The HUB

Improving Access to Arthritis Care Across Iowa

Chronic conditions often occur together, increasing health risks and impacting daily functioning. Arthritis is one of the most common co-occurring conditions and is a significant contributor to mobility limitations and fall risk. In Iowa, 619,000 adults are living with physician-diagnosed arthritis, representing more than one quarter of the state's population. More than half of adults in Iowa with heart disease or diabetes also have arthritis. And over one-third of adult Iowans who are obese also have arthritis.[1]

Arthritis is a leading cause of chronic pain, activity limitations, and disability.[2] Managing arthritis can be challenging, considering the complexity of the condition and the influence of social drivers that can be barriers to care, including transportation issues, cultural/language barriers, and even lack of awareness of programs and services that are available. The Iowa Community HUB has found an innovative way to help manage and prevent chronic diseases such as arthritis to ensure that everyone has access to the resources and opportunities they need to live a healthier life.

Supporting community health

The HUB supports community health by:

- Centralizing administrative support for local organizations that provide services such as food, housing support, and health programs to help them scale and sustain their impact
- Fostering clinic-to-community partnerships that extend healthcare beyond the clinic
- Partnering with residents and local organizations to raise awareness, share information, listen to community needs, and connect people to resources that support whole-person health across nutrition, physical activity, mental health, and chronic disease prevention and management
- Equipping HUB Navigators to help individuals overcome barriers to care while amplifying the voices of underserved communities

A network of diverse partnerships

Since 2019, the HUB, through its Advisory Group and its subcommittees, has created an open-network partner model, uniting more than 85 diverse partners to share their expertise, coordinate initiatives, and address community health needs collaboratively. This structure fosters strong relationships, ensures that diverse

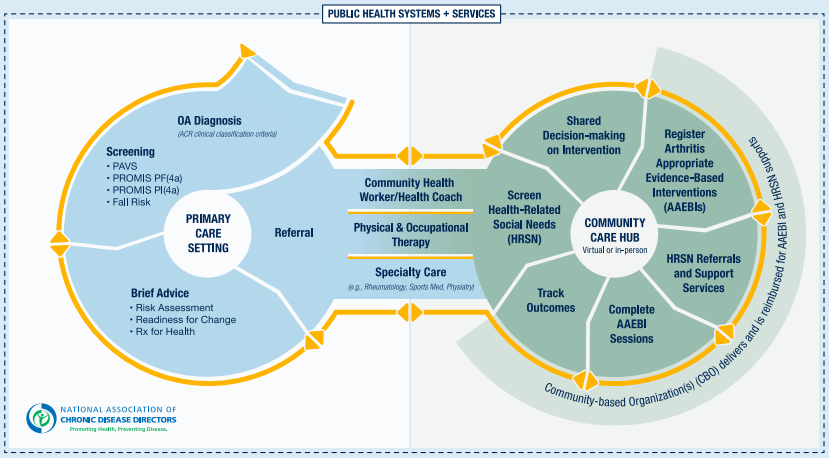
The Iowa Community HUB is a community care hub that brings together and supports a statewide network of partners dedicated to preventing and managing chronic disease, such as arthritis, by connecting Iowans of all walks of life to community health programs and support. By leading and coordinating teams focused on arthritis and falls prevention, the HUB brings together partners to expand access to and increase enrollment in Arthritis-Appropriate, Evidence-Based Interventions (AAEBIs). Healthcare providers refer patients and caregivers to the HUB, where Navigators work with them to identify specific needs and link them to the appropriate services and programs. This integrated model is especially impactful in rural and underserved areas, where access to services is limited.

The HUB and Primary Health Care presented at the 2026 Public Health Conference of Iowa on the patient journey from screening through referral into community-based programs for arthritis and falls prevention.

perspectives are represented, and enhances partners' capacity to implement and sustain community health programs across Iowa.

The HUB's ability to expand access to arthritis-focused programming, including Tai Chi for Arthritis and Falls Prevention and other Arthritis-Appropriate, Evidence-Based Interventions (AAEBIs), relies on strong cross-sector partnerships. The HUB has been working with both healthcare providers and managed care organizations (MCOs) to strengthen and support referral pathways into the HUB. As a result, a broad network of more than 600 providers across the healthcare system contributes to referrals into the HUB.

The HUB supports a network of more than 300 community partners, including those who deliver programs and connect individuals to needed resources. This network includes nonprofit organizations, public health agencies, healthcare and social service providers, and community-based organizations. The HUB also collaborates with a range of statewide partners across government, higher education, aging and disability network, advocacy groups, and professional associations. Examples of partners include



The Arthritis Care Model

The Arthritis Care Model project is a five-year initiative funded by the Division of Population Health, Healthy Aging Branch of the CDC and led by the National Association of Chronic Disease Directors (NACDD). This project aims to develop and implement an evidence-informed approach for healthcare providers managing arthritis. It establishes a comprehensive model that engages primary care providers in screening, counseling, and referral to a Community Care Hub, which matches them with evidence-based chronic disease programs and resources addressing health-related social needs.

In late 2023, a pilot study was launched in Iowa through a collaboration between Primary Health Care (PHC), Des Moines and the Iowa Community HUB. It implemented the model using a quality-improvement approach. The project emphasizes broad collaboration with multiple interest holders, including national organizations, state health departments, healthcare systems, and patients. Future plans include the development of a learning health collaborative to refine the model and promote best practices for healthy aging among adults with hip and knee osteoarthritis.

> "For Community-Based Organizations, data collection, reporting, and technology can be particularly daunting. This is an area where the Iowa Community HUB offers important infrastructure and support. [Its] unique strategy to integrate community health information with clinical health information is a key feature of the HUB that I feel bodes well for a sustainable business model."
>
> - Paul Mulhausen, MD, MHS, FACP, AGSF at Iowa Total Care

Arthritis Foundation, Easterseals Iowa, Area Agencies on Aging, and the YMCA.

What makes a strong partner for the HUB? Strong partners share a commitment to supporting the whole person, working collaboratively, and sharing information in a secure, timely, and meaningful way. They take action to remove barriers, expand access, and ensure that individuals successfully connect to the programs and services they need.

Partnership with Primary Health Care

Primary Health Care Inc. (PHC) and the HUB work together to close service gaps through innovative technology, data-driven programs, strategic partnerships, and targeted advocacy. Using fall risk screenings and electronic health record reporting, PHC helps identify individuals who may benefit from connection to the HUB.

PHC has also created a clinician alert that appears when “osteoarthritis” is added to a patient’s diagnosis. This Best Practice Alert (BPA) prompts the care team to educate the patient about AAEBIs and place a referral to the HUB, where appropriate.

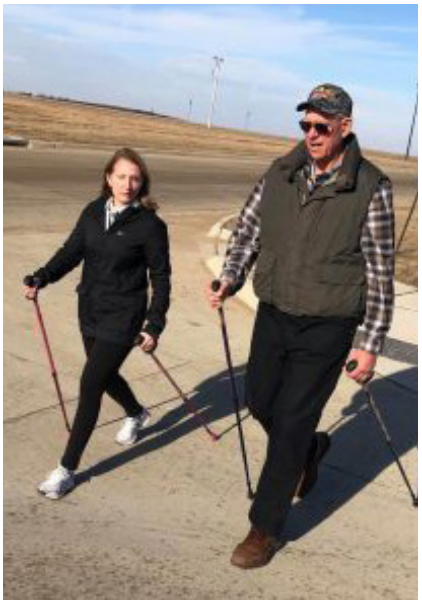
Additionally, through support from the National Association for Community Health Centers (NACHC), the Iowa team—which included healthcare providers, the COO from Primary Health Care, Inc., and leadership from the Iowa Community HUB—participated in an NACHC-facilitated 2025 Design Sprint to help accelerate the partnership between PHC and the HUB and advance arthritis work. The goal of the Design Sprint was to increase appropriate referrals to the HUB and ultimately support better outcomes for patient daily functioning and pain management that aligned with the Arthritis Care Model. This work was piloted at one of PHC’s clinics with the Nurse Care Manager trialing the process with patients diagnosed with degenerative joint disease of the hip or knee. Pain, activity limitations, and social factors were assessed, and a referral was provided to the HUB, which connected those individuals to programs in the community to increase physical activity.

> “Since partnering with the Iowa HUB, PHC has gained another intervention option that we trust will not only take a patient-centered approach to connecting PHC patients with evidence-based programs that improve their health, but the HUB will also identify and address any barriers and non-clinical factors influencing the patient’s health and connect them with resources to address them.”
>
> - Izzy Nielsen, Former Value-Based Care Program Manager at PHC

The role of the Navigator

The Navigator plays a vital role in the success of the HUB. After receiving a referral, the Navigator enters the information into the system and connects with the individual to discuss options and determine next steps together, including selecting a best-fit program. The Navigator also conducts a social needs assessment to ensure that the right supports are in place and to address any barriers to participation.

As individuals begin participating in HUB network partner programs, Navigators continue to support their journey by monitoring attendance and engagement. Navigators work with Connector Partners such as FindHelp to connect participants to additional community resources, such as transportation, to address barriers and support success.



The HUB stresses the importance of exercise, nutrition, and sleep.

The HUB also partners with Capital City Fruit to provide monthly home deliveries of fresh produce to ensure that participants in need have consistent access to healthy foods.

Measuring success

The HUB's success is measured using both objective and participant-reported outcomes.

- Functional outcomes, such as increases in activity (e.g., walking more minutes) are tracked through program attendance records and participant self-reporting.
- Feedback is gathered through post-program surveys to assess satisfaction with programs, program sites, and program leaders.
- Focus groups conducted after program completion provide valuable insights that guide screening and referral, inform navigation and program improvements, and support long-term health outcomes.

Information gathered is shared with the referring provider, closing the loop of the referral.

Looking ahead

The HUB hopes to eventually reach every corner of Iowa. A critical part of this vision is expanding screening and referral systems into rural Iowa for timely identification of health risks and seamless connections to care. Sustaining and scaling the HUB requires a strong contracting, billing, and payment system to support long-term financial sustainability for both the HUB and its network partners.

For more information about the Iowa Community HUB, contact: info@iacommunityhub.org or call 515-635-1285.

For more information about the Arthritis Care Model, contact: arthritis@chronicdisease.org.

"I completed a Walk With Ease class recently through Dallas County Public Health. The individuals participating in the class were seniors. Having spoken to them as we walked, several stated that they were food challenged with the high grocery prices. The home-delivered fresh produce boxes are certainly an added incentive to join the class in addition to the great exercise benefits to those of us with arthritis! I do hope it is something you are able to continue."

- Gene Grell, AAEBI Participant

To learn more about Community Care Hubs, check out the following resources:

Community Care Hub Overview
coveragetoolkit.org/community-care-hubs/

Clinician Resources
iacommunityhub.org/clinicians/

What is a Community Care Hub?
coe.aginganddisabilitybusinessinstitute.org/what-is-a-community-care-hub/

1. Arthritis Foundation. Iowa: Why arthritis matters. Accessed March 6, 2026. https://www.arthritis.org/getmedia/315323d5-a9a9-471b-90a1-f8d49716c90c/State-Arthritis-Fact-Pages-2019-IA.pdf

2. Fallon EA, Boring MA, Foster AL, et al. Prevalence of diagnosed arthritis – United States, 2019-2021. *MMWR Morb Mortal Wkly Rep*. 2023 Oct 13;72(41):1101–1107. Accessed March 9, 2026. https://www.cdc.gov/mmwr/volumes/72/wr/mm7241a1.htm. doi:10.15585/mmwr.mm7241a1

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