Beyond Compliance: Integrating Social Determinants of Health into Clinical Nutrition Practice for Diabetes Prevention and Care

"The problem isn't the plan, it's whether the plan fits the person."

Presented by: Dr. Walter E. Copeland II, DMSc, MBA, MSAN

CLINICAL NUTRITION | DIABETES CARE | SDOH

LEARNING OBJECTIVES

Session Objectives

1

01 — **Why Plans Fail**

Examine why well-designed nutrition plans frequently fail in real-world settings

2

02 — **SDOH & Diabetes**

Identify the five key Social Determinants of Health and examine the research evidence linking them to diabetes outcomes

3

03 — **REAL Care** Model

Introduce and apply this four-part framework for context-driven clinical practice

4

04 — **ALIGN** Framework

Explore this five-stage behavioral readiness model for matching care to patient readiness

5

05 — **Clinical Tools**

Equip participants with practical tools to assess barriers and adapt nutrition strategies accordingly

THE CENTRAL QUESTION

Why Do Well-Designed Nutrition Plans Fail?

Clinical recommendations often assume ideal conditions that patients do not actually have in daily life.

THE CENTRAL QUESTION

Why Do Motivated Clients Still Struggle to Achieve Results?

We create evidence-based nutrition interventions, yet outcomes remain inconsistent. The gap between clinical recommendations and real-world adherence is not a patient failure; it is a systems failure.

The Reality We Don't Talk About

The Plan

Sound clinical guidance, evidence-based strategies

The Science

Solid research, validated protocols

The Motivation

An engaged, willing patient

And yet — the outcome still failed.

THE CORE INSIGHT

This Is the Shift

Not a Failure of Knowledge

The clinician understood the science and applied it correctly.

Not a Failure of Motivation

The patient wanted to change and made genuine effort.

A Failure of Alignment

The plan did not fit the life the patient was actually living.

THE EVIDENCE

Why This Matters

50%

Adherence Rate

Average long-term therapy adherence — *World Health Organization*

55%

SDOH Impact

Health outcomes driven by social and environmental factors — *Healthy People 2030*

~20%

Clinical Influence

Share of behavior attributable to clinical care alone

Social and environmental factors outweigh clinical intervention by a significant margin. Ignoring them is not neutral — it is a structural disadvantage.

THE CORE PROBLEM

The Problem with Compliance

Traditional care asks a single question:

> *"Did they follow the plan?"*

But it rarely asks the more important question:

> *"Could they **realistically** follow the plan?"*

That distinction is the difference between a prescription and a partnership.

UNEXAMINED ASSUMPTIONS

The Hidden Assumptions

Every clinical plan carries invisible assumptions. When those assumptions are wrong, the plan fails — not the patient.

Food Access

We assume access to affordable, healthy food

Time to Prepare

We assume time and energy for meal preparation

Stable Environment

We assume housing stability and routine

Consistent Routine

We assume predictable daily structure

When these conditions are absent, the plan fails — regardless of clinical quality.

Reframing the Problem

Old Framing

Non-compliance is a patient failure — a gap in willpower or follow-through.

New Framing

Non-compliance is **misalignment** — behavior shaped by environment, not education alone.

FOUNDATIONS

What Are Social Determinants of Health?

The **conditions in which people live, work, and function** — these shape daily decisions, access to resources, and capacity for behavior change.

SDOH are not background factors. They are primary drivers of behavior and therefore, primary drivers of clinical outcomes.

- Where someone lives and works
- What resources they can access
- The social and economic pressures they face daily

KEY DRIVERS

What Shapes Nutrition Behavior

Food Access & Affordability

Geographic and financial barriers to nutritious food

Economic Stability

Income volatility, competing financial priorities

Time Constraints

Multiple jobs, caregiving demands, limited bandwidth

Health Literacy

Ability to understand and act on health information

Stress & Environment

Chronic stress disrupts decision-making and metabolic health

THE EVIDENCE

Evidence from Practice

Food Insecurity → Glycemic Control

Food insecurity is directly linked to poor glycemic control in patients with type 2 diabetes. — *American Diabetes Association*

Low Health Literacy → Poor Adherence

Patients with low health literacy are significantly less likely to follow clinical recommendations. — *NIH*

Chronic Stress → Metabolic Disruption

Chronic stress elevates cortisol, impairs glucose regulation, and undermines behavior change. — *CDC*

The Shift in Care

Compliance Model

- Prescribe the plan
- Expect adherence
- Attribute failure to the patient
- One-size approach

Alignment Model

- Design for reality
- Understand the environment
- Adapt to the person
- Context-driven approach

The goal is not a perfect plan. The goal is a **plan that works for this person, in this life, right now.**

KEY SDOH FACTORS

Key SDOH Factors in Diabetes Prevention & Management

THE EVIDENCE

What the Research Tells Us

2x

Food Insecurity

Patients with high food insecurity are twice as likely to have poor glycemic control

80%

SDOH Impact

SDOH explains up to 80% of modifiable health outcome variance

20%

Clinical Influence

Traditional clinical encounters address less than 20% of the factors driving non-adherence

Neighborhood Deprivation

Neighborhood deprivation is independently associated with elevated HbA1c levels, even after controlling for dietary intake

Health Literacy

Low health literacy correlates with reduced medication adherence and higher diabetes-related hospitalization rates

SDOH Screening

Integrating SDOH screening into nutrition encounters improves patient engagement and self-efficacy

The Clinical Imperative

Screening for SDOH is no longer optional. Major health bodies — including the ADA and AND — now recommend systematic social risk assessment as part of comprehensive diabetes nutrition care.

FRAMEWORK

Introducing the **REAL** Care Model

A structured, four-part framework built for real-world clinical practice — moving from assessment to sustainable action.

Each step builds on the previous. The framework only works when all four components are active.

R — REALITY ASSESSMENT

Understand the Patient's Actual Life

Work Schedule

How many jobs? What hours? What energy remains?

Family Responsibilities

Who else depends on this patient? What are their competing demands?

Stress & Energy Levels

Chronic stress is a clinical variable, not a personal failing.

⚠ Do not design the plan before understanding the life.

E — ENVIRONMENT MAPPING

What Does the Patient's World Actually Look Like?

Environment drives behavior. A plan that ignores environment is a plan built on assumptions.

Food Available

What can they actually access in their neighborhood?

What Is Affordable

Within their real budget constraints

What Is Accessible

Time, transportation, storage, cooking capacity

A — ADAPTIVE PLANNING

Build Plans That Bend Without Breaking

Flexible Strategies

Offer multiple pathways to the same outcome — not one rigid approach

Simple Substitutions

Lower-cost, lower-effort alternatives that preserve clinical integrity

Culturally Relevant Options

Honor food culture, traditions, and preferences as clinical assets

Focus on **sustainability over perfection.** A 70% plan sustained is more powerful than a 100% plan abandoned.

L — LONG-TERM SUPPORT

Behavior Change Is Not an Event :It Is a Process

01

Follow Up

Check in consistently — not just when things go wrong

02

Adjust

Revisit the plan as life circumstances evolve

03

Reinforce

Recognize progress — even incremental progress — as clinical success

Why REAL Care Works

Aligned Plans Increase Adherence

When the plan fits the life, patients can actually follow it

Practical Plans Improve Outcomes

Real-world feasibility drives clinical results more than clinical elegance

The Best Plan Is the One They Can Follow

Effectiveness is inseparable from accessibility

THE NEXT LAYER

But There's Another Layer

Even with a perfectly aligned plan — one that accounts for access, environment, and culture — outcomes can still stall.

Why? Because **timing matters.**

Not every patient is in the same stage of readiness. Delivering an advanced plan to someone who is not yet ready creates failure — not from the plan, but from the mismatch.

Introducing ALIGN

A behavior readiness framework for real-world care

Matching clinical intensity to patient readiness — at every stage of the journey.

THE ALIGN FRAMEWORK

The Five Stages of ALIGN

Each stage requires a different clinical response. Matching intervention to stage is the key to sustainable behavior change.

A — ACKNOWLEDGE

Recognition Is the Foundation

The patient **recognizes that a problem exists.** Without this awareness, no intervention can take hold.

No change happens before awareness. Your role at this stage is not to prescribe — it is to create the conditions for recognition.

- Open-ended questions that surface concern
- Reflective listening over directive guidance
- Build psychological safety first

L — LEARN

Understanding Begins to Form

The patient is actively **seeking information** and beginning to understand what change might look like for them.

- Provide clear, accessible health education
- Use teach-back methods to confirm understanding
- Tailor to health literacy level
- Avoid overwhelming with complexity

This is a pivotal window. Meet curiosity with clarity — not a full treatment protocol.

I — IMPLEMENT

The Patient Begins to Act

The patient takes **first steps toward change.** This is the most fragile — and most important — stage.

> ⚠ This is where most plans fail. Complexity, rigidity, and high expectations create early dropout. Start small, celebrate early wins.

- Set achievable micro-goals
- Reduce friction at every step
- Anticipate barriers before they occur

G — GROW

Consistency Begins to Build

The patient is **stabilizing new behaviors** into reliable patterns. Habits are forming.

- Reinforce consistency over perfection
- Expand goals incrementally
- Address setbacks as data, not failure
- Maintain accountability structures

Growth is nonlinear. Your role is to keep the patient oriented toward the trajectory, not fixated on any single data point.

N — NORMALIZE

Behavior Becomes Identity

What It Looks Like

Healthy behavior is no longer effortful — it is simply how this person lives

The Clinical Role

Shift from coaching to maintenance — check in, affirm, and prepare for life disruptions

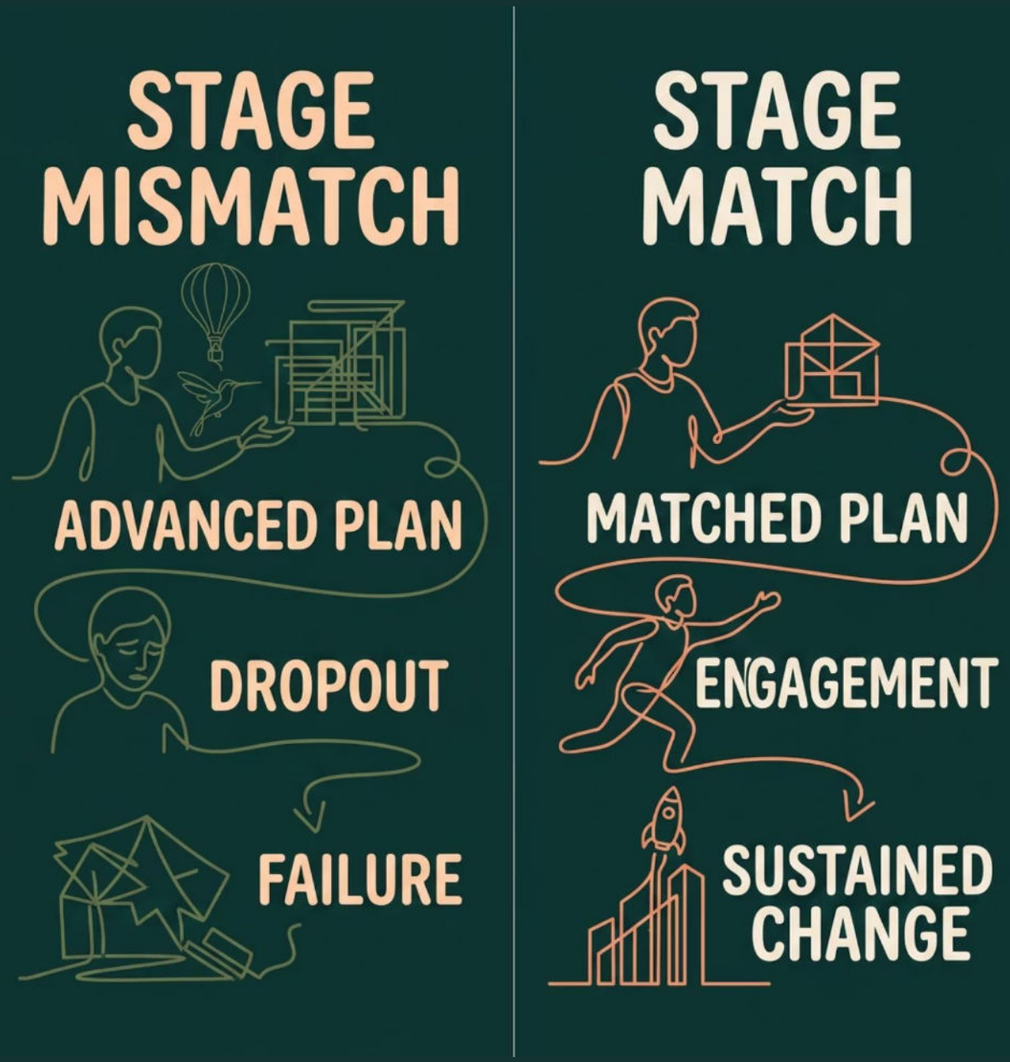
Long-Term Success

Identity-level change is the most durable form of behavior change

Why ALIGN Matters

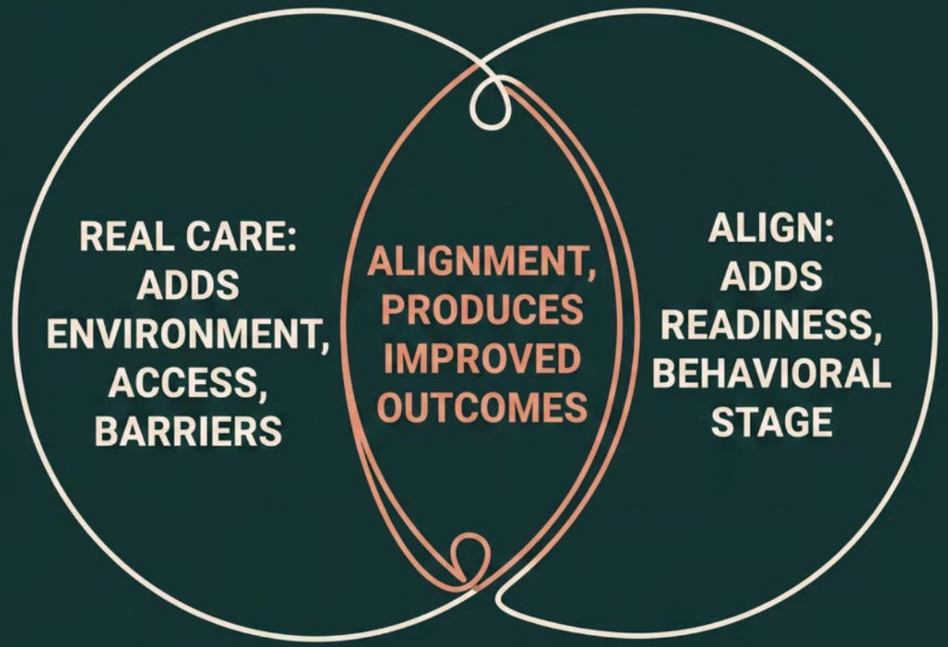
> You cannot give an advanced plan to someone in an early stage. Mismatch creates failure — not because the plan was wrong, but because the timing was.

Stage-matched care is not optional. It is the mechanism by which clinical effort converts to clinical outcome.



THE INTEGRATED MODEL

Bringing It Together



Two Frameworks, One Goal

REAL Care removes environmental barriers — making the plan possible.

ALIGN matches clinical intensity to patient readiness — making the plan timely.

Together, they create the conditions for **true alignment** — where the right plan meets the right person at the right moment.

Alignment is the mechanism. Outcomes are the result.

CASE STUDY 1

Meet the Patient

Patient Profile

- Type 2 diabetes diagnosis
- Highly motivated to change
- Given a structured, evidence-based nutrition plan
- Followed up consistently

The Clinical Expectation

With a motivated patient, a solid plan, and consistent follow-up, improvement was expected within 90 days.

⚠ No improvement was observed. Glucose remained uncontrolled. Frustration increased on both sides.

WHAT WAS MISSED

What No One Had Asked

Two Jobs

Working 60+ hours per week, leaving no time for meal preparation

Limited Food Access

No grocery store within reasonable distance; convenience stores only

High Chronic Stress

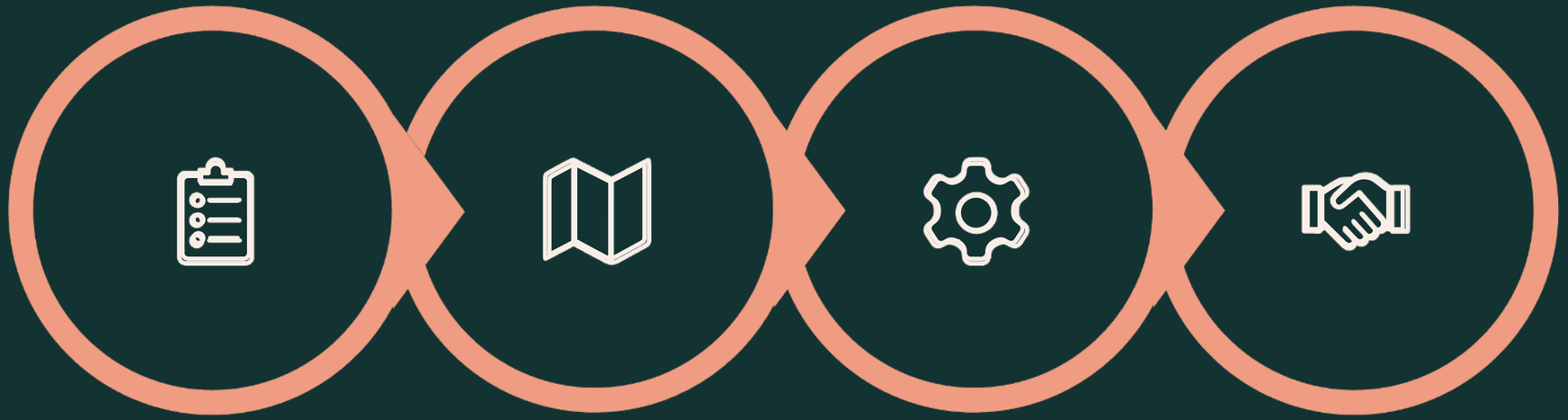
Financial instability, family caregiving, housing uncertainty

No Time for Meal Prep

The plan assumed 30 minutes of daily prep. That time did not exist.

REAL CARE APPLIED

Applying the Framework



Reality Assessment

Environment Mapping

Adaptive Planning

Long-Term Support

Each component of REAL Care surfaced a layer of the problem that the original plan had not addressed — and created a practical pathway forward.

CASE STUDY 1 — OUTCOME

What Changed

Improved Adherence

Simplified, realistic plan increased follow-through from inconsistent to sustained

Better Glucose Control

HbA1c trended downward within 60 days of plan revision

Reduced Frustration

Both patient and clinician experienced renewed confidence in the care relationship

CASE STUDY 2

The "Non-Compliant" Patient

What the Chart Said

- Labeled "non-compliant"
- Missed multiple appointments
- Did not follow dietary recommendations
- Appeared disengaged from care

The Clinical Response

Repeated reminders. Escalated recommendations. Increased documentation of non-adherence.

The label "non-compliant" closed the door on curiosity. What was actually happening went unasked and unanswered.

WHAT WAS REALLY HAPPENING

Behind the Label

Low Health Literacy

Written materials and clinical language were not accessible

Unstable Schedule

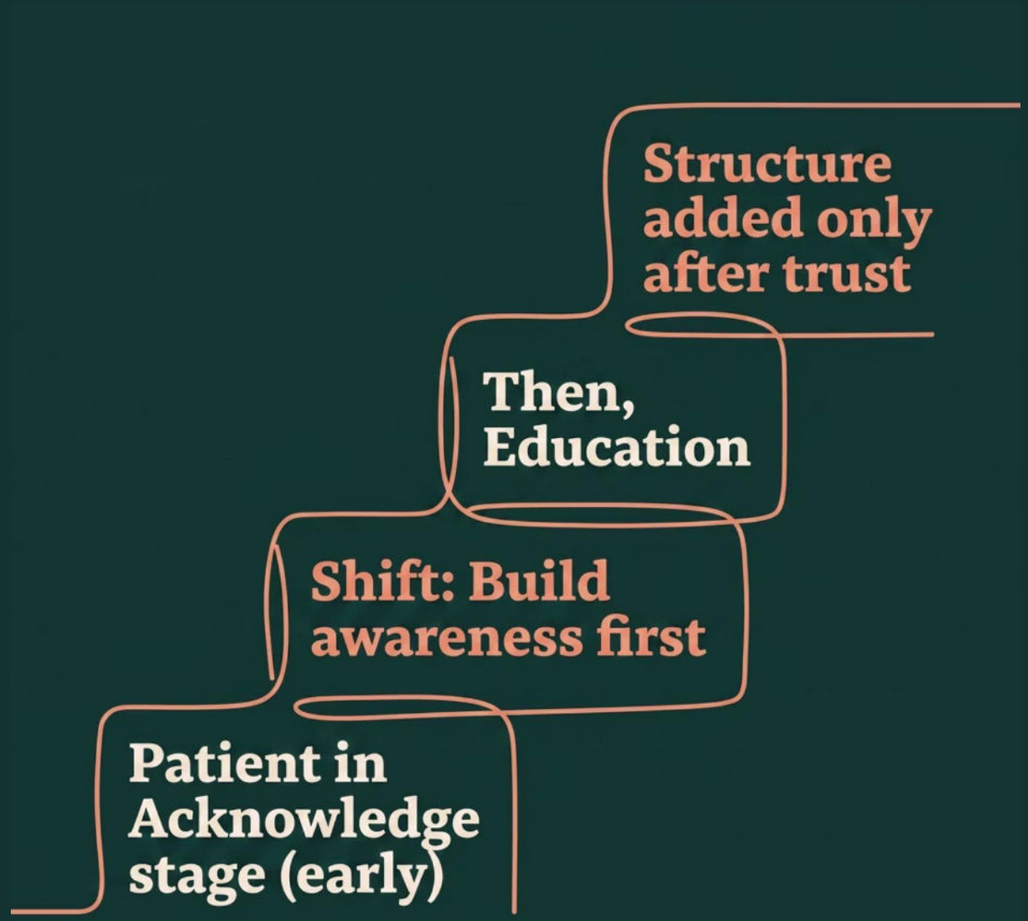
Shift work made appointment times consistently impossible

Emotional Stress

Active psychological distress made behavioral engagement nearly impossible

ALIGN APPLIED

Matching Care to Readiness



The Diagnosis Within the Diagnosis

The patient was in the **Acknowledge stage** — the earliest point in the ALIGN model.

- Needed awareness and psychological safety
- Needed accessible education, not clinical protocols
- Was not ready for a structured behavior plan

> Imposing strict structure at this stage does not accelerate progress — it destroys the therapeutic relationship.

CASE STUDY 2 — OUTCOME

What Changed When the Approach Changed

Engagement Improved

Patient began attending appointments and participating in conversations

Trust Increased

The care relationship shifted from adversarial to collaborative

Behavior Change Followed

Once readiness developed, sustainable behavior change became possible

CLINICAL APPLICATION

Ask Better Questions

The quality of care begins with the quality of inquiry. Shift your standard intake questions toward context-driven assessment.

1

What Is Realistic?

Given this patient's actual daily life — what can they genuinely do?

2

What Are the Barriers?

What environmental, financial, or social factors are working against the plan?

3

What Can Actually Be Sustained?

A plan that can be maintained at 70% indefinitely outperforms one that collapses at 100%.

PRACTICAL TOOLS

Starting Points for Practice

01

Brief Screening Questions

Food security screens (Hunger Vital Sign™), health literacy assessments, social history intake tools

02

Simple Environment Assessments

Ask about food sources, neighborhood access, cooking equipment, and daily schedule

03

Flexible Planning Strategies

Build plans with built-in alternatives — multiple paths to the same clinical outcome

IMPROVING ADHERENCE

Three Principles That Drive Results

Reduce Complexity

Every additional step in a plan is a potential dropout point. Simplify without sacrificing efficacy.

Increase Flexibility

Offer choices. Rigid plans fail when life disrupts routine — and life always disrupts routine.

Focus on Consistency

Sustainable consistency over time produces better clinical outcomes than periodic perfection.

SCOPE OF PRACTICE

Staying Within Scope

Integrating SDOH into care does not mean expanding beyond your professional role. It means practicing more effectively within it.

Recognize

Identify social and environmental barriers as clinically relevant variables

Adapt

Adjust plans and communication style to fit the patient's reality

Refer When Necessary

Connect patients to social workers, community health workers, and food assistance programs

KEY TAKEAWAYS

Three Things to Carry Forward

Compliance Is Not Enough

Adherence without context produces incomplete outcomes. Ask why, not just whether.

Context Drives Behavior

The conditions of a patient's life are clinical variables — not background noise. Assess them accordingly.

Alignment Determines Outcomes

When the plan fits the person — the environment, the readiness, the life — outcomes follow.

Final Thought

> "If the plan doesn't fit the life, it will not work."

Clinical excellence is not measured by the sophistication of the prescription. It is measured by whether the patient can actually follow it — and whether their life improves as a result.

DISCUSSION

Reflection for Your Practice

1

What barriers do you see most often?

Food access? Literacy? Time? Stress? Something specific to your patient population?

2

Where are your gaps?

Is your intake process capturing environmental and social context — or just clinical data?

3

What will you change immediately?

One question. One tool. One conversation you haven't been having.

REFERENCES

Sources & Further Reading

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Social Determinants of Health Framework. U.S. Department of Health and Human Services.

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National Institutes of Health

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Thank You

"See the whole person. That is where care begins."

— Dr. Walter E. Copeland II, DMSc, MBA, MSAN

Scan to Connect ↓