Phase 1
Summary
Report

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

CONTENTS

EXECUTIVE SUMMARY

MLPB's Aging and Health Related Social Needs (HRSN) Learning-and-Action Lab (the "Lab") is a two-phased initiative designed to inform and improve clinic-based 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* 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 people with lived experience and non-medical professional expertise to inform Phase 2 learning, which will integrate clinical practice members with programmatic support from the Care Transformation Collaborative of Rhode Island (CTC-RI) and convene in 2023.

Over five videoconference sessions in 2022, 25 Phase 1 Participants validated the importance of screening older adults in RI for HRSNs. Participants called out several HRSNs as top priorities facing older adults. In the process, they also shared many examples of how social needs were real and important factors in the health and happiness of themselves as well as of their families, friends, and neighbors. Participants detailed experiences of interactions with RI's health care systems related to their social needs. Some of these experiences were positive and productive. Many, however, were not. Ultimately, Participants agreed that health system screening for HRSNs for older adults in RI held important promise.

Participants articulated important messages about HRSN screening by health systems in two thematic categories: The 'What,' or which HRSNs were the most impactful for their lives, and the 'How' or, the experience of being screened for HRSNs.

> **I think it is very important for the doctors to know your situation at home or with your life. Because if you have [HRSNs], especially the older folks, the doctor can help them with resources, resources like food or those adult daycares or sometimes cultural [supports].**

As for the 'What,' Participants distinguished Housing, Food Security, and Social Isolation/ Connection as the most important categories of HRSNs to address for older adults in RI.

> **I often say if you've seen one older person, you've seen one older person... There are certainly multiple generational differences, but then you compound that. The sort of racial, ethnic, gender... I mean, there's so many different ideas of intersectionality. I think it's really critical that there are so many things coming in together to create a very unique situation for each older person, so you can't put them into sort of the same box.**

*Support provided through the Blue Cross & Blue Shield of Rhode Island Community Health donor advised fund at the Rhode Island Foundation.

Participants were wary, however, of health care's new mandates and systematized attention to HRSNs as they related to the 'How' of screening. They felt that screening needed to be approached thoughtfully and intentionally according to each patient.

> **[For the effectiveness of screening,] it matters where you're being asked within the clinical setting, who's asking and how much rapport they've built with you, how much prior trust you have, why you are at the visit. Like, if this is a critical care visit, it can be really jarring to have questions asked that feel really outside of what you're looking for.**

Although they supported better identification of HRSNs in health care settings, Participants also cautioned against screening indiscriminately. By their very nature, HRSNs are often delicate and stigmatized issues. Engaging patients about their HRSNs, therefore, should be approached with sensitivity. Conducting HRSN screenings without care for the patient and provider-patient relationship can be counter-productive, or even health-harming.

> **I've had [Case Management] staff who wouldn't make the calls and do the [older adult HRSN] screens because what am I going to do for that person? It's horrible for the older adults because it gives them false hope that someone out there is going to provide assistance to them when in reality it's just data [collection].**

Participants ultimately cautioned that HRSN screening by health systems is an opportunity to help patients, but also comes with its own risks of harm. They urged thoughtfulness, preparation, and thoroughness for providers seeking to engage their patients in conversations about their HRSNs and warned that, without these qualifications, providers should not engage older adults about their HRSN's at all.

ABOUT THE LEARNING AND ACTION LAB

Phase 1 launched in April 2022 with a recruitment process of 25 stakeholder Participants from a diverse array of demographic, professional, and lived experience backgrounds representing older adults (55 and over) and their care- and service providers. Facilitation was provided by MLPB staff and additional contributors to the sessions included representatives from the Lab's funder and CTC-RI. Four formal and one informal Lab sessions occurred between July 2022 and December 2022.

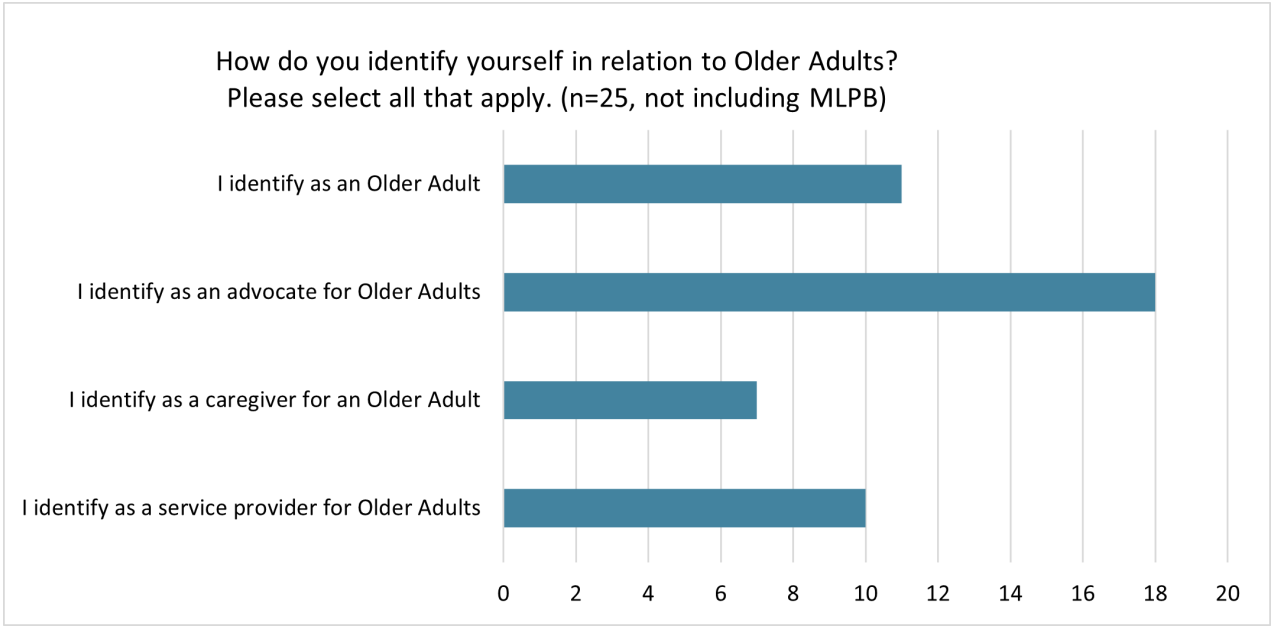
Through this series of facilitated conversations over Zoom, Participants, along with the facilitators and other Phase 1 contributors, interacted in robust small- and large-group dialogues, engaging with literature, research, and sample tools. From these conversations emerged stories about Participants'

personal experiences with HRSNs, healthcare, and screening for older adults—positive, negative, and neutral. While much of what was shared reinforced what is established in literature about Social Determinants of Health and HRSNs for older adults[1], the Lab coalesced around specific and unique findings that should be incorporated into HRSN screening strategies targeting older adults in RI. Rather than generalize about all older adults and HRSN screening practices, broadly, this report is specifically intended to summarize the situated perspectives of Participants. In contrast to monolithic approaches to reducing older adults to a single group experience, this report tries to highlight the diverse and novel Participant perspectives that emerged during the Lab. It prioritizes the many ways that older adults experience and act to preserve agency and dignity at the intersection of health and social care. Co-created by Participants and facilitators, finally, this report's recommendations represent an attempt to enrich the conversation around the HRSNs of older adults in Rhode Island with situated, lived experience.

METHODOLOGY

Phase 1 intentionally centered both older adult constituents and representatives of community-based organizations directly serving this population. In accordance with commitments made during the planning process, nearly half of the Lab's membership was comprised of older adults with lived experience (defined as people over the age of 55, see **Figure 1**).

Figure 1
Participant Survey Question



[1] MLPB conducted a thorough literature review of HRSN screening among older adults that was used to guide the discussion and to increase Participants' awareness of current understanding and practices around HRSN screening. See also: "Social Determinants of Health." Social Determinants of Health - Healthy People 2030, https://health.gov/healthypeople/priority-areas/social-determinants-health, and Northwood, Melissa, et al. "Integrative Review of the Social Determinants of Health in Older Adults with Multimorbidity." Journal of Advanced Nursing, vol. 74, no. 1, 2017, pp. 45–60, https://doi.org/10.1111/jan.13408.

Participant recruitment was restricted to residents of Rhode Island. Potential Participants were identified through several strategies including nominations from service organizations serving older adults and previous affiliation with MLPB and BCBSRI. In addition, a recruitment notice was circulated through a community health worker association e-newsletter.

Interested candidates were sent a recruitment flyer (see Appendix A) and an invitation to learn more through a one-on-one call with MLPB. The flyer and conversation outlined the expectations and requirements of Participants. Participants were offered a $1,000 stipend for their participation in at least three of the four planned Lab sessions.

Participants were selected to maximize distribution across several demographic and positional factors, including race, gender, age, professional, and personal experience. **Table 1** includes a summary of these self-reported characteristics for those Participants who completed a voluntary survey. Importantly, While the Lab was consistent with clinical guidelines to define "older adult" as individuals 55 and over, not all Participants over 55 self-identified as an older adult. Additionally, not all individuals who self-identified as an older adult were over 55.

Table I
Demographic characteristics of Lab participants
(n=25, not including MLPB)

Characteristic	**#**	**%**
Sex		
% Female	19	76%
% Male	6	24%
Race/Ethnicity		
White (Non-Hispanic)	14	56%
Black/African American	6	24%
Asian	1	4%
Hispanic	1	4%
Middle Eastern	1	4%
Multi-Racial	1	4%
Other	1	4%
Sexual Orientation		
Heterosexual/Straight	20	80%
Gay/Lesbian	0	0%
Bisexual	2	8%
Pansexual	1	4%
No Answer	2	8%

Most Participants lived in the eastern and southern parts of Rhode Island (see **Figure 2**). The ages of Participants are summarized in **Figure 3**.

Figure 2: Residence of Learning Lab Participants

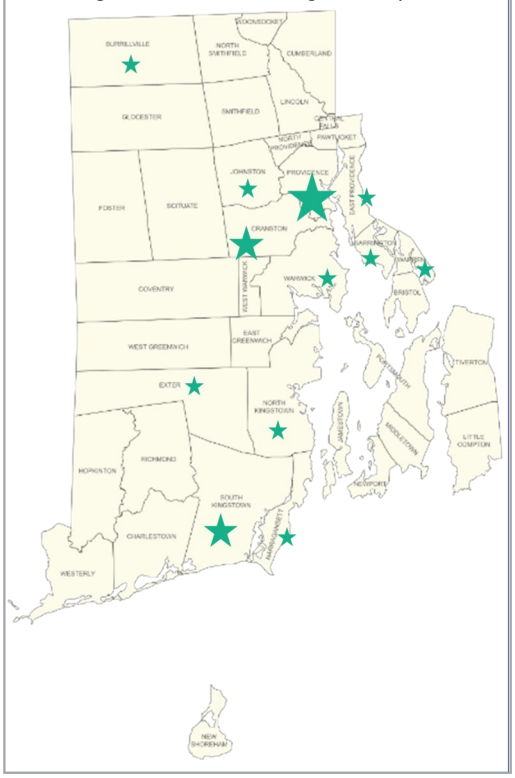
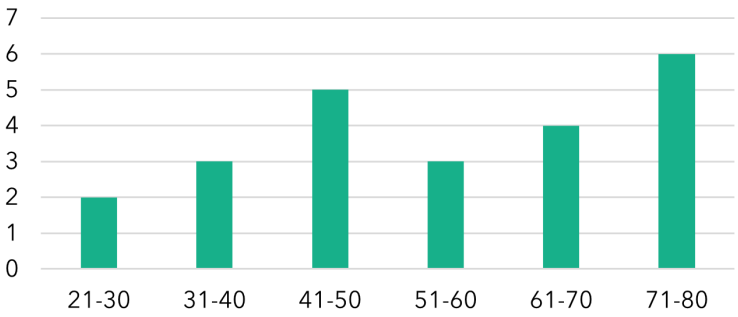


Figure 3: Age of Learning Lab Participants

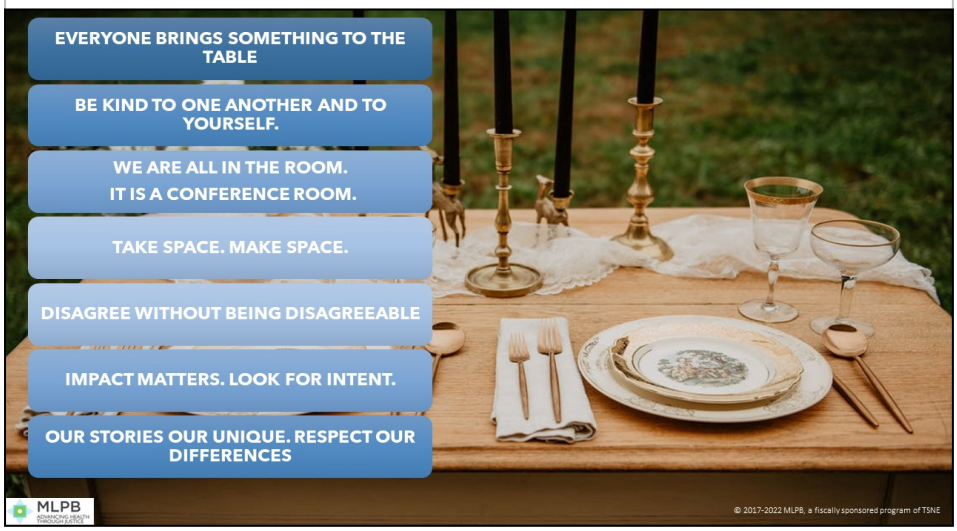
(n=25, not including MLPB)



MLPB team members utilized several strategies to share power and ownership of the Lab and its findings, and to reinforce accountability. These strategies included co-creating a Charter and list of shared values, which created safe and accessible opportunities for further comment, feedback, and digression, including a well-attended optional fifth session in November 2022.

Recognizing that Lab members were invited to communicate their intimate experiences with healthcare and social needs, several strategies were employed to create a forum grounded in mutual respect. These included starting each meeting with shared goals (see **Figure 4**) and an icebreaker, using break-out sessions for small group discussion and refection, and ending meetings with an open invitation for Participants to give feedback.

Figure 4: Shared Goals



To ensure that the Lab was Participant-directed, the core structure of meetings was outlined in advance but refined based on Participant input and as sentiment and themes emerged in each preceding meeting. MLPB staff inductively analyzed meeting notes and Participant survey results to develop each next meeting's agenda, content, and discussion themes.

FOCUS TOPICS FOR EACH MEETING

Lab facilitators created a Roadmap that was shared at the beginning of each meeting. The Roadmap detailed general themes that Participants would explore together. Over time, the Roadmap was amended to include an optional fourth meeting. Below is a list of themes for each meeting:

Meeting #1 — Introductions, Shared Language & Charter Development

- Building trust, subject matter understanding, and a shared purpose

Meeting #2 — What is the data telling us? What is your experience?

- Looking closer at HRSNs and screening in RI; Going beyond HRSN 'data' to tell 'our stories'

Meeting #3 — What needs to change? What are our priorities?

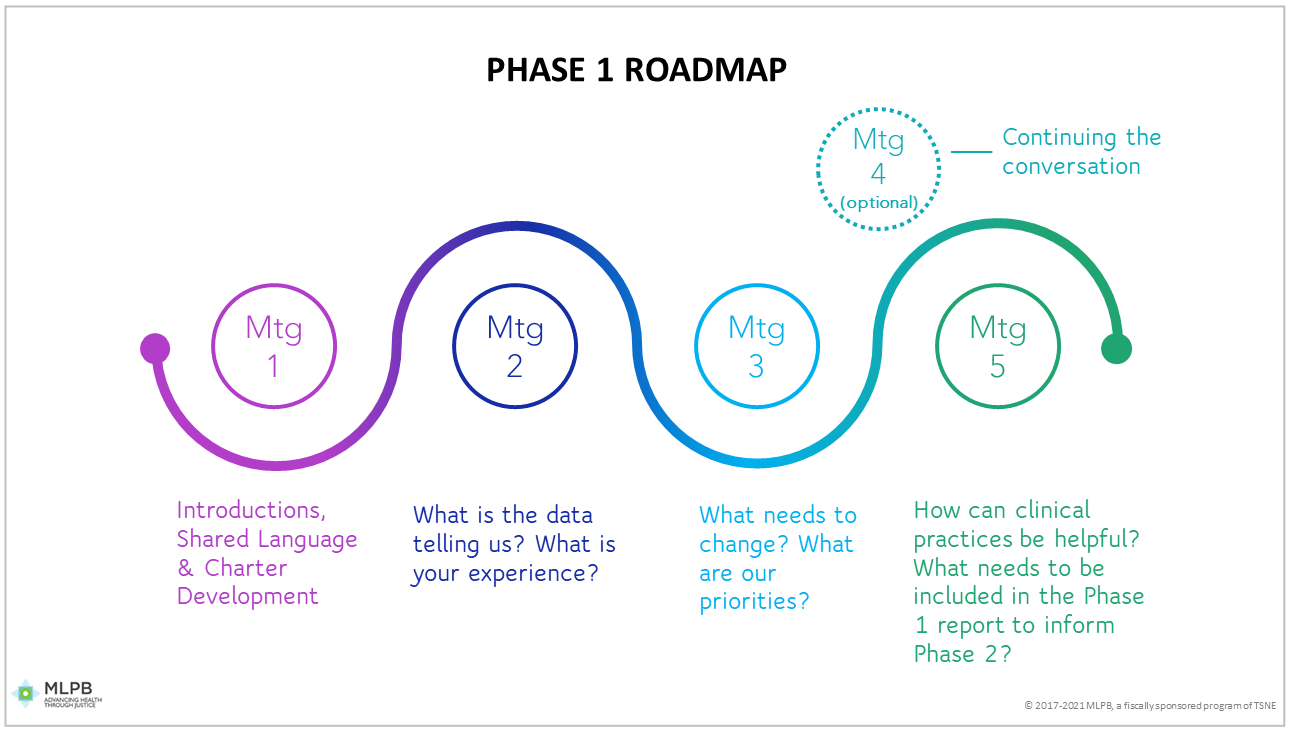
- Co-create priorities for HRSN categories

Meeting #4 — Continuing the conversation *(Optional)*

- Informal, Participant-led check-in discussing the Lab's themes and emerging findings

Meeting #5 — How can clinical practices be helpful? What needs to be included in the Phase 1 report to inform Phase 2?

- Honing feedback and findings; reflecting on Phase 1, and issuing a challenge for Phase 2



FINDINGS

Phase 1 Participants agreed that identifying and resolving HRSNs is important work for care teams that serve older adults in RI. Unsurprisingly, given the national crisis, housing emerged as the most important category of HRSN impacting older adults in RI. Specifically, Participants described the need for housing stock that was affordable, habitable, and met the particular needs of older adults.

> **Screening's fine, but if there's no capacity to follow through then it's quite meaningless. Someone needs to be there, trained about what resources are available in their community.**

Additionally, two other HRSN categories emerged as priorities: Food security and nutrition and social isolation/connection. The former is a well-studied HRSN across the country and within RI; the latter HRSN category has only emerged as a condition of interest to the field over the last five to ten years. Participants were equally convinced of the importance of screening universally for HRSNs as they were of the risk of harm from screening practices that are not person-centered and trauma-informed.

"THE WHAT"

Key themes emerged from Participant discussions in two categories: '**The What**'—or, which HRSNs are screened in older adults—and '**The How**,' or, how HRSN screening, referral, and resolution happens for older RI adults.

> **Any of the people I've talked to throughout the state… have said they just don't want to put up the cost to modifying their houses to live and age safely in place. But they want to age in place. And that's a real conflict because our housing stock is like the third oldest housing stock in the nation.**

Over the course of voting and free response discussion, Participants elevated housing, food security and nutrition, and social isolation/connection as the most important HRSN categories for older adults in RI—and as the categories to carry forward into Phase 2.

With regard to social connection, one Participant attributed the experiences of some older adults to shifts in technology:

> **[J]ust everything [is] going remote… and [everyone's] kind of trying to navigate through this new virtual world. Some folks have not adapted [to] some of the new technology tools that we have all sort of been utilizing…I know that a lot of folks, when I talk to them, they're just like 'I don't know what's been going on.'**

Participants also noted a strong objection to screening for any HRSN for which the provider could potentially do harm. And, screenings can cause harm to the patient-provider relationship, harm to the patient's emotions, or even instigate civil-legal harms for the patient. Participants reviewed examples of validated screening tools during sessions, and ultimately expressed skepticism. To them, 'validated instruments' applied carelessly or without proper contextualization or support for patients could be counterproductive.

Participants felt that HRSN screening had been overcomplicated and that questions were often poorly worded. In their estimation, comprehensive screening forms addressed too many HRSN topics, and meaningful HRSN screening needed to start with 'the basics' (e.g., "how did you get to the office today?") in order to be relevant and meaningful to patients.

While Participants sought a simpler screening process, they also expressed frustration with screening questions that failed to consider the diverse needs of communities. For example, nutrition screening that asks merely about having "enough" to eat or having food that was "nutritious", fails to ask if the food that is accessible is desirable. By not asking about quality, screening fails to detect if individuals have access to food that truly meets their needs and helps people feel connected to their culture and their community. Participants also highlighted the sensitivity around housing and loneliness discussions between patients and providers.

> **[L]oneliness is really having a terrible impact on people. And even though there are ways for people to get places. It's hard. And anytime there's friction preventing somebody from doing something, it's going to keep people from doing it, because people who are lonely are used to being lonely. It's always hard to get an object that is not in motion in motion. So, yes, I think the ALONE scale, I loved it. It's something that should be administered.**

Participants reviewed several screening tools used by RI health systems to identify HRSNs in older adults. They agreed that such tools—even validated ones—shouldn't be used uncritically. Even when validated for use in older adults, HRSN screening tools can be perceived as patronizing or unsettling. After reviewing the ALONE scale, which asks questions about an individual's 'attractiveness' to friends, Participants were skeptical about what value 'validation' had in practice.

> **I think that set of questions were just very...[sighs] I don't think it's realistic. I'm dubious that people answer those questions. If they get asked those questions, they're not necessarily going to give an accurate response. I would feel so bad if I'm like, 'okay, I want to be honest. I'm unattractive now. I feel crap about myself for answering.**

"THE HOW"

Participants raised important ideas and cautions about *how* screenings are carried out. This included a focus on the tools and roles administering the screens, patient-provider trust, respectful and informed administration of the screen, and the reliability and follow-through of solutions and referrals after the screening. Participants noted the variation in how screenings were carried out, where and by whom, and why it matters to patients.

> **Last time I went to my PCP I was handed a tablet. It makes a sound or feel like just another insurance question. No explanation provided about why it was needed. You know, older people are going to be struggling with a tablet. And, they volunteered someone to sit with me and help me do that, but frankly, am I really going to want someone in the office to know my answers to these questions? I think how things are done and their symbolism and sense of importance is really critical.**

Participants expressed interest in having more workforce resources dedicated to supporting screening for and treating HRSNs, like Community Health Workers. They emphasized the continuity of experience for older adults, and that the PCP visit does not start only once the clinician enters the exam room, but rather when they walk in the door and are greeted by office staff and handed a tablet.

Participants noted screening experiences lacked explanations about why the screening was being conducted, and the lack of context became a missed opportunity to build trust between the patient and screener. The timing and location of the screening also mattered. Some Participants described feelings of anger when screening was done at inopportune times, such as an emergency room visit or in the waiting room before an exam.

> **I think I've experienced the screening as a gateway. Finish the screen so then we can get on and see the clinician or the doctor. And so it wasn't valued for what was significant. And I think that's something that needs to be put in this position of where it is in the appointment and also where is it done? Is it done as you're standing there on the way into the door? Is it done in the room, sitting down? Those kinds of things. And for older adults I think there isn't an issue of trust and I like the idea there's also an issue of am I vulnerable, do I admit that I'm vulnerable? And I heard that in the embarrassment issue.**

Participants had perhaps their strongest feelings about the actual process of HRSN screening. Participants universally acknowledged that screening is an important tool for problem-solving, but that it is never a neutral act. Screening also doesn't end with the questionnaire or simply making a referral. To screen effectively and responsibly requires that there be underlying trust between the patient and the screener. Additionally, its value to the patient may appear lower if the patient feels like it's being rushed or is simply a checkbox on the way to the rest of an appointment.

Amongst many important ideas and cautions about *how* HRSN screenings could be carried out, Participants emphasized the importance of patient-provider trust, respectful and informed administration of the screen, and the reliability and follow-through of solutions and referrals after the screening.

> **When patients get screened, it has to be in the right place, by the right person, and on the right topics. I don't mean just the doctor, either. My doctor's office [staff]—lovely people—do a lot for me, and they're the first and last people I see. And the follow-through is so important, too. It's all about relationships and trust.**

The act of screening, itself, is an opportunity to build or destroy trust. Specifically, Participants cautioned providers from screening behaviors that deplete trust, including:

1. Broaching HRSNs or problems for which they don't have productive ways of supporting patients.

> **If you're going to ask the question, you have to be prepared for what the answers are going to be... So what if I know Mary doesn't have enough food, what am I going to do about that? Otherwise, it's pointless to ask people these questions, it's only data at that point, because that person's not going to be helped. That person is thinking maybe someone's finally going to come help me. And yet no help comes. It's awful.**

2. Demonstrating disinterest to patients, for instance by not following up, or by asking obviously irrelevant questions or using an apathetic tone.

> **We pick up on that empathy—in the first one or two questions, they're incredibly important because you take that feedback and decide what you're going to share moving forward. And also there might be some trauma involved or something if you're sharing a lot and the [provider's] feedback is (curtly:) Okay. Next question... That can be traumatic for people. How you ask the questions is important.**

3. Overstepping boundaries to ask questions out of context, or incongruous with the relationship between the patient and the provider).

> **You can't just ask...frankly, I don't think I'd want to be asked certain [HRSN screening] questions because they're kind of nosey. People need to be trained to ask those questions...because you have to have a relationship. I can't just sit here with Philip and say "are you feeling lonely today? How's your social network holding up?**

Participants recognized how a positive HRSN screen could be the opportunity for providers to intervene to help solve a patient's health barrier. However, positive screens were also opportunities to sow distrust between the patient and the provider. Participants described this as happening variously as a result of provider referrals to resources that had (a) complicated intake processes, (b) long wait-lists, or (c) had previously failed the patient.

> **I think there needs to be some effort made within the healthcare system to make sure that when they are providing this type of screening tool, that they really look into the folks that they're providing services to in the area and be really aware of what resources are available. And also to be very intentional because I felt almost like it was just to check out a box. Like all right. She stated there was insecurity in regards to food insecurity within the household. I got a follow up. Let me check the box. Let me give them this one phone number and call it a day.**

Finally, Participants stressed the importance of individuality and agency to older adults. Participants acknowledged the difficult balance between identification as an older adult and being reduced to an overly simplistic category that risks losing autonomy. Lab Participants appreciated the diversity present in the Lab and extrapolated this appreciation into a larger point for screening: Treating older adults as a homogenous category is a harmful underestimation. As illustrated in the Lab's own voluntary self-identification exercise, ones' own identity—including whether one identifies as an older adult in the first place—is subjective and unique. HRSN screening, therefore, has both symbolic and, as noted below, practical implications for older adults related to identity and self-determination.

> **[Older adults are] asked so many questions—to what end? A lot of people feel 'We ask these questions, but what comes of it?' I'm not going to say 'I'm lonely' because I don't want somebody to call me into protective service. There's a lot of hesitancy to answer questions because (a) certain people are tired of answering these questions and still having the same result, which is no result, and (b) many are afraid that if they [say] yes, I fell […] and no I don't have enough food, and I split my medications because I can't afford them, they're afraid that they're going to be taken out of their home or that their children or caregivers are going to get into trouble. So, many people just go along to get along because this is what they know, it's how they're surviving, and they don't want the change.**

Participants emphasized that older adults had to be savvy when being screened by their health care providers to avoid harm. Some of their desires and priorities—for instance, to age in-place and to maintain privacy and independence—were occasionally at odds with how social services and assistance programs ostensibly try to support older adults in RI. For older adults in RI, disclosing a HRSN such as difficulty feeding or getting around independently, risks a deluge of strangers with power to disrupt their lives and even separate them from their home and legal independence. They wanted providers to appreciate how HRSN screening introduces potential risks that many older adults are forced to navigate.

CONCLUSION

Participants were clear in their enthusiasm for the planning work that was the charge of Phase 1, but eager to see a significant change to HRSN screening practices in the state.

Participants ultimately expressed a shared urgency for better understanding and *acting* to improve screening, referring, and problem-solving of HRSNs for older Rhode Islanders. The majority of Phase 1 Participants have expressed interest in continuing to participate in the Lab's second Phase slated to begin in Spring 2023.

I so appreciated everyone's input and the very different perspectives that everyone offered. I'm excited to see how clinicians respond to our priorities and feedback and can't wait to see how we strike a balance between what we want and what clinicians can do.

PHASE ONE CONTRIBUTORS

Rhode Island Community Participants:

Roberta Hazen Aaronson
Annette Alves
Kristina Brown
Susanne Campbell
Orianna D. Carvalho
Rose Cazzani
Phillip Clark
Neyda DeJesus
Elizabeth Diaz
Susan DiMasi
Kenya Fullen
Lisa Hoopis
Teddi Jallo
Ahadi Kayembe
Joanne Kersh
Jennifer Kevorkian
Libby Lubera
James McNulty
LaTanya Miller
Michele Mitchell
Geoff Schoos
Judith Newburn Slane
Elizabeth Soriano
Kinzel Thomas
Deborah Wray

MLPB:

Meg Baker
Jeannine Casselman
Olivia Cella*
Marsophia Ducheine
Kate Gannon
Jeff Gilbert
Griffin Jones**
Rebecca Kislak
Annika Mathias*
Samantha Morton
Liana Safa*
Nedhi Teixeira

**MLPB interns*
***MLPB consultant*

Blue Cross & Blue Shield of Rhode Island:

Emily Chun
Brendan Generelli
Leanna Moran
Tarah Provencal

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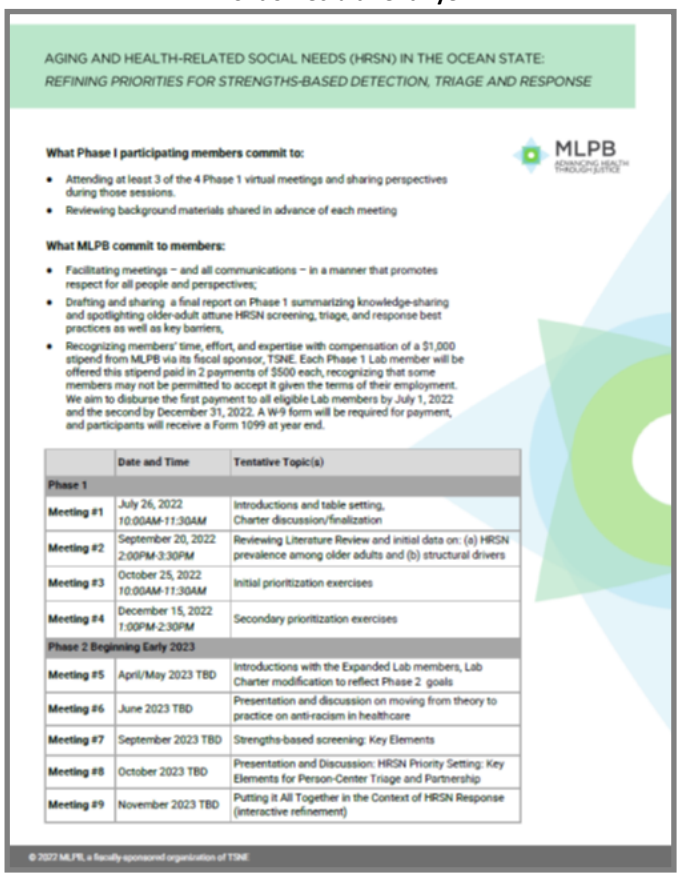
APPENDIX A: RECRUITMENT FLYER

Front of recruitment flyer



AGING AND HEALTH-RELATED SOCIAL NEEDS (HRSN) IN THE OCEAN STATE:
REFINING PRIORITIES FOR STRENGTHS-BASED DETECTION, TRIAGE AND RESPONSE

What Phase I participating members commit to:

- Attending at least 3 of the 4 Phase 1 virtual meetings and sharing perspectives during those sessions.
- Reviewing background materials shared in advance of each meeting

What MLPB commit to members:

- Facilitating meetings – and all communications – in a manner that promotes respect for all people and perspectives;
- Drafting and sharing a final report on Phase 1 summarizing knowledge-sharing and spotlighting older-adult attune HRSN screening, triage, and response best practices as well as key barriers,
- Recognizing members' time, effort, and expertise with compensation of a $1,000 stipend from MLPB via its fiscal sponsor, TSNE. Each Phase 1 Lab member will be offered this stipend paid in 2 payments of $500 each, recognizing that some members may not be permitted to accept it given the terms of their employment. We aim to disburse the first payment to all eligible Lab members by July 1, 2022 and the second by December 31, 2022. A W-9 form will be required for payment, and participants will receive a Form 1099 at year end.

	Date and Time	Tentative Topic(s)
Phase 1		
Meeting #1	July 26, 2022 *10:00AM-11:30AM*	Introductions and table setting, Charter discussion/finalization
Meeting #2	September 20, 2022 *2:00PM-3:30PM*	Reviewing Literature Review and initial data on: (a) HRSN prevalence among older adults and (b) structural drivers
Meeting #3	October 25, 2022 *10:00AM-11:30AM*	Initial prioritization exercises
Meeting #4	December 15, 2022 *1:00PM-2:30PM*	Secondary prioritization exercises
Phase 2 Beginning Early 2023		
Meeting #5	April/May 2023 TBD	Introductions with the Expanded Lab members, Lab Charter modification to reflect Phase 2 goals
Meeting #6	June 2023 TBD	Presentation and discussion on moving from theory to practice on anti-racism in healthcare
Meeting #7	September 2023 TBD	Strengths-based screening: Key Elements
Meeting #8	October 2023 TBD	Presentation and Discussion: HRSN Priority Setting: Key Elements for Person-Center Triage and Partnership
Meeting #9	November 2023 TBD	Putting it All Together in the Context of HRSN Response (interactive refinement)

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Back of recruitment flyer

AGING AND HEALTH-RELATED SOCIAL NEEDS (HRSN) IN THE OCEAN STATE:
REFINING PRIORITIES FOR STRENGTHS-BASED DETECTION, TRIAGE AND RESPONSE

MLPB is convening a **Learning-and-Action Lab** to inform and improve HRSN screening, referring, and problem-solving strategies impacting older adults who live in Rhode Island. Over the next two years, the Lab will bring together and honor the perspectives of people with lived experience and professional expertise over the course of two related phases.

We envision that learning from members' Phase 1 experience will inform Phase 2 design. The hope is Phase 1 Lab members will be interested in continuing participation in Phase 2.

The Lab currently is recruiting members for Phase 1 only.

PHASE 1 (THE LEARNING LAB)
ESTABLISHING VALUES AND SETTING PRIORITIES

Over four sessions, members will:

- Inform the development of a Charter that will guide how the Lab communicates and how available data and information will inform priority-setting among a landscape of potential health-related social need priorities; and
- Identify and prioritize several health-related needs facing older adults (as well as their related structural drivers) that will animate Phase 2 of the Lab's work, based on learning from external sources as well as Lab members themselves.

Phase 1 intentionally centers both older adult constituents and service organizations serving that population, as opposed to medical providers, who will be welcomed during Phase 2.

PHASE 2 (THE ACTION LAB)
BEST PRACTICES FOR STRENGTHS-BASED SCREENING, TRIAGE, AND RESPONSE

Over five sessions slated to start in early 2023, the Learning Lab will expand to include representatives from primary care practices serving older adults, and MLPB will be joined by the **Care Transformation Collaborative** (**CTC-RI**) to support implementation of practice transformation strategies.

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The project is funded by a grant from Blue Cross Blue Shield of Rhode Island. Created in 1939, the mission of Blue Cross Blue Shield of Rhode Island is to improve members' health and peace of mind by facilitating their access to affordable, high quality healthcare