Rainfall HEALTH

A health system CEO on partners who stay for the work

At the elbow

Mary Washington Healthcare's CEO on finding value under pressure, why dashboards aren't solutions, and what it takes for a partner to change how a hospital actually works.



Dr. Christopher Newman
President and CEO
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Eddie Qureshi
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Host of the podcast

More challenges than ever, and more reasons for optimism

Dr. Christopher Newman is President and CEO of Mary Washington Healthcare, a nonprofit regional health system in Fredericksburg, Virginia, anchored by Mary Washington Hospital and Stafford Hospital. A board-certified internist, his background spans primary care, hospital medicine, and post-acute care. He spent six years as the system's CMO and COO before becoming CEO in 2025.

This guide distills his conversation with Eddie Qureshi on the Rainfall Health Podcast. It's written for health system executives weighing which partners earn a place in their organization, and how to stay flexible while policy, labor, and technology all move at once.

Mary Washington Healthcare

2
Hospitals

$1.5B
System size, up from $1B

1,000
Physicians on staff, in a market that needs 2,000

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Founder and CEO of Rainfall Health, host of the Rainfall Health Podcast

The COO leads the troops. The CEO faces outward.

50%+

of his job is now external

As CMO and COO, he had responsibility for almost the entire organization. He knew every pain point. That role, he says, is internal facing — the commander in the field, close to the action every day.

He didn't expect the CEO role to change so much. It's about setting vision and strategy, and navigating headwinds with people outside the building. He underestimated how much of the job would be external.

Who fills the calendar now

Government
Officials and policymakers

Vendors
External partners of every size

Tech companies
Including Silicon Valley

Philanthropy
Raising large amounts of money

> **“The pace of change quite recently has just been more than anything I've seen in my career thus far.”**
>
> Dr. Christopher Newman

Eddie named the fronts: policy shifts, labor changes, technology. Newman agreed — everything all at once. That's the backdrop for every decision in this guide.

Looking for six-, seven-, and eight-figure opportunities

Revenue is perpetually squeezed while costs climb. In a growth market, he wants opportunities big enough to bend the cost curve down, take bureaucratic work off caregivers, and let them focus on what matters to patients.

Cost drivers

- Labor
- Pharmaceuticals and supplies
- Brick-and-mortar construction

The filter every solution has to pass

1. **Does it actually work?**
   There's a lot out there. The job is narrowing it down.
2. **Will it have an ROI?**
   Value has to show up, not just be promised.
3. **Is it cost effective?**
   Weighed against what it replaces.
4. **Will it overburden IT?**
   Easy to integrate, and light on the team once it's live.

On the policy front

Things are moving very rapidly, and he believes providers have to tell their story. In recent years, nonprofit providers in particular have somehow become cast as the bad guy — pressed by payers on one side and rising costs on the other, from organized labor to the removal of malpractice caps.

> “We're really under siege, both from payers but also cost drivers.”
>
> Dr. Christopher Newman

Three waves of opportunity, and the first one isn't finished

There's a lot of waste and white space in any healthcare journey. Removing it was the focus of his years as CMO and COO, and teams still look at it robustly at any given time.

Wave 1
Waste

Length of stay, transitions of care, redundant tests — the right test in the right place, at the right time, for the right reasons.

~$60M
a year, vs. 2019 costs

Wave 2
Access

Getting the right people seen at the right times with the providers he has, while growing a pipeline of licensed professionals.

~195
primary care doctors short

Wave 3 / now
Supply

Procurement of non-clinical services — elevator contracts, snow removal — where nonprofits compete with the Amazons and Microsofts of the world for price.

$10Ms
of cost nobody thinks about

A shortage that doesn't look like one

People picture physician shortages in rural South Dakota or Wyoming. His market ranks in about the 2nd percentile nationally for physicians per capita, with a population growing fast. The gap shows up across specialties and service lines, but most acutely in primary care — and closing it would only bring the market up to an average that is itself short.

1,000	2,000
On staff	Needed

Physicians, as described by Dr. Newman.

Too many solutions are still in search of a problem

Many great companies assume a health system has the problem they solve. It doesn't always pair up, and executives spend a lot of time combing through options. Established vendors can be great companies and still not deliver an ROI that fits.

The takeaway

Start from the system's problem. Co-develop the fit.

Flipping the direction

The usual way

Vendor brings a solution. The system works out whether it has the matching problem.

—

Mary Washington's venture arm

Innovators embedded in teams find the system's problems, then pair them with early-stage companies that need a proof of concept.

Both sides benefit. Sometimes there's an equity stake if a company takes off, but that's not the goal. The point is immediate operational value — and if that's all it turns out to be, that's good enough.

How he finds what works

Peer networks	Other CEOs and COOs on what worked and what didn't. Endorsements from operators go a long way.
Paying it forward	When something delivers an eight-figure ROI, he shares it with peers.
On the road	Some intriguing ideas work out extremely well. If they don't, fail fast and move on.

The cost work is largely done. Now it's about revenue.

After real success on cost, his challenge to the team is to find what drives revenue, EBITDA, and margin. A five-year strategic plan identifies the growth service lines. Their margin pays for the services the community needs that can't carry themselves.

Invest to drive margin

- Oncology
- Neurosurgery and neurosciences
- Cardiovascular
- Orthopedics

funds

Sustain the mission

- Behavioral health
- Primary care
- Women's health

Nonprofit, by design

The mission is to serve the entire community regardless of ability to pay. For-profit competitors can choose markets, demographics, and payer mix, and focus on margin-producing care. Nonprofits — including some in Virginia serving far greater need — stand in every day for everyone. That increasingly means partnering with community nonprofits on housing, food insecurity, and safety, funded through the system's foundation.

What's next

Diversified revenue. Health systems will need to view themselves as healthcare companies, with streams beyond fee-for-service and value-based payments.

> “We're the safety net provider. We take that very seriously.”

Dr. Christopher Newman

At risk for care you don't own

Eddie asked whether mandatory episode models reward systems that invest in the community. Newman's read is blunt: these programs shift cost, risk, and administrative burden from the payer to the health system. In a bundle, the largest share of cost sits in post-acute care — which the system doesn't own, but is at risk for.

How the reward works

Do well, and you won't get penalized.

What it takes to succeed — and what each piece costs

Analytics

A partner pointing you in the right direction, so there's no surprise at the end.

Gain sharing

Independent physicians have no skin in the game without it.

Post-acute steering

Directing patients to the right setting, even away from strong local IRFs.

$650K–$1.4M

Per hospital, per year, just to report on these models — from a Brown University analysis Eddie cited.

How far the industry has come

Atul Gawande's 2009 "The Cost Conundrum" opened his eyes to population health. Much of that waste has since been squeezed out — some by design, some by limited access.

Muscle memory

Mary Washington ran ACOs and joined bundles voluntarily, and succeeded. They're not in panic mode. It still costs.

> “We've learned to stop complaining long ago and just try to do the best we can.”

Dr. Christopher Newman

“I don't have a shortage of dashboards blinking red.”

Dr. Christopher Newman

He's a big believer in data for action. But thousands of data points and dashboards flashing red and yellow can overwhelm. As CMO and COO, his job was to prioritize: pick the drivers that matter now, and point doctors and nurses at them.

What he hears

“We can find this.”

More visibility into problems he already sees.

What's scarce

Time to fix

To work out solutions, deploy resources, and triage the bigger opportunity.

What he wants

A nudge to the answer

Not just what's wrong, but a solution presented alongside it.

Eddie's frame

Data alone hands a limited team one more thing to figure out. The question is "so what?" Technology should find where clinicians' time is best spent — with the clinician always in the loop, as the quarterback.

From bottom-decile length of stay to a habit nobody could break

When he arrived at Mary Washington, length of stay was bottom decile and care coordination in the hospital was "the Wild West a little bit." The partner that fixed it paired real-time analytics with process engineers working beside doctors and nurses.

Start

Visibility

Dashboards showing bottlenecks in real time.

~15 months

Boots on the ground

Engineers at the elbow, coaching the work as it happened.

Ongoing

Quarterly

Check-ins. The team runs it.

“If I told my team to go back to long length of stay and inefficient care, they wouldn't know how to do it.”

Dr. Christopher Newman

	Consulting engagement	Partnership
Delivers	Here are your problems and solutions. Good luck.	Solves them with you, then trains you to do it yourself.
Stays	Until the playbook is handed over	As long as results and ROI keep the business
Shares the win	Rarely	Better pricing for a home run, in exchange for telling peers

Consultants are useful for a specific, big problem, he notes. And no incentive design is perfect: go in eyes wide open about what you're mutually trying to accomplish.

The biggest concern is still labor

Care keeps getting more efficient. But without enough providers, he can't capitalize on opportunity — or even sustain the status quo. Hiring has become a matter of accepting almost any condition to get people willing to care for others.

Hip and knee, then and now

3–4 days
In hospital, 2014–2015

~18 hours
His father's recent stay

The burden technology should take back

Share of his day spent on administrative work



EMR documentation for two hours every night. Prior authorizations. He's hopeful technology will remove those burdens soon, so caregivers can get back to what they're trained to do.

The risk

A transactional mindset. When it takes hold, seeing patients as people starts to slip.

What he keeps driving

Why we do this. Bring the community and patients back to center.

Nobody has a crystal ball. Build for the pivot.

The CEO needs far more heads-up time than the COO — not three steps ahead, but one, two, four, five years down the road. He expects everyone's predictions to be wrong. The goal is to mitigate risk and stay flexible.

Rule 1

Flexible solutions

Things you can turn off, turn on, and pivot without major investment.

Rule 2

Community first

Every decision has to pass one test: what's best for the health of this community.

Rule 3

Stay optimistic

Today's problems may look very different five to ten years out.

What makes him optimistic

GLP-1s	He's seen colleagues, friends, and family change their lives within a year. Costs are high today, but may come down — and the long-term benefits may be profound.
Gene therapies	Million-dollar drugs raise hard questions. A cure for type 1 diabetes would be truly amazing.
Fewer beds, maybe	He's heard it for years while demand rose. With AI and new therapies, it may finally be a very different — and better — world for health.

> “There have to be other solutions going forward to really bend the cost curve down.”

Dr. Christopher Newman, on where episode models are heading

A partner that stays for the episode

Rainfall Health is an accountability and accessibility platform powered by AI, built for Medicare-mandated episode programs like TEAM. It's technology and services together — the pairing Dr. Newman says made his length-of-stay work stick.

He said	
Too many dashboards blinking red	Rainfall surfaces which episode patients need attention, so clinicians spend time where it counts — with the clinician as quarterback.
He said **At risk for post-acute you don't own**	One advocate follows each patient across settings after discharge, through the full episode window.
He said **Reporting costs real money**	Data from many sources, held to one standard, so the system isn't rebuilding the same reporting in-house.
He said **Don't overburden IT**	An end-to-end service that works alongside existing teams rather than handing them another tool to run.

Measured on

- Patient satisfaction
- Quality of care
- Outcomes
- Cost management

Rainfall HEALTH

Get connected

Let's work side by side

If you're running TEAM or other episode programs and want a partner invested in your results — not just your dashboards — we'd like to talk. Rainfall is the end-to-end solution, technology and services, for hospitals and health systems.

Learn more
www.rainfallhealth.com

Start a conversation
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