



MAPPING THE PATIENT JOURNEY

Primary Health Care – Iowa Community HUB



Introduction

Fragmented systems of care often limit patient engagement, especially among underserved populations facing complex social and medical needs. Working together through the IHI/Pfizer Collective Action Collaborative, Primary Health Care (PHC) and the Iowa Community HUB (HUB) developed a patient journey map to better understand and improve the patient experience across all stages of care coordination, from initial wellness screenings to post-program follow up.

This approach provides a structured visualization of patient emotions, barriers, and decision-making processes within the context of chronic disease prevention and health equity. The purpose of this initiative was to identify and optimize critical touchpoints where nurse care managers, community health workers, and navigators can reduce barriers, improve communication, and strengthen patient retention across the continuum of care. The journey map sought to capture how patients interpret screenings, manage fears, and navigate referrals to HUB-based social support programs.

Methodology

A qualitative, participatory design method was employed to co-create the journey map using data from patient interviews, navigator feedback, and care coordination observations. Each stage documented patient goals, emotions, questions, challenges, and provider opportunities to intervene through empathetic communication and motivational interviewing. Eight distinct stages were mapped:

Meeting with a Nurse Care Manager:

1 Patients come to the clinic with a mix of questions and concerns, seeking to understand how the care they receive will help them, how screenings relate to their health, and whether services are covered by insurance or will require out-of-pocket costs. Some worry about being judged or blamed for their health conditions, and their willingness to share information can vary day to day depending on pain, stress, or medications. Life circumstances such as unstable housing, limited transportation, and other social determinants often make health a lower priority, and some patients experience learned helplessness, feeling their actions have little impact on their health outcomes. Language barriers and limited health literacy further complicate communication, making it essential for clinic staff to approach each patient with empathy, patience, and clear guidance to ensure they feel supported and understood.

Determining Eligibility and Education

2 Patients seek support from the clinic to determine their eligibility for services, understand their health, and learn about available options for care or treatment. Patients often want clarity on the meaning of their results, whether their results are normal, and what steps they can take to reduce risk or improve their health. Many feel overwhelmed by the volume of information or anxious about trying new programs or treatment pathways, and barriers such as medical jargon, language differences, or unclear explanations can make it difficult to fully understand the significance of a diagnosis. Patients need their options explained clearly, with guidance, reassurance, and validation of their emotions and fears. They benefit from support in setting achievable health goals and learning about resources, such as the HUB, that can connect them with additional services and support systems to help navigate their care.

Referral to The HUB

3 The Iowa HUB connects patients to programs and services matched to their health needs, helping them avoid more invasive or high-risk treatments. They may have practical questions about the process, such as whether someone will reach out or if they need to call, potential costs, travel requirements or home-based options. Patients' feelings can range from excitement and curiosity about available resources to hesitation, anxiety, or even apathy due to uncertainty about HUB services. Many also face barriers such as limited transportation, mobility challenges, cost, low technology literacy, or difficulty prioritizing self-care. Providing reassurance, validating emotions and fears, answering questions carefully, clearly explaining next steps, and highlighting the support available through the HUB are all essential to helping patients feel confident, informed, and empowered to engage successfully.

HUB-Patient Connection and SDOH Screening

4 During their first meeting with a HUB Navigator, patients are screened for social drivers of health (SDOH) and begin identifying barriers that may affect their ability to participate in programs or improve their health. They often have questions about the purpose of the HUB, seek reassurance that the referral is appropriate for them, and want to know whether someone will follow up if they do not hear back from the resources they were connected to. While some patients may feel hesitant or uncertain about whether the HUB can help, this stage also begins to show them a path forward. HUB Navigators support patients by listening carefully, creating a safe and supportive environment, prioritizing the most pressing needs, connecting them to essential services and programs, and setting clear expectations for follow-up to maintain engagement and support improved health outcomes.

Shared Decision Making for Best Fit Program + Resources

5 Patients seek clear, understandable information about available programs, services, and resources and want to be actively involved in choosing options that align with their needs, values, and preferences. They often ask which programs are best for them, what is expected of them, whether there are costs, what are the time commitments, or eligibility requirements, and how participation will help them achieve their health or social goals. While many feel empowered and relieved to move from identifying problems to taking action, others feel unsure or anxious due to lack of prior experience or past negative interactions that make trust difficult. Patients need guidance and decision support, clear explanations of options and outcomes, and programs that are feasible in terms of location, timing, and cost. Walking patients through the process, simplifying steps, and maintaining connection over time helps build trust, support engagement, and ensure they can fully access and benefit from services.

Program Enrollment

6 During program enrollment, patients want a smooth and straightforward process that helps them understand what participation requires, including the program schedule, what happens if a session is missed, and whether a virtual option is available. They often have questions about what documents are needed, how long it will take to begin receiving services, who to contact for help, and whether the HUB will continue to support them after enrollment. While many feel hopeful and ready to take concrete steps toward change, others may feel overwhelmed by technical requirements, especially when facing literacy, language, or time constraints. Providing step-by-step guidance, simplifying the enrollment process, and having a trusted point of contact helps patients feel supported, more confident, and more eager to complete enrollment.

Program Participation

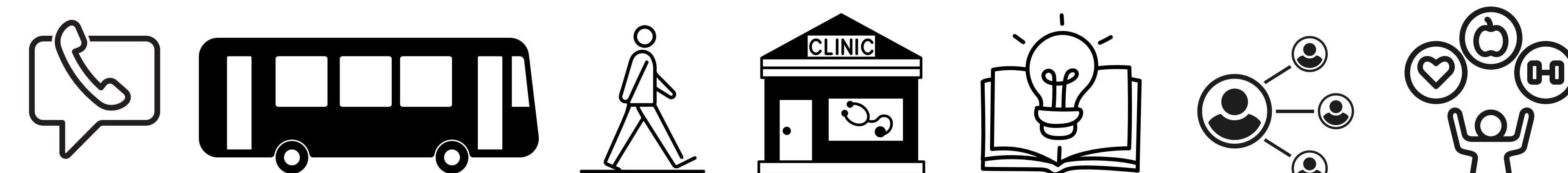
7 During program participation, patients work to follow through with activities and sessions, build confidence and skills to manage their health more independently, and ultimately complete the program while experiencing meaningful improvements in health, stability, and quality of life. They may have questions about how to handle challenges such as transportation, time, or motivation, whether their plan can be adjusted as needs change, and what happens if sessions are missed. Patients often feel excited to make progress and supported by the group, while also experiencing stress as they balance participation with other life responsibilities or frustration if progress feels slow. Ongoing support from instructors and peers, regular check-ins, celebration of small and large successes, accessible environments, and clear communication help maintain engagement. Program leaders emphasize that all progress counts, encourage self-management, and promote retention.

Post-Program Screening

8 After program completion, patients want to understand what supports and resources remain available and have a clear post-program plan to maintain the healthy habits they have built. They often have questions about what happens next, whether they can transition to additional programs if needs persist or change, and whether their healthcare provider will be informed of their completion. While many feel satisfied and proud of finishing the program, others feel nervous about losing support or fear "falling through the cracks" without continued guidance. Clear communication about progress, next steps, available resources, outcomes, and referrals, along with closing the feedback loop with providers, supports ongoing success.

Context:

Our patient is going to a Annual Wellness Appointment at Primary Health Care in Ames, IA. A Medicare Annual Wellness Visit (AWV) is a yearly, free preventive appointment to create or update a personalized, long-term health plan. It includes a Health Risk Assessment, review of medical/family history, routine measurements (height, weight, blood pressure), a list of current providers and medications, cognitive impairment screening, and a personalized, written prevention schedule.



Meet with Nurse Care Manager

Goal of the patient at this stage:

- Preventative care check in
- Access to condition management

Clinic Opportunities to Support:

- Reassure and validate feelings and concerns
- Slow down, spend the time to answer questions and educate on screenings and the implications of results
- Rapport strengthening and building
- Motivational interviewing

Referral to The HUB

Goal of the patient at this stage:

- Understand what the HUB is and how it can help
- Feel reassured, supported and confident in engaging with the HUB

Clinic Opportunities to Support:

- Validate feelings and concerns
- Encourage confidence by presenting the HUB as a trusted extension of the clinic.
- Provide clarity on next steps
- Support patients in their decisions to improve their health.

Shared Decision Making + Program Resources

Goal of the patient at this stage:

- Gain clear information about the programs and services available
- Be involved in choosing programs or services that align with their needs, values, and preferences
- Have an actionable plan for accessing programs and services
- Feel confident and supported in making decisions

HUB Opportunities to Support:

- Clearly explain available programs and services
- Provide decision support to help patient choose best fit program.
- Clarify expectations, time commitments, eligibility, and possible costs
- Through motivational interviewing, help patient develop an actionable plan

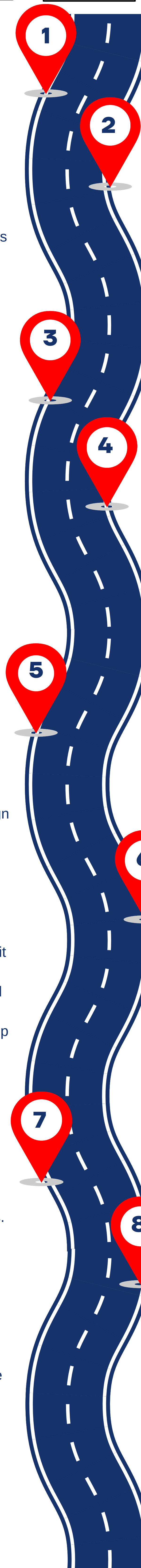
Program Participation

Goal of the patient at this stage:

- Follow through on activities and program sessions.
- Build confidence and skills for self-management.
- Complete the program
- Experience real benefits that improve health, stability, and quality of life.

HUB Opportunities to Support:

- Provide regular check-ins to keep the patient motivated and engaged.
- Help patients address new barriers that may come up during program participation
- Celebrate successes (big and small) to build confidence and reinforce commitment.
- Encourage self-management skill building
- Support program instructors as needed for improved patient experience



Determine Eligibility + Education

Goal of the patient at this stage:

- Seeking clear understanding of results
- Eager to improve health outcomes
- Learn about available options

Clinic Opportunities to Support:

- Explain options clearly and give guidance
- Validate feelings and concerns
- Help patients set achievable health goals
- Introduce the HUB and its programs and resources

HUB - Patient Connection

Goal of the patient at this stage:

- Prioritize health and social needs
- Explore resources that could impact health
- Feel comfortable sharing openly and build trust with HUB

HUB Opportunities to Support:

- Create a space where patient feels heard, respected and safe sharing sensitive information
- Guide patients in focusing on the needs that matter most to them.
- Provide immediate connections to essential services (food, housing, transportation, utilities)
- Plan regular follow-up to keep patients engaged

Program Enrollment

Goal of the patient at this stage:

- Understand what participation requires
- Complete enrollment
- Identify who to contact for help or questions
- Learn how to best prepare for the start date of the program

HUB Opportunities to Support:

- Assist the patient through the enrollment process
- Offer reassurance and answer questions
- Simplify technical, language, or literacy challenges
- Provide a consistent point of contact

Post-Program Screening

Goal of the patient at this stage:

- Understand what supports or resources are available after program completion
- Have a post program plan to maintain new healthy habits

HUB Opportunities to Support:

- Measure outcomes and celebrate achievements
- Connect them with another program that will further support their progress.
- Provide additional warm handoffs as needed
- Ensure healthcare providers are informed and close the feedback loop

Objective

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

1. Describe how the PHC-HUB patient journey map identifies emotional, structural, and communication barriers across the continuum of care for patients facing social and health challenges.

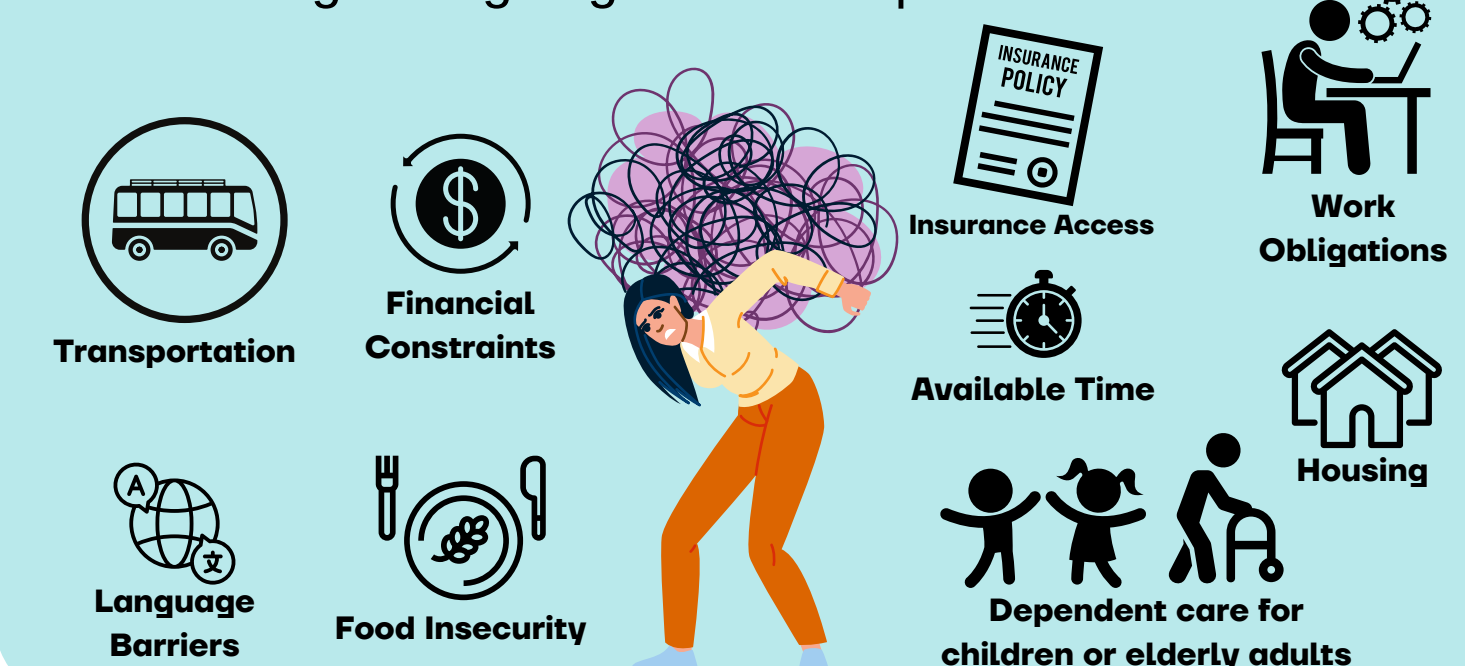
2. Analyze how nurse care managers, community health workers, and navigators can address social determinants of health (SDOH) to improve coordination and continuity between clinic and community systems.

3. Apply key learnings from the PHC-HUB patient journey mapping experience into practical strategies for building more engaging, trusted, and equitable care workflows.

SDOH

Social Determinants of Health (SDOH) are the social, economic, and environmental conditions in which people are born, live, work, and age, and they have a significant impact on health outcomes.

Individuals who experience unmet SDOH such as unstable housing, food insecurity, limited transportation, lack of insurance, language barriers, or discrimination often face additional obstacles to accessing care. These barriers can make it difficult to seek healthcare due to cost, time constraints, mistrust of healthcare systems, limited availability of culturally responsive services, and competing priorities for basic needs. As a result, health concerns may be delayed or go unaddressed, contributing to ongoing health inequities.



Results

- Patients experience a range of emotions and barriers throughout the journey.
- Follow-up, validation, and personalized support builds patient confidence and engagement in care.
- Step-by-step guidance improves participation.
- HUB interventions connect patients to critical resources.
- Patients can develop skills and self-efficacy with community programs
- Providers report better care coordination and greater confidence in community referrals.
- Long-term engagement requires continued support.

Analysis

The patient journey highlights the importance of clear communication, coordinated workflows, and consistent support as patients move from screening and referral to program completion and follow-up. Patients benefit most when processes are simplified, expectations are clear, and clinic and community teams remain connected throughout the experience. By aligning these systems and maintaining patient-centered support, the model improves engagement, strengthens care coordination, and helps patients translate referrals into meaningful health outcomes.

Conclusion

The PHC-HUB patient journey map offers a replicable framework for integrating community and clinical processes using a patient-centered design approach. This integrated approach fosters trust, clarity, and accountability among patients, healthcare teams, and community partners. Beyond improving care coordination, it advances public health equity goals and supports the statewide incorporation of social care into preventive and chronic disease management models.

Key Sources & Acknowledgements:

*Mapping the Patient Journey was peer reviewed by program participants who have experienced the process from patient screening to the completion of community-based programming.



Sources, References, & Digital version of the Journey Map:

SCAN ME!

