

THE BORDERLESS HEALTHCARE REVOLUTION

THE DEFINITIVE GUIDE TO
BREAKING GEOGRAPHIC BARRIERS
THROUGH TECHNOLOGY



SARAH MATT, MD, MBA

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More praise for *The Borderless Healthcare Revolution*

“Here in the United States, patients with little access to technology are all too often cut out of healthcare services. Dr. Matt has spent her career working diligently at the intersection of practice and technology to enable access to care and better outcomes. Her stories and research from the field will illuminate and empower a future in which all people, regardless of geography, will have the healthcare access and opportunities they need.”

—Betty Rabinowitz MD, Founder and Former CEO,
EagleDream Health

“This book is not a passive read. It is a challenge. It asks those of us who build, fund, and govern healthcare to stop measuring success by what’s technically possible—and start measuring it by whether people can actually get the care they need.”

—David Feinberg MD, MBA, Chairman, Oracle Health and
Lifesciences

The Borderless Healthcare Revolution

The Definitive Guide to Breaking Geographic Barriers Through Technology

Sarah Matt, MD, MBA

Foreword by

David Feinberg, MD, MBA,
Chairman of Oracle Health and Life Sciences

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*For everyone who needed care and couldn't get it, and for
the people reimagining what care can be.*

Foreword

Throughout my career, I have had the privilege of leading some of the most innovative healthcare institutions in the world. From UCLA Health to Geisinger, from Google Health to Oracle Cerner, I have worked across systems and sectors with one mission in mind: improving the lives of patients. No matter the setting, no matter the population, one reality has always risen to the top. Access to care remains the greatest unsolved challenge in healthcare.

We have built cutting-edge hospitals. We have trained extraordinary clinicians. We have deployed new technologies with extraordinary potential. Yet still, millions of people go without the care they need. Not because the care does not exist, but because they cannot reach it. They are blocked by geography, by cost, by language, by infrastructure, and by systems that were not built with them in mind. The problem is not capability. It is structure. It is delivery. It is follow-through.

That is what makes *The Borderless Healthcare Revolution* such an important and timely contribution. Dr. Sarah Matt has written a book that does what few others have managed to do. She connects the operational and the human. She moves fluidly from frontline realities to system-level strategy. And she makes a compelling case for how we redesign care not just at the margins, but at the core.

Dr. Matt brings an unusual mix of clinical precision and systems insight. She trained as a surgeon, where the stakes are high and decisions are irreversible. She then stepped boldly into the technology world, helping to lead large-scale transformation efforts in health IT, AI, robotics, and remote surgery. That breadth of experience gives her a perspective

that few can match. She understands where care breaks down, but more importantly, she understands how to build pathways that work in the real world.

This book is filled with powerful examples. We meet veterans navigating an impossible maze of benefits and care coordination. We meet migrants who are willing to risk everything to reach a clinic. We meet families in rural America who live closer to broadband towers than to pediatricians. We are reminded that care is not just about diagnosis or procedure. It is about logistics. It is about communication. It is about designing systems that are reachable, not just advanced.

Dr. Matt does not romanticize technology. She is clear about its potential, and equally clear about its limitations. AI can help clinicians triage faster, but it cannot overcome infrastructure that does not exist. Robotics can extend the reach of surgical skill, but only if the network is ready. Digital health can improve outcomes, but only when it is built on trust and delivered with clarity. What sets this book apart is its grounded optimism. Dr. Matt is not waiting for the perfect system. She is working with what is available, identifying where it is already working, and showing how it can grow.

She highlights organizations that are delivering care on street corners, in mobile vans, in rural clinics, and in homes. She walks us through how telehealth can reach communities that traditional health systems often miss. She lays out how remote surgery and AI tools can scale expertise, if thoughtfully deployed. She names the gaps in reimbursement, policy, and training that must be addressed to make these solutions sustainable. And she reminds us that access is not a buzzword. It is a measurable, practical, and actionable goal.

For healthcare executives, this book is a roadmap. For public officials, it is a briefing that connects data with real people. For engineers and technologists, it is a set of use cases with clear requirements and a reality check. And for clinicians like me, it is a powerful reminder of why we entered this field in the first place.

The people we serve are not always coming through our hospital doors. Some live in mountain towns where winter closes the roads. Some live in crowded apartments and cannot take time off work to get to a clinic. Some are caregivers who place everyone else's health ahead of their own. Others are aging alone in places where digital tools could offer the only consistent point of contact. The barriers are diverse, but the message is the same. Unless care is truly reachable, it cannot be considered delivered.

Dr. Matt understands this intuitively. She writes with the urgency of someone who knows the stakes, and with the clarity of someone who has built teams, run programs, and worked through the obstacles. She is not writing from the sidelines. She is in it. And she is bringing together the perspectives of patients, providers, policymakers, and technologists in a way that few have done before.

The Borderless Healthcare Revolution is not simply a title. It is a directive. It is a shift from care that exists in fixed places to care that exists wherever it is needed. It is a move from systems built for convenience to systems built for connection. It is about reducing the friction, shortening the distance, and delivering care that fits into the lives of real people, not just into facility hours or coverage maps.

I am honored to write this foreword because I believe deeply in what this book stands for. I believe in what Dr. Matt is building. And I believe that when we take seriously the full picture of access; physical, financial, cultural,

digital, and informational, we can finally begin to close the gap between what healthcare is and what it should be.

When that happens, we will not just improve systems.

We will restore trust.

We will prevent suffering.

We will fulfill the promise of care that reaches everyone, everywhere.

—David Feinberg, MD, MBA
Chairman Oracle Health and Life Sciences
Former President and CEO, Cerner Corporation
Former Head of Google Health
Former President and CEO, Geisinger
Former President and CEO, UCLA Health

Preface

I didn't write this book because I had time. I wrote it because I couldn't stop seeing the gap between what healthcare *could* be and what it still is.

I've worked in operating rooms, free clinics, and startup war rooms. I've helped build platforms used by millions and walked patients through care plans written in a language they didn't speak. I've been a surgeon, a strategist, a tech exec, and a street medic. Every role taught me something different. The failures all pointed to the same truth.

Access is not only about technology. It's also about design, trust, and execution. The tools matter, but only if they reach the people who need them.

This book is a field guide for people who want to build healthcare differently. For leaders who are tired of hearing, "we can't." For clinicians who know the system doesn't work. For founders and policymakers who want to lead with clarity and urgency instead of buzzwords.

The Borderless Healthcare Revolution is not a manifesto or a blueprint. It's a challenge. If we have the tools, what's stopping us?

You're here because you're part of the answer. Let's get to work.

—Sarah Matt, MD, MBA

About the Author

Sarah Matt, MD, MBA, is a physician, technologist, and systems thinker who has spent her career pushing healthcare to reach the people it too often leaves behind. Trained as a surgeon, she moved early into the technology sector, leading the development and deployment of digital health tools across the globe. Her work has spanned remote robotic surgery on multiple continents, electronic medical record rollouts in under-resourced regions, AI at the Edge, and large-scale patient engagement platforms that transformed access to care.

At Oracle Health, she helped steer enterprise-wide initiatives focused on digital delivery, mobile-first strategies, and clinical cloud infrastructure. She has advised government health programs, collaborated with global health teams, and worked hands-on with startups building platforms for the front lines. Throughout, she has focused not only on what's trendy, but also on what is functional, scalable, and built to last.

Dr. Matt continues to practice medicine, treating patients with complex chronic illness, many of whom are uninsured, unstably housed, or disconnected from traditional healthcare systems. These firsthand experiences with patients who fall outside the mainstream care model continue to inform her approach to innovation and design.

She holds degrees from Cornell University, SUNY Upstate Medical University and the McCombs School of Business at the University of Texas at Austin. She teaches first-year med students at SUNY Upstate and is a frequent speaker at global healthcare and technology forums. Her talks center

not on potential, but on execution; how to turn promising tools into meaningful change.

Dr. Matt wrote *The Borderless Healthcare Revolution* to challenge the assumption that access is someone else's problem. Drawing from global case studies, patient interviews, and field experience, she outlines what it takes to deliver care when distance, cost, infrastructure, and trust all stand in the way.

She lives in upstate New York with her husband, Gus, and their four children. Their house is full of curiosity, arguments about dinner, and an unreasonable number of roller skates.

CHAPTER 1

The Geography Problem

From the Front Lines

The summer heat in Texas hits you like a wall when you step outside. On this particular August morning in 2012, I was making my way up the cracked concrete path to Maria's mobile home, my medical bag feeling heavier with each step. The window-mounted air conditioning unit hummed desperately against the rising temperature. This was my third attempt to see Maria; we had previously been unable to find her trailer after two attempts to work through an interpreter, poor phone connections, and constantly changing locations of residence. So here I was, bringing the clinic to her. Maria's story would become one of countless examples I'd encounter of how geography shapes health in ways both obvious and subtle. But let me back up a bit. Let me tell you how I found myself making house calls in the Texas heat, and what it taught me about the deep divide in American healthcare.

When I moved to Austin, TX, I was amazed at the availability of jalapeños. You could literally get them at any restaurant. What's better than jalapeños? Well, tacos for breakfast, lunch, and dinner of course! The city was bustling with music, people, and cutting-edge tech. It was a far cry from Upstate NY where I grew up. At the same time, the stark contrast within the city nearly gave me whiplash. By night, I navigated the sleek corridors of the UT McCombs MBA program, surrounded by future tech executives and management consultants. These were people of privilege, who were funding advanced degrees, with many of us already managing teams at big firms around town.

But by day, I wound through neighborhoods where the American Dream felt more like a distant mirage, and where few who did not live there would venture. I was providing medical care to patients who couldn't leave their homes. Patients who nobody wanted to see in their offices, because they were so complex, and whose situations were seemingly unfixable. The city's famous breakfast tacos and vibrant music scene had drawn me here, but it was these house calls that would reshape my understanding of American healthcare. Each doorway I stepped through told a different story of how geography, whether measured in miles or mere city blocks, could become an insurmountable barrier to care.

Fact Check

1. In 2022, 7.8 percent of U.S. counties did not have a primary care physician. The national ratio of primary care physicians was 83.8 per 100,000 people.^{[1](#)}
2. Over the course of the last 10 years, more than 120 rural hospitals have ceased operations, further limiting access to care for populations which are older, less healthy, and less affluent than their urban counterparts.^{[2](#)}
3. An analysis of 2021 Medicare claims showed that beneficiaries in rural areas received less specialty care than those in urban areas.^{[3](#)}

The Reality of Home-Based Care

So, what does “homebound” actually mean? According to Medicare guidelines, homebound patients have conditions that make leaving home difficult without considerable effort and assistance. When I started practicing in the early 2000s,

this meant I could see patients monthly; a stark contrast to the typical once- or twice-yearly primary care visits many Americans experience. This increased frequency of care should have meant better outcomes, but the reality was far more complex.

According to the Centers for Medicare & Medicaid Services (CMS), a patient is considered homebound if they meet the following criteria.⁴

Criterion One

- The patient must either:
 - Require the aid of supportive devices such as crutches, canes, wheelchairs, or walkers; the use of special transportation; or the assistance of another person to leave their place of residence due to illness or injury; or
 - Have a condition such that leaving home is medically contraindicated.

Criterion Two

- There must exist a normal inability to leave home; and
- Leaving home must require a considerable and taxing effort.

Even if the patient leaves the home, they may still be considered homebound if the absences are infrequent, of short duration, or for the purpose of receiving healthcare treatment.⁴

Stories from the Field: Physical Barrier Spotlight

The cards were still scattered across Fred's small table when we arrived, evidence of the game we'd interrupted. The air in his apartment was thick with the kind of stillness that comes from windows rarely opened. "¿Cómo está?" my medical assistant Art asked, his casual Spanish immediately putting Fred at ease. None of us could have known then how the next few hours would unfold, or that this routine visit would become a race against time.

Fred (Frederico per his chart) was a 66-year-old Spanish speaking Latino man living alone in a 65 and up low-income housing apartment on the southeast side of Austin. Two million elderly Medicare patients were completely or mostly homebound in 2011.⁵ Fred was just one of this ever-increasing population.

He told me he had "bad feet" for over a decade and scooted along the halls of his apartment complex in a wheelchair at a steady but snail's pace. He was jovial and when we got to his apartment, he had a friend over playing cards. After his wife died almost five years earlier, he had turned to smoking cigars, didn't go to the doctor, and had very few ties with his family. But he had a few friends on his floor in the apartment building and generally seemed to be in a good mood. His social worker had referred him to us. She had helped him get on Medicare, get food stamps, and connect him with a free community service to bring him groceries to his apartment. His home was small and cluttered, not particularly well kept, but then again, he was a bachelor doing his best on his own. These stories from Austin aren't unique to Texas or even to the United States. Across the globe, healthcare systems struggle with similar challenges of access—quality and inclusive care—although their solutions often differ dramatically.

Sometimes I would see new patients without much history to go on, and sometimes it was going to just be a surprise. Less than one-third of primary care physicians in the United States

report making home visits, a rate significantly lower than in other high-income countries.⁶ This time all we knew was that he had “bad feet.” So, when we arrived, we were pretty much ready for anything. My medical assistant fortunately came with me everywhere I went. His Spanish was casual but was extremely helpful when seeing patients. While he had been scolded by more than one abuela for his casual grammar, it was certainly better than my own Spanish, which was abysmal.

We went back and forth with Fred, asking him questions about his living situation, his health history, and any medical problems he might have. He was worried about his feet; they had caused him pain for years and recently they had become even more numb in spots and were “making his socks dirty.” But he said he had no other medical issues, was not on any medications, and had not seen a doctor for many years. So, we drew some blood, and I started my exam. He had a low fever to start, his blood pressure was elevated, and his heart rate was increased. But then again, having a doctor in a white coat at their house often stresses folks out a bit. As I moved through my exam, things continued to be rather insignificant.

Then I asked him to remove his socks and shoes for me so I could look at his legs and feet. He said he couldn’t do it by himself and admitted that he had been wearing this same set of shoes and socks continuously for over a week straight. We removed the shoes, and a terrible stench filled the room. The socks were stuck onto his feet in multiple places, and after removal, revealed multiple wounds, ice cold toes, and no palpable pulses. But what sealed the deal was the redness spreading up his ankle, and a crackling feeling up his leg with discoloration consistent with necrotizing fasciitis. This is “flesh eating bacteria” for the uninitiated. This is a medical emergency. He had not seen the color and crackling feeling a week earlier when he had gotten help to change his socks. In fact, he hadn’t been concerned, because he couldn’t feel it.

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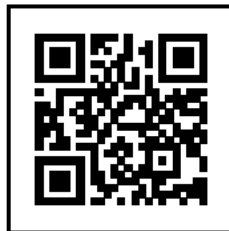
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