IHS EDUCATION SERIES

Putting Social Determinants into Practice

How CHRs Strengthen Tribal Diabetes Programs

Community Health Representative Program | Tribal Diabetes Initiative

About This Session

Audience

Tribal Community Health Representatives, Program Directors, Physicians, Public Health Nurses, and Healthcare Team Members

Purpose

Explore how CHRs use their unique community position to identify and address social determinants affecting diabetes outcomes

Format

60-minute interactive session with case discussions, practical tools, and team planning activities

Learning Objectives

By the end of this session, participants will be able to:

1. Identify social determinants of health (SDOH) as a priority in tribal diabetes care and their impact on diabetes self-management and health outcomes.

2. Apply SDOH screening tools to identify social needs and connect patients to appropriate resources.

3. Integrate SDOH findings into team-based diabetes care by documenting social needs, communicating them to the care team, and supporting culturally responsive care planning.

SECTION 1

Understanding Social Determinants of Health

What Are Social Determinants of Health?

"The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes."

— Healthy People 2030, ODPHP

SDOH account for up to

80% of health outcomes

Economic Stability

Income, employment, poverty, food security

Education Access

Literacy, early childhood education, language

Healthcare Access

Health coverage, provider availability, quality

Neighborhood & Built Environment

Housing, transportation, water quality

Social & Community Context

Social support, discrimination, civic participation

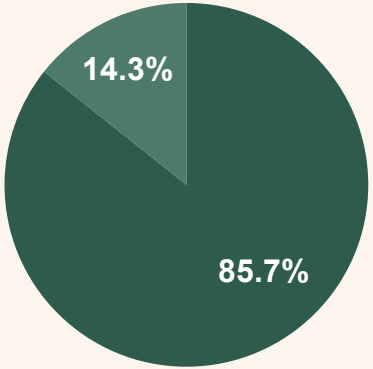
The Five Domains of SDOH

Economic Stability	Education Access	Healthcare Access	Neighborhood & Environment	Social & Community
Poverty Food insecurity Housing instability Unemployment	Low literacy Language barriers Lack of health education Early childhood gaps	No insurance Provider shortages Distance to IHS/clinic Language barriers	Poor housing No safe spaces Water quality Transportation gaps	Social isolation Discrimination Community trauma Historical loss

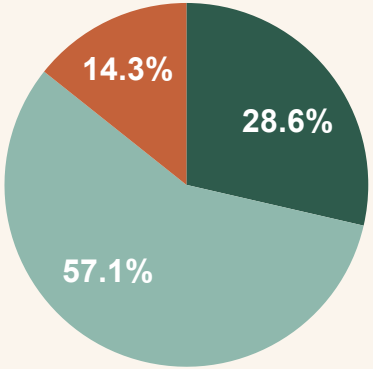
SDOH Prevalence in Urban Indian Communities

National Council of Urban Indian Health | Survey of 7 California Urban Indian Organizations, Winter 2025–2026

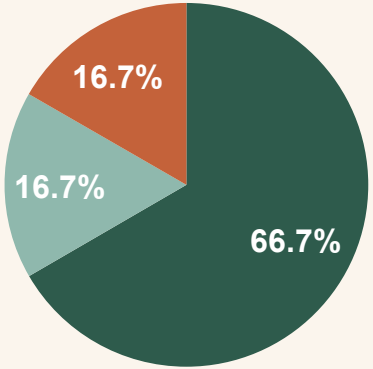
Housing Insecurity



Transportation Barriers to Care



Food Insecurity



High Prevalence | Moderate Prevalence | Low Prevalence | No Prevalence

Common Barriers

- Insufficient space & culturally competent staff at housing facilities
- Inaccessible public transportation or rideshare options
- Inadequate healthy food options in food deserts and food swamps

83%+ of UIOs Report Success Through:

- ✓ Referral to social services, transitional housing & shelters
- ✓ Telehealth services and patient transportation programs
- ✓ Community gardens, food pantries & nutrition education

Source: NCUIH, 2025–2026 | Full report: ncuih.org/sdoh2026

SDOH & Diabetes: The Connection

Food insecurity	→	Poor glycemic control, inability to follow meal plans
Transportation barriers	→	Missed appointments, delayed diagnoses, gaps in medication
Housing instability	→	Inability to store insulin, no space for exercise, chronic stress
Low health literacy	→	Misunderstood discharge instructions, low self-management
Social isolation	→	Depression and diabetes distress, reduced treatment adherence

SDOH in Tribal Communities

Tribal communities face compounding SDOH factors shaped by historical and structural inequities:

Structural & Geographic

- Geographic isolation and long distances to care
- Limited grocery stores with healthy food options
- High rates of poverty and unemployment
- Overcrowded or substandard housing conditions
- Limited broadband and telehealth access

- Intergenerational trauma and historical loss
- Distrust of healthcare systems
- Cultural and language barriers in clinical care
- Disruption of traditional food systems
- Underfunded IHS and tribal health programs

The Data: Why This Matters

American Indian and Alaska Native communities bear a disproportionate diabetes burden

2–5×

Higher diabetes prevalence in AI/AN populations vs. white Americans

14.7%

Diagnosed diabetes rate among AI/AN adults (vs. 7.5% national average)

50%

Of AI/AN adults with diabetes report food insecurity as a barrier to management

Sources: IHS National Diabetes Program; CDC National Diabetes Statistics Report; USDA ERS Food Security Survey

SECTION 2

CHR Roles & Scope of Practice

Who Are Community Health Representatives?

The CHR Program

- ✓ Established in 1968 by the Indian Health Service
- ✓ One of the longest-running CHW programs in the U.S.
- ✓ CHRs are members of the communities they serve
- ✓ Trained and supervised by IHS and tribal programs
- ✓ Bridge clinical care and community life

Home Visits

Regular visits to assess health needs in the community

Care Coordination

Connect patients to clinical and social services

Health Education

Culturally tailored diabetes self-management support

Advocacy

Speak on behalf of patients within health systems

The CHR's Unique Position

Community

Trusted neighbor
Cultural knowledge
Local relationships
Language & context

CHR Bridge Role

Healthcare System

Clinical team
IHS/tribal programs
Specialty referrals
Care coordination

"CHRs know what's happening at the kitchen table. No one else on the care team does." — IHS Diabetes Program Advisor

CHR Scope: Addressing SDOH in Daily Work

Identify

Use conversation, observation, and screening tools to spot SDOH needs during home visits and community encounters

Connect

Link patients to food pantries, transportation assistance, housing support, and other community resources

Educate

Provide diabetes education that accounts for SDOH — meal planning with available foods, budget-friendly exercise

Advocate

Communicate patient social needs to the clinical team so care plans reflect real-life circumstances

Follow Up

Check back after referrals to ensure patients accessed services and that unmet needs are re-addressed

Document

Record SDOH findings in patient records to support team-based care and track community-level patterns

Collaboration with the Care Team

SDOH information gathered by CHRs should inform care team decisions

CHR	Identifies social needs, provides education, connects to resources, follows up
Physician / PA	Adjusts treatment plans based on SDOH (e.g., insulin timing, medication cost)
PHN / RN	Coordinates care management, monitors chronic conditions, supports CHR documentation
Dietitian	Creates culturally appropriate meal plans using foods actually available to the patient
Behavioral Health	Addresses depression, diabetes distress, historical trauma impacts on self-care
Program Director	Ensures CHR SDOH activities are supported, resourced, and tracked in program data

SECTION 3

Real Stories, Real Impact

Community Case Studies

CASE STUDY 1

Food Insecurity & Diabetes Management

Scenario:

Maria, 58, has T2D with an A1C of 11.2%. Her dietitian's meal plan includes fresh vegetables, but the nearest grocery store is 45 miles away and she receives food commodities. She often skips meals to avoid hypoglycemia.

CHR Actions

✓ Screened for food insecurity using an SDOH screening tool

✓ Connected Maria to the tribal food pantry program

✓ Notified dietitian to adapt meal plan to commodity foods

✓ Educated Maria on managing blood glucose without skipping meals

Outcomes

★ A1C dropped from 11.2% to 8.4% over 6 months

★ Maria no longer skips meals to avoid hypoglycemia

★ Dietitian revised guidance using accessible foods

★ Maria shared information with three neighbors

CASE STUDY 2

Transportation Barriers & Missed Care

Scenario:

Thomas, 67, missed 4 consecutive diabetes clinic appointments. He lives 30 miles from the clinic, has no personal vehicle, and his wife recently had a stroke. He ran out of metformin 3 weeks ago.

CHR Actions

- ✓ Identified missed appointments through CHR tracking log
- ✓ Arranged IHS transportation voucher for future visits
- ✓ Set up telehealth visit with provider for urgent follow-up
- ✓ Helped Thomas access emergency medication supply

Outcomes

- ★ Thomas resumed care within 1 week
- ★ Medication gap resolved; A1C re-tested
- ★ Transportation plan established for ongoing visits
- ★ Caregiver stress flagged for social work referral

CASE STUDY 3

Mental Health & Diabetes Distress

Scenario:

Linda, 44, was diagnosed with T2D 2 years ago. During a home visit, her CHR notices she seems withdrawn, has stopped checking her blood sugar, and says "What's the point?" She recently lost her brother.

CHR Actions

- ✓ Used active listening; validated Linda's feelings
- ✓ Administered PHQ-2 depression screening
- ✓ Notified care team of depression risk and diabetes distress
- ✓ Connected Linda to tribal behavioral health counselor

Outcomes

- ★ Linda engaged with behavioral health within 2 weeks
- ★ Care team adjusted diabetes management approach
- ★ Linda resumed blood sugar monitoring after 1 month
- ★ Traditional healing incorporated into care plan

PROGRAM SPOTLIGHT

Jemez Pueblo: Food Security as a Diabetes Intervention

Context:
Jemez Pueblo's health program lost access to their Certified Diabetes Educator (CDE). A1C levels that had been brought below 8 in 10% more patients under the CDE began rising again. With no CDE replacement, the team launched an aggressive food security intervention to stabilize outcomes.

What the Program Did

- Launched an aggressive nutrition clinic streamlined to food security services
- Consistent reminder calls ensuring every food-insecure diabetic patient was contacted
- Achieved 100% outreach coverage for food-insecure patients with diabetes
- Expanded food security program from ~60 to 112 patients enrolled

What They Found

20%	Improvement in nutrition clinic audit score
100%	Food-insecure diabetic patients reached for outreach
A1C Stable ↓	Levels stabilized or declined despite no CDE on staff
IHS Award	IHS Director's Award for food sovereignty program excellence

Key Insight: Among elders, even the *fear* of food insecurity — not just actual scarcity — can drive anxiety and poor diabetes outcomes. Both belief and reality must be assessed.

Discussion: Lessons from the Field

Share observations about your community in the chat.

1. What SDOH are you seeing most in your community right now?
2. What barriers do you face in addressing SDOH within your CHR role?
3. What resources or partnerships are working well in your program?
4. What does your team need to better support SDOH-informed diabetes care?

SECTION 4

Tools, Screening & Referral Pathways

SDOH Screening: Where to Start

Screening Principles

- Ask with purpose — only screen if you have resources to address the need
- Use language the patient understands; offer the option to decline
- Create a safe, private environment for sensitive conversations
- Follow your tribal program's protocols for documentation and referrals
- SDOH screening is an ongoing process, not a one-time event

Common Screening Tools

PRAPARE

Comprehensive SDOH screening — 21 items across 5 domains

Hunger Vital Sign

2-item food insecurity screener (validated)

AHC Health-Related Social Needs

CMS model for SDOH screening in Medicare/Medicaid

PHQ-2 / PHQ-9

Depression screening — critical for diabetes distress

AUDIT-C

Alcohol use screening (impacts glycemic control)

PRAPARE: A Closer Look

Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Personal Characteristics

Race/ethnicity, language, education level

Family & Home

Housing stability, household size, housing conditions

Money & Resources

Income, employment, insurance, material hardship

Social & Emotional Health

Social support, stress, incarceration history

Optional Domain

Physical activity, seasonal migrant status, refugee status

PRAPARE is available in EHRs including RPMS (IHS) and can be documented directly in the patient record. Free training and implementation guides available at nachc.org/prapare

Building Referral Pathways

1. Identify

Notice SDOH signals during home visit or encounter

2. Screen

Use validated tool (PRAPARE, Hunger Vital Sign, PHQ-2)

3. Connect

Match need to local resource; warm handoff when possible

4. Follow Up

Confirm access within 2–4 weeks; re-screen if needed

Local Resources to Know

Food:	Tribal food pantry, WIC, SNAP, food commodity program, senior meal programs
Housing:	Tribal housing authority, HUD Indian programs, emergency shelter
Transport:	IHS transportation benefit, tribal transportation services, Area Agency on Aging
Behavioral Health:	Tribal BH counselors, IHS BH, crisis hotlines (988), SAMHSA

Documentation & Tracking SDOH in CHR Practice

Why Document SDOH?

→ Ensures entire care team knows patient's social context

→ Drives program data for grant reporting and funding

→ Identifies community-level patterns for health planning

→ Supports continuity when CHR or provider changes

→ Demonstrates CHR program value and impact

What to Document

SDOH screening results

Use Z-codes (ICD-10-CM Z55–Z65) when available in RPMS or other EMR.

Referrals made

Resource name, date, contact person, patient consent

Follow-up outcomes

Did patient access service? Was need resolved?

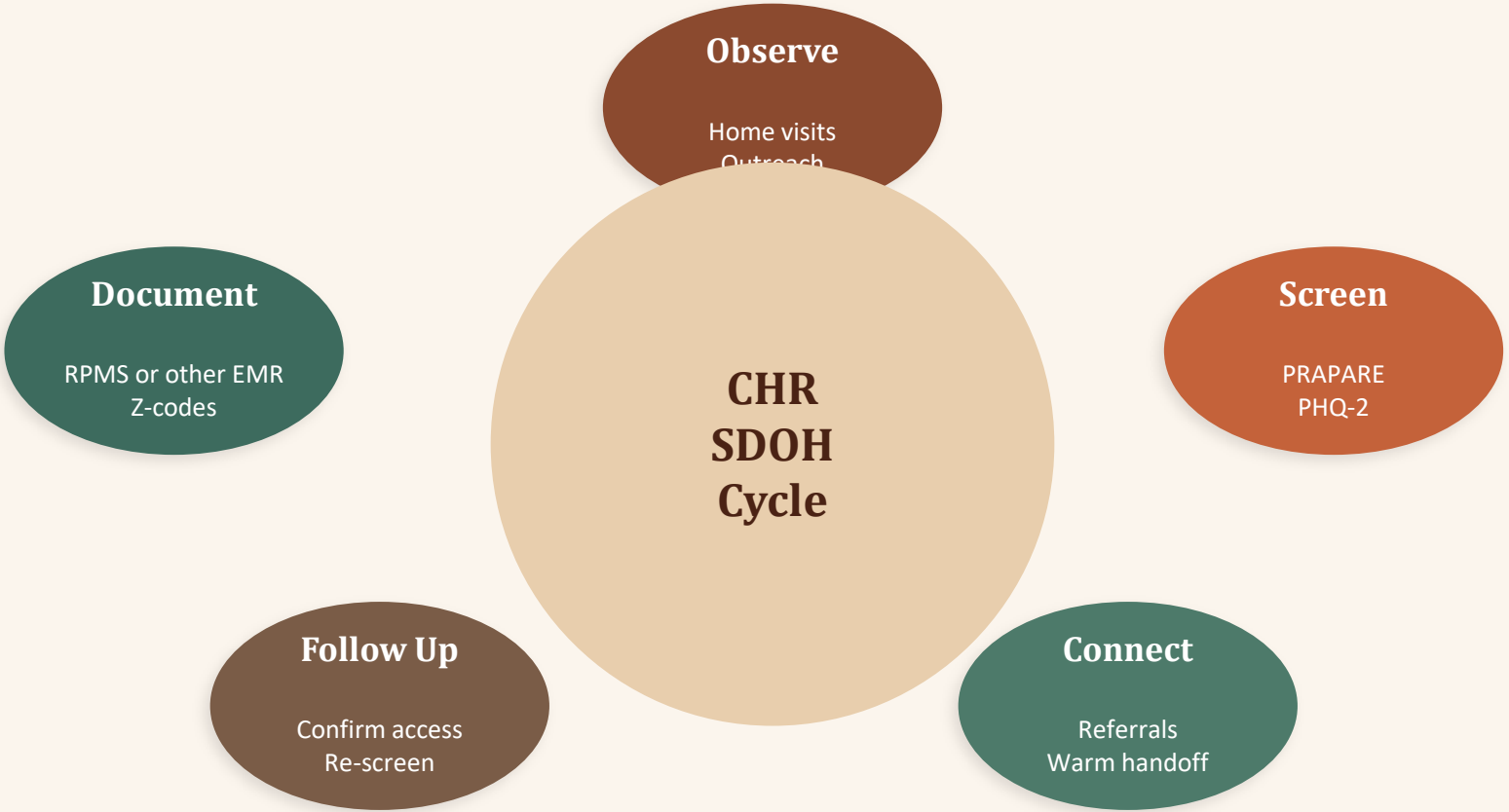
Patient preferences

Declined services, preferred methods, cultural factors

Care team communication

Date and nature of handoff to nurse, dietitian, or provider

Putting It All Together: The CHR SDOH Cycle



Team-Based Diabetes Care: SDOH Integration

Each team member contributes a unique lens — SDOH requires everyone's participation

CHR	First-line SDOH screener, community connector, follow-up
Physician / PA	Integrates SDOH into differential and prescribing decisions
PHN / RN	Care management, chronic disease monitoring, CHR support
Dietitian	Adapts nutrition counseling to patient's actual food environment
Behavioral Health	Addresses trauma, depression, and diabetes distress
Program Director	Policy, resources, data, and CHR program support

Key Takeaways

1. SDOH drive up to 80% of health outcomes — tribal communities face compounding barriers that directly worsen diabetes control
2. CHRs are uniquely positioned as trusted community members to identify SDOH that clinical staff cannot see
3. Validated tools like PRAPARE and the Hunger Vital Sign make SDOH screening practical and documentable
4. Effective SDOH action requires team collaboration — CHRs identify, clinical staff adapt care, directors resource the work
5. Document, follow up, and track — SDOH work must be visible in data to sustain program funding and demonstrate impact

Your SDOH Action Plan

Before you leave today, commit to one action in each area:

Screening	Which SDOH screening tool will I implement (or use more consistently) in my next 5 home visits?
Referrals	What is one local resource I will connect with this month to strengthen my referral pathway?
Communication	How will I share SDOH information more effectively with my care team?
Documentation	What change will I make to document SDOH findings in patient records?

Resources & References

IHS Resources

- IHS National Diabetes Program: www.ihs.gov/diabetes
- CHR Program Resources: www.ihs.gov/chr
- RPMS SDOH Documentation Guide (IHS Division of Information Resources)

Screening Tools

- PRAPARE Tool & Implementation Kit: nachc.org/prapare
- Hunger Vital Sign: childrenshealthwatch.org
- AHC HRSN Screening Tool: cms.gov

Clinical Guidance

- ADA Standards of Care in Diabetes – Social Determinants of Health
- CDC Tribal Diabetes Prevention & Control Program
- USDA Food & Nutrition Service Tribal Nutrition Programs

Thank You

Questions & Discussion

IHS Education Series | Tribal Diabetes Initiative | CHR Program

"Strengthening communities through knowledge, relationships, and care."

For questions about this training, contact: IHS Division of Diabetes Treatment and Prevention

Partner with TribeAID

Consulting Services for Tribal Community & Behavioral Health

- CHR program development, training, and capacity building
- Behavioral health program design & CARF accreditation preparation
- Medicaid third-party billing and IHS 638 contract strategy
- Strategic planning for tribal health sovereignty and self-determination
- SDOH screening implementation and community health program evaluation

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Strengthening Tribal Health Systems Through Expertise, Partnership, and Community