



DESIGNING FOR HEALTH

THE HUMAN-CENTERED APPROACH

THE BONUS CHAPTER

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HEALTH BEYOND HOSPITALS

Let's get something out of the way right now: when most people hear the word healthcare, they don't picture their living room. They think of white coats, fluorescent lights, beeping machines, and that smell that's half bleach, half mystery. They think of hospitals and clinics, not kitchens and couches. That makes sense; our system is built that way. For decades, healthcare has been delivered where the care is: inside facilities, institutions, and physical places designed around doctors and nurses, not patients.

But that's changing. Or, at least, it needs to. Because here's the truth: most of what actually determines your health doesn't happen in a hospital. It happens in the in-between moments: what you eat for breakfast, whether you remember to take your meds, if your blood pressure monitor is working, if you slept well, if you can get down the stairs without falling, and whether someone actually notices when you can't.

The home is where health lives. And increasingly, it's where healthcare is delivered. One home-based pilot program used discreet motion and door sensors to track daily routines in older adults. When the system detected subtle changes, like fewer bathroom visits or a change in wake-up time, it triggered a follow-up, uncovering early issues like infections or mobility decline. A companion study of community-based home modifications showed in-home falls dropped by nearly 40% after simple changes: things like better lighting, grab bars, and non-slip flooring. That's healthcare happening in the background, designed around real life.

Now, that sounds innovative until you realize it's not really a new idea at all. Remember that doctors used to make house calls. What is new, though, is the scale of what's possible. Thanks to technology, broadband, and a cultural shift catalyzed by (you guessed it) a global pandemic, we're now able to bring meaningful care into people's homes, not just sporadically, but systematically. **That's where human-centered design comes in.**



Designing healthcare systems for the home isn't just about shipping out a blood pressure cuff and calling it a day. It's about rethinking how we serve people in the places they live: places not designed for IV poles and wound vacs. It's about designing workflows, technology, and touchpoints that fit into real lives, with all their glorious messiness. (Pro tip: the average kitchen counter is not sterile. Shocking, I know.)

This chapter is about that shift. We'll explore how human-centered design – when done right – can make home-based healthcare safer, smarter, and more dignified. We'll look at how remote monitoring can be more than just data capture. How aging in place can actually support health instead of quietly eroding it. How post-acute recovery can be smoother and less bewildering. And how managing chronic conditions at home doesn't have to feel like a full-time job with no benefits.

Along the way, I'll bring in the voices of a few folks who've thought deeply about this. People like Brian Urban, a long-time strategist focused on healthcare innovation, who understands what it takes to make remote care not just possible but personal. And Dr. Diana Anderson, an architect and physician, who reminds us that the built environment is not neutral; it either heals or it hinders.

This is the chapter that was missing from the book. If we're serious about designing for health, we can't ignore the place where health actually happens: home.





PRINCIPLES OF HUMAN-CENTERED DESIGN APPLIED TO THE HOME

If you've read the rest of this book (and if you haven't, I'm not angry, just very, very disappointed), you know that human-centered design (HCD) is not about making things look nice. It's about making them make sense for the people who use them, in the places where they use them, at the times they actually need them. It's about designing systems and tools that work with human behavior, not against it. It's also about respecting that most humans, even the highly trained ones, are tired, distracted, overburdened, and occasionally make mistakes because that's what humans do.

Nowhere is this more apparent than in the home. Healthcare delivered in the hospital has the luxury of infrastructure: signage, sterilization, supply closets, nurses' stations, specialists a page away. In the home? You've got a nightstand, a confused golden retriever, and a stack of discharge paperwork that is often confusing and written at a high-reading level.

That's why HCD is not a "nice-to-have" when we move care into the home; it's essential.

Let's revisit a story I've told before (see Chapter 1) because it illustrates this beautifully (and painfully). A young mom was sent home with a nebulizer to treat her toddler's wheezing. The instructions were, technically speaking, "clear". They included the medication names, the dosages, and how often to administer them. But no one adequately explained that there were two medicines that needed to be mixed together: albuterol and normal saline. She gave only the normal saline (aka salt water) for days, and the child's asthma never got better. She made this mistake not because she was negligent, but because the system was.

The problem wasn't the device. Or the medications. Or the mom. **The problem was the design.**



A human-centered approach would have asked: Where will this medication be stored? How will she tell the vials apart? What's the lighting like at 3 a.m.? What if she's holding a squirming toddler in one arm and reading instructions with the other? These are not hypotheticals. They are the context in which health happens.

When we apply human-centered design to home-based care, we prioritize clarity, accessibility, and empathy.

That means:

- **Reducing cognitive load** – If instructions require higher education or a quiet room for contemplation, they won't work.
- **Designing for distraction** – Because no one administers meds at home in a perfectly calm, silent, well-lit environment.
- **Testing with actual humans** – Not just clinical experts or engineers, but the people who will use the tools while juggling life, laundry, and (let's be honest) probably a little panic.

Crucially, human-centered design isn't about making everything foolproof. It's about assuming that even smart, capable people will be tired, overwhelmed, or just unfamiliar with medical jargon. It's about removing the "gotchas" from the system, those tiny traps that can cause big harm.

And here's the kicker: doing this well doesn't just make things safer. It makes them faster, more efficient, and more likely to be used the way they're intended. Which means better outcomes. Which means fewer readmissions. Which means cost savings. Which means we stand a good chance to make healthcare better.

So, before we dive into the specifics of remote monitoring, aging in place, post-acute care, and managing chronic conditions, let's agree on the ground rules: if it's going into someone's home, it has to make sense in the home. Not in the lab. Not in the product demo. Not in the boardroom where someone approved the budget. In the home. Because that's where people are. That's where their lives happen. And that's where our design has to meet them.



THE HOME AS A HEALTHCARE HUB

Let's talk about the most underfunded, underappreciated, and under-designed healthcare facility in America: your living room. Or maybe your kitchen. Or your basement, or whatever spare space you've got available now that a family member has come home from the hospital with a wound vac, oxygen concentrator, and a complicated care plan. The point is: the home has officially entered the chat as a site of care. But our systems, and frankly, our thinking, haven't quite caught up.

We've spent decades optimizing the hospital: throughput, reimbursement, patient satisfaction scores, and infection control. Meanwhile, the home, the place where health begins, continues, and often ends, has been treated as an afterthought. A nice bonus. It's time to take it seriously. The home isn't just where people want to receive care. Increasingly, it's where they must.

Whether it's because of hospital overcrowding, workforce shortages, value-based care incentives, or the collective realization during COVID that, yes, you can be seen by a doctor from their own bedroom, the pressure is on to move care out of institutions and into everyday life.

Brian Urban described it as **“the third peak”** in the evolution of population health. The first peak was data: getting information about people. The second was tech: building the platforms and infrastructure to process that data. The third, and current, peak is actionable service delivery in the home: actually bringing care to where people live.

And guess what? That's difficult. Because the home is not a controlled environment. It doesn't come with built-in EHRs, medical gas hookups, or a nurses' station down the hall. It comes with pets, kids, clutter, cultural context, and about seventeen different ways to misplace your medication.



Numerous home health startups have stepped into this space in a big way. As Urban puts it, they're not just delivering devices; they're delivering humans who help make those devices usable. Their model recognizes that technology doesn't work on its own. It needs installation, education, interpretation, and, occasionally, troubleshooting when your Wi-Fi cuts out during your remote cardiac monitoring session. Their field teams (real people, in real cars, driving to real homes) are quietly becoming some of the most important players in care delivery.

This is where **human-centered design** proves its worth. When you accept that healthcare is now happening in the same space as dinner and dog hair, you design differently. You stop relying on assumptions about perfectly compliant patients and pristine countertops. You start asking better questions:

- Where will this device sit?
- Who else in the household needs to understand how it works?
- How does a clinician know if it's being used correctly or at all?
- What happens when (not if) it fails?

You design workflows that anticipate confusion. You build redundancies that don't rely on technical proficiency. You create systems that follow up after the delivery, not just during the sale. And you recognize that the home isn't a downgrade.

It's a different kind of upgrade: one that prioritizes comfort, autonomy, and dignity, but also demands an entirely new set of tools, protocols, and expectations. The home is not a hospital; it's not supposed to be. But if we design with the home in mind, from day one, not day ninety, we can make it a place where real healing happens.

We're not quite there yet. But we know what it will take: intentionality, empathy, and a willingness to let go of old assumptions about what healthcare should look like. Because in the future, healthcare might look a lot like your living room. We'd better make sure it works there.



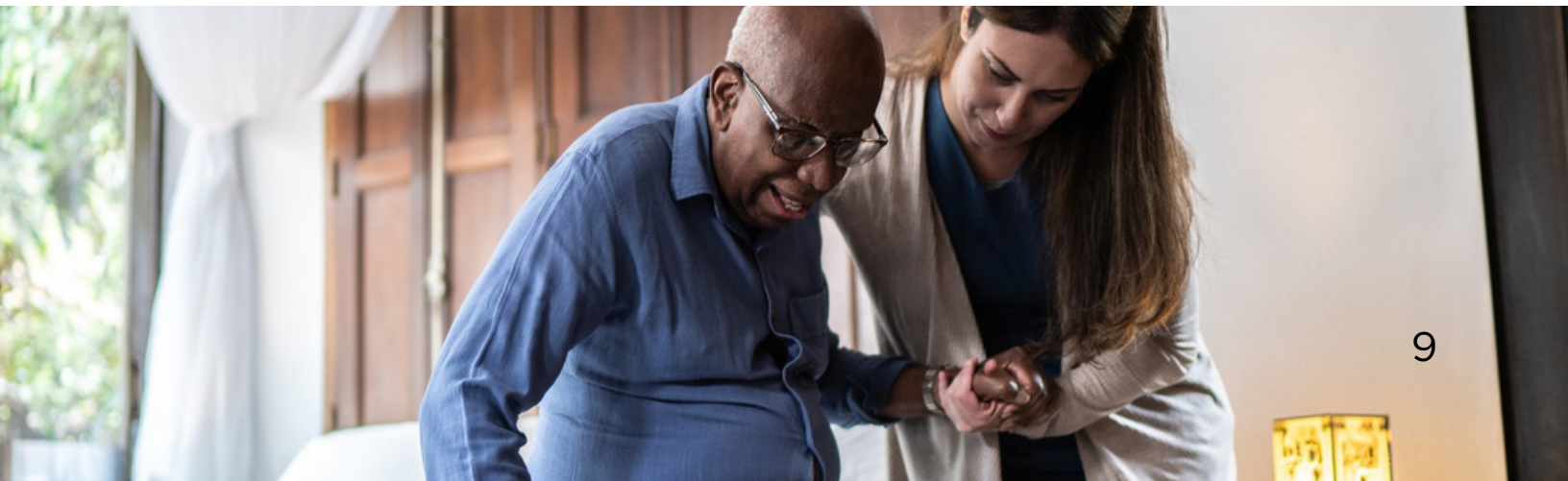
REMOTE MONITORING AS AUGMENTED HUMAN TOUCH

Let's be honest: remote monitoring sounds way cooler than it usually is.

When people talk about remote patient monitoring (RPM), it conjures up a futuristic vision: maybe a smartwatch that detects early signs of heart failure and automatically pings a care team of ninja-level specialists who leap into action before breakfast. And sure, that can happen. But what usually happens? Someone mails you a blood pressure cuff, you open the box, look at the instructions, then either stick it in a drawer or text your nephew to come over and set it up. This is the fundamental truth of remote monitoring: the technology is important, but it's not enough. Data aren't care. Connectivity isn't compassion. And no amount of streaming vitals will replace a clinician who actually knows what to do with them.

Brian Urban puts it simply: **"You still need a human to synthesize the data."** That human might be a nurse in a command center, a health coach on a video call, or a technician knocking on the front door to explain how to use the pulse oximeter. But someone needs to make sense of all that information and, more importantly, decide what to do with it.

This is where human-centered design becomes non-negotiable. If the remote monitoring experience is clunky, confusing, or intimidating, guess what happens? It doesn't get used. Or it gets used wrong. Or it becomes yet another piece of expensive, underutilized technology collecting dust next to the elliptical machine.





A human-centered approach starts by acknowledging reality. Here's what that looks like:

- **Device setup that assumes zero technical fluency.** If it needs an app download, Bluetooth pairing, account creation, and Wi-Fi configuration, there had better be clear instructions – preferably on paper and via video – and someone to call when things go sideways.
- **Feedback loops that actually loop.** If a patient's numbers are off, they need to know what that means and what happens next. Silence isn't reassuring; it's confusing. And it erodes trust.
- **Clinician workflows that aren't nightmares.** Spoiler alert: clinicians don't want another dashboard. They want actionable insights that integrate into their existing systems, not another tab to click through after hours of charting.
- **Human backup for everything.** Technology fails. People forget. Context matters. Successful home health companies understand this, which is why they've built a clinical command center that's staffed with actual humans who can interpret data in context and reach out when something looks off.

This kind of model, hybrid, responsive, and grounded in empathy, is what Urban calls “an accelerant to care.” It doesn't replace clinical teams; it extends them. It fills in the gaps between office visits, especially for patients managing chronic conditions or recovering from acute events.

Now, could we automate some of this? Sure. AI can flag trends, suggest actions, and filter noise. But even the best algorithm still needs a person – someone with judgment, experience, and context – to make the final call. That's not a failure of technology; it's a feature of humanity.



And speaking of humanity: we can't forget that remote monitoring can feel intrusive. It can amplify health anxiety. It can reinforce the sense that you're being watched but not seen. So, design matters. Voice, tone, timing, and even aesthetics; these elements can make the difference between a person feeling empowered or surveilled.

Remote monitoring, when designed well, doesn't just deliver data. It delivers peace of mind. It says, "We're here. We see you. We'll notice if something goes wrong." That's not just a technical service. That's a promise. And that's how we should think about remote monitoring in the home: not as a gadget delivery system, but as a new layer of human connection, one that's only as strong as the design holding it together.





AGING IN PLACE: DESIGNING DIGNITY

There's a popular phrase in healthcare that gets tossed around like a beach ball at a Jimmy Buffett concert: "aging in place." It sounds nice, doesn't it? Peaceful. Grounded. Maybe even inevitable. And for many people, it's exactly what they want: to stay in their homes, surrounded by familiar smells, family photos, and furniture that carries their personal history. But "aging in place" without thoughtful design can quickly turn into "struggling alone."

If we're going to support people aging in place, we need to design systems that don't just let them stay home but help them thrive there. That means thinking beyond grab bars and Life Alert buttons (though those are absolutely necessary). It means acknowledging that the home itself: the layout, the lighting, the acoustics, even the carpet, is either helping or hurting the aging process. No one understands this better than Dr. Diana Anderson, a rare and welcoming hybrid of architect and physician. She calls it like it is: "**The built environment is not neutral**". It either supports health, or it erodes it. There's no middle ground.

Anderson's work focuses on environments for older adults, often those with cognitive impairment. Her insight? Most care environments are designed for staff efficiency and regulatory compliance, not for the actual humans who live (and maybe die) in them. Too often, we trade comfort for control and end up with spaces that feel more like holding tanks than homes.

Think about a standard assisted living facility or memory care unit. Now ask yourself: would you want to live there? If the answer is no, that's a design problem. Anderson points out that **small changes can make a huge difference**:

- **Lighting** that mimics natural circadian rhythms can reduce confusion and improve sleep.
- **Color and contrast** can help those with low vision distinguish between surfaces.
- **Clear sightlines** reduce disorientation in people with dementia.
- **Access to nature**, even through a window, can reduce stress and speed healing.



These aren't design frills. They're clinical interventions, baked into the walls and windows.

And this isn't just about preventing falls (though yes, let's definitely do that). It's about preserving identity, dignity, and autonomy. When we design homes that adapt to changing mobility, cognition, and needs, we give people the power to stay in them longer.

Unfortunately, that's not the norm. Most homes weren't designed with aging in mind. Narrow doorways, slippery tubs, poor lighting, and multi-level layouts. So, if we want aging in place to be more than a buzzword, we have to start earlier. At the policy level. The planning level. The home construction level. Otherwise, we're just layering Band-Aids on buildings that were never meant to support frail bodies or fading memories.

Human-centered design gives us a framework to fix this. It asks: What does this person need to live well, not just stay alive? It starts with the assumption that aging is not a failure. It's a phase of life, like any other, and it deserves intentionality, not just tolerance. Here's the kicker: when you design well for older adults, you design well for everyone.

Slower, clearer, safer, calmer: it turns out those qualities are good for kids, caregivers, and overworked clinicians too. Universal design isn't just an idealistic goal. It's a practical strategy.

Anderson advocates for what she calls **"dignified spaces"** that reflect who a person is, not just their diagnosis. That means personalized design. Smaller, community-style living. Places where people can bring their own furniture, their own routines, their own selves.

So, when we talk about aging in place, let's make sure we're also talking about designing for that place. Not with pity. Not with panic. But with purpose, and a healthy dose of common sense. Because aging isn't a problem to solve: it's a reality to design for. And if we do it right, we'll all benefit sooner than we think.





POST-ACUTE CARE AT HOME: RECOVERY BY DESIGN

Hospital discharge is often framed as a milestone. You're stable! You're going home! But here's what no one says out loud: going home can be the most dangerous part of the healthcare journey. It's the transition zone, where structured, staffed, protocol-driven hospital care hands off to... well, whatever someone can manage at home. Which is often a loosely organized mix of well-meaning family members, conflicting instructions, a plastic bag full of medications, and a phone number that "you should call if anything changes." If we're serious about making post-acute care at home safe and effective, we need to design the transition itself. And that means thinking like human-centered designers.

Brian Urban describes this period as a **crucial bridge in care**, where forward-thinking companies are stepping in to stabilize the wobbly handoff. Their approach combines remote monitoring, in-person tech support, and human follow-up to make sure what's supposed to happen after discharge actually does happen.

Let's unpack that. Because as elegant as this sounds, post-acute care is messy in real life. Think about the typical scenario:

- A patient is discharged with three new meds and two follow-up appointments.
- They're told to weigh themselves daily and watch for swelling.
- They're expected to report symptoms, manage a wound, or maybe even self-administer injections.
- And they're doing all this while tired, possibly confused, and often alone.

Now layer on limited mobility, a language barrier, low health literacy, or digital inexperience. Congratulations! You've just designed a system that almost guarantees failure.



This is where HCD can shine. Because human-centered design assumes the system should do the heavy lifting, not the patient. What would that look like?

- Clear, prioritized instructions with visuals and plain language. (If your discharge packet looks like a mortgage application, we've already lost.)
- Redundant reminders through text, call, or app because people forget, especially when they're stressed.
- Visual aids showing how to perform tasks like dressing changes or setting up medical equipment.
- Human support that is available as long as necessary.

We also need to reframe how we think about the home during this phase. Too often, we see it as a downgrade: a place without sterile surfaces or hallway crash carts. But in many cases, it's where patients want to be.

They heal better in familiar surroundings. They sleep in their own bed. They eat their own food. That comfort is therapeutic, but only if it's supported by a system designed to function there. When post-acute care at home is done well, it reduces readmissions, prevents complications, and actually helps people get better faster. But that doesn't happen by accident. It happens when we build care around real humans, in real spaces, with real limitations.

We need to stop asking patients to pick up where the hospital left off. Instead, we need to extend care into the home with the same intentionality we apply inside the hospital walls. Recovery doesn't start at home. It continues there.

And it deserves design that acknowledges just how critical, and how fragile, that continuation really is.





MANAGING CHRONIC CONDITIONS AT HOME

If there's one thing our healthcare system is impressively consistent at, it's underestimating how hard it is to manage a chronic condition at home. On paper, it looks manageable: take your meds, check your numbers, maybe avoid salt, and see your doctor every few months. Easy, right? Now add in unpredictable schedules, spotty insurance coverage, five different portals with five different passwords, a refrigerator full of food that contradicts your discharge plan, and maybe a 20-minute wait on hold to ask a basic question.

Managing a chronic condition at home is not “low-acuity care.” **It's full-time project management with high stakes and no PTO.**

And yet, that's where most chronic disease care happens. Diabetes, heart failure, COPD, hypertension: these conditions live in the day-to-day, in the moments between appointments, in the little decisions that add up.

That's exactly where human-centered design can (and should) do its best work. Brian Urban describes the opportunity here as being “an accelerant to care,” not just passively collecting data, but actually making it easier for people to understand their condition, stick to their plan, and feel supported in real time.

Let's take diabetes, for example. The design problems aren't just in the glucometer. They're in the instructions, the finger-stick routine, the app that may or may not sync, the hemoglobin A1c goal that no one explained clearly, and the feeling that you're alone in this.



What does a **human-centered approach** look like?

- **Simplification.** Cut the clutter. Translate clinical goals into clear, achievable actions. Design interfaces that show what to do next, not just what's "out of range."
- **Personalization.** Not everyone needs the same level of intervention. Design should flex; some patients need daily reminders and nudges, others just want to check in if something changes. Let them decide how much support they need.
- **Contextual care.** A high blood pressure reading means something very different after climbing stairs vs. lying on the couch. Devices (and the people reading the data) need to account for that context.
- **Support that doesn't shame.** Too often, design assumes non-compliance is a moral failure. But people don't skip meds or blow off appointments because they're lazy; they're juggling 100 other things, or they can't afford a refill, or they didn't understand the instructions in the first place. Design like you believe people are trying.

Once again, this is where hybrid models shine. Good home health companies don't just drop off a blood pressure cuff and walk away. They check whether it's being used, whether it's working, and whether the patient understands what the numbers mean.

They're not just delivering tools; they're delivering interpretation, encouragement, and course correction in real time. That level of feedback is critical because chronic disease is slow-moving but relentless. You don't always know when you're off track until it's too late. Design can help by building signals, scaffolding, and gentle accountability. It can surface patterns that people might not notice on their own.



And let's not forget: managing a chronic condition isn't just physical. It's emotional. It's exhausting. It's lonely. So, when we design systems for chronic care, we need to include space for humanity.

Chronic disease management at home is where design gets real. It's not flashy. It's not about early adopters or shiny tech. It's about long-term engagement, invisible frictions, and small wins that accumulate over time. The goal isn't perfection. It's sustainability.

Can we design systems that people can live with, not just for a week, but for the long haul? Systems that reduce the burden, build confidence, and leave room for life to keep happening? That's the challenge. And if we get it right, we don't just manage chronic disease; we change the trajectory of people's lives.





THE DESIGN TENSION: STANDARDIZATION VS. PERSONALIZATION

In healthcare, we love standardization. It's efficient. It's scalable. It makes things easy to replicate, bill, audit, and explain in PowerPoint slides. And yet, if you've ever met more than one human being, you know that standardization has its limits, especially in the home. This is one of the core tensions in designing for in-home healthcare: the push to scale solutions that are safe, reliable, and affordable, without bulldozing the unique needs, preferences, and contexts of the people who actually live there.

Dr. Diana Anderson sees this clearly in her dual roles as architect and physician. She's spent years inside long-term care environments and hospital-adjacent living spaces, many of which were designed to meet every regulation and efficiency metric, and yet completely miss the mark on livability. **"We've normalized environments that are not normal,"** she says. Translation: just because something meets code doesn't mean it meets human needs.

Anderson pushes back against the idea that institutional or cookie-cutter design is "good enough" for older adults. The truth? People deserve spaces that reflect who they are and not just what's wrong with them. But let's be fair. There's a reason standardization is attractive. It allows for safety checks, consistency, and predictability. It makes things easier to teach, easier to manufacture, and easier to scale across health systems, retail partners, or large tech-enabled service organizations.

We're left with a design paradox: **personalization feels more human, but standardization helps more humans.**

The trick is not picking a side; it's knowing when to flex. Human-centered design offers a roadmap.

The goal isn't to build 10,000 completely different solutions. The goal is to create **modular systems** that adapt to the individual without reinventing the wheel every time.



In practice, that might mean:

- Devices that are plug-and-play but allow for caregiver input in setup.
- Instructional materials that follow a core template but come in multiple languages and literacy levels.
- Scheduling platforms that default to certain rules but respect religious, cultural, or social constraints.
- Home visit protocols that require checkpoints and space for personal conversation.

Think of it like LEGO bricks. The components are standardized, but what you build depends on who's using them. The structure doesn't collapse, but there's room for creativity, preference, and context.

Brian Urban's work also reflects this tension. They operate at national scale, with repeatable logistics and tech protocols, but they also bring humans into the home to adjust for whatever "standard" didn't account for: low lighting, broken Wi-Fi, multiple caregivers, or a patient who's just plain overwhelmed.

The magic happens in the middle, in the space where you offer enough consistency to make the system reliable, but enough flexibility to make it usable. That's not compromise; that's just good design. Because here's the uncomfortable truth: if we over-standardize, we risk building systems that are technically functional but practically unlivable. And if we over-personalize, we create bespoke one-offs that burn out staff and bankrupt budgets.

Designing for health in the home means walking that tightrope with intention. Start with a strong foundation but leave room for the messiness of real life. Build protocols that assume variation, not perfection. Create tools that guide, but don't dictate. In the end, the question isn't "standardization or personalization?"

The real question is: For whom are we designing? And if the answer is "real people, in real homes," then the system has to bend, at least a little.



A HOME FOR HEALTH, NOT JUST FOR LIVING

We've come a long way from thinking of the home as just the place you go after care happens. It's not a backdrop anymore. It's not the place where patients disappear once they're discharged. It's not just where health happens; it's where it has to happen. And if we're honest, we've been behind the curve on this.

We've designed the heck out of hospitals, optimized workflows in clinics, and built entire infrastructures to support care that happens on our turf. But when it comes to the home? We've mostly improvised: shoving technology into spaces never meant for clinical care and hoping for the best. That must change.

If we're truly committed to designing for health, then we need to invest in the home like we mean it. Not as a secondary site of care, but as a primary partner in the healthcare system. That means better tools, smarter interfaces, clearer communication, and yes, more humans involved at the right moments. We spend billions outfitting hospitals with the latest tech, ergonomic furniture, and sterile art, but most people would rather recover in their own bed, with their dog nearby and the thermostat set just right.

We wouldn't dream of sending a surgeon into the OR without the right tools. So why do we send patients home with vague instructions and hope for the best?

We need to reimagine what care looks like when it's designed around the contours of actual lives. When it fits around the kitchen table. When it accounts for what's in the fridge. When it happens while someone's juggling grandkids, part-time work, and two chronic conditions. That kind of care doesn't have to be more expensive. In fact, if we design it right, it'll be less expensive because we'll catch things early, prevent avoidable complications, and stop making people choose between dignity and medical compliance.



It's time to treat the home not as an afterthought, but as an operating environment. That means shifting investments upstream, not just into new devices or apps, but into workflows, built environments, policies, and education that respect the complexity of real life. We have the tools. We have the models.

What we need now is **intention**. To build systems that acknowledge people are messy, distracted, fallible, and still entirely worthy of thoughtful, respectful design. Especially at home. Let's stop pretending the home is a neutral zone. Let's treat it as what it really is: the most important healthcare setting we have. Not because it's the most efficient. Not because it's the most scalable. But because it's theirs. And that, in the end, is what **human-centered design** is all about.

