

Connecting Conversations to Care: Applying Motivational Interviewing to Address Social Determinants of Health

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Healthier Tomorrow!

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Disclosure Statement

- Bethanne Brown and Nira Kadakia have no relevant financial relationship(s) with ineligible companies to disclose.
and
- None of the planners for this activity have relevant financial relationships with ineligible companies to disclose.





Learning Objectives

At the completion of this activity, the participant will be able to:

1. Describe how social determinants of health (SDOH) impact health outcomes in underserved populations.
2. Apply principles of motivational interviewing (MI) to address patients' SDOH challenges.
3. Develop strategies to imbed SDOH screening and MI-based interventions into existing pharmacy practice workflows.

Assessment question 1

A patient with diabetes reports frequently missing doses of her insulin because she “can’t always afford refills.” This example BEST illustrates a challenge within which of these SDOH domains?

- A. Education access and quality
- B. Social and community context
- C. Economic stability
- D. Neighborhood and built environment



Assessment question 2

How do the SDOH impact health outcomes in underserved populations?

- A. SDOH influences patient satisfaction and has minimal effect on clinical outcomes
- B. SDOH affects access to care and chronic disease state management, which can contribute to health disparities
- C. SDOH are relevant only for patients without health insurance
- D. SDOH harm health outcomes equally across all groups



Assessment question 3

A patient states, “I know my blood pressure is high, but healthy food is expensive and not nearby.” What pharmacist response is most aligned with MI principles?

- A. “You should prioritize your health despite these challenges.”
- B. “Many patients manage to eat healthy on a budget.”
- C. “What options have you found that work for you given what’s available?”
- D. “Do you want to be at higher risk of heart attack or stroke?”



Assessment question 4

Which of the following techniques most aligns with MI and may help a pharmacist assess patient-identified barriers to their health-related goals?

- A. Providing direct education about the importance of behavior change before asking for the patient's input
- B. Using open-ended questions to explore the patient's experiences and perspectives
- C. Correcting inaccurate beliefs and misconceptions to ensure the patient understands their plan of care
- D. Emphasizing expectations of the patient's plan of care to motivate the patient to change



Assessment question 5

Which of the following are **NOT** ways to incorporate SDOH screening and MI interventions into pharmacy workflow?

- A. Identify workflow touchpoints for SDOH screening
- B. Use brief SDOH screening tools during routine encounters
- C. Incorporate MI-based communication strategies into everyday patient interactions
- D. Utilize only the pharmacist as the health care professional responsible for these tasks



**DETERMINE HOW SOCIAL DETERMINANTS
OF HEALTH IMPACT HEALTH OUTCOMES IN
UNDERSERVED POPULATIONS.**



Social determinants of health

Social Determinants of Health



Social Determinants of Health
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Healthy People 2030



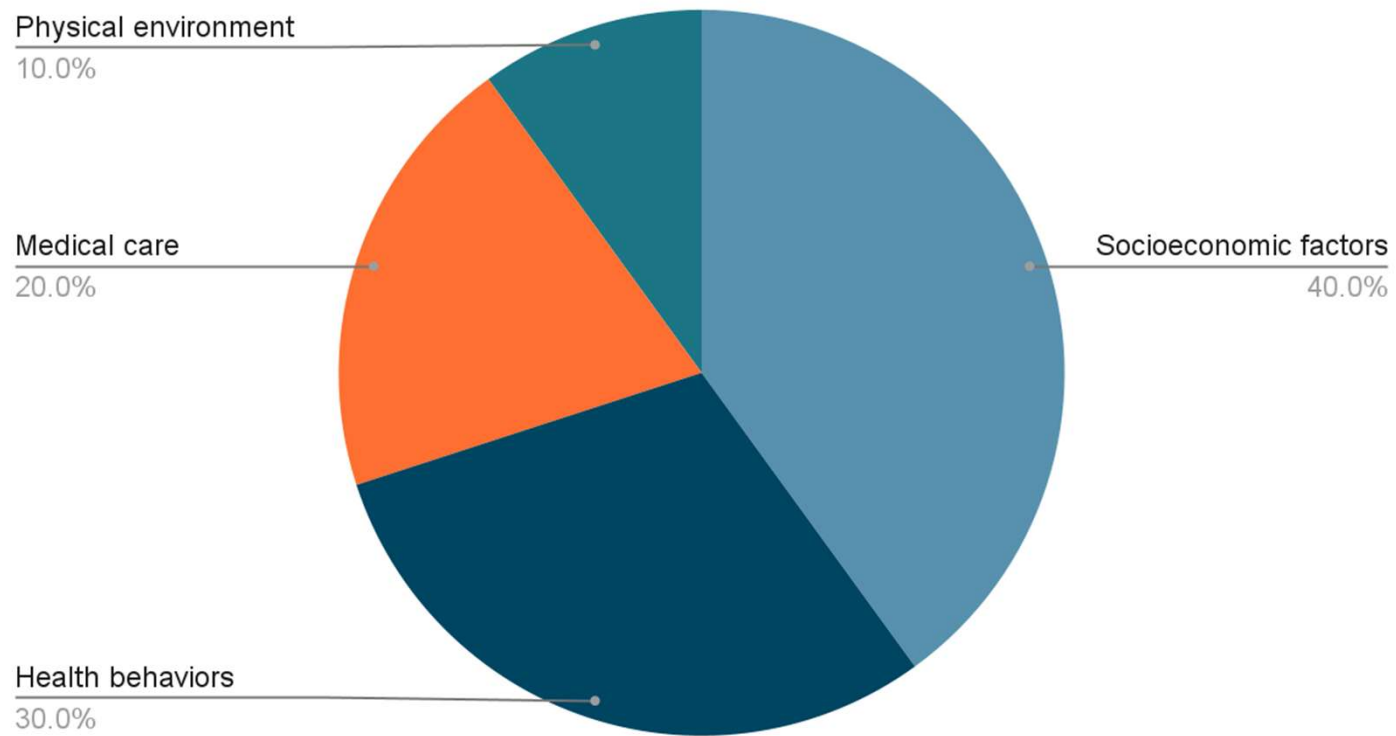
“Equity is the absence of unfair, avoidable or remediable differences among groups of people ... Health equity is achieved when everyone can attain their full potential for health and well-being.”

WORLD HEALTH ORGANIZATION

World Health Organization. Health equity.



Impact on health



SDOH and disparities

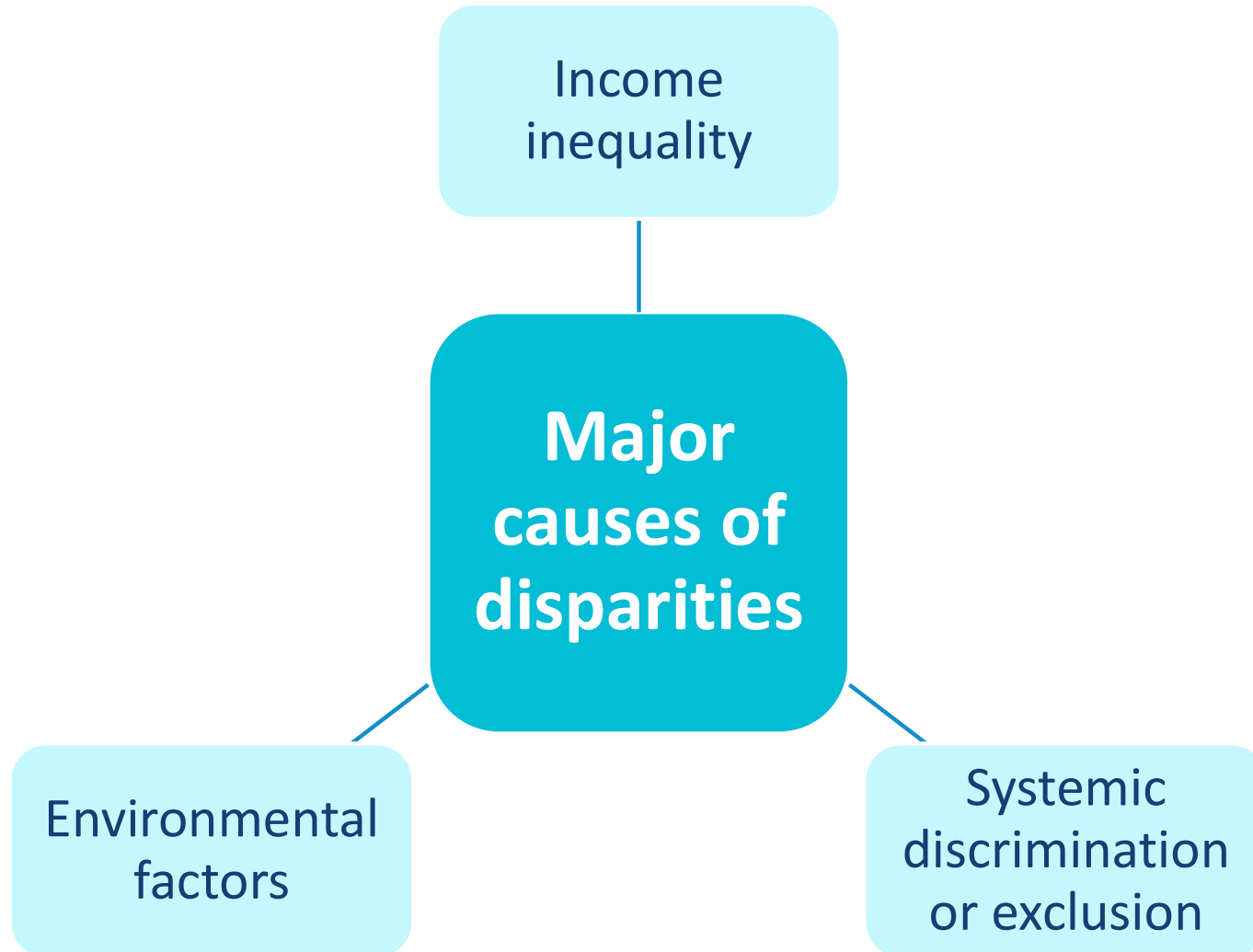
Health disparity

- Higher burden of illness, injury, disability, or mortality experienced by one group relative to another

Health care disparity

- Differences between groups in health insurance coverage, access to and use of care, and quality of care





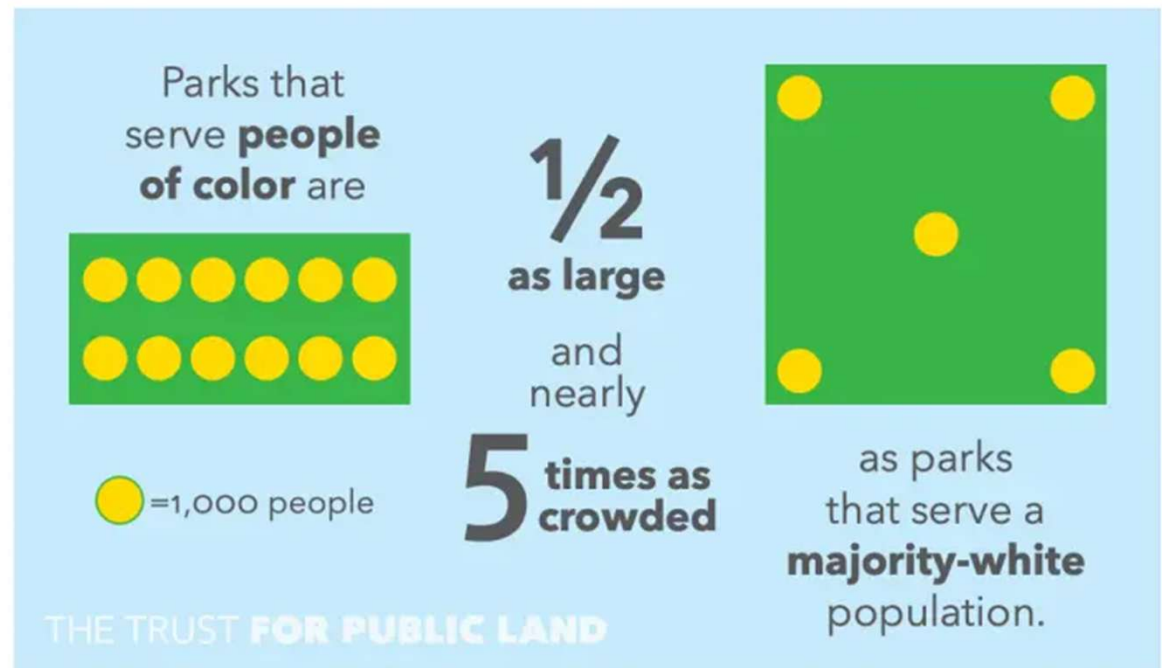
SDOH and underserved populations

- Determinants like economic instability and disadvantaged neighborhood environments contribute directly to delays in care, reduced quality of treatment, increased hospital readmission rates, and increased mortality
- Poorer populations have worse health outcomes compared to richer populations
- Higher educational attainment is associated with longer and healthier lives



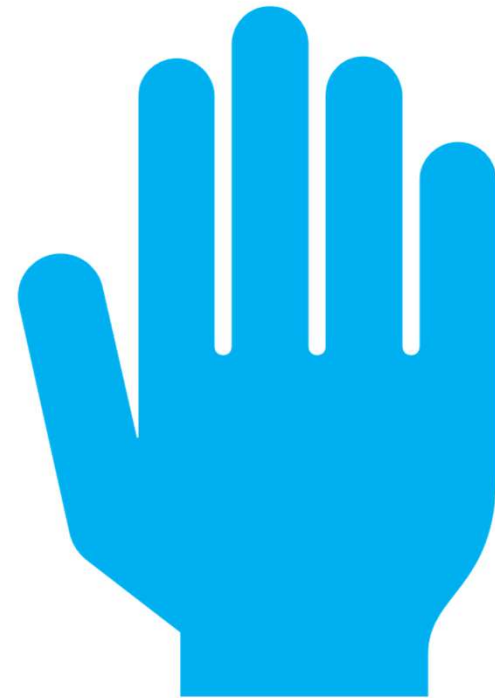
SDOH and underserved populations

- Chronic conditions can be improved by helping patients make changes related to modifiable factors
- Patients' ability to make changes can be impacted by access to resources



Audience show of hands

- How many of you have noted that access to a safe environment to exercise or access to fresh food has impacted your patients?
- In the past month, how many would say they've had a conversation about SDOH with a patient?



Why change is so hard

What emotions could you see in your patients?



APPLY PRINCIPLES OF MOTIVATIONAL INTERVIEWING TO ADDRESS PATIENTS' SDOH CHALLENGES.



Motivational interviewing is “a particular way of talking with people about change and growth to strengthen their own motivation and commitment... It is a collaborative partnership that honors and respects [others’] autonomy, seeking to understanding [people’s] internal frame of reference” within an atmosphere of acceptance and compassion.

MILLER AND ROLLNICK, 2023

Miller WR and Rollnick S.



Spirit of MI

Attitude toward helping,
fostering a safe, non-
judgmental space for
personal exploration



Connecting SDOH and MI

- SDOH can impact behaviors and one's ability to make changes in the environment in which they live
- Screening for SDOH challenges requires asking sensitive questions and encouraging a relationship-driven conversation
- MI supports the process of understanding patients' lived realities and their health-related goals



Benefits of MI

Reduce
burden of
disparities

Problem-solve
barriers to
treatment

Promote
fairness

Foster social
justice



Benefits of MI

- Useful as a tool in primary care settings:
 - HIV viral load
 - Blood pressure lowering
 - Sedentary lifestyle
- May be helpful when incorporated into health promotion and disease prevention interventions
- Can potentially enhance patients' readiness for change

Lundahl B, et al.
Morton K, et al.
Purath J, et al.
VanBuskirk KA and Wetherell JL.



Transtheoretical Model of Change

Five stages of readiness:

Pre-contemplation (I won't)

Contemplation (I might)

Preparation (I will)

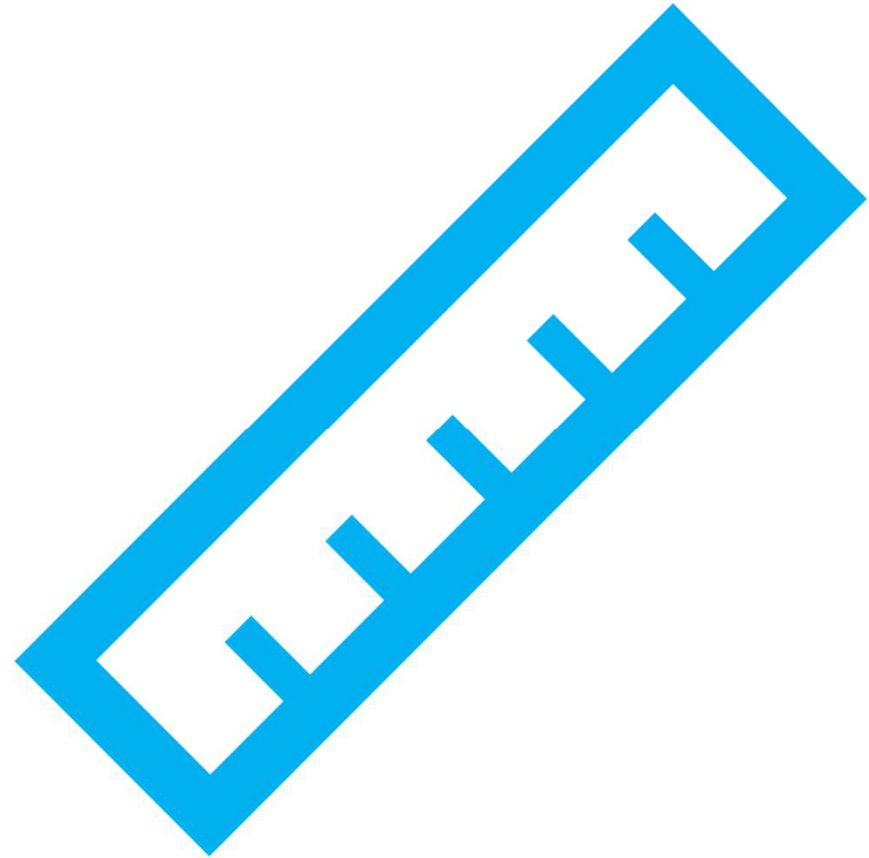
Action (I am)

Maintenance (I have)



Readiness ruler

A tool that can help you identify how ready a patient is to make a change



Readiness ruler

Stage of readiness	Definition	Readiness ruler
Pre-contemplation	I won't	0/1 to 2
Contemplation	I might	3 to 4
Preparation	I will	5 to 6
Action	I am	7 and above
Maintenance	I have	N/A



When to use MI?

Resistance

Ambivalence



Resistance

- Resistance (Noun):
 - An act or instance of resisting:
OPPOSITION
 - A means of resisting
 - The power or capacity to resist
- Resist (Verb)
 - To exert force in opposition



Ambivalence

Ambivalence (noun)

- Simultaneous and contradictory attitudes or feelings (as attraction and repulsion) toward an object, person, or action
- Continual fluctuation (between one thing and its opposite)



HOW DO WE NAVIGATE AMBIVALENCE AND RESISTANCE?



Communication skills used in MI

READS

R: Roll with resistance

E: Express empathy

A: Avoid argumentation

D: Develop dissonance

S: Support self-efficacy

OARS

O: Open-ended questions

A: Affirmations

R: Reflective listening

S: Summarizations



Communication skills used in MI

READS (D):
developing
dissonance

Highlight the discrepancies in behavior vs. health-related goals

How?

1. On one hand... On the other hand...
2. Good things and less good things



Tasks of MI

Processes that govern the flow of an MI encounter

Engaging: foundation

- Use OARS

Focusing: strategic direction

- Use OARS

Evoking: elicit change talk

- Use READS and OARS

Planning: bridge to change

- Use SMART Goals



Tasks of MI

Engaging: foundation

Establishing a trusting relationship with your patient

- Welcoming patient
- Developing rapport
- Determining chief complaint
- Showing empathy
- Listening



Case

RJ is a 56-year-old man who comes to your community pharmacy to pick up refills of his medications. RJ takes lisinopril 5 mg, atorvastatin 20 mg, and metformin 1000 mg. He has been coming to this pharmacy for years and occasionally checks his blood pressure while he is there. Today, RJ's blood pressure is elevated (156/90 mmHg), and the pharmacy technician notes it was elevated last month, too (152/88 mmHg). Additionally, RJ has had delays in his lisinopril refills for the past three months.



Refer to your handout and answer question 1.

1. How would you engage this patient? Write a short phrase.



Tasks of MI

Focusing: strategic
direction

Developing the agenda for your
time with the patient

- Identifying main goals
- Maintaining a balance between engaging and focusing
- Allowing the patient to choose direction
- Asking permission to explore



Case

RJ tells the pharmacy team that he understands high blood pressure is not good, but he is unclear about the long-term consequences of uncontrolled hypertension. He states he doesn't always feel any different when he misses doses of his lisinopril.



Refer to your handout and answer question 2.

1. How would you focus this conversation? Write a short phrase.



Tasks of MI

Evoking: elicit change talk

Determining patient's motivation for change based on health-related goal

- Determining importance
- Assessing barriers
- Developing dissonance
- Addressing sustain/change talk



Determine importance and patient-identified barriers

Use open-ended questions

“How important is making this change for you?”

“What barriers do you see preventing you from being successful?”

“What has helped you be successful with this task in the past?”



Dissonance and change vs. sustain talk

Dissonance

- On one hand (current behavior)
- On the other hand (health-related goal)
- What are your thoughts?

Change vs. sustain talk

- Change talk
 - “I wish...”
 - “I want to...”
 - “If only I could...”
- Sustain talk
 - “It’s just so hard...”
 - “It sounds too difficult...”
 - “It will never work.”



Case

RJ works full time in a retail setting and often works on repairs for his church. RJ lives in an apartment in an urban setting. He has family nearby and two grandchildren he enjoys spending time with. While he lives close to a grocery store, he finds groceries to be expensive and relies on fast food and convenience store snacks for meals. While acknowledging that medications can be helpful, RJ admits to skipping doses of his medications to spread out his finances, especially at the end of the month.



Refer to your handout and answer questions 3 and 4.

1. How would you determine this patient's motivation for change?
2. How could you create dissonance?



Tasks of MI

Planning: bridge to change

Developing a change plan

- Creating a roadmap for making a change in collaboration with patient
- Starting small and being specific (SMART)



SMART goals



S:
Specific



M:
Measurable



A:
Achievable



R:
Relevant



T:
Timely/
timed



SMART goal example

“I will eat one serving of vegetables for dinner each weeknight for the next seven days to help lower my blood sugar.”



S:

Weeknight
dinners

M:

One serving

A:

Small
change for
one meal
only

R:

Vegetables
= lower
carbs =
lower blood
sugars

T:

Seven days



Case

RJ attended a family gathering where a cousin discussed recovering from a stroke, which increased his concern about his own blood pressure management. RJ values staying independent and continuing to work to support himself without relying on family. RJ takes his atorvastatin most evenings while watching TV around 9:30 p.m. He has a predictable afternoon break around 3:00 p.m. between jobs. RJ uses a smartphone and keeps track of appointments on his phone calendar.



Refer to your handout and answer question 5.

Write out a SMART goal for RJ.



**DEVELOP STRATEGIES TO IMBED SDOH
SCREENING AND MI-BASED INTERVENTIONS
INTO EXISTING PHARMACY PRACTICE
WORKFLOWS.**



Incorporating SDOH screening and MI into workflow

- Identify workflow touchpoints for SDOH screening
- Use brief SDOH screening tools that fit within routine encounters
- Incorporate MI-based communication strategies into everyday patient interactions
- Utilize different team-based roles to support screening, counseling, and referrals
- Integrate documentation and interventions into current software

Spears J, et al.
PioneerRx. Motivational Interviewing for Independent Pharmacy.
Foster AA, et al.
Han J, et al.

Brackett A, et al.
Saclolo A and Desselle SP.
Nguyen KT and Warunek L.
Cormier R.



Identify workflow touchpoints for SDOH screening

- Medication therapy management
- Chronic disease state visits
- Transitions of care
- Immunizations
- Prescription pick-up
- Intake (for appointments)



Use brief SDOH screening tools that fit within routine encounters

- Questionnaires that address SDOH needs (Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences [PRAPARE[®]] or Accountable Health Communities Health-Related Social Needs Screening Tool [AHC-HRSN])
- “Grassroots” or “homegrown” form





AHC HRSN Screening Tool Core Questions

If someone chooses the underlined answers, they might have an unmet health-related social need.

Living Situation

1. What is your living situation today?³

- I have a steady place to live
- I have a place to live today, but I am worried about losing it in the future
- I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. Think about the place you live. Do you have problems with any of the following?⁴

CHOOSE ALL THAT APPLY

- Pests such as bugs, ants, or mice
- Mold
- Lead paint or pipes
- Lack of heat
- Oven or stove not working
- Smoke detectors missing or not working
- Water leaks
- None of the above

Food

Some people have made the following statements about their food situation. Please answer whether the statements were **OFTEN**, **SOMETIMES**, or **NEVER** true for you and your household in the last 12 months.⁵

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.

- Often true
- Sometimes true
- Never true

³ National Association of Community Health Centers and partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PRAPARE. <http://www.nachc.org/research-and-data/prapare/>

⁴ Nuruzzaman, N., Broadwin, M., Kourouma, K., & Olson, D. P. (2015). Making the Social Determinants of Health a Routine Part of Medical Care. *Journal of Healthcare for the Poor and Underserved*, 26(2), 321-327.

⁵ Hager, E. R., Quigg, A. M., Black, M. M., Coleman, S. M., Heeren, T., Rose-Jacobs, R., Frank, D. A. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. *Pediatrics*, 126(1), 26-32. doi:10.1542/peds.2009-3146



Incorporate MI-based communication strategies into everyday patient interactions

- Open-ended questions or reflective statements during patient interactions
- Explore ambivalence by developing dissonance and supporting self-efficacy
- In-person or telephonic



Utilize different team-based roles to support screening, counseling, and referrals

- Pharmacy technicians
- Community health workers (CHW)
- Medical assistants
- Pharmacy interns
- Pharmacists
- Health coaches

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Integrate documentation and interventions into current software

- Clinic visit note templates
- Pre-visit preparation
- Document labs, goals, vitals, etc. in pharmacy management system
- Integrate into electronic health record

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Quick Search: Test, Payer Next Patient Patient does not have Rxs in the current filtered time frame of 2 years.

Phone: (620) 555-5555 DOB: 1/1/1950 76 Health Coach: Facility: Delivery Zone:

Profile Other Medications Care Plan Vaccines Labs Events Medication Reconciliation Messages

Common [1] | Action List [2] | Measures [3] | Submission Hx [4] | Goal: Socioecon Issues x | +

General | SocioEconConnect x | SNAP Benefits x | New Care Action x | +

Goal: Improve Socioeconomic Issues Short Name: Socioecon Issues 16/25
 SNOMED: 161020004 - Low income benefits Category: Benefit Investigation ...

[Add Condition](#)

[Goal Services](#): CPESN Adherence Issue - Patient Unable to Obtain Medication; CPESN Referral - Referral to Care Coordinator; CPESN Referral - Referral to dietician; CPESN Referral - Referral to general practitioner; CPESN Referral - Referral to Health Care Provider; CPESN Referral - Referra...

Rxs, Medications, and Retail Items | Primary Rx: <Choose> Collapse/Expand | View: Default (Location) + Add Menu Legend

Drag a column header here to group by that column.

Type	Medication	Directions	Last Completed Date	Supply	MPR	Gap	Qty	Status	Workflow	Comment	Latest RX	NDC	UF

3 Records | Action: All Collapse/Expand | View: Default (Location) + Add Action Edit Menu

Drag a column header here to group by that column.

Description/Notes	Start Date	Status	Added By	Due Date	Added On	Changed By	Changed On	Notes	Method - Target
Patient uses SNAP benefits for groceries	1/28/2026	Active	Ryan Waldschmidt	1/28/2026	1/28/2026 1:28 PM	Ryan Waldschmidt	1/28/2026 1:31 PM		Other - Patient
Patient acknowledges difficulty with taking morning medications	1/28/2026	Active	Ryan Waldschmidt	1/28/2026	1/28/2026 1:29 PM	Ryan Waldschmidt	1/28/2026 1:29 PM		Other - Patient
Connect patient with resources to improve identified socio-econ...	1/28/2026	Active	Ryan Waldschmidt	1/30/2026	1/28/2026 1:25 PM		1/28/2026 1:29 PM	Patient has:	Referral - Other

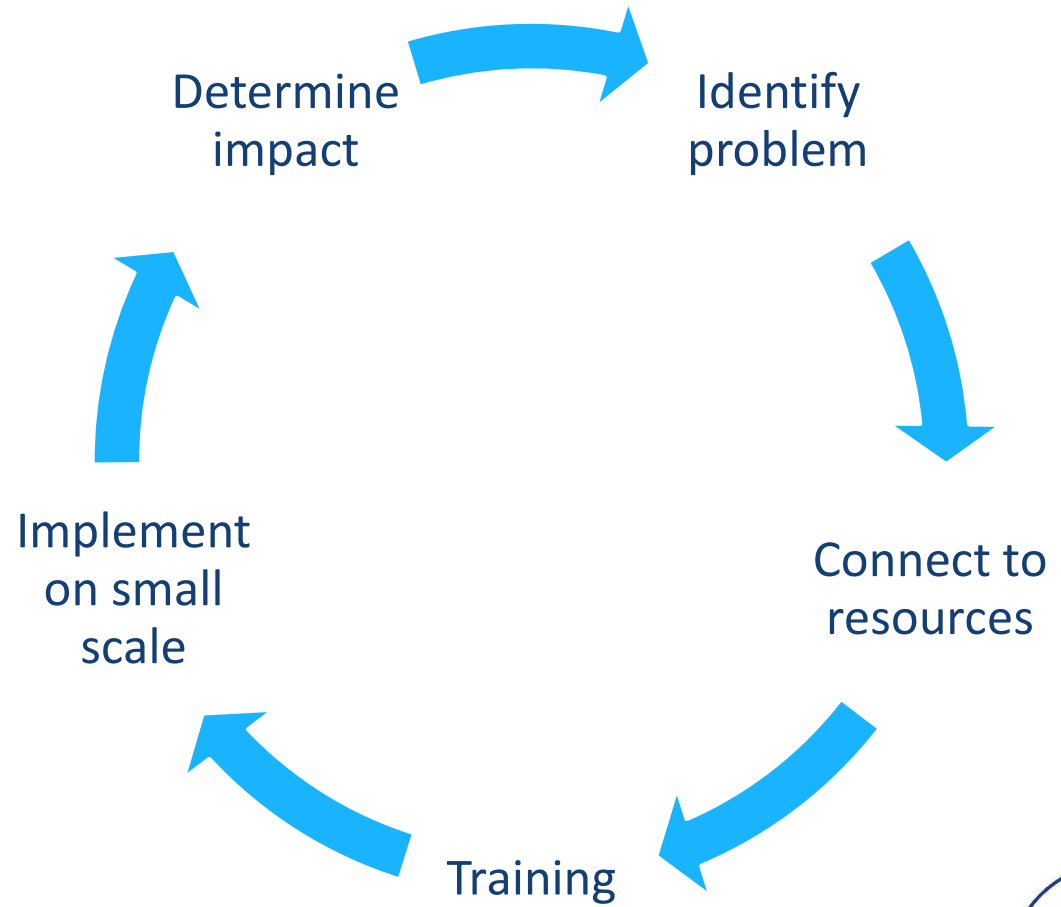
Cost Avoidance: <Choose>

Status: Address Socioeconomic Issues

Pioneer Rx, courtesy of R. Waldschmidt



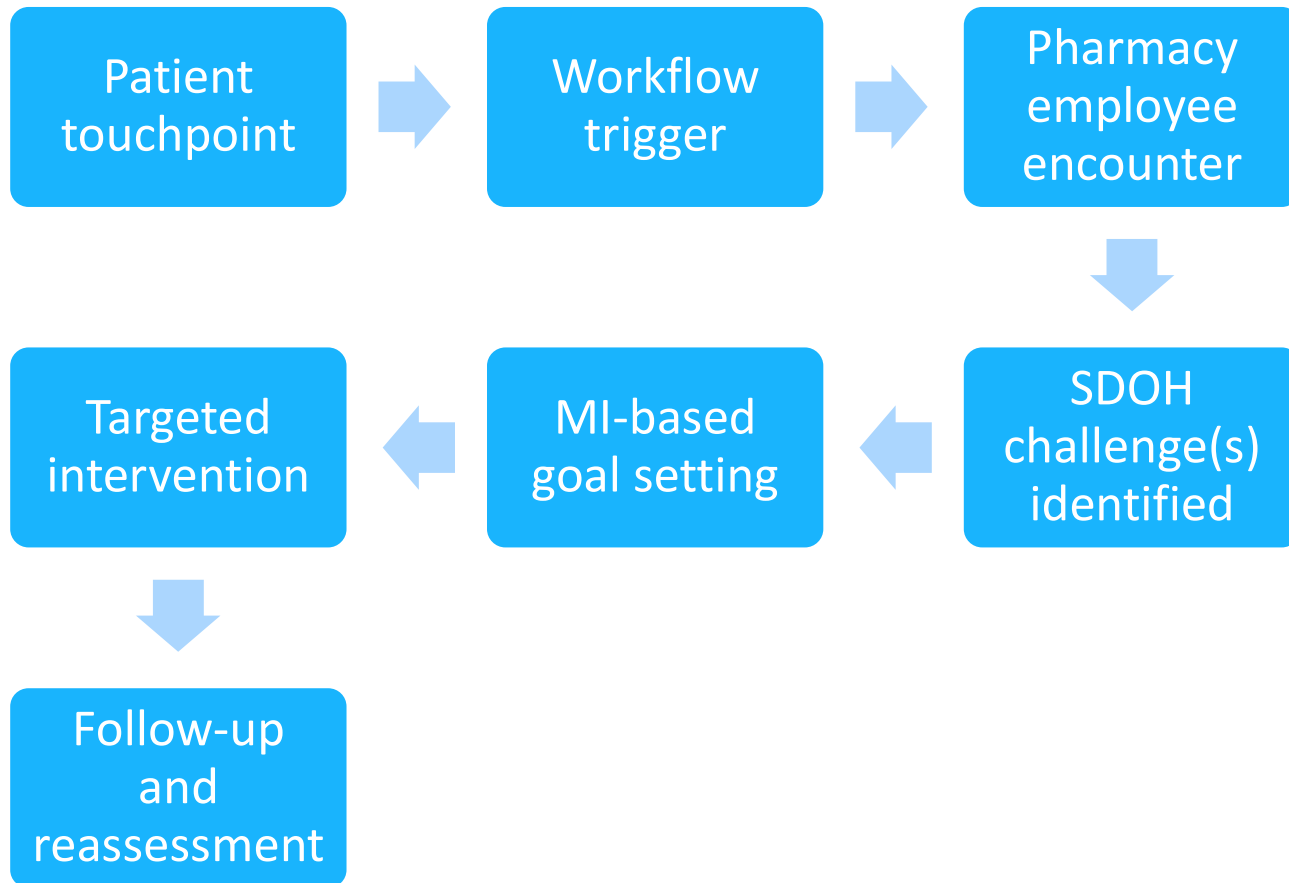
Implementation



Example:
Implementing
motivational
interviewing-based
SDOH interventions
into community
pharmacy
hypertension care



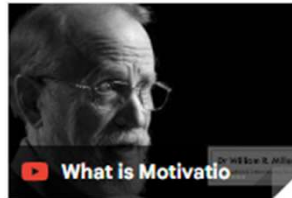
Example



Video resources to practice MI



[Lifting the burden in MI](#)



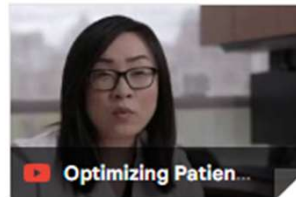
[What is MI?](#)



[The Four Processes of MI](#)



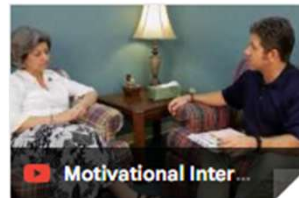
[Rolling with Resistance](#)



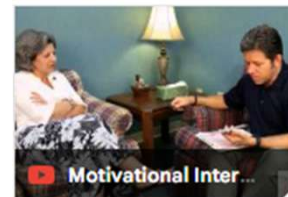
[Optimizing Patient Care](#)



[Introduction to MI](#)



[Good example](#)



[Bad example](#)



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