

# Community Health Navigator (CHN) Program Patient Journey

## Addressing Social Determinants of Health

### Patient

John, a 43-year-old man recently diagnosed with type 2 diabetes and hypertension. He is struggling to maintain his blood sugar and blood pressure levels due to poor dietary habits, lack of physical activity, and stress from financial instability.

### CHN Role

#### Assessment

- Meet with John to identify his challenges, including limited knowledge about managing his conditions, financial constraints affecting his ability to buy healthy food, and a sedentary lifestyle.

#### Action Plan

- Connect John with a local food bank and a subsidized healthy meal program.
- Assist in the reviewing of printed resources he has been provided by his family doctor for blood pressure management.
- Support finding a low-cost gym and accompany him to sign up.

#### Outcome

- John develops better dietary habits, incorporates regular exercise, and gains confidence in managing his chronic conditions.

## Building Self-Management Skills

### Patient

Maria, a 67-year-old woman with heart failure and stage 3 chronic kidney disease. She is overwhelmed by her complex medication regimen, dietary restrictions, and frequent appointments.

### CHN Role

#### Assessment

- Identify Maria's difficulties with understanding her treatment plan, adhering to a low-sodium and low-potassium diet, and managing transportation to medical appointments.

#### Action Plan

- Simplify her medication schedule by coordinating with her pharmacist for a blister pack system.
- Assist in connecting her with a transportation service for seniors so she can attend her medical appointments consistently.
- Start a health journal to track her symptoms, weight, and diet for better communication with her healthcare team.

#### Outcome

- Maria feels empowered to take control of her health and begins making sustainable lifestyle changes.

## Facilitating Access to Mental Health Support

### Patient

Ahmed, a 45-year-old man recovering from a recent hospital stay for a heart condition and is experiencing signs of depression and social isolation.

### CHN Role

#### Assessment

- Discusses Ahmed's feelings of isolation and the potential impact of his mental health on his physical recovery

#### Action Plan

- Connect Ahmed with a local support group for individuals managing heart conditions.
- Support him in finding a provider for mental health support and assists with scheduling an initial appointment.
- Helps Ahmed access community centers offering social activities to rebuild his social connections.

#### Outcome

- Ahmed feels less isolated, gains tools to manage his mental health, and improves his overall recovery journey.