BREAKING BORDERS

Sarah Matt, MD '08, Tackles Healthcare's Most Urgent Problem: Access

The patient should have been easy to reach.

The appointment reminder had gone out. The instructions were clear. The clinic had availability. But when the day came, the patient never arrived. Again.

In many healthcare systems, the explanation would have been swift and unsatisfying: *noncompliant*. But Sarah Matt, MD '08, MBA, knows that word often obscures more than it explains.

"It might not be just because they can't afford the copay," she says. "It's for all the secondary reasons we don't really think about sometimes. They didn't have transportation. They had to take a bus—three transfers. They had to pay for child-care. Or they work a nine-to-five job without sick leave, and if they miss work, they could lose their job."

In other words, the system was built for someone else.

"Access problems almost never show up as access problems," she says. "They show up as no-shows, delayed care, and worse outcomes."

To Matt, that missed appointment is not an isolated inconvenience. It is a structural signal. And it reflects what she believes is the most universal—and most solvable—problem in American healthcare.

"You can walk into any room, anywhere, and everyone has an access story," she says. "No matter where you're from or how much money you make, access touches everyone."

A well-insured executive waits months for a specialist. A rural patient drives two hours for follow-up care. A working parent cancels appointments because clinic hours collide with shift work. A young adult with patchy coverage postpones preventive care until symptoms force action. These are not isolated glitches. They are design outcomes.

And after two decades spent inside operating rooms, health technology companies, startup boardrooms and community clinics, Matt has reached a conclusion: access failures are rarely accidental.

Dr. Matt teaches Foundations of Medical Reasoning at the Norton College of Medicine.

They are engineered by incentive structures.

"We're a healthcare sector based on reimbursement," she says. "The way insurance works defines how care is delivered, how technology is built, how patients are scheduled. Everything flows from that."

Matt occupies a rare vantage point. She has led product and corporate strategy inside major health technology companies. She helped shape global healthcare cloud initiatives. She played a significant role during Oracle's acquisition of Cerner. And she continues to practice medicine and volunteer in community care settings.

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"Having hands-on patients is vitally important to me," she says.

That dual lens—technology executive and clinician—changed how she sees access.

When she spoke with physicians, patients, and innovators across the country, she expected to hear about technical limitations.

Trained as a surgeon, Matt now focuses on advising technology startups in the healthcare sector with a goal to improve healthcare access for all.

Instead, she found something else.

"The technology is there," she says. "Technology is the easy part."

Matt recalls hearing that sentiment in executive meetings early in her technology career and thinking it sounded simplistic. But after listening to rural physicians, military veterans, startup founders, and patients themselves, a different pattern emerged.

Tech companies were building impressive tools and still struggling. Providers were working tirelessly and still falling short. Patients were trying to engage and still getting lost in the system.

"It wasn't because of the tech," she says. "It was because of other reasons."

Those "other reasons" almost always traced back to incentives.

Matt asserts that the U.S. healthcare system is not broken in the way many clinicians believe but is working exactly as it was designed to work.

Clinics operate nine-to-five because reimbursement supports it. Preventive care struggles because late-stage intervention pays better. Digital tools assume broadband access because vendors build for the most profitable users first.

The system behaves according to its design, which is precisely why Matt believes access must be treated not as charity—but as strategy.

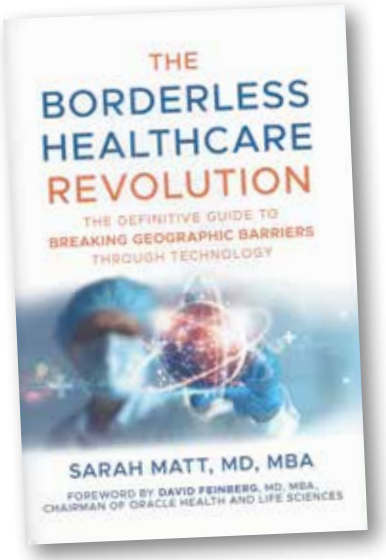
"It has to be intentional," she says. "If your goals for your product, solution, or business don't include access, you're not going to build access into your solutions."

That pragmatic perspective—critical but not cynical—has made Matt a respected voice across clinical, academic, and industry settings. It also helps explain the arc of her own career, which has unfolded across operating rooms, startups, global technology firms, and classrooms.

Dr. Matt speaks frequently on topics of healthcare access and medical technology.

"We can't just burn it all down and start over," Matt says. "People need care right now. So, we have to work within the system while we make these changes."

That conviction became the foundation of her book, *The Borderless Healthcare Revolution* (Wiley, 2025).



THE FIVE PILLARS

In 2024, Matt was approached by nonfiction publisher Wiley about writing a book on healthcare. The subject was up to her. "It was a very polarizing time, particularly in the United States, and I wanted to focus on a topic that would not only help people but bring them together," she says. "For me, access is a topic where I think everyone can put differences aside to work on this one thing that will actually help every single person."

Drawing from her own professional experiences and interviews with professionals across the country, Matt set out to build a framework for action. "The book's focus is not on futuristic solutions, but on practical shifts—some technological, some organizational, some cultural—that can be made now," she says.

Matt focuses on what she calls the five pillars of access—geographical, financial, cultural, digital, and trust and knowledge. The framework is intentionally practical, meant to help clinicians and leaders identify root causes rather than symptoms. "When you really break those things apart, every story makes sense," she says.

Geographic barriers are obvious, but not simple. A zip code can determine whether a patient has access to robotic surgery or only basic procedural care. A two-mile boundary can separate advanced treatment from limited options.

"Geographic access isn't just rural versus urban," Matt explains. "It's whether people can actually get to care in a way that fits their lives."

That includes clinic hours, availability of specialists, transportation, and the number of visits required to receive care. A patient may live close to a hospital and still lack access if appointments are booked months out or require repeated time away from work.

Active in her community, Matt serves as a volunteer firefighter with the Fayetteville (N.Y.) Fire Department.

Financial access is often reduced to insurance coverage, but Matt argues that view is far too narrow.

Patients may appear disengaged when, in reality, they are navigating impossible tradeoffs. "A lot of people end up having to choose survival instead of healthcare," Matt says.

Cultural access asks whether care is designed for the people receiving it.

"Our system is built for people who speak English as a first language, who have cars, and who have nine-to-five jobs with sick leave," Matt says. "A lot of people don't fit that mold."

Cultural access also includes historical context. "There are hundreds of years of real experiences that have created mistrust," she notes. "You can't just wipe that away."

Improving cultural access requires listening, adapting communication, and meeting patients where they are—rather than expecting them to conform to the system.

Digital barriers include broadband gaps and literacy, but also overengineering.

"If we assume everyone has broadband internet and the latest phone, we're designing for a very small population," she says.

Digital access includes connectivity, data limits, device literacy, and comfort with technology. "Sometimes the most effective solution isn't a fancy tool," Matt adds. "Sometimes it's a phone call. Or a letter."

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The goal, she says, is not more technology—but the *right* technology.

Trust and knowledge form the most difficult pillar.

"Healthcare is no longer trusted by default," Matt says. "People are going to research. They're going to question. And that's not a bad thing."

The challenge is helping patients navigate information safely and meaningfully. "The real education," she explains, "is knowing what to trust, when to question, and what the limitations are."

According to Matt, the five pillars offer a diagnostic lens. "When you break access down this way, you can take any problem in healthcare and start to understand the root cause."

And once the cause is clear, she adds, "every single person in the system can do something about it—today."

FROM UPSTATE TO SYSTEMS THINKING

Long before she became a strategist or author, Matt was a medical student at Upstate Medical University, drawn to surgery and the team-based intensity of procedural care. During her clinical training at the Binghamton clinical campus, she found mentorship that cemented that path.

She completed surgical residency training at Washington Hospital Center in Washington, DC, which she followed with a burn surgery fellowship, dividing her time between clinical work and research. "I was doing complex experimentation, writing grant proposals, and getting money, and I began tapping into another skillset," she recalls.

She wasn't just practicing medicine, but solving problems. "It was operations and project management," she says.

Matt began to question whether she wanted to impact health care one patient at a time.

"In surgery, you might see 20 or 40 patients on a very busy day," she says. "I realized I could make a bigger impact—hundreds, thousands, maybe millions of people at once."

Matt and her husband relocated to Austin, Texas, where she enrolled in the MBA program at the University of Texas. While studying strategy and operations, she ran a Medicare house-call practice, caring for homebound patients whose circumstances made traditional office visits impossible.

The juxtaposition was instructive.

By day, she analyzed markets and incentives. By night, she navigated the lived realities of patients for whom transportation, scheduling, and cost—not medical complexity—were the primary barriers to care.

Midway through her MBA, Matt began applying for roles that would allow her to bridge medicine and systems design. She joined NextGen Healthcare as a physician advisor—initially to explain what clinical care actually looks like inside hospitals.

Within months, she was asked to lead clinical product management for an acute-care electronic health record system serving critical access hospitals nationwide. The role put her at the intersection of regulation, usability, and clinical reality.

It was difficult work. Hospitals were under pressure to digitize. Clinicians were frustrated. Technology was advancing faster than workflows could adapt. But Matt saw something others missed: how profoundly system design shapes daily medical practice.

Over time, Matt rose to serve as chief strategy officer and chief of staff at NextGen, leading global teams and working on mergers and acquisitions. Later, at Oracle, she helped build the company's healthcare and life sciences cloud strategy worldwide, collaborating with ministries of health, payers, pharmaceutical companies, and large health systems.

Matt also enjoys roller derby, although she fractured her leg last fall.

Her role expanded further during Oracle's $29 billion acquisition of Cerner, the largest healthcare technology acquisition to date. Matt was deeply involved in evaluating Cerner's software portfolio—deciding what to keep, what to rebuild, and what the future electronic medical record should enable.

The lesson, once again, was that technology alone is never the answer.

"The technology is the easy part," Matt reiterates. "Trust, adoption, reimbursement—that's the hard stuff."

That belief guided her next move into startups focused on remote robotic surgery and prehospital care—efforts aimed squarely at breaking geographic barriers to expertise.

REBUILDING BORDERS

During the pandemic, Matt relocated her family—she's the mother of four boys—back to her hometown of Fayetteville, New York. Today, she divides her professional time between consulting with startups working in the areas of health technology and healthcare delivery systems, providing volunteer clinical care at the Mary Rose Clinic in Oneida, New York, and teaching at the Norton College of Medicine. She's also a volunteer firefighter, though she is currently sidelined from responding to calls after breaking her leg playing roller derby.

Firefighting, parenting, and even roller derby have reinforced the same lesson she applies to healthcare reform: conditions change quickly, teamwork matters, and progress depends on the ability to absorb impact and keep moving forward.

"You can build teams that do the same thing every day," she says, "or you can build teams that are comfortable doing new things when the situation changes. Some people see chaos and shut down. I see complexity and a problem to be solved."

At Upstate, where she teaches Foundations of Medical Reasoning to first- and second-year medical students, Matt challenges future physicians to think systemically.

"We're no longer in a world where you can just memorize information," she says. "There's infinite information. What matters is knowing how to think, how to question, and how to use tools safely."

For Upstate alumni practicing across Central New York and beyond—many serving rural communities, safety-net hospitals, small practices and large health systems alike—her message carries particular weight.

"Physicians already have more influence than they think," she says. "Access is shaped by everyday decisions—how we schedule patients, how we communicate, and how we challenge assumptions."

The Borderless Healthcare Revolution is not a call to abandon medicine as it exists, but an invitation to practice it more intentionally, says Matt. For her, that intention was forged at Upstate, where she learned not only how to care for patients, but how to see medicine as a responsibility that extends beyond individual encounters.

"Borders in healthcare aren't inevitable," she says. "They're built by systems. And systems can be rebuilt." ■