Phase 2
Summary
Report

Rhode Island Aging and Health-Related Social Needs Learning-and-Action Lab

MLPB
ADVANCING HEALTH
THROUGH JUSTICE

HRSN LEARNING-AND-ACTION LAB
PHASE 2 SUMMARY REPORT

EXECUTIVE SUMMARY

MLPB's **Aging and Health-Related Social Needs Learning-and-Action Lab** is a two-phased initiative designed to inform and improve clinic-based health-related social needs (HRSN) screening, referral, and problem-solving strategies impacting older adults who live in Rhode Island. Through generous funding from the Blue Cross & Blue Shield of Rhode Island Community Health Fund (BCBSRI's advised fund at the Rhode Island Foundation), and with programmatic support from the Care Transformation Collaborative of Rhode Island (CTC-RI), the Lab explores how the screening experience of RI-based older adults (age 55 and over) can be enhanced, and how care teams and insurers can be more responsive to patients' goals. Phase 1 centered the perspectives of Rhode Islanders with lived experience and non-medical professional expertise to identify key priorities among this population. Phase 2 integrated members of clinical practices in Rhode Island to identify shared insights and develop concrete recommendations to improve HRSN screening, referral, and problem solving.

Insights:

1. The health-related social needs that matter most are the ones that matter to the patients.
2. Understanding the context for health-related social needs screening can significantly improve the experience and effectiveness for patients.
3. Effective health-related social needs screening both requires a trusting relationship between the patient and healthcare practice, and presents an opportunity to build one.
4. Despite divergent incentives and expectations, older adult and provider participant groups often vocalized similar challenges in, and potential fixes to, health-related social needs screening.

Recommendations:

1. Ensure adequate time for older adults to talk with someone on the healthcare team about their health-related social needs.
2. Build shared language and skills among all practice members to communicate the process and rationale of health-related social needs screening to patients.
3. Empower entire healthcare practices to create a culture of trust between patients and all members of the team, not solely their primary provider.
4. Protect time and space for providers and team members to better connect with the communities they serve and to co-create solutions to persistent problems.

MLPB
ADVANCING HEALTH
THROUGH JUSTICE

ABOUT THE LEARNING AND ACTION LAB

Phase 1, comprised of four formal and one informal Lab sessions, ran from July through December 2022. Phase 2 launched in July 2023 with a recruitment process for clinical practice representatives in partnership with CTC-RI. MLPB and CTC-RI jointly developed a recruitment survey for clinical practices, which was distributed through CTC-RI's network. Interested practices were invited to speak with MLPB to identify individuals to participate in the Lab. These representatives included a mix of healthcare roles (including physicians, nurses, social workers, a pharmacist, etc.) and individuals who perform social needs screening as part of their role (e.g., medical assistants and community health workers).[1]

These new participants joined 13 returning participants from Phase 1. Priority was given to those who are over the age of 55 and/or represent a diverse racial/ethnic background, as well as those who work directly in social needs screening (e.g., community health worker) regardless of race or ethnicity.[2] Clinical practice and community representatives were paid a stipend for their participation in the Lab.

Over five sessions between September 2023 and January 2024, participants learned from experts in the fields of anti-racism in medicine, strengths-based screening in health systems, and policy to support older adults in Rhode Island. Participants discussed challenges and imagined solutions to improve HRSN screening among older adults in Rhode Island.

Most discussions included a mix of new and returning participants. In others, MLPB created groups of participants who represented similar roles (e.g., older adults, social service providers, health care providers). Additionally, MLPB conducted brief one-on-one interviews with health care providers to gain deeper insight into their perspectives.

In a continuation from Phase 1, MLPB employed several strategies to share power and ownership of the Lab and its findings. New and returning participants were invited to provide edits and feedback to the project charter and shared values, and session topics and discussion were adapted based on participant direction and feedback.

FOCUS TOPICS FOR EACH MEETING

Meeting #1: Welcome to Phase 2 of Our Learning-and-Action Lab

Meeting #2: Moving from Theory to Practice on Anti-Racism in Healthcare
Guest Facilitators: Baraka Floyd, MD, MSc; Swen Ervin, MS

---

[1] MLPB and CTC-RI recruited several small community-based practices, some of which affiliated with a hospital or a collaborative organization of multiple practices. Despite best efforts, Federally Qualified Health Centers, practices that primarily accept public insurance, and hospital-based practices were not represented in the participant roster.

[2] Phase 1 participants were provided a list of represented practices and were given the option to opt out of the Lab should they feel uncomfortable collaborating with their provider in a small group. No one chose to opt out.

Meeting #3: Key Elements of Strengths-Based Screening
Guest Facilitator: Ariel Singer, MPH

Meeting #4: Priority Setting: Key Elements for Person-Centered Triage and Partnership
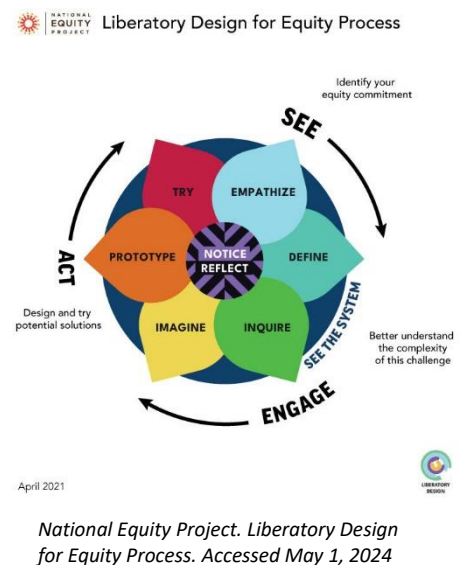*Guest Facilitator*: Maureen Maigret, RN, BS, MPA

Meeting #5: Putting it All Together

INSIGHTS

After being briefed by experts about the background and various frontiers of HRSN screening, participants formulated insights and recommendations to help improve HRSN screening for older adults in Rhode Island. All discussion was informed by principles of the Liberatory Design for Equity Process, which was introduced during Meeting #2. Phase 1 mapped roughly on the **identification of the problem[3];** Phase 2 centered on understanding the complexity and imagining an ideal solution; a potential final phase would prototype and test these insights. The following takeaways from Phase 2 are organized into a series of **general insights** about how to better understand HRSN screening among older adults and a resulting set of **recommended steps** that participants believe are ripe for practice-based prototyping and experimentation.

National Equity Project. Liberatory Design for Equity Process. Accessed May 1, 2024

Insight #1: The health-related social needs that matter most are the ones that matter to the patients.

During Phase 1, participants identified Housing, Food Security, and Social Connection/Loneliness as key priorities for HRSN screening among older adults. Quickly into Phase 2, however, participants converged in agreement that the most important social needs to discuss are always the ones that matter most to the patient during their visit. While monitoring of population-level data is important, and some

"I think the first thing we just need to do is say, 'What's the most important thing to you?' Maybe just begin by trying to understand."

needs tend to be more prominent in older adults, open-ended screening questions may be best at surfacing what matters most. Comprehensive screening tools and surveys, by contrast, risked feeling impersonal and irrelevant. Participants acknowledged the importance of thorough screening and monitoring of population-level health-related social need data, but noted that, in a one-on-one setting, extensive screening distracted from patient-led exploration of the health-related social need that felt most important to them to address.

---

[3] Rhode Island Aging & Health-Related Social Needs Learning-and-Action Lab Phase 1 Report (2023)

MLPB
ADVANCING HEALTH THROUGH JUSTICE

Insight #2: Understanding the context for health-related social need screening can significantly improve the experience and effectiveness for patients.

Lab participants stressed the importance of designing workflows so that the person administering the HRSN screening knows why they are doing it, and therefore can introduce that "why" to the patient. Without contextualization, HRSN screening can feel like a battery of invasive and inappropriate questioning. If standardized tools – important for thoroughness and population health surveillance – are to be used during screenings, participants wanted to at least have a "bridge," or a warm introduction to questioning that would feel more coherent and empowering. This would ideally include explaining why the questions were being asked, how the data will and won't be used, and the ultimate value to both the patient and the practice. This context is especially important when discussing a HRSN associated with stigma or where an older adult perceives potential risks to their autonomy.

This context is particularly important because the screening experience may be harmful to patients. As identified during Phase 1 of the Lab, older patients may feel vulnerable, stigmatized, or discouraged during a screening.[4] They may also fear a loss of autonomy following a screening, or have experienced similar loss or trauma personally. For this reason, participants were especially encouraged to see strengths-based HRSN screening methods (as opposed to tools and processes that primarily identify a patient's deficits).

Insight #3: Effective health-related social needs screening both requires a trusting relationship between the patient and healthcare practice, and presents an opportunity to build one.

Both older adults and providers recognized that there can be huge variations in the screening experience, often predicated on how much effort the health care practice or individual provider puts into relationship building.

"I think the forms are addressing wonderful things. I still feel there's a huge challenge in the timeframe and in the process. And along with these forms, I would like to see a pathway or an entrance of maybe a bridge going from an impersonal to a more personal access."

"I think a lot of older people are afraid of having information used to force them to move or to change their circumstances, even if they're not very good. They're afraid the information will be used in a way that they will not actually benefit them."

"I had one doctor that never paid any attention to [HRSN screening] until maybe the last year that he treated me, and I wasn't really aware…I never really got the hang of what was supposed to happen [in an appointment] until my latest primary care doctor."

---

[4] Phase 1 report, pages 10-11

MLPB
ADVANCING HEALTH
THROUGH JUSTICE

Some providers attributed these differing experiences to both the individual care team member *and* the practice's norms and culture. Several social workers and physicians expressed that, were it not for time and funding constraints, their ideal workflow would be to conduct HRSN screenings and do subsequent follow-up directly with patients, rather than sharing responsibilities with other team members. Older adult participants clarified, however, that they did not need their provider to be the one conducting the screening, so long as the team member who screened them was appointed to this role by their provider.

> "It just depends also on the primary care physician. Some really get into…the questions and really talk with their patients to get their input, and do warm handoffs…when needed. But some other practices, they just give you the form at your yearly appointment and say, 'Hey, fill this out.'"

Insight #4: Despite divergent incentives and expectations, older adult and provider participant groups often vocalized similar challenges in, and potential fixes to, health-related social needs screening.

During the Lab, older adult and provider participant groups often raised similar ideas. Some of these were broad – such as a shared feeling that short appointments limited the ability for providers and patients to connect, or a proposed appointment structure of shared agenda-setting – while others were quite specific. Both older adults and providers wondered, for example, if the annual Medicare Wellness Visit might be the ideal time for in-depth HRSN screening and problem-solving. Both groups even used similar analogies in discussion, likening conversations between physicians and patients to a lawyer gathering context to better represent their client.

In both shared and role-alike spaces, the gap between what providers and patients see as the ideal HRSN screening process was quite small, even if the rationale for arriving at this ideal looked different. For example, providers voiced frustration at a rushed screening process, and many expressed a desire to engage more deeply with their patients despite this being more time intensive than current workflows. This paralleled patient experience that the screening processes was rushed and that there was often little follow-up to their answers. Though MLPB recruited a diverse array of individuals to the Lab, they arrived at similar conclusions on what might be mutually beneficial improvements to the screening process.

RECOMMENDATIONS

Throughout the Learning-and-Action Lab, participants were invited to imagine what better health-related social needs screening and response for older Rhode Island adults *could* look like. Both patients and providers understood the 'reality' of the healthcare system – including resource, time, and workforce limitations. They nevertheless identified several ways in which

practices could provide social care to older adults in more strengths-based and person-centered ways. Their recommendations are summarized as follows:

Recommendation #1: Ensure adequate time for older adults to talk with someone on the healthcare team about their health-related social needs.

In addition to any checklist screening tool, ensure there is time to ask **open-ended questions**, like "what is important to you to address today?" Older adults stressed that they see their scheduled appointments as *their* time – and that the priorities that they bring to an appointment should be the priority. Providers, too, noted that **shared agenda-setting** would help create bilateral communication, ensure that the insights that surface are high value and actionable, and empower both patients and providers.

"Let people talk, especially the older they are. **Let them talk, ask them questions, engage with them, because everybody's going to tell you their story, but they're always going to tell you their story differently**…the conversation is possibly more important in the long run than the actual question, because you're at least getting confidence that the information that you're mining is actually legitimate to the person giving you that information."

Discovery through open-ended questions may take more time than a rapid-fire checklist, but ultimately has the potential to yield more relevant answers. By investing time and effort into conversation, the likely result is better and more trusting relationships between the patient and healthcare team.

Recommendation #2: Build shared language and skills among all practice members to communicate the process and rationale of health-related social needs screening to patients.

Prior to any HRSN screening – whether accomplished through a form, a checklist administered by a staff member, an open-ended conversation, or a combination of several strategies – older adults highlighted the **need for adequate contextualization**. The individual administering the screening should ensure that they provide basic information regarding how the tool will be used and what, if any, follow up or assistance patients can expect. This is especially true for potentially invasive, awkward, or sensitive questions.

This may also require that the healthcare institution provide **culturally responsive training** to staff and providers involved in health-related social needs screening and problem-solving. This training might include a suggested script or framework for administering the screening, including trauma-informed and assets-based interviewing practices. Ultimately, all team members involved with the screening process should have a clear understanding of why the screening is important and how information will be used in the future.

Recommendation #3: Empower entire healthcare practices to create a culture of trust between patients and all members of the team, not solely their primary provider.

Participants in the lab emphasized that patients' **healthcare experience includes the entire practice**. From telephone support during scheduling, to the front desk administrator who may

MLPB
ADVANCING HEALTH
THROUGH JUSTICE

provide a paper- or tablet-based screening tool, to the medical assistants, to other providers who may engage with patients to discuss their HRSNs, there are many opportunities for a patient to feel heard (or conversely, to *not* feel heard). All staff should be trained to understand how and why social needs screening is conducted in a health practice so they can answer questions and provide a patient-centered experience.

<u>Recommendation #4</u>: **Protect time and space for providers and team members to better connect with the community and to co-create solutions to persistent problems.**

In Session 2, Lab participants learned about the importance for health care providers to have dedicated time to connect with the communities they serve. This time might include volunteering in the community, attending community meetings, or other strategies. The community is an important context for patients, healthcare providers, and the social service organizations that are often deployed to intervene with identified HRSNs. Having the time to do this can help providers connect with their patients' social needs *and* their communities' resources in meaningful ways. However, all participants acknowledged that provider time to meet with patients is precious and blocking time for community involvement is difficult. This final recommendation is a lofty one, but one that could help support patients and providers.

CONCLUSION

In bringing patients and providers together to discuss their experiences, this second phase of the Learning Lab created a unique space of collective reflection and ideation. The result of this process is not a step-by-step guide that will make HRSN screening and problem-solving perfect overnight, but rather a set of shared principles that can guide future prototyping and testing of workflows and clinical practices.

To get to this place of shared understanding and trust, providers carved out specific time in their schedules to participate in this Lab and share views and perspectives that patients might not otherwise be aware of. In turn, the older adults who participated were able to reflect on their experiences in the presence of the very people who have created positive and negative interactions in the past. It is rare to have such immediate interaction and discussion, and for these individuals to be compensated for their time and insight. As the Learning became Action – and the Action in turn portends additional Learning and additional Action - this group of stakeholders has created a blueprint for collaboration and collective impact.

"Sometimes, especially when [we] are very engaged in doing the right thing, we can somewhat get paralyzed by the process of "we have to have it as perfect as possible before we take action." And [slowing down] really invites us to get something down and try it out and see how it can work. Again, not trying to reach some specific endpoint, but **trying something out, seeing if it'll stick, seeing if it works, and then accepting feedback**."

- Baraka Floyd, MD, MSc | Guest Facilitator

MLPB
ADVANCING HEALTH THROUGH JUSTICE

CONTRIBUTORS

MLPB would like to thank the following people for their roles in participating and leading this second phase of the Learning-and-Action Lab.

Phase 2 Participants

Annette Alves
Thomas Bayer
Phil Clark
Neyda DeJesus
Elizabeth Diaz
Susan DiMasi
Connie Ducharme
Kenya Fullen
Katherine Johnson
Joanne Kersh
Jennifer Kevorkian

Jen Leavitt
Emelia Lima
Joyce Masse
James McNulty
Michele Mitchell
Nicole Nadich
Geoffrey Schoos
Judith Slane
Elizabeth Soriano
Hugo Yamada

MLPB

Meg Baker
Jeannine Casselman
Amy Copperman
Stephanie Duggan-Lykes
Kate Gannon
Jeff Gilbert
Griffin Jones
Rebecca Kislak
Nedhi Teixeira
Sarah Yan

CTC-RI

Yolanda Bowes
Susanne Campbell

BCBSRI

Carolyn Belisle
Emily Chun
Brendan Generelli
Tarah Provencal

Guest Facilitators

Baraka Floyd
Swen Irwin
Ariel Singer
Maureen Maigret