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From Pilot to Production

Why 95% of healthcare AI never ships, and what the other 5% do differently.

Bob Klein · CEO and Founder

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CEO and Founder · Digital Scientists

ABOUT

Founded Digital Scientists in 2007. Nineteen years building production software for organizations that can't afford for it to break — the last ten of them in regulated healthcare.
His team built and runs NeverAlone, the post-acute telemedicine platform CommuniCare uses across 130+ skilled nursing facilities, and HealthContext.AI, ambient documentation live in production.

TRACK RECORD

100%
PRODUCTION RATE

$20M+
VERIFIED CLIENT ROI

100K+
CALLS IN 2024,2025

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WHERE THIS COMES FROM

Five healthcare AI systems. All five reached production.

Not pilots. Most have since been handed to the teams that own them. That is build, operate, transfer, and it has a catch.

Medical Coding AI

Finds missed HCC codes across six clinical sources

CASE STUDY

MDS / PDPM

Surfaces uncaptured diagnoses before submission

CASE STUDY

HealthContext.AI

Ambient documentation on live telehealth calls

CASE STUDY

Guardian Vitals

Reads vitals off any monitor brand, in the OR

CASE STUDY

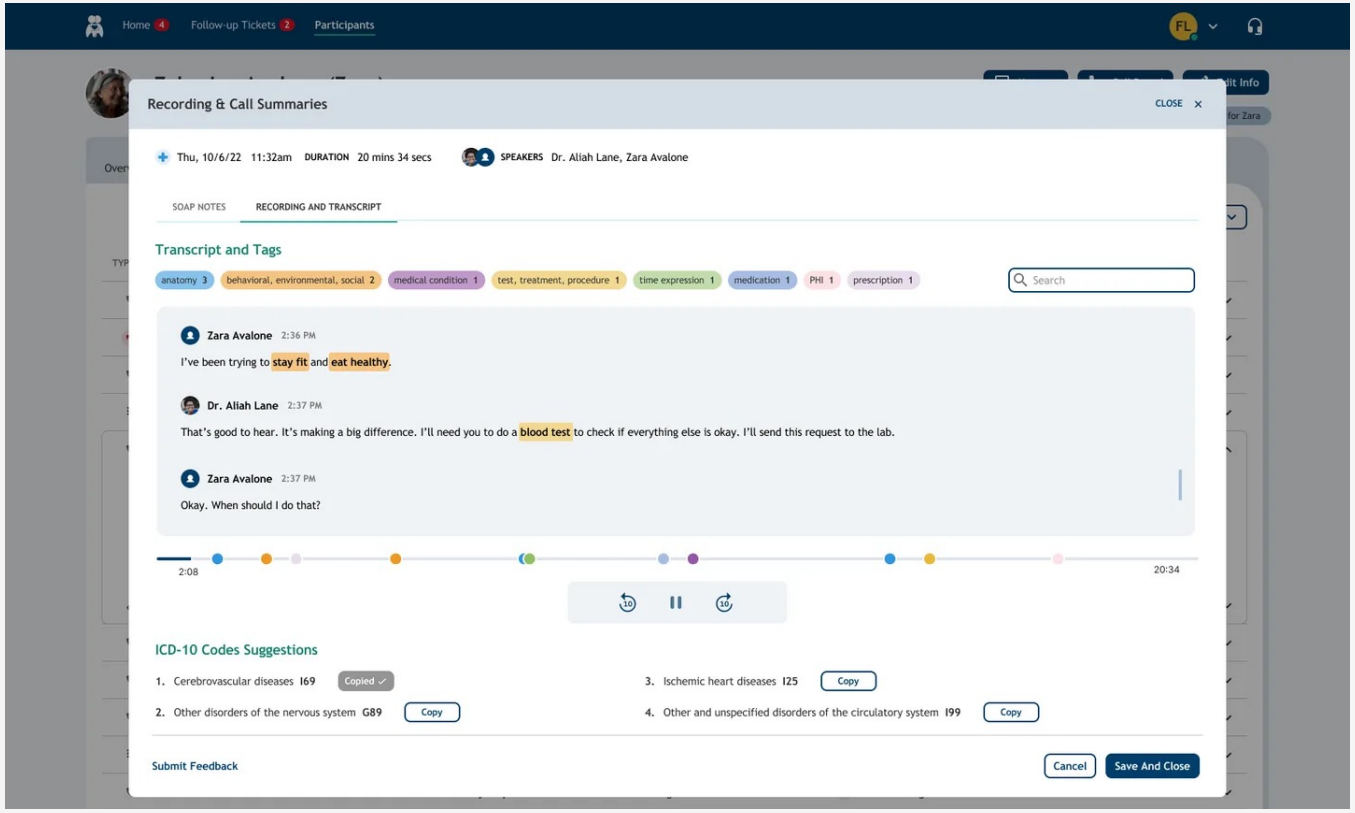
Harbor Care

Referral intake. Reads the packet, alerts staff

IN PROGRESS

All five belong to the client. Two are products those companies sell. We do not keep any of them.

Not a mock-up. This is the screen.



The transcript
what it heard, tagged live

Eight tag types
one of them is PHI

ICD-10 suggestions
what it proposes

Save or cancel
a person decides

HIPAA compliant
encrypted, inside the boundary

It reads, your rules decide, a person signs off, everything logs. **Remember those four.**

TEN OF THE FORTY-FIVE MINUTES, AND THE MOST USEFUL TEN

Before I show you anything.

Your organization, and the one AI project that's stuck. One sentence each.

Payers. Labs. Risk adjustment. Triage. Pharmacy. Virtual care. Different businesses, same production problem.

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WHY THE DEMO STALLS

Building got easy.
Shipping didn't.

In healthcare the gap between those two is the widest it has ever been. That gap is the 95%.

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WHAT I KEEP HEARING

Any of these sound familiar?

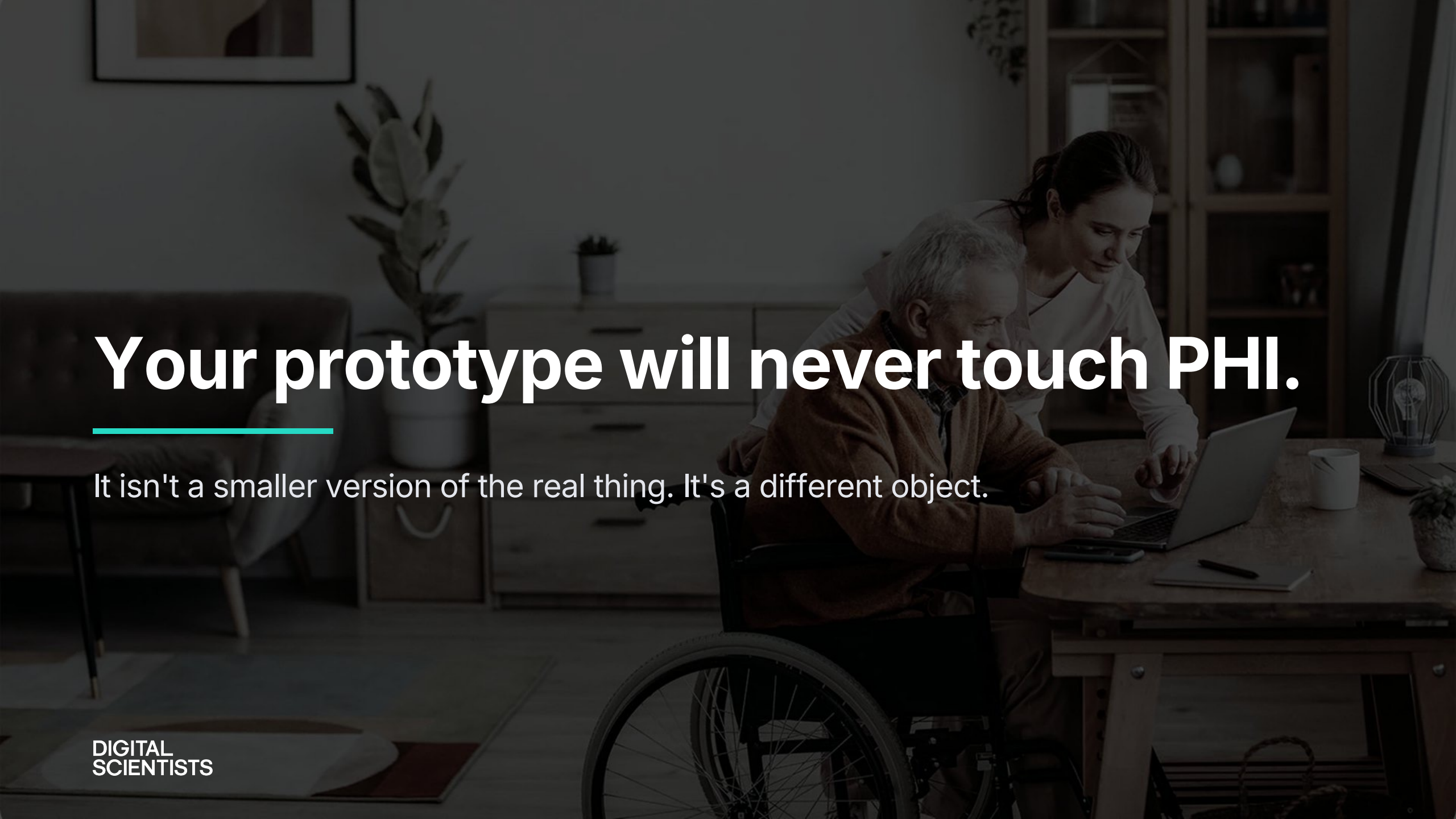
Put the one that's closest in the chat. I'll read them back.

> **“Referrals still come in as faxes, and somebody reads every one.”**

> **“Our best coder does it in her head. Nobody else can.”**

> **“The nurses tried it for two weeks and went back to the phone.”**

> **“Every health system wants a different version of it.”**



Your prototype will never touch PHI.

It isn't a smaller version of the real thing. It's a different object.

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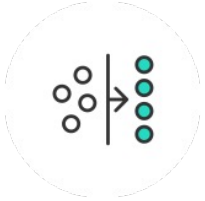
WHAT A DEMO SKIPS

The four things a weekend prototype never has.

It's never the code.



Real data

PHI. Dirty, late, legally radioactive.

Real integration

Epic, PointClickCare, Cerner. Each with an owner.

Real guardrails

HIPAA, the BAA, the audit trail, access control.

Real ownership

A phone rings at 2 a.m. and a nurse is waiting.

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THE TITLE ASKED A QUESTION, SO HERE IS THE ANSWER FIRST

What the other 5% do differently. Two things.

01

They decide before they build.

One workflow, chosen on purpose, that can pay back this year.

02

They start from the constraints, not the demo.

Constraints in week one, or you build it twice.

Two things. Not five, and not a framework.

ONE QUESTION

Can you name it right now?

The workflow. The data it runs on. And the person who owns it.

If you can't, that's one. If you can and it still isn't live, that's two.

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SAME SHAPE, DIFFERENT BUSINESS

You already have one of these.

Diagnostics at volume	Incomplete test orders. Chase the ordering office, escalate the rest.
A health plan	Prior-auth case assembly. Pull the evidence, flag what is missing.
Risk adjustment	Pre-visit prep. Claims, labs, meds and open gaps, assembled up front.
Nurse triage	Post-call follow-through. Did the visit happen. Did the med arrive.
Long-term care pharmacy	Prescription exceptions. Missing signature, coverage problem, chased.
A post-acute network	Referral coordination. Who has capacity, who answered, what sits unplaced.

> **Listen for it:** “every morning someone checks…” · “we’re always waiting for…” · “after the handoff nobody knows whether…”

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How to pick the workflow that pays back.

The expensive mistake is improving the wrong workflow first.

Manual load

Real hours today

Clear return

Moves money or capacity

Contained downside

A person can override

Few integrations

One or two inputs

Visible win

Weeks, not quarters

> **Give me one of yours, said like this:** when [trigger] happens, the agent reads [what], decides [one bounded question], and sends [exceptions] to [a person].

HARBOR CARE FOUNDATION, LOS ANGELES // 30 RECUPERATIVE-CARE BEDS

AI referral intake, live in about a month

15-20 min
WINDOW TO RESPOND

~1 month
FIRST EMAIL TO LIVE

98%
REFERRALS, ONE INBOX

1
WORKFLOW, IN PRODUCTION

The worst it could do was recommend something a person then overrode. That is why it was a good first project.

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DIFFERENCE TWO // START FROM THE CONSTRAINTS

The architecture that gets signed off.

The model never decides and never has the final call. Your written policy decides, the same way every time.

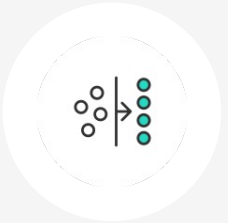
It launched in shadow mode: it recommended while people still decided, so we could compare the two before it held authority.

HOW YOU KEEP IT FROM BREAKING IN PRODUCTION

Every release had to pass a live test, not a lab test.

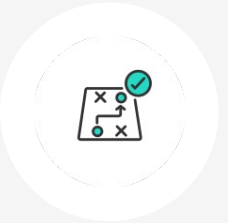
A real email

Fake patient content, live inbox



The real pipeline

Not a mock, not a stub



Checked

Against the known answer

The staff screen

Opened in a real browser

It caught two problems before they reached production: a payer-matching bug that would have accepted a patient whose insurance was not covered, and a shortcut in the error handling that would have destroyed real data.

51
TEST REFERRALS, KNOWN ANSWERS

~220
CODE CHANGES, PHASE ONE

85+
LIVE IN PRODUCTION

ASK THIS FIRST OF ANYONE, INCLUDING US

You own the result. We keep our methods.

The code, rules, and pipelines

Open standards. Nothing you cannot export.

Your cloud, your BAA

Patient data never leaves it and never trains a model.

No new platform

Build, operate, transfer. It goes into the systems you already run.

That is the whole difference from renting a platform. It also means owning it is a commitment, not a trophy.

Three ways to start // all of it free // none of it needs your email

What to do next, whoever builds it.

DO IT YOURSELF

Score your candidate

The five tests as a worksheet. Score three workflows, name the bottleneck, pick one.

AI Workflow Opportunity Scorecard

DECIDE WHO BUILDS IT

Check your own bench first

An honest read on the eight capabilities it takes to build the first one in-house, and what to ask anyone else.

In-house readiness check

Partner evaluation checklist

OR TALK IT THROUGH

Bring me the one that's stuck

Thirty minutes, no deck. I'll tell you what I'd do, whether or not you hire us.

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If the answer is your own team, or another partner, that is a good outcome. The point is that you start.

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APPENDIX // FOR THE CTO WHO ASKS WHAT'S UNDER IT

The model is about 20% of the build.

Assurance and delivery	Evals, observability, EHR write-back, CI/CD	
Agentic orchestration	Tool calling, business rules, human in the loop	
Models and AI	Model-agnostic. Claude, GPT, open source, fine-tuned	**~20%**
Data and integration	EHR, HL7 and FHIR, connectors, pipelines	
PHI and compliance	HIPAA, signed BAAs, encryption, full audit trail	

One layer is the model. The other four are the difference between a demo and a system.

QUESTIONS // AND WHAT HAPPENS NEXT

Questions?

Drop them in the Q&A panel — we'll take as many as time allows.

01

Get the recording

Slides and the full replay land in your inbox within 24 hours of today's session.

02

Book a working session

30 minutes on your pilot. We map the gap between demo and production.

03

Keep in touch

bob.klein@digitalscientists.com
linkedin.com/in/roberthaywardklein