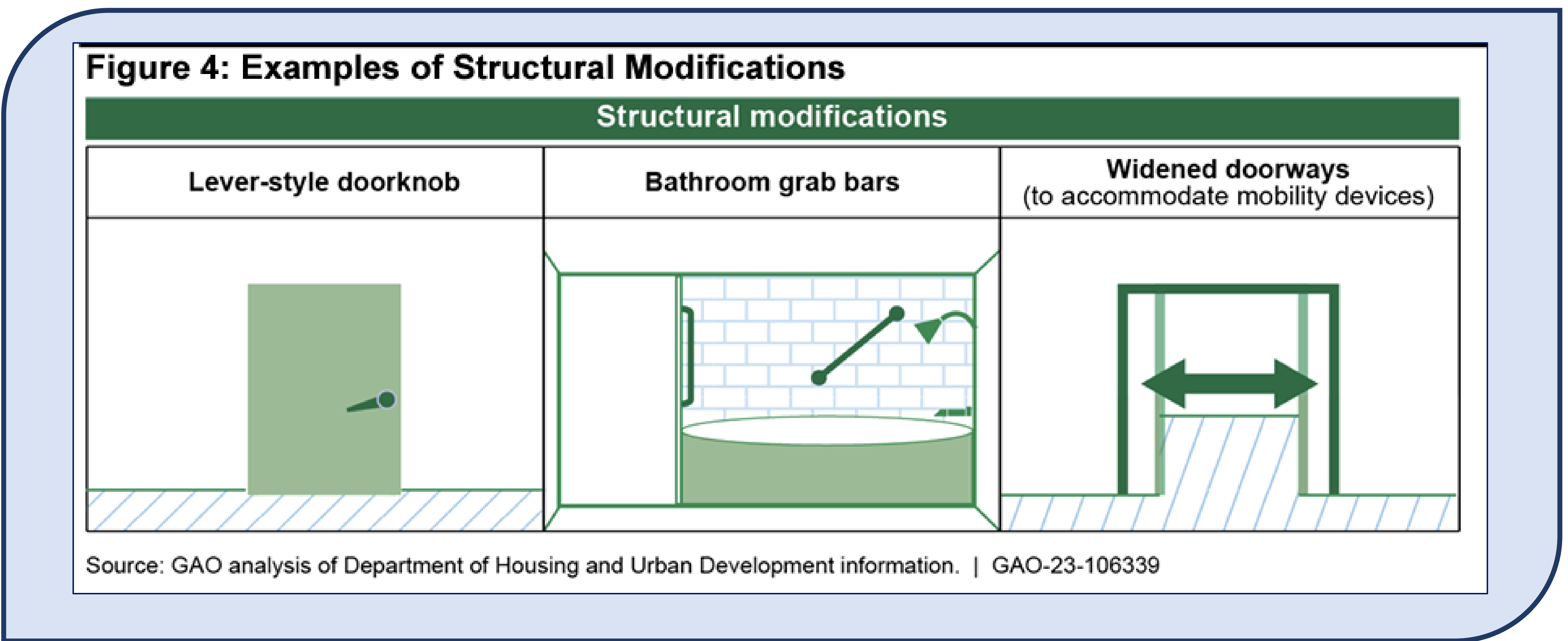



Link to resource: GAO report

National Center for Health in Public Housing

# 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*




Link to resource: **GAO report**

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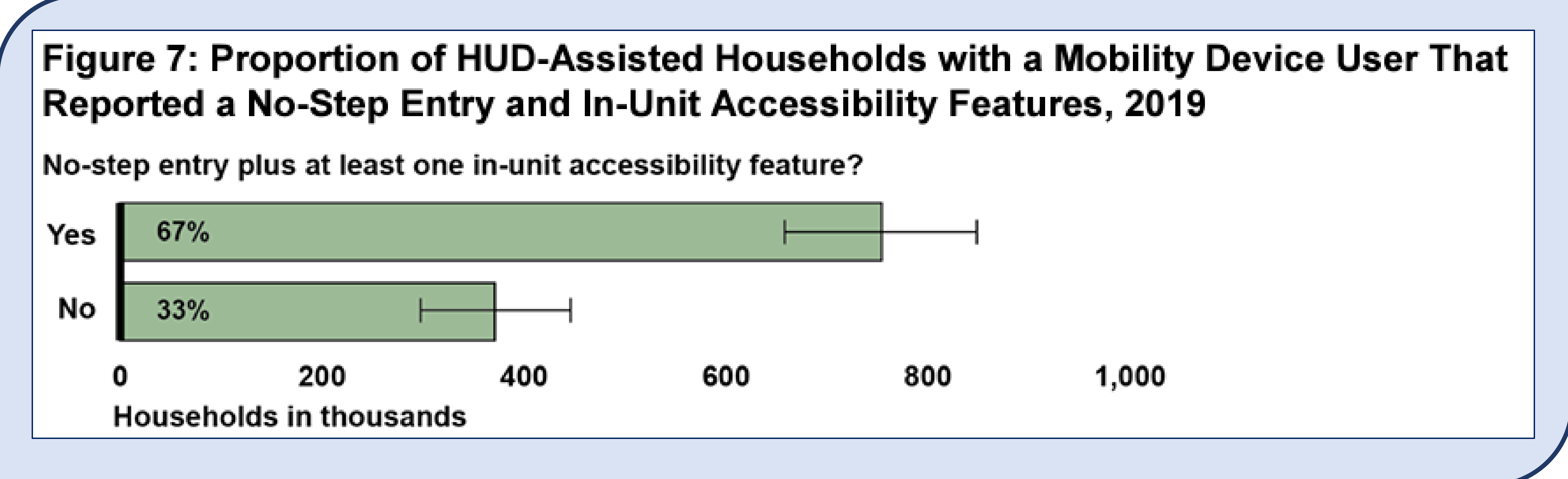
# By the Numbers: HUD-Supported Residents with Disability

*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*




Link to resource: [GAO report]

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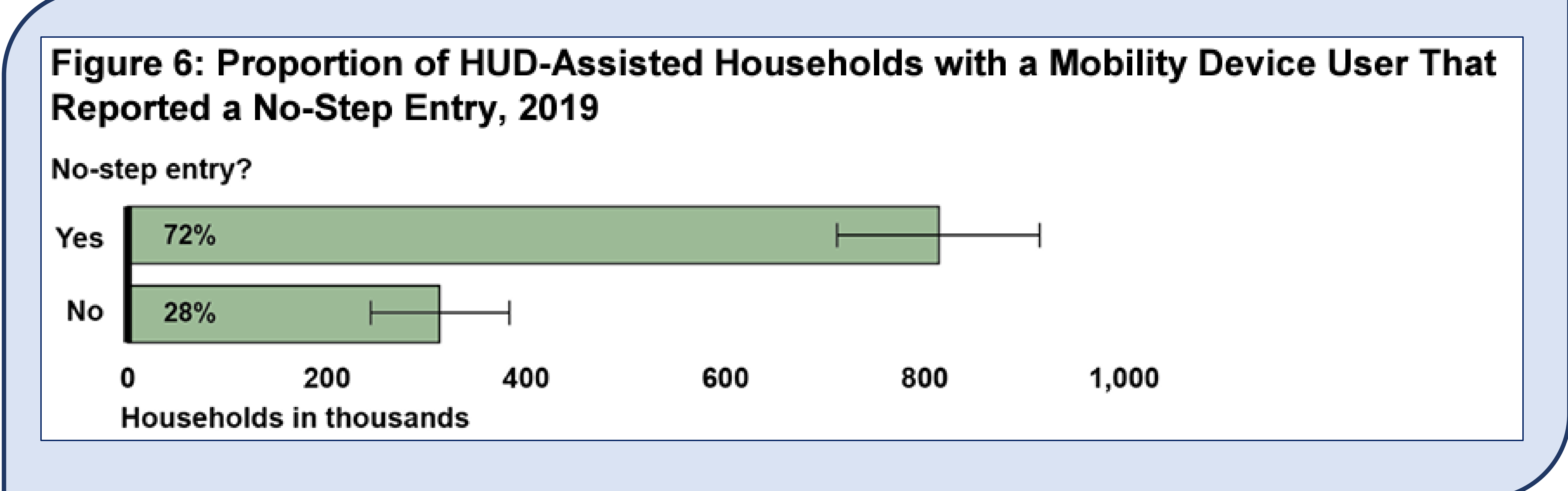
# By the Numbers: HUD-Supported Residents with Disability

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




Link to resource: [GAO report]

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# Q&A Session

# Upcoming LC Sessions

**Session 2 (03/04/2024):** The trials and tribulations of the provider

**Session 3 (03/11/2024):** Data-driven interventions

**Session 4 (03/18/2024):** Conclusion and case studies engagements

# Complete our Post Evaluation Survey

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# Thank you!