KLAS RESEARCH | Healthcare IT Insights



Segment Insights

2026 KLAS Emerging Solutions Top 20

November 2026

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The partnerships healthcare organizations develop with technology vendors and services firms can shape healthcare outcomes for years. However, amid an ever-crashing wave of emerging solutions, it can be difficult for healthcare organizations to identify which partners are best positioned to assist in their efforts to achieve the Quadruple Aim of Healthcare. This report has two goals: (1) to rank the top 5 emerging solutions best positioned to impact each arm of the Quadruple Aim and (2) to share insights from our panel of interviewed healthcare leaders regarding the innovations most salient to the healthcare market today.

Help KLAS Discover the Next Emerging Solution

You can contribute to our research—if you know of an emerging HIT vendor or services firm that KLAS should measure, reach out to your KLAS representative or email etech@klasresearch.com.

Report Methodology

The feedback included in this report is primarily **perception based**; 38 healthcare thought leaders (see full list starting on page 5)—many with executive or C-level experience—rated eligible solutions on a 1–9 scale based on the solutions' potential to impact each arm of the Quadruple Aim, i.e., to (1) improve outcomes, (2) reduce the cost of care, (3) improve the patient experience, and (4) improve the clinician experience.

The top 5 rated solutions in each area are ranked in the sections below and collectively make up the KLAS Emerging Solutions Top 20 for 2026. To be eligible for consideration, a solution must have been highlighted in a KLAS Emerging Company Spotlight report or First Look report between July 1, 2025, and August 5, 2026, and it must have received an overall score from customers of at least 85 (out of 100). 23 solutions met this criteria (see full list on page 5).

2026 KLAS Emerging Solutions Top 20

The companies ranked below are those that received the top 5 scores within each arm of the Quadruple Aim. In addition to being featured in this report, the Top 20 Emerging Solutions were recognized at the 2026 HLTH Conference in Las Vegas.

All comments below come from the participating provider thought leaders who rated the solutions and shared their perceptions after reading the KLAS emerging solutions reports. Each thought leader read 8–10 reports. While some thought leaders have direct experience with the solutions they rated, most do not.

Click on any report title to access the full report.

Top 5—Improve Outcomes

1 Insight RX

InsightRX 2025: Reducing Medication Dosing Errors & Adverse Events via Clinical Decision Support

"InsightRX is my top-rated solution because it demonstrates the practical promise of AI in healthcare, helping clinicians make safer, more individualized medication decisions while reducing toxicity, unnecessary testing, and avoidable costs. Its combination of specialized clinical models, pharmacy expertise, treatment data, and EHR integration creates a differentiated capability that could evolve into a true digital pharmacist as the platform expands." —Provider thought leader

2 Latent

Latent Health 2026: Simplifying the Patient Medication Access Journey with Enterprise Pharmacy Intelligence

"Prior authorization is a major access and administrative bottleneck, so automation that reduces turnaround from days or weeks to a few days can directly improve time to therapy while reducing manual work. Latent's strongest potential is an end-to-end, EHR-integrated workflow that removes friction for patients, pharmacy teams, and providers." —Provider thought leader

3 

Arkstone OneChoice 2026: Enhancing Provider Decision-Making with Clear, Personalized Pathogen Reporting

"This solution provides strong antimicrobial-stewardship decision support and turns complex pathogen and resistance data into clear, actionable antibiotic guidance for non-ID providers, which is where the outcomes potential really sits." —Provider thought leader

4 

Sayvant 2025: Automating Clinical Documentation with AI to Reduce Physician Burden

"What distinguishes this platform is its focus on inpatient and emergency care, rather than the outpatient settings targeted by most ambient documentation tools. By capturing clinical information in real time and turning it into usable insights, it may support key hospital decisions, such as admissions, patient-status classification, and length-of-stay management. This wider operational and financial impact makes it more than a traditional ambient scribe." —Provider thought leader

5 

Heidi 2025: Reducing Clinician Documentation Burden via AI-Driven Scribing & Workflow Tools

"This solution improves documentation quality across specialties, reduces provider documentation burden and potential scribe costs, frees providers to focus more on patients and communication, delivers high provider satisfaction, and is built around the physician's workflow." —Provider thought leader

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Top 5—Reduce Cost of Care

1 

Casechek 2025: Reducing Billing Errors & Workflow Inefficiencies Through Automated Integration & Real-Time Data Visibility

"Casechek addresses a highly manual, error-prone implant and bill-only workflow by reconciling EHR, vendor, and purchasing data. The potential for meaningful savings and staff-efficiency gains is high, with a secondary benefit from better documentation and workflow reliability." —Provider thought leader

2 

Sublimation Health 2025: Providing Healthcare Cloud Services Through Expert, Transparent Partnership

"Cloud migration, application rationalization, and managed services can improve resilience and reduce infrastructure cost when executed with strong healthcare-specific expertise. The potential is high for IT cost savings and highly reliable infrastructure." —Provider thought leader

3 

Latent Health 2026: Simplifying the Patient Medication Access Journey with Enterprise Pharmacy Intelligence

"Tools to automate prior authorization are incredibly valuable in healthcare. The differentiators are the link to payer policies and the vendor's willingness to pilot and improve their solution." —Provider thought leader

4 

InsightRX 2025: Reducing Medication Dosing Errors & Adverse Events via Clinical Decision Support

"InsightRX functions as a scalable substitute for per-patient lab-driven dosing. Bayesian precision dosing structurally reduces the number of monitoring draws per treatment course, and each avoided draw eliminates assay cost, phlebotomy time, and pharmacist recalculation. A lab informs one patient at one point in time. The software applies across every dosing decision at zero marginal cost. With customer-reported reductions in acute kidney injury (one estimating six-figure annual savings) the cost mechanisms scale strongly in the software's favor." —Provider thought leader

5 

Arintra Autonomous Medical Coding 2026: Improving Coding Accuracy & Efficiency with AI-Driven Automation

"This is Arintra's primary strength. It supports direct-to-bill autonomous coding, allowing the majority of claims to move directly to billing while routing exceptions to humans. Coding is embedded within the EHR rather than requiring another application." —Provider thought leader

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Top 5—Improve Patient Experience

1 

Assort Health 2026: Improving Patient Access with Customizable, AI-Driven Automation

"Customers report reduced staffing requirements, lower call-center workloads, shorter wait times, and the ability to address employee attrition through automation. Assort Health automates inbound calls, scheduling, FAQs, triage, insurance questions, appointment changes, and after-hours coverage—all functions traditionally requiring significant staffing." —Provider thought leader

2 

Latent Health 2026: Simplifying the Patient Medication Access Journey with Enterprise Pharmacy Intelligence

"Faster authorizations and higher approval rates directly reduce the frustrating gap between a physician prescribing something and the patient receiving it. The voice-agent capability also supports welcome and refill outreach and automates payer status work." —Provider thought leader

3 

NextPatient 2025: Enhancing Patient Scheduling, Communication & Management Through EHR-Integrated Software

"Scheduling and check-ins are a very time-consuming, manual, and labor-heavy area of healthcare. NextPatient automates much of that and has tremendous potential to reduce staffing and give patients an easier, better experience to get real-time scheduling support via a simple text. By making it easy to schedule and get appointment updates via text, it can also reduce leakage and ensure patients make their necessary appointments." —Provider thought leader

4 

Heidi 2025: Reducing Clinician Documentation Burden via AI-Driven Scribing & Workflow Tools

"I see strong patient-experience potential. Reducing screen-driven interaction allows clinicians to remain more present with patients, and Heidi reports high patient acceptance and improved rapport, although the ultimate impact on clinical outcomes and total cost is more indirect." —Provider thought leader

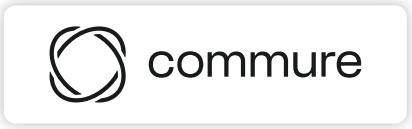
5 

InsightRX 2025: Reducing Medication Dosing Errors & Adverse Events via Clinical Decision Support

"The benefit is largely clinical rather than experiential, but safer dosing, fewer side effects, and avoiding preventable complications unquestionably improve the patient's care journey." —Provider thought leader

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Top 5—Improve Clinician Experience

1 

Commure Ambient AI 2025: Reducing Provider Documentation Burden Through Ambient AI

"Customers reported reductions of 1–2 hours in documentation per shift, less cognitive burden, and fewer after-hours charting demands. These time savings improved clinician work-life balance and allowed providers to focus more fully on patients, supporting a very high potential to improve provider satisfaction." —Provider thought leader

2 

Heidi 2025: Reducing Clinician Documentation Burden via AI-Driven Scribing & Workflow Tools

"Customers described immediate and substantial reductions in provider documentation time and after-hours work, including estimated savings of 7–9 minutes per encounter. Providers reported lower burnout, greater enjoyment of clinical practice, and improved work-life balance, with some reconsidering plans to reduce their hours or retire." —Provider thought leader

3 

InsightRX 2025: Reducing Medication Dosing Errors & Adverse Events via Clinical Decision Support

"I like this one. I think the EHR will do this someday, but it is still a slog to get the dosing right for patients. With the advent of genetic testing as more commonplace, this will be more important to get great outcomes for patients and for health systems to save money but get the dosing right." —Provider thought leader

4 

Sayvant 2025: Automating Clinical Documentation with AI to Reduce Physician Burden

"Sayvant is particularly compelling because it moves AI documentation beyond transcription into real-time documentation quality, clinical evidence alignment, medical necessity, and financial defensibility. By identifying gaps before the note is signed, the platform has the potential to improve clinical quality while reducing downstream queries, rework, denials, and missed charge capture; this is a meaningful convergence of clinical and financial value rather than documentation efficiency alone." —Provider thought leader

5 

Matic 2026: Reducing Clinical Documentation Time by Generating Accurate, Customizable Medical Notes Through AI

"Matic delivers a scribe platform that provides a custom templating function, allowing providers and organizations to add nuances to their notes that other platforms may not capture." —Provider thought leader

All Eligible Solutions

Below are all 23 solutions and services that were eligible for an Emerging Solutions Top 20 award. Each was highlighted in a KLAS Emerging Company Spotlight or First Look report between July 1, 2025, and August 5, 2026, and received an overall score from customers of at least 85 (out of 100). These solutions represent only a sample of all emerging companies/solutions that KLAS measures. To see additional reports, please visit the KLAS website.

Click on any vendor name to access their full report.

Arintra Autonomous Medical Coding 2026

Arkstone OneChoice 2026

Assort Health 2026

Canvas Medical EMR Platform 2025

Casechek 2025

Commure Ambient AI 2025

Connext Global Solutions 2026

Corti 2026

Heidi 2025

InsightRX 2025

InterScripts MyChart Support Services 2026

Intruno Privacy Monitoring 2025

Latent Health 2026

Magical 2026

Matic 2026

NextPatient 2025

Pharmacy Stars Compounding360 2025

RAAPID AI Retrospective Risk Adjustment 2026

Sapphire Health Cloud Services 2026

Sayvant 2025

Sublimation Health 2025

TREND Health Partners Denials Management Services 2025

UST HealthProof BPaaS 2025

Participating Provider Thought Leaders

We are grateful for the thoughtful review and engagement from our prominent healthcare thought leader team.



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LifeBridge Health



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Technology Innovation Themes

Many of the participating thought leaders who gave ratings for the Top 20 report also shared their thoughts on an HIT subject for which they have expertise and passion. These thoughts—on topics such as AI, cybersecurity, interoperability, and staffing—are shared below.

The Patient Who Never Came: Population Health, AI & the Primary Care Denominator



Faisal Al-Qahtani, MD, MSc-HCM
Executive Director of Primary & Community Healthcare
Eastern Health Cluster

A family physician learns the denominator the hard way. The patient I think of is a man in his fifties with diabetes who simply stopped coming. His name stayed on my list. His HbA1c stayed at the last value anyone had recorded. The next time the system saw him was in an emergency department, with a foot that should have been looked at months earlier. Nothing in the clinic had failed; the visits he did attend were good visits. The failure was in the months when nobody was looking.

Nearly every solution in this year's cohort makes something inside the clinic faster or safer: the note, the claim, the authorization. Almost nothing in the stack was built to find the people who never walked in. That is where population health lives, and primary care is the only part of the system positioned to own it.

Hospitals see a numerator: the encounter in front of them. Primary care owns the denominator: everyone registered to a center, whether or not they came this year. In the 1980s, family medicine researchers named this the denominator problem. The data have improved enormously since. The problem has not.

The encouraging trend is that AI is starting to move from the visit to the registry. A July 2025 comment in npj Digital Medicine argued that population-level AI is primary care's next frontier and pointed to early evidence: a randomized trial in JAMA Network Open in which a chatbot handled cancer genetic-risk outreach and follow-up for more than 3,000 primary care patients, with uptake equivalent to the standard process; multilingual AI agents that raised colorectal screening uptake among Spanish-speaking patients whom conventional outreach was missing; and AI-generated "chase lists" for Medicaid care teams that, in an NEJM Catalyst evaluation, were associated with a 23% drop in acute events and a 48% drop in ambulatory-care-sensitive admissions against matched controls.

The evidence also demands discipline. A 2024 systematic review in BMJ Health & Care Informatics found that most real-world evaluations of primary care risk stratification tools showed no change, or an increase, in utilization among the targeted groups. A cluster-randomized trial across 16 Kenyan primary care facilities, published in June 2026, found that LLM assistance improved documentation but not treatment outcomes at 14 days. Identification is not an intervention, and a better note is not a better patient. A model that produces a list nobody has the slack to call is an expense, not a strategy. That is the real case for the administrative automation in this report: it frees a team to work its registry instead of its inbox.

Governments are organizing around the same idea. England's 10 Year Health Plan puts AI triage at the front door of the NHS App and builds neighborhood teams around population health and predictive prevention. Saudi Arabia's Health Sector Transformation Program has made prevention the starting point; Seha Virtual Hospital links 241 hospitals and more than 1,400 health centers, and the Sehhaty app passed 31 million users in 2025, a national channel for reaching people between visits. WHO's European readiness survey shows what still holds the field back: 86% of countries cite legal uncertainty, only 8% have liability standards for AI in health, and fewer than a quarter train health workers in it.

So the ask of emerging vendors is specific. Build for the registry, not the room. Surface the people who are overdue, unreachable, or deteriorating; rank them by what a team can act on this week; close the loop into the booking system, not a dashboard. Measure success in screenings completed and HbA1c controlled across a population, not minutes saved per note.

Value is created where health begins, not where disease ends. The AI that matters most for population health is the kind that finds the patient before the system does.

AI Won't Just Change Healthcare Software—It Will Change Who Builds It



Emily Borlas
VP, Enterprise Applications
HonorHealth

The biggest threat to healthcare software vendors over the next decade may not be a competitor. It may be their own customers. For years, healthcare organizations have purchased software because building it themselves was too expensive, too slow, and too specialized. If a hospital needed a scheduling platform, referral management tool, patient engagement solution, or analytics application, they typically turned to a vendor. Artificial intelligence is beginning to change that equation.

Today, low-code and no-code tools allow non-technical users to create surprisingly sophisticated applications. The next step seems inevitable: software developed largely through conversation. Instead of writing detailed requirements and waiting months for development, healthcare leaders may simply describe a workflow, policy, or business problem and watch AI generate a working application in minutes. As software creation becomes dramatically easier, many vendors will face an uncomfortable reality—if their primary value is automating a workflow or digitizing a process, health systems may increasingly be able to build those solutions themselves.

The disruption will eventually go even deeper than software development. Most healthcare applications today are built around graphical user interfaces. Users log in, click buttons, navigate menus, and move through screens. But AI agents do not need dashboards. They need access to data and rules and permission to act. Imagine a future where a care manager says, "Identify every patient overdue for follow-up, contact them, schedule appointments, and summarize any barriers to care." No reports. No queues. No navigation menus. The AI completes the work and provides the outcome. If that future emerges, healthcare organizations may stop evaluating products based on the quality of their user experience and start evaluating them based on the quality of their underlying intelligence.

That does not mean all healthcare technology vendors are at risk. In fact, some may become more valuable than ever. The most defensible companies will likely be those with assets that cannot be easily recreated. FDA-cleared algorithms, clinically validated AI models, and Software as a Medical Device (SaMD) solutions may gain value because regulatory approval creates barriers that AI cannot quickly erase. Specialized clinical intelligence may be another durable advantage. While general-purpose AI models will become increasingly common, organizations that possess unique clinical datasets, disease-specific expertise, or highly specialized healthcare LLMs may develop competitive moats that are difficult to cross. Ultimately, the winners may not be the companies with the best software. They may be the companies with the best evidence, the best data, and the most trusted intelligence. For decades, software was the product. In the AI era, software may become a commodity. The real value will lie in the knowledge, validation, and trust that sit behind it. And for many healthcare software vendors, that distinction may determine who thrives and who disappears.

Ambient Documentation & Shifting the Burden



Rhiannon Doherty, DHA, APRN, CHCIO
Director of Usability & Clinical Optimization
Baptist Health—Jacksonville

Ambient documentation is changing clinical documentation quickly and, for the most part, it seems like a good thing. But sometimes I think we are asking the wrong question about its impact. I keep seeing the question: does it save clinicians time? And of course time matters. But documentation burden has never been just about time.

Research on clinical documentation burden found three interconnected factors underlying the experience: poor usability, perceived task value, and excessive mental exertion. That helps explain something most clinicians intuitively understand: two tasks can take exactly the same amount of time and feel completely different. Ambient documentation makes that distinction even more important because it fundamentally changes the clinician's job. We are moving from authoring a note to editing and validating one. On paper it sounds easier, and it can be, but it is different work.

Instead of thinking about only what they need to document, clinicians are now needing to ask themselves: Is this accurate? Is anything missing? Did the AI misunderstand what the patient said? Does this actually sound like my clinical reasoning? Those questions require attention, judgment, and vigilance, and I'm not convinced our current metrics capture that shift. If an ambient tool cuts note-writing time by five minutes but replaces it with five minutes of a cognitively demanding review, is that an improvement? Maybe, maybe not. We need better ways to tell the difference.

As these tools mature, I'd like to see health systems and vendors look beyond time-in-note and after-hours work. We should also be measuring editing intensity, correction patterns, cognitive effort, trust, perceived value, and whether the final note actually reflects the clinician's thinking and the patient's story. I do believe that ambient AI gives us a real opportunity to reduce documentation burden, but we have to make sure we aren't simply moving the burden somewhere new.

The People Behind the Revenue



Miriam Flores
VP, Revenue Cycle
The University of Texas MD Anderson Cancer Center

AI and business office transformation are becoming inseparable within revenue cycle operations. Yet too often, conversations about automation focus narrowly on one outcome: reducing the cost to collect. While financial efficiency is important, organizations must be careful not to lose sight of the people who make revenue cycle performance possible.

Many revenue cycle functions, including coding, billing, claims follow-up, and collections, are sometimes viewed as routine processes that can be easily automated. In reality, these roles require a significant degree of expertise, critical thinking, problem-solving, and empathy. The value of experienced revenue cycle professionals extends beyond task completion. They understand payer nuances, documentation requirements, compliance risks, and the unique challenges that arise when policies change or exceptions occur.

The greatest opportunity for AI is not replacing these employees but elevating their work. By automating repetitive and rules-based activities, organizations can free skilled team members to focus on more complex responsibilities that require judgment, reasoning, collaboration, and empathy. Revenue cycle leaders have a responsibility to communicate this vision clearly throughout the organization. Executive leaders need to understand that successful transformation requires both technology and people, while frontline staff need reassurance that automation is intended to support, not replace, their expertise.

Equally important is investing in workforce development. Skilled coders, billers, and collectors should not feel forced out by automation. Instead, organizations should prioritize training and upskilling programs that enable employees to work effectively alongside AI tools. Their institutional knowledge is invaluable in refining workflows, identifying errors, and improving system performance. After all, without employee engagement and expertise, how can organizations effectively evaluate, validate, and continuously improve these technologies?

Today, a human-in-the-loop approach remains essential. AI is already generating efficiencies and reducing administrative burden, but accuracy rates across complex payer policies, medical record documentation, and coding scenarios are not yet sufficient for fully autonomous operation.

Recommendation: Cost-to-collect improvements will come at the right time. In the meantime, continue investing in human capital. Revenue cycle professionals will not only help organizations adopt automation successfully, but they will also ultimately pave the way for sustainable, scalable, and responsible AI-driven transformation.

Responsibility in a Time of AI Decisions



Claire Floyd, **MSN, RN-BC**
Nursing Informatics Specialist
Frederick Health

At 3:00 in the morning, a nurse gets an alert saying a patient is at risk. There are eleven seconds to decide whether to believe it, and no way to know that the model behind it learned from a field that two units define differently.

Nurses generate the richest clinical data in healthcare, and I do not believe we have earned the right to hand it to artificial intelligence yet. Our greatest failure came when electronic health records arrived and none of us, nursing or IT, owned the record together. Clinicians walked away from the design table, and technology teams were left holding decisions they were never meant to make alone.

We are still living in the house nobody agreed to build. Walk into almost any hospital and ask what a single documentation field actually means, who defined it, and who is accountable for it today, and you will get shrugs, guesses, and the name of someone who left three years ago. We tolerated that because it only produced confusing dashboards, and confusing dashboards can be explained away in a meeting. Algorithms cannot. When one unit charts ambulation as distance walked and another charts anything that happens out of bed, that is not a documentation quirk. It is a flaw an AI model will faithfully learn, amplify, and deliver to the bedside as guidance about a real person in a real bed.

Data that belongs to everyone is governed by no one, and a catalog without named owners is just a very organized list of things nobody is responsible for. So here is the stand I am asking you to take, and it is smaller than you think—pick one field you chart or review on every shift or on every dashboard, ask who owns its definition, follow the answer until you reach a person, and refuse to accept "nobody" as the answer. The nurse standing at that alert at 3:00 in the morning deserves to know who is behind it. So do you.

AI Should Remove Not Add



Devin Gregory
Practice Manager
Coastal Carolina Family Practice

If you ask what keeps me awake at night, at least when it comes to healthcare these days, the answer isn't the question of what is missing. My thoughts lean more toward what we can take away, and while that may sound counterintuitive in a healthcare environment in this country, where so many are in need and lack cohesive, adequate care, our problems don't stem from a lack of resources. Instead, they exist in the layers added in the name of capitalism, while patients and caregivers are down in a sea of well-intentioned "fixes." So the question becomes: should healthcare IT's next innovation be less healthcare IT? Not literally less technology, but less technological fragmentation.

The fact is, the next generation of healthcare innovation shouldn't be measured primarily by how many new capabilities we add. It should be measured by how much unnecessary work, duplication, fragmentation, and infrastructure we can remove while improving care. And if we are really being honest, the most transformative healthcare technology may not be the solution that adds the most functionality but the one that makes several existing functions—and the administrative work surrounding them—unnecessary.

While this may not be the most popular position in the free-for-all that has become the healthcare technology landscape, it is an honest one as we consider how we got to where we are and where we go from here. And while I may not necessarily have the answer, I think half the battle lies in asking the hard questions. Is it government regulation, capitalism, or privacy; the perfect storm of all three; or just a lack of imagination?

Where Is the Emerging Technology for Nurses?



Karen Hunter, DNP, RN, NI-BC, CENP
Former CNIO
Adventist Health

Serving on this evaluation board for five years has been a privilege. This cycle, the privilege came with a sting. I reviewed eight emerging solutions. They were genuinely impressive—ambient AI that gives emergency physicians their evenings back, precision dosing that prevents kidney injury, and agents that automate the revenue cycle. I happily rated them, and I'm glad they exist.

But as a nurse, I noticed something: not one of the solutions was built for nursing. Physicians got documentation relief. Pharmacists got clinical intelligence. Billing got automation. The largest licensed workforce in healthcare—the people delivering the majority of hands-on patient care—got nothing in my stack of solutions.

I understand the investment logic. Physician time converts directly to billable revenue, so tools that recover physician hours have an ROI story a CFO can approve in one meeting. Nursing's value is real but harder to capture. It shows up as costs avoided rather than revenue generated: the deterioration recognized early, the readmission prevented, the fall that never happened, and the experienced nurse who didn't resign. Because that value is diffuse and preventive, it rarely fits a vendor's pitch deck.

Think about a pit crew. The driver gets the trophy, but the car reaches the finish line fastest only when every member of the crew has top-notch tools, processes, and skills. Healthcare is no different. Every measure in the quadruple aim runs through nursing. Cost of care? Turnover costs $60,000 per departing nurse, and documentation burden and cognitive overload drive the burnout behind it. Patient experience? No role shapes it more. Outcomes? Medication safety, discharge education, and care navigation are all nursing work. Clinician experience? Nurses are clinicians, though our industry's vocabulary keeps forgetting that.

One caution for vendors who do turn toward nursing: you cannot hand a nurse a physician's tool and call it innovation. Nursing workflows are fundamentally different. Nurses do not experience one patient at a time; they are juggling many patients continuously, all while being interrupted and trying to complete a range of tasks that span assessment, intervention, coordination, and education. Ambient documentation, acuity and staffing intelligence, and cognitive-load support all have obvious nursing applications, but they must be designed for how nursing actually works. The hard engineering is already done. It just hasn't been pointed at nursing.

So, my challenge to the emerging-solutions community: where is nursing's emerging technology, and who is looking for it? The vendor that brings physician-grade innovation to the nursing workforce—built for nursing's workflow and measured by nursing's economics—won't just find a grateful market of four million nurses. It will find the widest path to improving every dimension of the Quadruple Aim at once, because when the whole crew has the best tools, the whole team wins.

Capacity as an Asset in the Age of AI



Khurram Mir, FACHE, CHCIO
Managing Director
UCI Health | Ventures & Innovation

Healthcare IT has the potential to relieve some of the ever-growing financial and operational pressures that all health systems face. It also makes it increasingly difficult for systems to sustain the same playbook given that we are dealing with constrained resources, access challenges, and a changing policy environment. We are in a technology and innovation cycle with AI disrupting and introducing change at faster rates than previous technologies did. AI presents an opportunity dilemma—rather than just deploying another application, what if we implemented AI thoughtfully and harnessed its potential to create capacity across the organization?

From my vantage point, I see capacity as an asset that all leaders should be deliberate in approaching. They need to understand the capacity impact that various technologies have across the continuum, including internal operations, patient throughput, patient access, and the employee/patient experience. We must also consider how we reinvest this saved capacity into other problems. We need healthcare IT to move beyond the traditional playbook and help organizations understand what capacity a technology released, where that capacity went, and whether it can be reinvested to create additional operational and, eventually, financial value. If we can do that repeatedly, the gains can begin to compound. If not, the efficiency simply disappears back into the organization.

Healthcare's Next AI Test



Greg Nelson, MMCi, FACHE, CPHIMS
Executive Director, Data Strategy & Governance
Cleveland Clinic

AI is entering the era of token economics.

For the past few years, enterprise AI operated in a subsidized environment. Projects were small, usage limited, and inference costs often absorbed through vendor contracts, cloud credits, or innovation budgets. Effectively, tokens were free.

That changes as AI becomes part of the operating model. Ambient solutions scale across thousands of encounters. Agents reason, invoke systems, retry failed steps, and increasingly act on behalf of people. At an enterprise scale, token discipline becomes an operational requirement: choosing the right model, limiting unnecessary reasoning and retries, and understanding the cost of each workflow.

For CIOs, the conversation shifts from asking what AI can do to what is worth spending money for AI to do. But there is a sharper question: should the work exist at all?

The bigger opportunity in token economics is not using fewer tokens to do the same work. It is using inexpensive intelligence to eliminate transactions, handoffs, and processes that should not exist at all.

Ambient documentation showed the first part of this evolution. These solutions reduced documentation burden and returned time to clinicians. Now the market is moving beyond the ambient scribe.

Recent KLAS Emerging Solutions cohorts make that shift visible. In 2025, companies such as Ambience, DeepScribe, and Nabla demonstrated the value of AI that assists clinicians. By 2026, companies such as Corti were moving from "scribe" to "assistant," while agents expanded into coding, prior authorization, denials, scheduling, and payer operations.

Healthcare AI is moving from helping humans do the work toward increasingly doing the work under human direction. That is the real test.

Consider prior authorization. One path uses AI to generate increasingly sophisticated requests while payers deploy AI to review, challenge, or deny them just as efficiently. We could end up with two optimized systems arguing over the same decision while the patient waits. That would be technically impressive and economically meaningless.

The other path looks more like gold-carding. Use data to establish that a provider consistently meets the criteria and remove the authorization requirement altogether.

In the first case, we automate the friction. In the second, the transaction disappears.

The measure of this technology should not be the number of transactions it automates. It should be the number it makes unnecessary.

For CIOs and digital leaders, this suggests a different way to evaluate AI investments. Architecture, governance, integration, and token consumption matter. But ROI should also capture the work eliminated: fewer handoffs, queues, controls, and process steps.

The first phase of AI economics may focus on conserving tokens. The more important phase will focus on conserving transactions.

A CIO can optimize an agent to consume fewer tokens. The bigger prize is designing a system in which the agent never needs to run.

For fifty years, healthcare has layered new technology onto old complexity. Agentic AI gives us a chance to do something different.

This time, the goal should not be to make the machinery run faster. It should be to need less machinery.

A Collaborative Start with AI



Dr. Walid Rafeh, DBA
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Using AI for diagnosis is becoming increasingly common in medical imaging, and healthcare leaders need to decide whether their organizations will make their own solutions or buy from companies. When organizations buy everything, it seems to cause problems, such as increased costs, integration complexity, and systems not working together well.

Additionally, vendors can lock organizations in once things are set up, meaning that healthcare organizations lose some control over their own data. Connecting everything together can be messy, resulting in significant complexity and cost to switch solutions down the road.

Pooling resources can be a practical and sustainable way for healthcare organizations to advance AI, rather than relying solely on third-party solutions or developing everything independently. Academic medical centers can collaborate to develop and validate shared AI tools across a broad range of healthcare applications, including clinical decision support, medical imaging, workflow optimization, predictive analytics, patient safety, and population health. This collaborative approach would help share development costs, accelerate innovation, and encourage knowledge exchange and transparency. Each organization would retain control over its own data through secure, privacy-preserving collaboration, allowing institutions to benefit from collective expertise without compromising data privacy or governance.

However, this option is easy to miss when everything feels urgent. Organizations generate the data, but the vendors end up with the power on pricing and direction. I think this creates an imbalance that is hard to fix once it is already in process. This feels like a trap that requires deep collaborative analysis. Maybe consortia is a way forward, but I admit I am not totally sure how to initiate it or how it might play out in practice.

The Real Next Step for AI in Healthcare Revenue Cycle



Robert Rodgers
VP of Revenue Cycle Management
Arches Medical

For the better part of a decade, artificial intelligence has been heavily promoted across healthcare RCM. Vendors and conferences have framed each new release as a breakthrough. In reality, much of what we have seen is the steady maturation of automation and the improved ability to apply technology to repetitive, rules-based work. That evolution has now reached a point of near ubiquity.

Today, most revenue cycle professionals have access to a capable LLM, whether through a free consumer version or a work-provided enterprise account. In a single conversation, these tools can surface roughly 95% of the knowledge needed for common revenue cycle questions: coding guidance, denial reason interpretation, payer policy summaries, and documentation requirements. When comparing the output quality of leading general models against specialized coding solutions or autonomous coding platforms, the differences are often narrower than marketing materials suggest. The larger gaps appear in cost and in how quickly usable answers can be delivered inside actual workflows.

This reality points to a clearer path forward. The next meaningful advance will not come from attaching another label to the next point solution. It will come from tighter, more practical integrations that feed the model richer, more current context. Connecting LLMs directly to electronic medical record systems, payer portals, and supporting APIs allows the technology to move beyond generic knowledge and

into the specific data that drives revenue cycle performance—eligibility details, claim status, provider documentation, contract terms, and real-time policy updates.

When an LLM can pull live information from these sources and return it in context, the value shifts from answering questions to supporting decisions. Staff spends less time gathering information across multiple systems and more time acting on it. Organizations gain speed without sacrificing accuracy, and the cost of specialized tools becomes easier to justify only when they deliver measurable integration advantages rather than marginal improvements in model quality alone—improvements that are increasingly hard to claim given the rapid pace of Claude, Grok, and ChatGPT.

AI in revenue cycle has already proven it can make knowledge widely available. The organizations that will pull ahead are those that treat the technology as infrastructure—something that must be wired into the systems where revenue cycle work actually happens—rather than as a point solution. The future is less about the next clever prompt and more about closing the last mile between insight and action. If a vendor tells you they have agentic AI, ask them to first define it and then explain the orchestration layer.

The Next Governance Gap: When AI Agents Act, Not Just Answer



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Most healthcare AI governance conversations focus on outputs—bias, accuracy, and explainability. That's necessary, but no longer sufficient. As AI agents move from pilot to production, the real shift isn't what they answer, but what they do—taking autonomous, multi-step actions across clinical and administrative workflows, often touching data and systems with no single policy fully anticipated.

Think of it as a new kind of "knock on the door." An agent reads a document, an email, or a support ticket and then acts on what it finds. It isn't malfunctioning; it's doing exactly what it was designed to do—read, interpret, act. But that same capability means small, unexamined inputs can quietly steer real decisions. Consider a prior authorization agent empowered to approve routine requests automatically; an overlooked edge case could trigger approvals that look routine but aren't, with no one the wiser.

We need to move beyond governing AI at the review stage. Agentic AI needs people to govern over the data an AI agent can touch, the decisions it can make alone, and the trail it leaves behind. That means treating AI systems the way we treat new clinical devices—validated for what they do right and stress-tested for what happens when they don't. We need clear data access boundaries, real-time monitoring of agent behavior, and audit trails detailed enough to reconstruct any decision after the fact.

In my own work building AI governance for a regulated, multi-payer environment, this principle has been central—human-in-the-loop review, risk tiering, and audit logging aren't compliance boxes to check. They're what let an agent act with real autonomy while staying accountable to the data and decisions it touches. Autonomy without accountability isn't intelligence; it's exposure.

Technology with Purpose: A Rural Healthcare CIO's Perspective



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Healthcare IT leadership in a rural health system is both challenging and incredibly rewarding. Unlike large health systems with extensive resources and specialized teams, rural organizations are often asked to deliver the same level of innovation, cybersecurity, and digital transformation with far fewer people and dollars. Technology leaders in rural healthcare quickly learn that success is not about having the most resources. It is about making the most of the resources available.

One of the greatest challenges is scale. A large health system may assign entire teams to a single technology platform, while a rural hospital may rely on one individual supporting multiple applications and projects. Workforce shortages, cybersecurity demands, regulatory requirements, and financial pressures require leaders to constantly prioritize, adapt, and find creative solutions.

Yet these same constraints often drive innovation. Rural healthcare organizations have become experts at leveraging partnerships, telehealth, automation, and, increasingly, artificial intelligence to expand access and improve efficiency. We cannot simply add more people when workloads increase. Instead, we redesign processes, embrace technology thoughtfully, and focus on solutions that create measurable value for patients and caregivers.

What fuels the passion of rural healthcare IT leaders is the connection to the communities we serve. Our patients are not anonymous data points. They are our neighbors, family members, teachers, business owners, and friends. Every technology decision has a direct impact on the people we know and care about. That creates a level of purpose and accountability that is difficult to replicate elsewhere.

The future of rural healthcare will require leaders who can bridge technology, operations, clinical care, and workforce strategy. The challenges are real, but so is the opportunity. Rural healthcare organizations have repeatedly demonstrated that innovation does not require scale. It requires resilience, collaboration, and a relentless focus on improving access and outcomes for the communities that depend on us. At its best, healthcare IT is not about technology. It is about people, and nowhere is that more evident than in rural healthcare.

Redefining Clinical Excellence: The Healthcare Ecosystem Is Changing, Medical Education Should Too



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Executive Clinical Director
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The clinician of tomorrow won't simply deliver expert clinical care—they'll orchestrate increasingly intelligent systems that make expert care possible.

Artificial intelligence is rapidly becoming part of everyday clinical practice, yet graduate medical education continues to prepare clinicians largely for the healthcare system of yesterday. Tomorrow's physicians and advanced practice providers will undoubtedly learn to use ambient documentation, predictive analytics, clinical decision support, and increasingly intelligent diagnostic tools. But learning to use technology is fundamentally different from learning to lead in a technology-enabled healthcare system.

Tomorrow's clinicians will not compete with AI—they will collaborate with it. Success will depend less on memorizing information and more on asking better questions, synthesizing increasingly complex data, recognizing the limitations of algorithmic recommendations, and maintaining accountability for decisions that ultimately remain human. Clinical judgment will become less about possessing every answer and more about integrating human expertise, digital intelligence, and patient values into the best possible plan of care.

That evolution demands an equally significant shift in graduate medical education. Beyond anatomy, physiology, and evidence-based medicine, tomorrow's clinicians should develop competencies in data literacy, health informatics, implementation science, systems engineering, AI governance, cybersecurity, quality improvement, and human-centered design. Just as importantly, they must learn skills that have historically received far less attention during clinical training: leading multidisciplinary teams, navigating organizational change, evaluating emerging technologies, distinguishing meaningful innovation from digital noise, and responsibly implementing technology at scale.

Ironically, as technology assumes more analytics and administrative work, the uniquely human dimensions of medicine become even more valuable. Empathy. Communication. Trust. Shared decision-making. Technology should never compete with the patient relationship; it should strengthen it by allowing clinicians to spend less time managing information and more time understanding the person behind it.

The organizations that lead the next decade will not necessarily be those with access to the most sophisticated technology. They will be those that cultivate clinicians capable of integrating people, processes, data, and digital tools into a cohesive system of care—always grounded in better outcomes, greater affordability, and a more meaningful patient experience.

For more than a century, graduate medical education has focused on developing exceptional clinicians. The next century must develop exceptional clinical leaders. Clinical expertise will remain the foundation—but the ability to integrate people, technology, and systems into better care will become the defining force multiplier of true clinical excellence.

AI Use for Cybersecurity



Vincent Vitali, CHCIO
CIO
Borland Groover Clinic

AI is all the rage. In Gartner's hype cycle, we are definitely in the Peak of Inflated Expectations but fast approaching the Trough of Disillusionment.

One area that is impacting my organization, and I am sure many others, is the use of AI by bad actors to increase the effectiveness of phishing attacks and exploitation of vulnerabilities. In our most recent quarter, we had 18.6 trillion network transactions and log lines screened. Over 700,000 were flagged as reportable, almost 6,000 were investigated by our outsourced SOC, 531 were escalated to our internal security team (2 FTEs), and 9 were found to be critical events (all resolved with no breach).

This is a credit not only to our team and tools, but also to our contract vCISO that provides expert guidance. AI is also being used by KnowBe4, our cyber education and testing firm. We create and issue monthly phishing tests and track the outcomes. Over the past year, we have exceeded our targets for phishes reported by staff and click rate, so the education is working, but we need to update it often. We run monthly Nessus scans and monitor and catalog common vulnerabilities and exposures (CVEs) but focus on known exploited events (KEVs), which we've seen significantly increasing. The most recent Microsoft patch had over 400 CVEs, with 42 being critical! We are also preparing for the coming HIPAA Security Rule, now postponed until July 2027. Of the 22 proposed requirements, we are ready for 6, are partially ready for 13, and have 3 gaps, one being the 72-hour requirement to recover critical systems.

We are constantly looking at ways we can use AI to reduce our risk and enhance our resilience. We tend to rely on our cybersecurity vendors to add AI capability to their products to help us combat the growing threat from bad actors using AI, but it is an ongoing battle! Good luck to others!

Build Versus Buy



Mark Weisman, MD
CIO/CMIO
TidalHealth

Healthcare CIOs and CMIOs need to rethink the traditional build versus buy conversation.

For many years, the answer seemed obvious. Commercial vendors could spread development costs across hundreds of customers, innovate faster than individual health systems, and provide a level of support that would be difficult for a single organization to replicate. In many cases, that logic still holds true. The problem is the influx of venture capital into our traditional vendor space, which has led to pricing and support behaviors we cannot tolerate. Over the last few years, we have watched multiple technology vendors impose dramatic price increases on nonprofit healthcare organizations. These increases are often disconnected from any meaningful increase in value. We are not treating more patients. We are not improving outcomes. We are not gaining significant new functionality. Instead, vendors are relying on the reality that many of their products are deeply embedded in our operations. The switching costs are enormous, and they know it.

This creates a dangerous situation. When a health system becomes completely dependent on a single vendor for critical infrastructure, it loses leverage. Replacing an enterprise identity platform, virtualization environment, communication system, or IT service management platform is not something that happens overnight. The cost, risk, and disruption can be substantial. Vendors understand this dynamic, and some have chosen to exploit it.

The answer is not for every health system to become a software company. Internal development has real costs. Recruiting talent is difficult. Maintaining applications is a long-term commitment. Most organizations cannot absorb that risk alone. Emerging technologies may provide an opportunity to explore a different path before healthcare becomes dependent on another generation of expensive proprietary platforms. It may be time for healthcare leaders to explore new models for technology development and ownership. One approach worth considering is an open-source healthcare technology cooperative, where nonprofit health systems jointly invest in and govern common technology platforms. Imagine dozens of nonprofit health systems pooling resources to develop and maintain the foundational technologies we will all likely need. Consider the looming costs of ambient nursing documentation and other audio- and video-enabled bedside AI workflows, such as fall prevention. These capabilities have the potential to become foundational components of the hospital room of the future and will create significant switching costs once they are in place. In addition to reducing long-term licensing costs, cooperative ownership could provide participating organizations with greater control over how patient, operational, and clinical data are used to improve future generations of these technologies.

No single health system would bear the full burden. Development costs, governance, security, and operational support could be shared across participating organizations. The cooperative would exist to serve its members rather than maximize quarterly profits. Healthcare has a long history of collaboration. We already work together through purchasing groups, quality collaboratives, clinical research networks, and data-sharing organizations. Technology should be no different.

This is not an argument against commercial vendors, nor is it a recommendation to replace foundational platforms such as EHRs. Rather, it is an opportunity to identify a subset of emerging technologies where shared ownership may be more sustainable than perpetual dependence. If we work together, we may be able to create sustainable alternatives for select technology domains, preserving resources for patient care while strengthening our collective negotiating position.

Workflow AI: Improving Care Without Replacing the Clinician



Mony Weschler, MBA, FHIMSS, CPHIMS
Chief Operating Officer
DocPanel

Artificial intelligence has the greatest potential in healthcare when it supports clinicians rather than attempts to replace them. The clinician remains responsible for interpreting the complete clinical picture, exercising judgment, communicating with patients and other providers, and making the final decision. Workflow AI can improve that process by organizing information, reducing administrative friction, and bringing relevant data to the clinician at the right time.

In radiology, high-quality interpretation depends on more than viewing the current images. Radiologists also need easy access to prior examinations, earlier radiology reports, the patient's medical history, laboratory results, pathology findings, operative notes, and other relevant clinical information. Today, this information may be scattered across different systems or buried in a lengthy medical record. Workflow AI can assemble a concise longitudinal patient summary and place the most relevant details alongside the imaging study.

Visual AI can provide another layer of support by identifying findings that may deserve closer review, comparing current images with prior examinations, and helping radiologists detect subtle changes over time. These tools should function as decision support, with the radiologist independently reviewing the images and determining whether the AI-generated observations are clinically meaningful.

The benefits extend beyond the radiologist. When the interpreting physician has better access to imaging history and longitudinal clinical data, the final report can be more complete, better organized, and more responsive to the question that prompted the examination. The report can clearly explain important findings, relate them to prior imaging, and provide appropriate recommendations for the specialist who ordered the procedure.

This is the practical promise of workflow AI. It does not remove the clinician from care. It gives clinicians better information, reduces repetitive work, and helps them devote more attention to interpretation and communication. When designed with appropriate safeguards and human oversight, workflow AI can improve diagnostic quality, strengthen collaboration between radiologists and referring specialists, and ultimately support better patient care.

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Note

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