The Patient Shouldn't Be the Integration Layer

Why health data that's stored but not connected fails the whole person, and what we built Standfast Systems to fix.

is ready for your voice pass.*

Somewhere today, a person who fought their way into recovery is sitting on exam-table paper, waiting to summon the words. The doctor is kind, competent, and about to write a prescription for a painful but ordinary thing. And it falls to the patient, in that thin gown, to say the sentence out loud: please don't give me opioids. They have to disclose the hardest chapter of their life to a near-stranger, on the spot, because the system that knows their history is not the system holding the prescription pad. The two don't talk. So the patient becomes the bridge between them. If their nerve fails, or the moment moves too fast, the cost of that gap can be a relapse. Sometimes worse.

That isn't a rare story. It's the everyday shape of how healthcare data works. The information that would keep someone safe exists. It's just sitting in a system that can't reach the room where the decision gets made.

A few miles away, someone is two weeks out from major surgery and the anxiety is eating them alive. Their therapist knows. The surgical team preparing them does not, because that note lives in a different chart, in a different system, behind a different login. So the person walks into one of the most frightening days of their life carrying it alone, while the people responsible for that day never see it.

And somewhere else, an athlete is coming apart a few months after the injury that ended their career. They were already fighting a losing battle with depression, and losing the thing they had built their identity around only deepened it. The joint is healing on schedule. The orthopedic record tracks range of motion and follow-up dates. Nothing in it is watching the person disappear.

The common thread is simple, and it's the reason I started this company. The data is all there. Nobody can see the person.

We taught healthcare to store everything and connect nothing

For two decades we have been very good at teaching healthcare systems to record. We have spent almost no effort teaching them to connect. Every clinic, every specialty, every device runs its own system, and each one is excellent at holding its slice of a person. None of them holds the

person. The record is complete and the patient is invisible, because completeness was never the same thing as coherence.

It shows up even inside a single specialty. In behavioral health we measure one instrument at a time and call it progress. A depression score drops four points and everyone exhales, while on a screen nobody is watching, the drinking climbs. The number went down. The person got worse. We mistook a falling line for a healing one, because we were only ever looking at one line.

It shows up in the alerts, too. Clinicians drown in reminders that fire because a date rolled over, not because the patient in front of them needs the thing today. We built a machine that interrupts constantly and informs rarely, then asked the people using it to pay closer attention.

In behavioral health, the gap is where people get hurt

In much of medicine, a disconnected record is an inconvenience. A test gets repeated. A form gets filled out twice. Annoying, expensive, survivable.

In behavioral health, it is not survivable in the same way. Substance use, depression, anxiety, suicide risk: these are exactly the conditions where the dangerous part is the part you cannot see from any single chart. And they are not a separate department from the rest of medicine. They run through all of it. The anxiety before the surgery. The depression after it. The pain management that quietly becomes a relapse risk. The body and the mind belong to one person, and that person is the single place the data refuses to meet.

Which brings it back to the gown and the prescription pad. When the systems will not talk to each other, someone has to carry the information across the gap, and it is almost always the patient. We have built a world where the most vulnerable person in the building is quietly handed the job of systems integration, in the exact moment they are least equipped to do it. That is the failure in one sentence. The patient shouldn't be the integration layer.

What good actually looks like

Fixing this is not one more dashboard or one more alert. It is not a black-box "wellness score" that blends everything into a number nobody trusts. It is quieter and harder than that. It is making the data interoperable and meaningful: orchestrating the scattered pieces into one honest picture of a whole person that a clinician can see and trust.

That comes down to a few specific commitments. The data should follow the patient, built on open standards instead of locked in a vendor's basement, so a history of substance use is simply present when the prescription pad comes out. The systems should surface the signal that matters and stay quiet otherwise, so that when an alert fires, it means something. And it should be built to extend, not just to pass an audit, because compliant and extendable are different bars and only one of them is worth paying for twice.

Through all of it, the clinician stays in the chair. The job of good software here is not to decide. It is to make sure the person making the decision can see the whole patient before they make it.

Why I built Standfast Systems

For years I've worked on two problems that turn out to be the same one. In behavioral health, my work was about getting mental-health assessments into the hands of the patients who need them. The interoperability side, the work of moving data between systems that were never built to talk to each other, I learned in other industries. Standfast Systems is where those two meet. I am a veteran, and the people this fails hardest are often the ones I care about most. Veterans. Anyone carrying the weight of substance use, depression, or a mind in crisis.

> *A friend put it better than I ever could. When I told him what I work on, he said something I asked his permission to share, because it's the whole problem in one sentence: "Every time my doctor changes, I have to relive so much traumatic shit." He wasn't describing an inconvenience. He was describing having to hand the hardest parts of his history to a stranger, over and over, because the systems that already knew couldn't carry it for him.*

This work is not abstract to me. I have seen what the gap costs, up close, and I have no interest in building one more system that stores everything and understands nothing.

The version we're building

The data is all there. The work is making it see the person.

That is what Standfast Systems is for. There is a version of this where the patient in the paper gown never has to say it out loud, because the record already knew. That's the one we're building. If you design, buy, regulate, or live inside health systems and that sentence lands for you, I'd like to talk.

Standfast Systems. Always forward.