

OREGON ACADEMY OF FAMILY PHYSICIANS · MAY 2, 2026 · BEND, OR



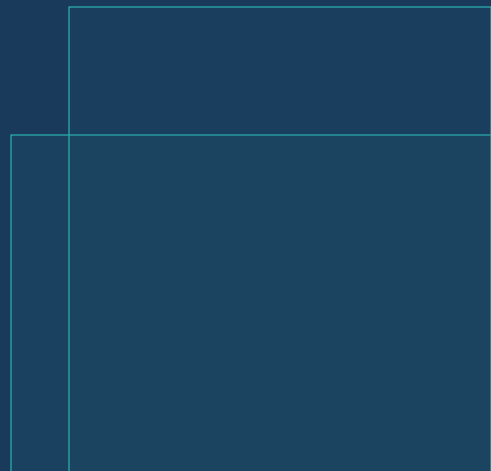
ROOTED IN COMMUNITY

BEYOND SILOS:

The Patient Journey Across the Continuum

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Redesigning Care for the AI and Value-Based Era

I have no actual or potential
conflict of interest in
relation to this presentation

NOVELLA
INSIGHTS

About the Speaker

- **Chief Medical Officer**

Legacy Mount Hood Medical Center

- **Medical Director**

Legacy Medical Home

Legacy GoHealth Urgent Care

ZOOM+Care

- **Entrepreneur & Consultant**

Novella Insights

- **Primary Care Physician & Residency Faculty**

Legacy Internal Medicine

What's Wrong with Silos?

You're comfortable.

You know exactly what to do.

You don't have to think about the big picture...



THE PROBLEM

Your patient is walking a tightrope between every silo in the system



We only see one slice. The patient lives all of it.

What We'll Cover

01

The Patient Journey

Across the continuum – home to hospital and back

02

Lean Process-Mapping

Identify delays and failure points

03

Human-Centered Design

Patients as activated consumers

04

Future Directions

VBC, AI, and beyond

05

What Can You Do Monday?

Concrete action steps and takeaways

What You'll Be Able to Do



Understand how to apply Lean process-mapping to identify failure points and transition risks across the patient journey



Use a Human-Centered Design framework to recognize how patient profiles — including attitudes toward tech, communication, and healthcare — shape the clinical encounter before the visit



Identify at least one concrete, practice-level intervention to improve the patient journey from either a Lean or Human-Centered Design perspective

01

Walking the Full Patient Journey...

and why should we care?

What is the Patient Journey Anyway?

**Physical Settings /
Events the Patient
Moves Through**



**Experiences They Have
Along the Way**

Shaped by their values, preferences, and prior experiences

Why is Understanding the Journey So Important?

Better care, better relationship, better clinician experience



Actual care improves

Expose bottlenecks and failures, mitigate known risks during transitions



Better patient experience → more therapeutic relationship

A patient who feels heard and respected is more receptive, adherent, and likely to heal



Reduces clinician frustration

Understanding patient behavior can help us feel more compassion

Why is Understanding the Journey So Important?

In a **VALUE-BASED CARE** environment, we are incentivized for good health outcomes (not more services)



Improved care → incentive payments

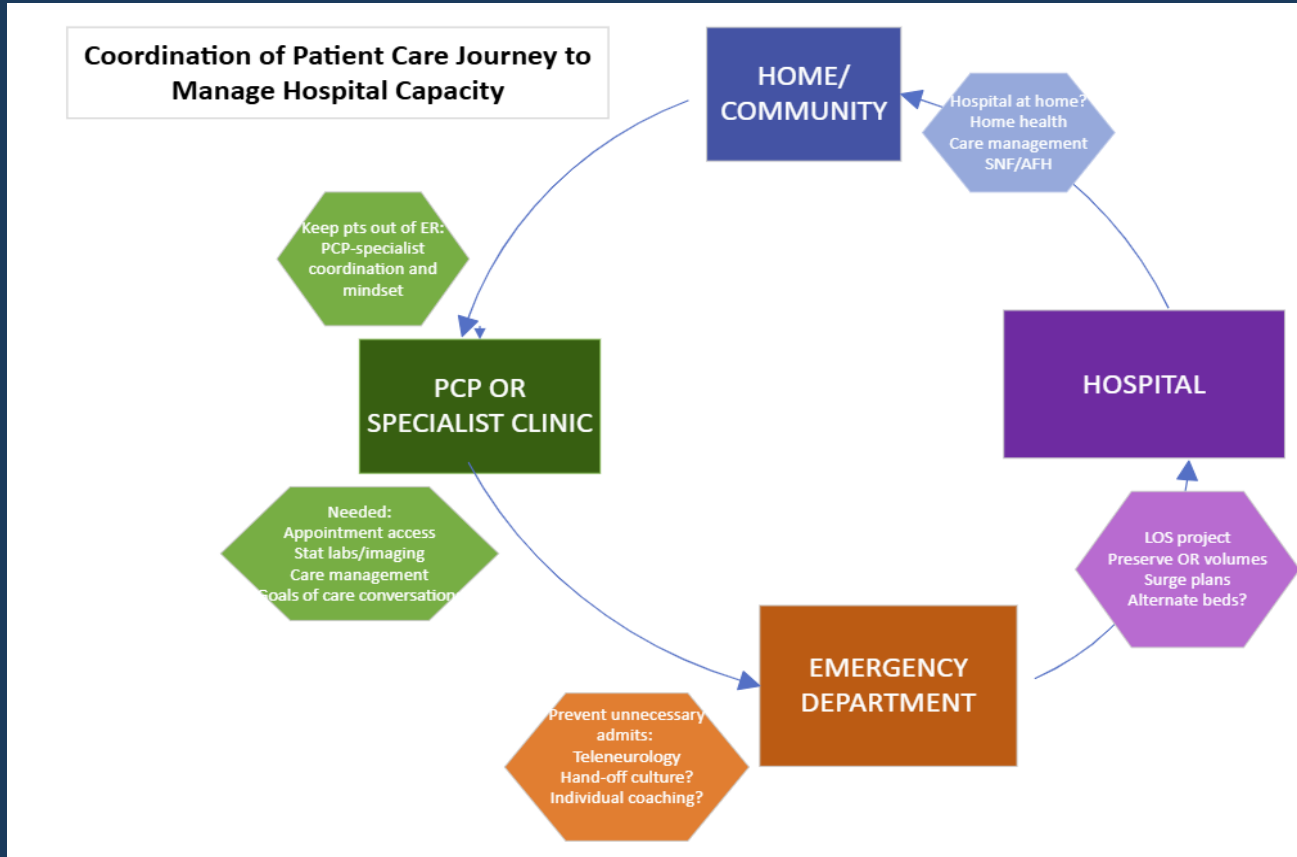


Margin = Mission = Purpose

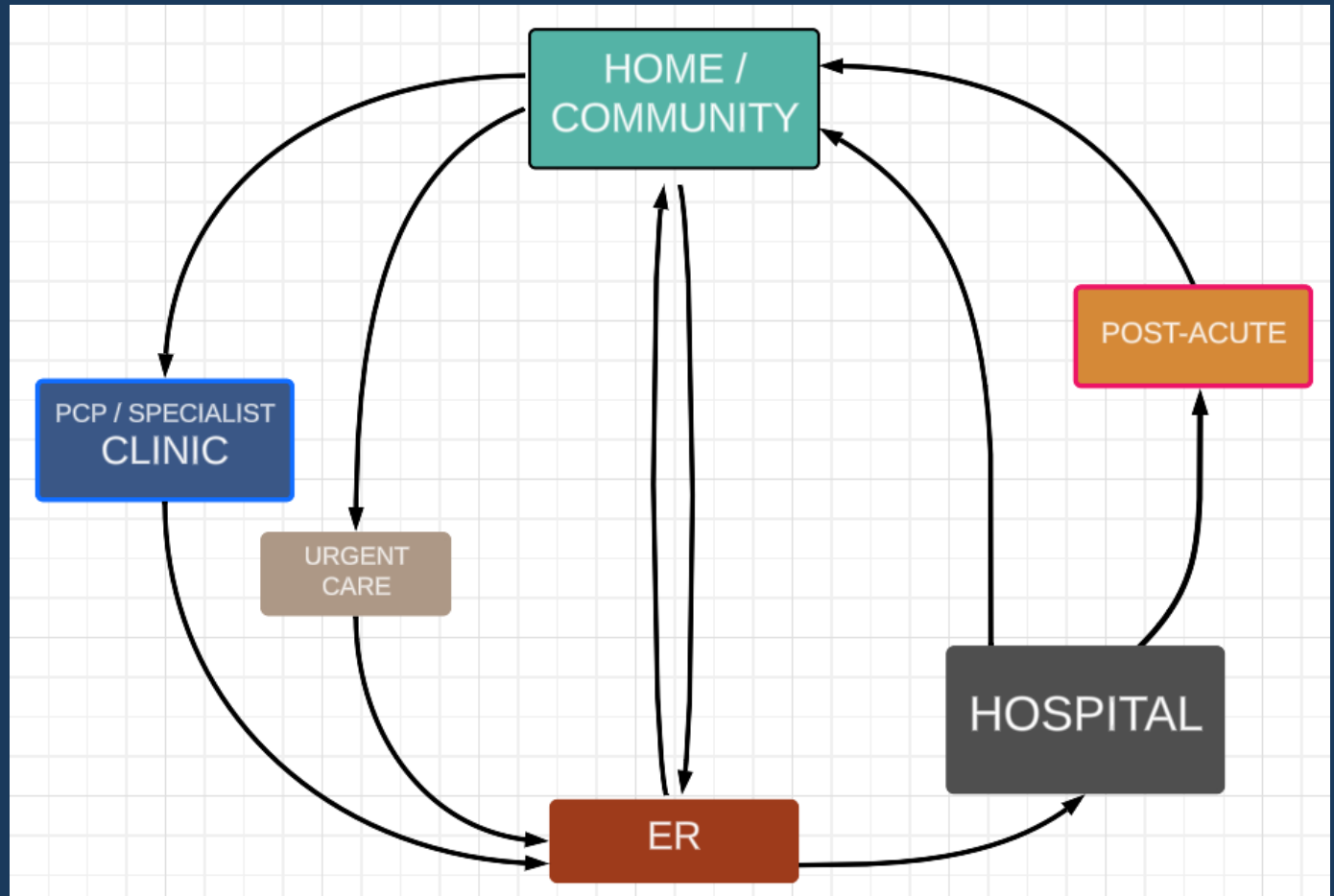
Where Does the Patient Journey Begin?

(When Does a Person First Become a Patient?)

Old Thinking



New Thinking



When Does a Person First Become a Patient?

Google, AI, Social Media

Searching symptoms at 11pm, asking Claude or Chat GPT Health, reading patient forums, going on TikTok, Facebook, or Insta...

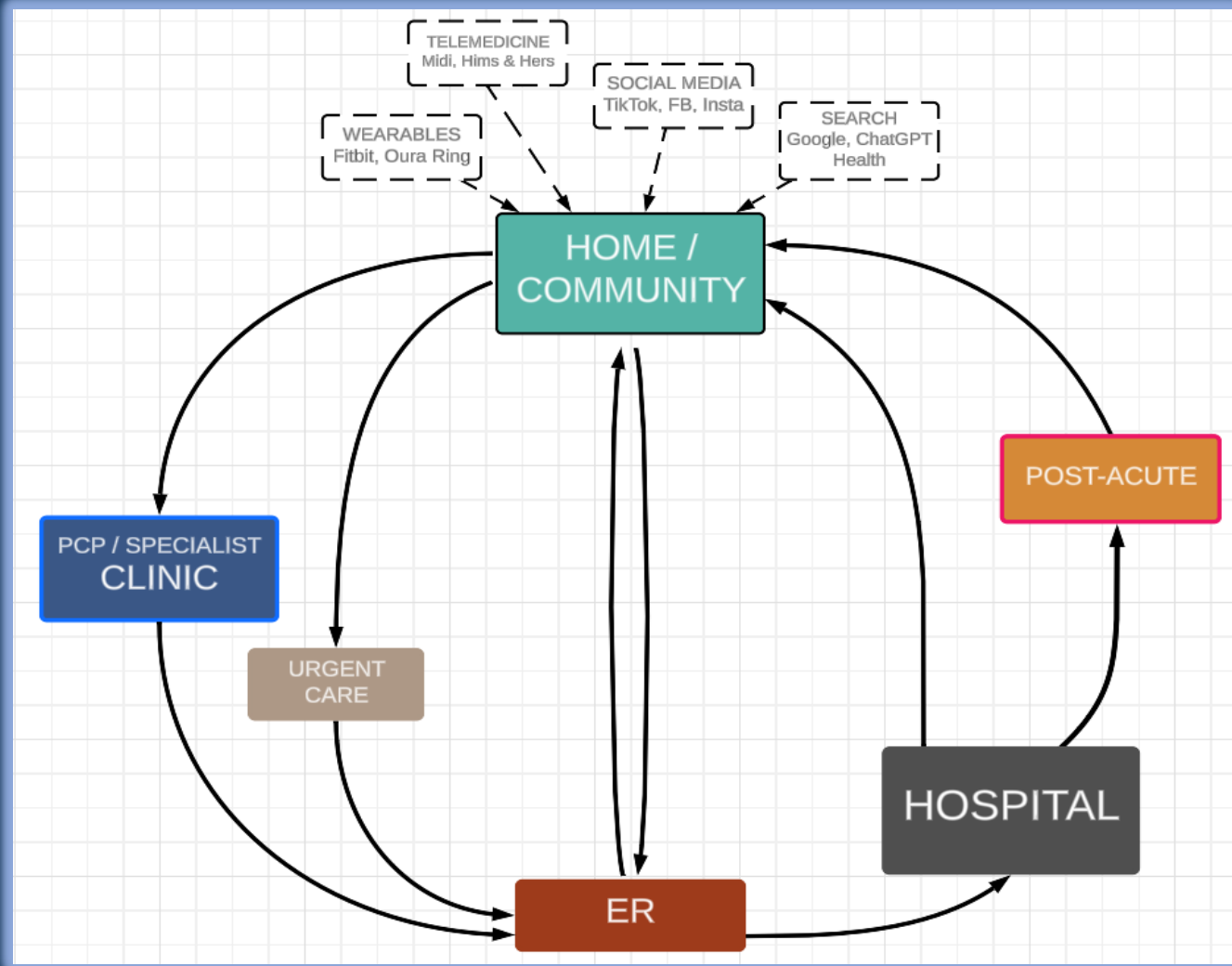
Home Data

Checking Oura ring HRV, CGM readings, blood pressure cuff trends

Network

Texting a friend about perimenopause symptoms, getting a recommendation

Newest Thinking



02

Lean Process-Mapping One Patient's Journey

Meet Mr. Mason: what does his “GoPro” Show?

81-year-old man

- Lives in his car — by choice
- PMH: Chronic heart failure, HTN, DM, Afib, edema with wounds
- Complex med list: coumadin, furosemide, amiodarone, amlodipine, empagliflozin, atorvastatin, etc.
- Hasn't seen PCP in 2 years
- Two adult children, one local



Car → ER → Hospital → Daughter's House

01

His Car

Edema, dyspnea worsen. New bloody diarrhea

02

The ER

Presents in acute HF, with AKI and GI bleed. Hb 8.4, Creatinine 2.3, INR 9

03

Admitted

Colonoscopy, IV iron, PRBCs. Warfarin, ASA, amlodipine, empagliflozin held

04

Discharged

To daughter's house: meds have been adjusted, BPs are soft, no follow-up labs planned. Fortunately they scheduled a follow-up...

No discharge summary or final med list

The everyday conundrum: heart vs. kidneys. Start Torseamide or not?

Start Torseamide?

- ✓ HF needs diuresis, previously on furosemide
- ✓ Edema, labored breathing, coarse sounds
- ✓ Likely intended by hospitalist

Hold off on Torseamide?

- ✓ AKI + soft DBP of 46 at home
- ✓ Last Creatinine 1.95 at discharge, Na 132
- ✓ Could check BMP first

Plan at Clinic Visit

Managing Everything Else....

- **“He can’t live with me forever”** → SW referral
- **“He’s depressed, does he need a medication?”** → PHQ 9 next time
- **“He doesn’t seem to want to live, can he make his own decisions?”** → Discussion of capacity and values
- And....CXR, start diuretic and recheck BMP in 1 week, BP med adjustment and BP log, stay off anticoagulants, stool studies for ongoing diarrhea...

40-minute visit

Just barely enough time to dig in.
Still ran late.

20-minute visit?

Forget it. This patient gets lost.

What Is Process-Mapping?

Lean comes from manufacturing — Toyota, airlines — but we can learn from it in healthcare

Respect for People

Go to where the work happens. Listen to the people doing it

Find the Waste

Delays, rework, redundancies, failure points

Focus on Safety

A safe, reliable process protects patients at every step

Map the Work

Visualize every step, delay, and branch point — don't assume

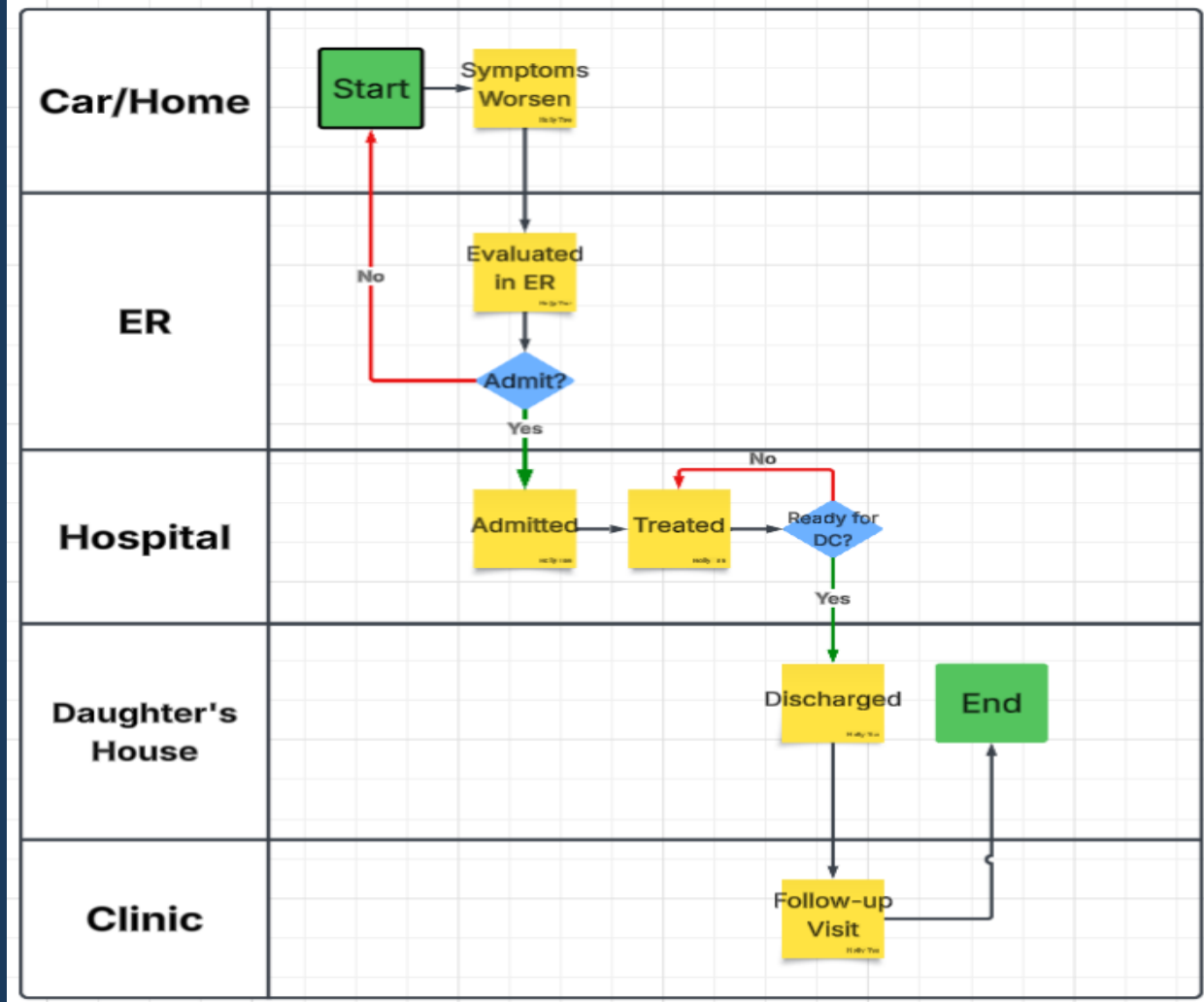
See → Solve → Share

Identify the problem, fix it at the root, spread the learning

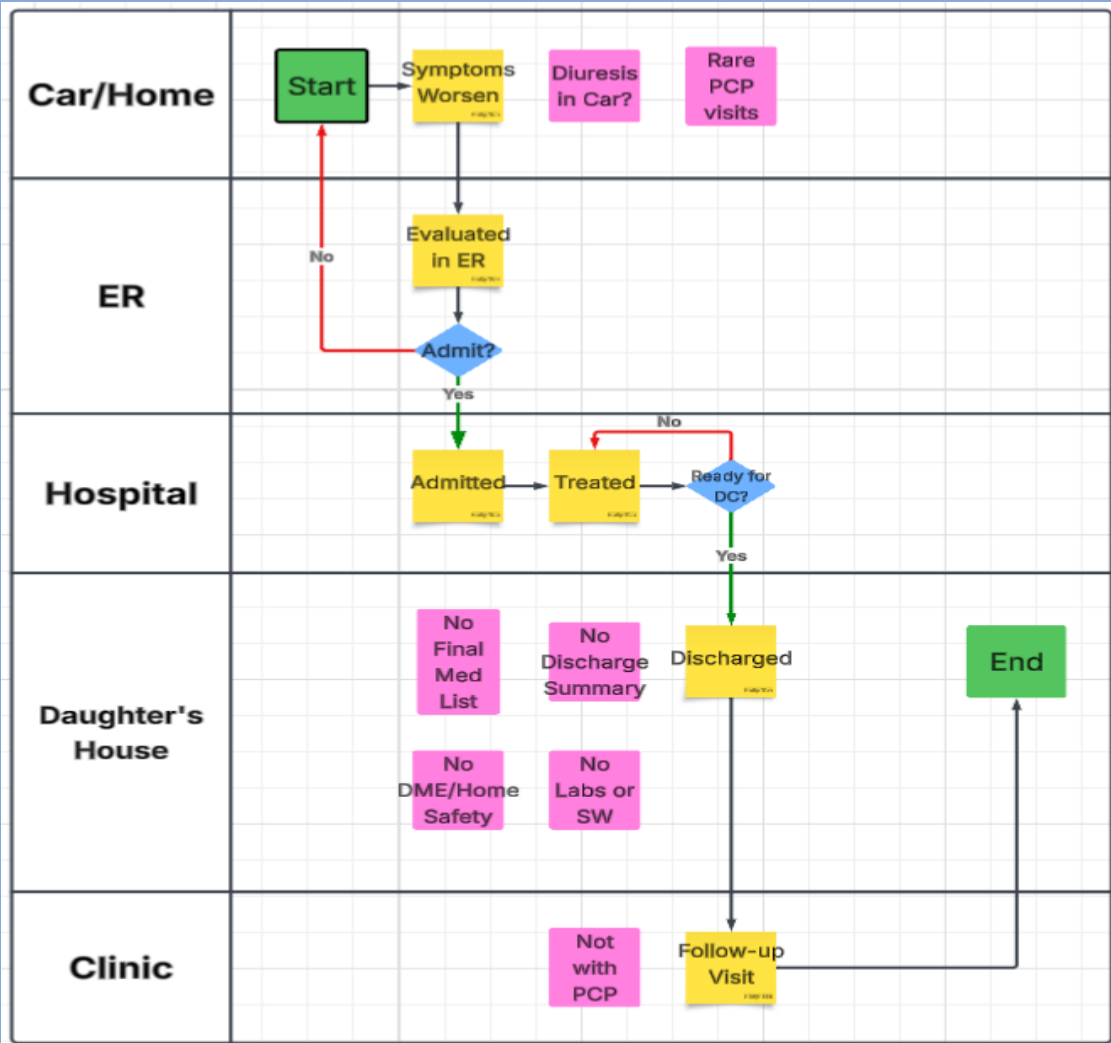
Not Dehumanizing

Not a conveyor belt — it's about making risky steps safer

Basic Map



Failure Points Added



How to Process-Map

The Color Language



Green square

Start / End of process



Yellow square

Process step



Blue diamond

Yes / No decision



Pink square

Delay, risk, or failure

Practical Tips to Make Your own Map

- Watch a 5-minute process map video first
- Define your lanes: patient, MA, PCP, specialist
- Define start and end points before drawing
- Explore Yes branches first, add in No branches, then pink failure points
- Use sticky notes, write in pencil, move things around
- Try it at a provider meeting, then add in the staff perspective

Map reality, not the ideal process!

Common Failure Points Across the Continuum

01

At Discharge

- No discharge summary to PCP
- **Formulary substitution for home meds**
- **Critical Rx not filled before leaving, or supply x 1 week**
- Home health can't start for a week, needed DME missing

02

At Transitions

- **Med reconciliation: "any changes?"**
- No PCP follow-up made
- **Interoperability**—can't search Care Everywhere or see other EMRs

03

In the Clinic

- Instructions too complex for patient to absorb
- Capacity/guardianship gaps not caught
- **Post-hosp no-show, no outreach**

Talk with a Neighbor

Share a story of a breakdown during a patient's journey — and what effect it had on their care

Think of a transition, information drop, or med switch...

We'll hear a few stories before diving into our second patient case

03

Seeing the Patient Through Human-Centered Design

and how it helps

We've Looked at WHAT Gets Dropped...

Now let's look at WHO the patient is:

Human-Centered Design

A framework that puts the person being served at the center — not the system doing the serving. This means designing care around how real patients (people!) communicate, make decisions, and experience the world

Because patients are now consumers, whether we like it or not...

How can Human-Centered Design Benefit Us?



1. Understand WHO our patient is

Knowing factors that drive behavior can help us take it less personally and feel more compassion



2. Understand WHO WE are as PATIENTS

Knowing our own profile as a patient may improve our healthcare experience



3. Understand WHO WE are as CLINICIANS

Our clinician profile doesn't align perfectly with every patient, and that's okay

Patients Vary Along Dimensions

Tech-savvy



Tech-averse

Proactive



Laissez-faire

“Wants the best”



“Wants care local”

A few axes to consider

Patients Vary Along Dimensions

Transactional



Relationship-focused

Western medicine



Complementary care

High trust



High skepticism

Universal: Everyone wants to feel respected and genuinely cared for

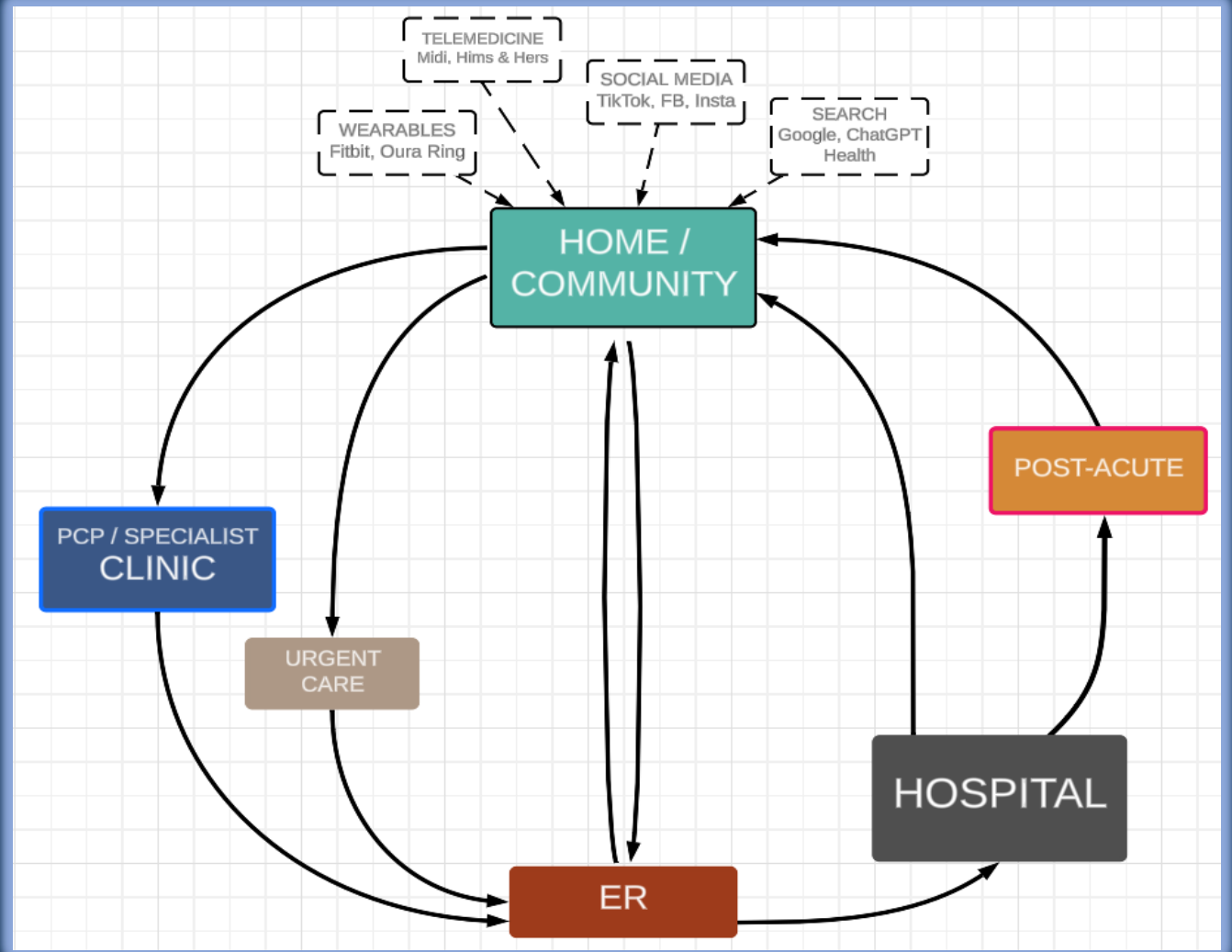
Meet Our Second Patient: Ms. Chang

65-year-old woman

- No primary care physician
- Arrives with her own research done
- Tech-savvy, proactive, data-focused, transactional
- Uses wearables, AI tools, social media, and her network
- High skepticism, self-advocacy, wants the best



Ms.Chang's Journey



Getting to You

1. Finding a PCP

Confusing insurance website. Next available appointment is weeks out

2. The Intake Forms

REALD / SOGI questions feel invasive. Why are we asking if she has enough food? Vaguely insulted

3. The Weigh-In

MA didn't let her remove shoes. She didn't want to know her weight

4. Topic-Limiting

"I'm here for sleep issues, but the MA said I can't talk about my sinuses"

5. "What Brings You In Today?"

You ask — after the MA already asked. Aggravation comes off as uncooperative

The Workup & Beyond

Order breast U/S

Call each imaging center separately, though she's willing to drive anywhere

Results arrive

You're on vacation. Covering provider misses it. Two weeks pass

Diagnostic mammo needed

Delay already eroded trust. She's told three people the same story

Breast specialist referral

Different EMR. Records transfer delayed. Appointment 6 weeks out

Surgery & Recovery

Follow-up in clinic months later, where you try to rebuild the relationship

A Customer Service Failure

The Story

Describe a customer-service failure on a patient journey (yours, a loved one, or a patient). Focus on the parts that were within someone's control

The Fix

What's one thing that could have made this better? Brainstorm with your partner

We'll debrief together — then move into HCD for US

Who are YOU as a PATIENT?

- Maximalist or minimalist?
- On top of all your health maintenance, or putting off that mammogram?
- “Be your own doctor” vs. let them?
- Quantified self vs. just trying to get some steps at lunch?
- Bring on acupuncture and chiropractic, or just PT?



Who are YOU as a CLINICIAN?

- “Kitchen sink” vs. watchful waiting?
- Refer early, or do everything you can first?
- Relational or transactional?
- Lifestyle / prevention vs. fancy treatments?



04

Where the Patient Journey Is Heading

VBC , AI, and Beyond

The Journey Is Getting More Complex

01

Shift to Value-Based Care

Better journeys → better outcomes → better performance

VBC makes the patient journey a financial and clinical priority simultaneously

02

Patients as Consumers

The concierge surge isn't a niche trend. Patients are exercising more choice — and comparing you to Midi, Chat GPT Health, and Door Dash, not just other clinics

03

Access as the Bottleneck

With easy access to information and retail telehealth, every friction is a potential loss. Patients who can't get in easily will go elsewhere — or go without

“Dr. AI” on the Patient Journey

01

“Dr. Google” on Steroids

Home data becomes clinical data. The journey starts in the bathroom. Claude and ChatGPT are first-line triage. Patients arrive with Ddx and requested tests

02

Agentic AI Outreach

AI schedules calls, does pre-visit data collection and questionnaires, post-discharge check-ins. How will patients react?

03

Patient- Controlled Data

Patients may soon carry complete health records and graphs of wearable data, bypassing interoperability problems entirely

Connecting the Dots Across Pharmacy, Home, and Clinic

The failure points we mapped? AI can be trained specifically to watch for them

Pharmacy integration



Pharmacy data feed shows Mr. Mason never picked up diuretic + rising weights at home + vague portal message. Alert triggers outreach by clinical team → diuretic on board. ER visit for HF exacerbation is prevented. Failure point of "med not filled at discharge" is solved proactively

Predictive analytics



The 80/20 rule: 80% of the complexity comes from 20% of patients. AI can identify high-risk individuals before they crash — based on SDOH, visit frequency, medication gaps, and comorbidity patterns. Your highest-risk patients get proactive outreach before they call 911

05

What Can You Do Monday?

From frameworks to action

What is one solution you can implement?

Lean Lens

- Run list of post-hospital discharges — who needs a follow-up? Better yet, a protocol
- Process-map one workflow at your next team meeting (even on a whiteboard)
- Proactive follow-up for patients who no-show post-hospital
- Ask your MA: where do things slip during med reconciliation?

HCD Lens

- Fix one friction point in your intake process
- Don't say "What brings you in today?"
- Consider how patients with different profiles find your practice
- Explore your own HCD profile as a patient and clinician
- Try to categorize your next challenging patient along a few axes — observe how it changes your emotions
- Review patient satisfaction surveys and complaints for patterns (gulp)

KEY POINTS

Six Takeaways

1 A smoother patient journey is more therapeutic — not just more pleasant. Better relationships, better outcomes, better for us

2 Mapping the journey (settings/events + experience) makes fragmentation and risk visible and fixable

3 Human-centered design helps us understand our patients AND ourselves

4 We work within a broken system, but understanding the journey can foster more compassion

5 The shift to VBC makes the journey even more important: better outcomes improve the margin that supports your mission

6 Tools in your toolbox: process-mapping and human-centered design lens

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