

# ArcBITS Newsletter

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## ArcSys Hot Tip

A "connection closed by host" is a good/bad news type of thing.

The "good" means that your workstation is talking to the server.

The "bad" is that there are (usually) not enough data base licenses to allow you to join the party.

A "connection refused" means that your workstation can't talk to the server. Either your router needs resetting, the Internet connection is down, or the server is down.

## Dad

Over the past 4 decades one of my many roles has been that of a systems analyst. I have watched hundreds of providers interact with the MegaWest and Red Planet software systems. From this unique vantage point I feel my experience provides depth and perspective to the world of EHRs. That being said, the following personal history is what I refer to as an encounter with "silos".

My dad is 99 years old. Having moved him to Utah 6 months ago into a retirement home, our first step was to get an appointment with a new primary care physician. I brought along a list of his medications and watched the nurse tediously look up and enter each into the EHR. (Hmm, I thought, nothing better or easier than Red Planet.) Dad and the doctor got along great on that first visit. She assured us that she could help manage his medications. There was nothing realistically that could be done to really improve quality of life. When you're 99, you're stuck.

Around the middle of March Dad noticed blood and clots in his urine. Off to the primary care provider we went. They took a sample of urine, tested it, and there was no sign of an infection. Maybe we should look up a specialist in urology. A referral was given and a few days later the urology practice contacted us to make an appointment. Dad declined.

He didn't want to see another doctor. Period. But day by day, the blood was always present in the urine. He started to worry and finally relented to going to the urologist. Off to the new doctor. Oh, yes, I brought along the list of medications and watched another nurse go to the process of keying them in.

The next day, I got an email via Updox saying there was a message from Dad's doctor. Updox?? Really?? That was pretty cool. After being on the front end where Red Planet uploads everything, this was interesting to see how another EMR system was employing Updox. Sure enough, there was the urologist's note that had been completed 3 hours after the appointment. But, as I read it, I couldn't help feel a little disappointed. The note's content read:

Hematuria, Gross When were you told that you had blood in your urine? 03-2018 He has noticed blood off and on in the urine for a couple of months. He is not having pain. His urinary stream is still fairly strong. Did you see the blood in your urine? Yes , Do you have burning or discomfort when you urinate? No , Do you have to strain or bear down to start your urinary stream? No , Do you dribble at the end of urination? No , Do you have pain? No , Have you had blood in your urine recently? Yes , Are you having flank pain? No , Are your bowels moving normally? Yes .

A boilerplate. Since I had been in the room, I knew what was asked. Some questions were never asked and obviously inferred. Maybe a minor point, but I knew it. Anyway, the recommendation was to get an ultrasound. Off to another provider!

Within one day another message alert came from Updox. On logging into the Updox account, there was the report from radiology. Good news, nothing out of the ordinary.

A week passed and it was back to the urologist for a cystoscopy. I was in the room with Dad while the doctor performed the procedure. "Want to see this tumor?" the doctor asked



me. "Sure." I replied. I concentrated hard on looking at what was displayed on the scope and not *where* the scope was inserted. (I mean, really, this was a little uncomfortable.) Through the scope I could see a dark mass on the wall of the bladder. The recommendation was to perform surgery to remove the mass and biopsy it.

Another alert came through within a day via Updax. Still the same boilerplate style with default answers. Oh well, if nothing else it was timely.

On May 21 the procedure was done at an outpatient surgical facility. This time I was lucky: No one had to enter the list of medications. From here, unfortunately, things started to go downhill. Dad was left with a catheter and a bag which became his (our) buddy for 10 days. The unfortunate thing was being confined to his room. He could (would) not walk to the dining room for his meals. So the meals were brought to him each day in a white clam shell styrofoam container. One piece of good news was delivered via Updax, the biopsy was benign.

Once the catheter was removed, he could be mobile, but was too weak to walk. He languished in his room. I coaxed him to try walking. No result. Others in my family encouraged him with the same non-result. I finally took him back to the primary care doctor. One look at him, and she noticed that the spark of life had been extinguished. She took me aside and asked if she needed to play hard ball with him. "You bet" was my response. In a firm way she told Dad that if he didn't start walking he was going to be dead in 3 months.

That was the trick. Dad was furious that a doctor would be so "unprofessional" as to say anything like that. As soon as we arrived at the retirement home he pushed his walker half way down the hallway to the dining room just to prove he could walk just fine, thank you. (Mission accomplished.)

But when you're 99, the body just doesn't really get better. There was still blood and clots, but were told that would be expected. A couple of weeks later he calls me to say he was in excruciating pain and can't pee. By the time I arrive the pain was so bad I need to get a hold of the paramedics. They show up in 5 minutes and whisk him to the ER.

Fortunately, the ER has his list of medications so I'm spared having to go through that process. The doctor on call briefly examined him and turned control over to the nurse. A few hours later we have our "friends" the catheter and bag and head home. At least he was committed to walking to the dining room.

A couple of weeks pass and I received a phone call from the paramedics who inform me that Dad had a fall on his way to breakfast. They are transporting him to the ER. He was diagnosed at the ER with a bladder infection and they are concerned about his cardiac functions. Lab results also indicate *e. coli* and sepsis. Since they don't have an on-site cardiologist, he was transferred to another hospital and admitted. And, yes, we have to go through the whole list of medications there because they don't have access to that information? Go figure.

He hated the hospital. There was no rest. Every hour someone was taking vitals, getting him up, doing this, doing that. He was desperate for sleep and rest. At discharge, the cardiologist gave me explicit verbal instructions to take him off Furosemide. She also gave orders for home nursing and physical therapy.

Whew. He was back home but again too weak to walk to the dining room. The Updax report came through and the written instructions by the cardiologist tell him to continue all meds including Furosemide. Really? Did she forget what she told me. Did she not take her own notes? The nurse showed up at his apartment, took lots of notes, asked lots of questions and examined him. Hmm. Concerned about the swelling in his feet and ankles. It was bad. We confer and decided the Furosemide needed to be restarted. The nurse reached out to the PCP who concurred.

Over the next 3 weeks the swelling slowly receded. The nurse and physical therapist helped him but the improvement was ever so slow. This story will continue.

What I have experienced was a medical world of silos. Each health care provider focused on just what they do. The urologist was pleased with surgery and how well it turned out. But he didn't have to deal with 3 months of bags, styrofoam meals, ER visits, depression and hospitalizations. None of the doctors conferred with each other about the best treatment. The number of times I filled out past medical histories was finger-numbing. The written documentation didn't accurately match what took place or what was verbally instructed. The cardiologist was adamant about the meds which would be best for his heart. Within each silo the people were kind, compassionate, caring and professional. But, the EHR systems just seemed to get in the way of real care. Yes, INDIVIDUALLY, everything was working, but PEOPLE and their SYSTEMS were not interacting to solve the problem.

On the up-side, not one out-of-pocket penny was spent. Insurance and billing performed flawlessly. On the down-side, let me just say that insurance has paid considerably.

Clearly, providing health care is not easy. Maybe things should have been done differently. This was a relatively simple issue, but there was no clear direction. Will any healthcare administrator ever be aware of this situation? Probably not. Will any insurance company ever study this case? Doubtful. In hindsight, it would have been just as easy for me to pass out copies of medications and histories and have people tape them to the wall. A few phone calls between providers would certainly have come up with a better solution. But here we are and *tens* of thousands of Medicare dollars down the road and Dad is not a happy camper. Is anybody listening?