CASE STUDY

THE VALUE METER

Redesigning how care work is defined, tracked, and prioritized across 85 patients

ROLE	COMPANY	DOMAIN	STATUS
Lead Product Designer	Pair Team	AI-First Healthcare	Prototyped – Tested

THE PROBLEM

85 patients, and no way to know what mattered next

Care managers, called LCMs, were asked to manage caseloads of up to 85 patients. The existing system could tell them work needed to be done. It could not tell them **what to do next, in what order, or how much value it would deliver**.

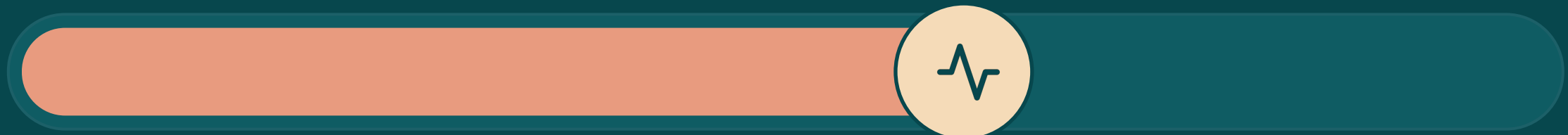
> ***The system knew that work needed to happen. It had no idea whether the work was happening, whether it had happened, or whether it was the right work at all.***

The same intervention might be completed in three steps by one LCM and eight by another. There was no consistent definition of what done even meant.

THE CORE INSIGHT

Every patient has a meter.

It diminishes with time. Every action a care manager takes **replenishes it**. The goal: keep every patient's meter as full as possible, across a caseload of 85.



Decreases with time

Increases with value delivered

WHY IT MATTERED

One idea, aligned three functions

To reframe the problem for the team, a mental model was needed that could align **engineering, product, and clinical leadership** around a single idea. The Value Meter made abstract care quality visible and actionable, before development began.



Engineering

A clear, buildable target: calculate and surface meter state for every patient



Product

A shared language for prioritization that didn't require re-explaining each sprint



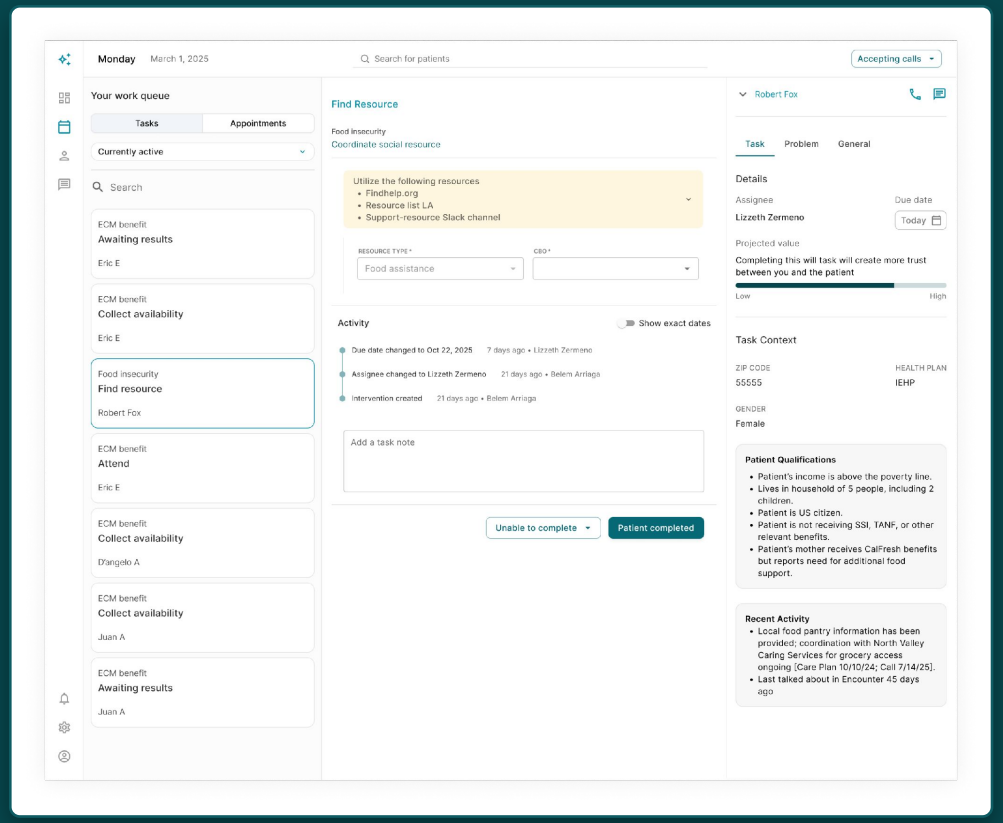
Clinical Leadership

A model that matched how care already worked, intuitively, not a new process to learn

This alignment held before a single line of the new system was built.

WHAT WAS BUILT

The meter, made visible in the queue itself



The work queue on the left surfaces tasks **ranked by projected value**, not just listed by intervention. An LCM opens their day already knowing what matters most across their caseload.

Inside each task, a **projected value gauge** (low to high) makes the meter concept concrete: this task detail card shows, in the shipped product, exactly the model described on the previous slide.

10 Lead Care Managers tested this interface before build was finalized

THE ROOT CAUSE

Interventions said something needed doing. Tasks said how.

Arc organized work as **Interventions**, high-level states like “Coordinate dental care.” These were status flags, not actionable units. They told an LCM that something needed doing. They said nothing about how.

BEFORE, INTERVENTIONS

- Coordinate dental care: Schedule
- Coordinate social resource: Complete intake
- Coordinate PCP appointment: Schedule
- Create care plan

AFTER, DISCRETE TASKS

- **Find dental provider**
- **Call to schedule appointment**
- **If no response: leave voicemail**
- **Send update to patient**

THE ARCHITECTURE

Three structural changes, one flexible system



Branching logic

Each task outcome determines what comes next. Did the patient pick up? Branch to schedule or voicemail.



Timing logic

Interventions define delays between tasks. A voicemail today surfaces the next outreach in two days, not immediately.



Dependency logic

Downstream tasks don’t appear until upstream conditions are met. A care plan task waits for onboarding to complete.

THE CONNECTION

Task flows are dialogue trees wearing a clinical vocabulary

Each decision node asks a question. Each branch represents a possible response. Each terminal node is a completed interaction. The vocabulary is clinical, but the discipline is **identical to designing dialogue trees** for a conversational AI system.



> ***"Designing how a care manager moves through a patient interaction, question by question, decision by decision, is the same cognitive work as designing how an AI moves through a conversation."***

The task detail view in Arc made this explicit: each card surfaced exactly the information needed for that moment, no more, no less, and presented a structured set of next actions. The LCM was, in effect, following a conversation flow the system had designed for them.

OUTCOMES

What changed, once tasks replaced interventions

Consistent work definition

Every LCM operates from the same task definitions, eliminating the variance in how interventions were completed across the team

Measurable value delivery

For the first time, the system could track what work had been done and calculate meter state per patient

Intelligent prioritization

With tasks as the atomic unit, the system could surface the highest-value next action across all 85 patients

Reduced cognitive load

Care managers no longer had to hold the question of what comes next in their heads. The system carried it

STATUS

Prototyped – Tested

Designed and aligned across product, engineering, and clinical leadership before development began. **The task decomposition model and dynamic flow architecture were fully specified and tested with 10 Lead Care Managers**; build was underway at the time of departure.

The clearest sign the model worked: engineering could build against it without the room ever wondering what "done" meant.