Guidehouse®

EPISODE
06

What's next in healthcare innovation? An insider's view

Guest: Cris Ross, Healthcare Advisor, Investor, and Author



CRIS ROSS: I think we've, you know, connected, we've automated, and we've done some fundamental digitization. But the thing we really haven't done is to think about, okay, now what business and clinical things could we redesign knowing that we have that technology and then do the work of applying the technology to it.

VOICEOVER: Outwitting complexity starts here. Welcome to The GuideLine.

STUART BROWN: Cris, welcome to GuideLine. Really excited to have you here today because you're the first guest I've had to really talk about healthcare and tech, and the lens of how those two things go together. I think it's going to be a fascinating conversation. You also bring a really broad perspective, which I appreciate in the space. When I think about tech and healthcare, I think about the application of it and the usage of it and the transformation that could happen. So, I'm excited about exploring all those different options.

But obviously you spent years in the CIO seat, also serving as an advisor. So, you've sort of been on all sides of this conversation as well as a board member and others.

CRIS ROSS: Can't keep a job down.

STUART BROWN: Exactly. So, I'd love, you know, I didn't do anything of what you've done justice. So, I'd love for you to give a little bit of overview of yourself, your journey, and why you're so passionate about this subject.

CRIS ROSS: Well, Stuart, thanks a lot. I stumbled into healthcare in 2003 when a former grad school classmate asked me to come interview at UnitedHealth and I was negative at first and he said, yeah, I know, but come interview anyway and I did, had an opportunity to get involved in the behavioral health business there as CIO and I just really loved it. It was a passion of mine. Went on from there to help form MinuteClinic, which was basic primary care in a drugstore and other convenience locations. That was a blast.

Went to SureScripts, helped build the clinical interoperability network to parallel the pharmacy network, was recruited to Mayo, was CIO there for twelve years. In the last two years I've been working in a portfolio of things, working for two venture capital firms, Aegis Ventures and Insight Partners, and doing consulting either directly or through a couple of partners. And I'm really enjoying portfolio life, opportunity to serve on boards and to try and, you know, move healthcare forward in little ways that I might be able to help.

STUART BROWN: No, that's great. And I think what a journey and a transformation healthcare has been on. And I think what we're going to talk about today also is the promise of where things are going. I think it's one of those areas where the technology and the application of artificial intelligence and other things are potentially going to revolutionize, sort of, how we as humans live and our health. So, let's start with when innovation meets healthcare realities, because one of the things that's always been the challenge is there's always been the promise of innovation to apply to healthcare, or you know, wellcare or whatever.

But I think the challenge becomes the realities of applying it and the challenges of the ecosystem and the time to do it and interrupting the flow of the day-to-day because unlike some industries, you can't stop to transform in the healthcare industry because you've got, you know, every day is a new day and you can't predict everything that's going to come through the door. So, you have this amazing background. I'd love to sort of get your thoughts around, sort of, how innovation and healthcare meet and what is the reality of what can happen.

CRIS ROSS: Well, I'd say two things as a preface. One is I used to say to my team at Mayo all the time that we had two jobs, which was to run one of the best hospitals in the world at an absolute level of safety and performance that our patients and our providers would be, you know, happy with. The second was to innovate at Silicon Valley speed. And people would say, boss, we can't do both of those at the same time. And they were right. So, it's really around how do you have that dual mission. So, you know, that dichotomy is always going to be with healthcare.

The second is I think a lot of innovation has come to healthcare. You know, you think about how complex the domain is. And the fact that we've been able to bring, you know, AI into customer service, into patient care, into creating records and interpreting records, managing data at hyperscale, being able to interoperate data pretty successfully, you know, it's easy to see lots of great opportunities, which is exciting.

But it's also the case that we shouldn't ignore some of the amazing things that have happened in the last, say, fifteen years, to move healthcare from manila folders and paper notes to a largely digitized economy in the U.S.

STUART BROWN: I think that's a great point. I mean, we don't always stop to realize how far we've come. And I think it's been the last fifteen years, hasn't it, where that's really happened. And the promise that the next five is maybe faster, maybe more transformative than the last fifteen. Right?

CRIS ROSS: Totally. I totally agree.

STUART BROWN: And, I mean, I remember when we go back to sort of the healthcare records and having portability, and we'll talk a little bit about the EHR systems and other stuff in a little bit. But one of the biggest challenges, you know, so my new role, Chief Transformation Officer, is all about how do we help clients transform, how do we help ourselves transform? How do we, you know, there's the application of technology, the promise of technology means nothing if it doesn't get adopted in a way that is natural to the end user, whether that be a doctor, a provider, a payer, whomever.

So, tell me, I mean you dealt with the challenge of bringing this technology into these organizations that, like I said, A) they don't always believe the promise when someone tells them this is going to revolutionize and make your life easier. And they also don't have the time because they're working such large shifts. Help me understand the application of the technology, what you've seen, the lessons learned and, no matter what industry people are in that are watching this, they can get something out of it.

CRIS ROSS: Yeah. Well, Stuart, this is why you've got such a fantastic gig and have so many opportunities ahead. To bridge back to the last answer, I think we've, you know connected, we've automated, and we've done some fundamental digitization. But the thing we really haven't done is to think about, okay, now what business and clinical things could we redesign knowing that we have that technology and then do the work of applying the technology to it.

So as an example, you know, I would see as a CIO, and I saw as a patient, instances where the patient journey is interrupted and can be really difficult, even within an integrated system like Mayo. And a lot of that has to do with the fact that we're still struggling with the last challenge, which was to make healthcare really safe.

You know, the evidence is clear that there's a lot of you know, hospital-created infection and other kinds of risks. We've been trying to fix that. So what do we do? We put great departmental rules in place to keep people safe. But the problem is that those rules are not combined in a way that aligns across a patient journey. So, I have to navigate the rules of oncology and the rules of radiology and the rules of physical therapy and they don't align. So, you know, you'd ask the question, Well, why can't I do that?

Well, our department doesn't work the way that the other department works. It's those kinds of questions that we need to address. And you know that once we decide, hey, we're going to realign processes in a way that's really right for patients and providers, and not necessarily for individual departments, then we're engaged in, you know, call for change, creation of change, and then change management to make sure people adopt. So, it's a human endeavor as much as it is a technology endeavor.

STUART BROWN: I think it's majority human endeavor. I think the technology piece is sort of ubiquitous. I absolutely agree. And I think this is where I'd love to get your thoughts as a CIO and as an advisor now, around the challenge of the leaders above you to set the strategy and the mission and the goal because you will get a lot of resistance. And one of the things I've seen over my career, whenever I've rolled out a big transformation program, is number one, you need to find those folks that everyone will look to and say, well, if Cris is on board, I'm on board. You need the change agents in your organization. But more importantly, you need the leadership above to say, "This is the direction, this is the strategy." So, I'd love to get your thoughts on, sort of, where you went, you know, in your career, sort of what you saw as good in that scenario.

CRIS ROSS: Well, an example that I was involved in and I was really proud to participate in was the EHR transformation that we did at Mayo Clinic, where we went from three EHRs to one, changed a lot of systems, got rid of 350 pieces of software and so on. The reason why we were able to do that, and when people would ask why did you have a successful implementation, it was because there was an underlying business goal which had been articulated by the previous CEO, Denis Cortese, and strongly articulated by the CEO at the time, Dr. John Noseworthy, that we were going to move from a holding company to an operating company across all of our geographies and operate in a similar way. And that required clinical convergence and business process convergence.

And so the leaders of that work, like Dr. Mike Harper or Dr. Dawn Milliner drove for years processes to get us to think in a combined way. Well, that set the entire foundation for doing the EHR work and the other technical and process change things underlying it. So, you know I think the strategic cause has to be identified in order to create any kind of burning platform for change, if you will. And the burning platform can be either, we're in trouble if we don't act, or we'll miss an opportunity if we don't act.

And at Mayo it was a little bit of both, but it was largely led by this opportunity to really be the integrated healthcare system that we were created to be and aspire to be across all our geographies. And it was super exciting to be involved in that.

STUART BROWN: Well, I like the vision. I mean, I think the idea was there was a strategy set, and there was a reason for the journey. Right. I think that's always important. People will follow people when they understand at the end that there's a realization because, and I want to dig in this a little bit, like 350 systems, ripping out three EHRs, that's non-trivial. It is non-trivial to a machine that works at scale every day and can't stop. It's non-trivial to rip out three ERP systems in the company, let alone EHR systems where people's lives are on the line.

You don't put, you know, if you're doing ERP, all right, we don't close the books today, we'll close the books tomorrow. Not a big deal. EHR systems are a bit different. And so I'd like to understand a little bit, sort of, as you're dealing with these embedded legacy systems, and you're saying we're going to be replacing these with new systems. There's a comfort zone that people have with those old systems, even if they don't like them. There's the change management of getting them up to speed on the new systems while you have the old systems. And I imagine, unlike in some old ERPs, you're not keeping all of these in parallel and keeping one in the background. You've got to make these cutovers. So, I'd like to understand one, how'd you deal with that challenge? Number two, the techie in me wants to know big bang versus rollout. How did you do it?

CRIS ROSS: Yeah, yeah. Well, it was a monstrous endeavor, and we had great support from EHR vendor Epic and then some other partners in addition that supported it. But really, it was led by a great guidance committee that was led by Dr. Mike Harper and administrator Mary Jo Williamson through the whole project. We had some really, really great leaders.

Kevin Paige was identified as the person to help lead change process forward. So, we engaged about 2,000 people in some form or fashion. Some of them were, you know, part-time advisors. They participated on a committee that advised on a practice, whatever it might be. And we had a full team of about 500 people who were working on documenting and understanding what the new things like, what are the new order sets going to be, and what are the new rules that we want to embed in clinical decision support.

And there was lots of pressure testing around that. And most of it worked pretty well, and we had some mistakes, and I can describe a couple of those. But once we were ready to go and we went fast, and we had to go fast in part because a little bit of the technical sunset of the software that we had in Rochester, which was our largest campus. And the way we moved forward is we had four rollouts, and the initial rollout had two subparts.

We rolled it out to our health system, which was regional hospitals and clinics, not the destination centers in Rochester, Florida, and Arizona. And, you know, they took one for the team, to be honest. They were the first to roll out, they were enthusiastic to do it, the leaders were gung-ho, said do us first, and it was the right thing to do. And we learned a lot in that first implementation where we got some things wrong.

One example would be we had designed orders to be for the convenience of the receiving department. So how does radiology and lab like to receive orders? But it turned out that we had this huge complex library of orders and a primary care physician was like, I don't know which chest x-ray type to pick. I've got eight. I don't know. And so we had to flip that a little bit. And we did that between implementations and later.

So, we did the health system first then we did the main campus in Rochester about six months later. That was Big Bang. It was all systems, everything all at once. And we had swarms of people in town. The local newspaper noted people wearing these kind of crazy green jackets, just you know, swarming the town because we really hit it hard with lots of support from Epic and others, to make sure that we had feet on the ground.

And then we did Arizona and Florida to follow. And by the end of that, it was pretty stable. But it took maybe a year and a half, two years to get to a stability mode, to learn lessons, also to continue to implement new clinical activities and guidelines as things changed. And then we had a really big pressure test when COVID came along about two years later, but actually about a year and a half after we were done with our last rollout.

So, it was intense, it was rewarding. People worked really hard. You know, the results were positive. It's always the case when you do change, you have people who are disrupted and are upset and unhappy. And there's been a lot of effort ongoing to continue to address how can we make what works work even better for clinicians and for patients.

STUART BROWN: Well, I like, and thank you for going through that because I think it's important for those to understand how these rollouts go. And I like the fact that you were adaptable after the initial rollout, lessons learned, the fact that you had those systems willing to go first and sort of give that feedback and be able to tweak that both from them and the future was really good. Because sometimes you go live and now you're in the midst of dealing with some of the, you know, some of the, what we call the valley of despair where you're dealing with the things you didn't catch or things where you're over.

There's always the things that, you know, everybody's like, I want that alert and then you have thousands of alerts. You don't get to the real ones. All the stuff you've got to put in. So I think that's really good. And maybe let's talk a little bit more about Epic as a platform because obviously Epic has been transformative when it comes to healthcare and providers. I think it really has been the core system of record out there. And I think, I'd like to understand what they get right about healthcare and the technology and that some other technology platforms maybe miss and then what are the opportunities for other tech companies to still add value in the healthcare ecosystem around an Epic implementation?

CRIS ROSS: So, there's an awful lot of things that Epic has done right, and that's why they built so much market share. I think their biggest sort of secret out in the open is that they're really, really good at understanding what the priorities are for their customers and then building around those priorities. You know, they engage hundreds of advisors who offer up time to suggest how the product should be better. And their teams are really good at it.

They have done a lot to modernize their technology and move in all kinds of ways that probably are unheralded. You know, they went from a fat client implementation that frankly was pretty creaky to one that is web-based and so on. And some of the folks who, you know, will criticize Epic for its old technical stack really are pointing at the database structure more than anything else.

Almost everything else is really, you know, modern web-based. They did a lot to create a stable hosting business so that more and more customers now are hosting with Epic. Mayo did that. It was a fantastic financial gain for us to get out of data centers, to move to an actual modern SaaS world. And Epic has been a reliable partner with that. We spent a lot of time looking at scalability and they worry about it a lot.

And I think that's what's made them reliable. You probably saw in the news Judy Faulkner was at a conference and said that they were pausing some development to focus on cybersecurity. That's great. You know, there's a degree to which, you know, that's a gift that keeps on giving. Because in a lot of ways, given that customers ask a lot from Epic, Epic puts a ton on the conveyor belt. And it's a little hard for health systems to adopt absolutely everything that Epic puts forward. That's the other side of the coin.

STUART BROWN: Sure.

CRIS ROSS: But I think that's what they get right. With respect to innovation and, you know, what are the opportunities? Look, there's a bunch of things that Epic is not going to do. They've been pretty clear about not having their software be a software as a medical device, but an EHR which is not regulated in an FDA sense as a software as a medical device. So that means there's a ton of clinical things that are on the edges Epic isn't going to touch.

So to me, that seems like one of the more fruitful things to do, as opposed to A) the vision of, I'm going to build a better module than Epic has, and I'm going to try to sell it in such a way that kind of breaks the unified model of Epic in favor of a module that might be an A rather than maybe Epic's is a B or a B minus. Oftentimes the B minus, if it's integrated, is better than the A. So, you know, I don't know if there's a real market for that.

And then the second thing that people take on B) is, you know, I'm going to create an Epic killer. That's a pretty massive challenge. Might happen. But you know, that's a long-term, big money bet to try to disengage them.

STUART BROWN: Yeah. I mean, I think there may be pieces and parts. I think we'll see in the innovation of rapid development where there may be components of things that get done better than pieces of what Epic does, but I think you're right. I think going after it as a whole doesn't make a ton of sense. I think it's a great product, it's a great system, it's ubiquitous, it's got a lot of ecosystem, and I think that helps give a solace to a system of record that the providers need.

So, we talked a little bit about the change from the paper-based and manila folders. We've talked a little bit about Epic as an EHR and the, you know, really the enablement there. I really want to get into the patient experience because in the end, I mean, well, it's the patient experience, but we can even weave into there the provider experience as well. But like, from a patient experience perspective, you know, our patients are becoming more and more used to being served in a rapid customer way. We want the provider spending more human time with the people.

And yet people talk about AI as if it's going to take that away. And I think I'd love to get your thoughts around, I think both you and I don't think that's the case. We think it's the opposite. I think we'll get more human time if we leverage the AI, but I'd love to get your thoughts on the patient experience, how you see that has evolved, where you see it evolving, and what you think the promise is of what's coming.

CRIS ROSS: Yeah. So, I've been a patient at Mayo through two cancer journeys, and I learned a lot from that. I think the things that are happening in practice right now that are very patient positive are things like ambient listening and documentation in a doctor's office. When I go in for routine checkups now, you know, a doctor will say, "Hey, we've got this ambient listening thing. You may have heard of it. Do you mind if we try it?"

And I'm like, of course. And I love it because the clinician turns away from the computer, except for when they want to look something up that's complicated, or maybe they want to show me an image on a screen. But other than that, they're talking to me. And we're having a straightforward conversation. I can see then the note that shows up in my patient portal, and it's accurate. And it feels like a much, much, much more human experience, to be honest. The second is the ability of these tools to create a comprehensive record ahead of time. So, I go visit a clinician I've never visited before, and they speak to me as if they've been with me through my whole journey and they know everything. They get the gist. And I know that they didn't read my whole record. They couldn't. But they read everything that was salient, and they understood everything that was relevant to my care. And I think that just behind the scenes is doing amazing stuff.

There's also places where machine learnings are adding to therapies. So, one of the things that I get tested for is using residual measurement of disease tests, where this is, you know, all created using big data and machine learning techniques 10, 15 years ago, but it's a foreshadowing of what we'll have. So, I get a blood test done.

And the craziest thing is, you know, my tumor was sequenced and it looks for the particular variant associated with the tumor I have in this bloodstream, which is just absolutely full of DNA of all different types, my own and that of viruses and bacteria and god knows what. And they're able to find it. And I read the papers, and it's now getting to the point where the clinical accuracy is approaching or exceeding CT scans. So this is great, right?

STUART BROWN: Wow.

CRIS ROSS: A way that we can avoid extra radiation from scans and instead be able to identify a disease, you know, through a simple blood test. And you can think of all the examples in the way that this is coming. Already there are tools implemented that help radiologists identify priority cases or pinpoint specific things that they should review. A lot of things are still in the FDA approval pipeline that are coming to therapeutics and identification of things that clinicians should focus on. I'm super excited about all that.

STUART BROWN: Cris, I agree. And I think, you know, what's interesting with your journey is where I see AI changing individual solutions for patients. You know, we've talked about targeted, it looking for, you know, specific markers in your blood, where you know, they're now developing these really, you know, no more do we need to develop broadcast drugs. We're going to be having direct drugs and direct treatments based on and that just fascinates me.

I mean, I think, you know, I think we have so much doomerism that gets talked about AI. I don't think people talk enough about the potential life cycle extension for humans and I think it's going to be fascinating.

CRIS ROSS: Yeah, I mean, it's clear that AI can be applied for bad purposes for sure. I think it's mostly a hero story in healthcare. You know, I think there's some things we need to be really careful about. Like, you know, there's times when people might want to talk to a human being and an AI agent conversation might be frustrating to a patient. So, you know, adopters have to think intelligently about, you know, if someone has reached the limit of their patience in talking to an AI agent about something important, there ought to be a way to pop out or have some other kind of, you know, response to a patient. But we'll learn all those things, hopefully.

STUART BROWN: One of the things I definitely want to go to here, which maybe it relates, is around the governance conversation, right?

I think, when we talk AI and you can't avoid this as a CIO, right? We've got to talk governance. We talk about data governance and healthcare all the time with HIPAA rules and other things. You know, the innovation that's coming at scale cannot be at the expense of the governance conversation here. And nowhere is that more important than inside of the healthcare ecosystem and with HIPAA rules and everything else. And so, you know, it's really easy to use that as a crutch while we can't do things. I'm glad we're moving quickly, but I'd love to get your take on sort of innovation at scale and governance and AI inside the healthcare space.

CRIS ROSS: So, this is a problem and a challenge that, you know, predates the large scale AI, but it's just accelerated with AI. And that's the, you know, kind of the question about data sharing, because we know that two things are true. One is that patient privacy is paramount and patients should have the ability to direct how their data is used. At the same time we know that more data means more cures, for the examples we just gave. So, I think there's ways that you can do both of those things if you keep dual north stars in mind.

But it means navigating things like, when you're working with a third party, what data do they want to use and under what terms? And then how do you validate that they will keep the data secure and private? And that's both a security issue, but it's also a third-party risk management issue that's not just traditional cybersecurity.

I'm worried about a third party that gets hacked. I'm also worried about a third party that uses data for purposes that as a health system I wouldn't want, and as a patient, I might not want. And it's complicated to manage hundreds or thousands of third-party relationships, especially when you know that there are fourth parties and fifth parties. So, you need to put controls in place that say, the third party is not going to misuse data by giving it to someone else, etc.

So, an innovator who believes and knows that a technology is going to advance something really important for patients justifiably has a sense of urgency to move that forward. But at the same time, you know, if you move forward with urgency without putting the right kinds of evaluation and protections in place, that's how we lose data. That's how we create cyber risk for attack into a health system or into the vendors who are managing data on behalf of.

So yes, it's a complicated process, and I think governance is mostly about being transparent about opportunities and risk, being honest with each other about what needs to be done, both to serve the therapeutic interest and the data and other interests of the patient and the whole system, and to try and move with speed.

STUART BROWN: Yeah, I agree. And I think, I mean, that's any organization, not just healthcare, but obviously there's a uniqueness there when it comes to patient records. And we do have the other side of that equation now, which is we have younger generation going to the ChatGPTs and others and giving their healthcare information and getting it from there, so there's more willingness to share data. Whether we agree with that or not, where we are, I think I understand the, you know, that they're doing that because there's a value to it.

But also when they share that data with us, just like when they shared it with them, that trust is there. The governance to me really comes in the back end of a trust.

CRIS ROSS: One hundred percent.

STUART BROWN: Like in, and to your point around, we used to talk about this in a previous place when I worked where, you know, you are the company that you keep as an organization. And your brand is associated with those that you keep. And if you're a third party, you need to know where the fourth and fifth parties are. They need to understand your expectations and your standards because you're right, you can't know all of that.

But I think the idea of having a structure that says, you know, I always view them as sluice gates or filters, right? Like, we need to make sure that we're putting filters in, but I don't want to have a corral where you can't run around in it. And I want to make sure that we can move as quickly as we can, but also safely. And I think that's what you're saying.

CRIS ROSS: I totally agree.

STUART BROWN: So, get down to my final question, Cris, that I get to ask everybody. So, you know, I ask everybody what their guideline is. You know, when you talk to yourself, when you think about what you want to do, what you want people to take away from, what is, you know, your guideline, how you view things, how you approach things. I'd love to just get your thoughts on that from you.

CRIS ROSS: So, Stuart, my focus right now is about bringing innovation and change to healthcare. And the guideline I would say is, every innovative company should ask themselves the question, why isn't somebody, they should be able to answer this question: Why isn't somebody already doing what you propose to do? And I ask that question and the way that they answer it is always really insightful to me. You know, sometimes they'll say, well, a lot of people are, we're just going to do it better.

I love that answer. That's a perfectly good answer. Another one might be, well, you know, we had this insight and there was a regulatory or statutory change and we think that creates a window of opportunity. I like that answer. The one that says, well, the incumbents are dinosaurs and stupid is not a very compelling answer, in my opinion.

But boy, just asking simple dopey questions. I'm sort of the king of simple dopey questions when doing due diligence. And you get a lot from that.

STUART BROWN: Well, I love that because I'm a very first principles approach type of person. I mean I look at it like, you know, if you look at some of the, why can't we use a reusable rocket? Why can't it land on its own? Well nobody does it. That's silly. Well, what if we could? Right? And I think that's the answer. Maybe people should ask more and more, what if we could? And have the circumstances change. So I think, to your point, there's always reasons why we can't. But the question is, what barriers are in front of you to answer the, why we could?

CRIS ROSS: Well, so let's just go ask everybody those two questions, Stuart.

STUART BROWN: If everybody asked that question, I mean we would be, I mean I get fascinated by those folks that make, those innovators, the people we look at, and obviously, you know, they're all across all the industries, they're the ones that said, why not? And people are like, well, no, you can't, well, I'm going to do it, and we'll see what happens. And we need those folks. We wouldn't be where we are today.

Cris, thank you. It's been amazing. I look forward to catching up in person in the future and talking more about tech and healthcare. And thank you for doing what you're doing.

I think this is the work that is going to change lives and, you know, not everybody knows it when they walk through the door of the clinics and the hospitals you worked in, but thank you for the work you've done and the service you've given to those that don't know your name but have the results of your hard work and your team's hard work. So, thank you.

CRIS ROSS: Thank you, Stuart, and keep up the good fight. I really look forward to collaborating in the future.

The GuideLine is a podcast brought to you by Guidehouse. Subscribe wherever you listen to podcasts so you never miss an episode. To see more from Guidehouse, head to our website, guidehouse.com.

About Guidehouse

Guidehouse is a global professional services firm delivering advisory, technology, and managed services to the commercial and government sectors. With an integrated business technology approach, Guidehouse drives efficiency and resilience in the healthcare, financial services, energy, infrastructure, and national security markets. guidehouse.com

© 2026 Guidehouse Inc. All rights reserved. This content is for general information purposes only and should not be used as a substitute for consultation with professional advisors.

outwit complexity™