

AI for Healthcare Practices

8 Mistakes to Avoid



**Ownership
Mistakes**



**People &
Personnel Mistakes**



**Timing
Mistakes**

A note from the author

Most of what you have read about AI in healthcare is some version of the same two warnings: write a policy, and protect your patient data. Both are true. Both are also what every advisory shop and IT provider in this industry is now saying. When everyone says the same thing, none of it helps you decide what to actually do on Monday morning.

I wanted to write down the part nobody is saying. Path Forward runs IT for independent practices and groups. We handle EHR consulting, MIPS and value-based care reporting, security and compliance work, and now the AI builds. The AI part is new. The rest of it is what we have been doing the whole time, and it is the reason we can tell you which of these mistakes actually costs money.

After more than twenty years in healthcare IT, I have watched a few technology shifts come through: the move to the cloud, the rise of mobile, the electronic health record mandate. **This one is different, and the practices that treat it like just another software purchase are going to look back in two years and wish they had understood it sooner.**

This guide is not a sales pitch. It is the honest version of what I would tell you if we were sitting across the table. **Eight mistakes almost no one is warning you about, and three ideas that tie them all together.**

Read it, argue with it, and use what is useful. One bias to declare before you start: everything in here points toward building capability your practice keeps, rather than renting it from someone else.

— Nick Recker, Founder, Path Forward IT



Founder, Path Forward IT

Healthcare IT, EHR, compliance, and AI for independent practices.

Why it's time to **reexamine your approach to AI**

Most of the AI advice reaching healthcare practices right now comes from people selling licenses, running one-off workshops, or repeating the same two warnings. None of it is wrong. All of it is incomplete, and incomplete advice, followed in good faith, is how a practice ends up “covered” without actually being ready.

It's also worth naming what most AI advice skips. AI doesn't fix what's underneath. It amplifies it. Clear workflows and defined ownership get amplified into more of the same. Gaps get amplified too, just faster and at scale. That's simply how the technology behaves, regardless of who's using it. So the honest starting point is “what's already true about how we run today,” rather than “what can AI do for us.”

If any of this sounds familiar, it's because it's exactly what the noise tells you to do:

- **You bought a tier of Copilot or ChatGPT licenses for the leadership team.**
- **Someone in marketing or HR ran a pilot and called it a win.**
- **A young staffer quietly became the “AI person” without a budget or mandate.**

None of that is the differentiator.

The practices pulling ahead aren't buying something different. They're doing something different with what they already have. Buying AI is one step. Using it well is another. Knowing what to point it at is the step that sets you apart.



AI judgment is the first step, not capability

The practices that pull ahead aren't the ones with the most licenses. They're the ones whose leaders can answer four questions about any problem:

- **Does AI belong in this answer at all?**
- **Which tool actually fits?**
- **What would it take to do it safely?**
- **If we build it, who owns it afterward?**

That skill has a name. It's judgment, and it's the one thing a license will never give you.

If you saw your practice in those three bullets, you're not behind, you're exactly where most of healthcare is right now. The rest of this guide breaks that judgment into eight specific places it's costing practices today.

The 8 mistakes the market is not warning you about

The rest of the market is warning practices about two things: write a policy, and protect your patient data. Both matter. Neither is what's actually costing practices right now.

What follows are eight mistakes the industry keeps making, grouped three ways. Each group opens with the one idea that reframes everything in it.

Three categories, one thread running through all of them: **who ends up owning the capability once the work is done.**



Ownership Mistakes

- 1 Rented capability costs you** when the market shifts
- 2 Buying before thinking** buries your best use cases
- 3 Waiting on the EHR vendor's roadmap** keeps you a step behind



People & Personnel Mistakes

- 4 Not building an institutional memory** means starting from scratch every time someone leaves
- 5 Overlooking physician burnout** will stall every other AI initiative
- 6 Parking AI on one person's desk** stalls AI progress
- 7 Treating AI learning as a one-time event** widens the literacy gap



Timing Mistakes

- 8 Moving slow** means payers gain an advantage

Ownership Mistakes

If you left your AI platform tomorrow, what would you keep? For most practices, the honest answer is nothing. The learning lives inside someone else's tool.

The practices getting this right treat the context they build as the asset, not the tool they happen to build it in. Own your context; don't rent it.

Owning it has a specific meaning, and it is worth being precise. It means the system runs inside your own environment, on your own data. It means the workflows your team builds are documented and exportable. It means the underlying model can be swapped without rebuilding the work sitting on top of it. And it means that if the relationship with whoever built it ends, the capability stays with you.



1 Rented capability costs you when the market shifts

THE PROBLEM

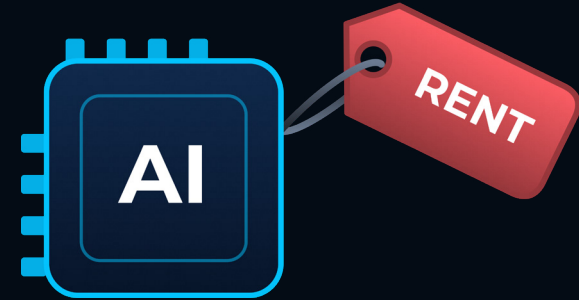
Most of what practices build today lives entirely inside one product. **It cannot be exported in any useful form.** It is not versioned, and it does not belong to the practice.

THE COST

When the vendor raises prices, gets acquired, or falls behind, a practice that rented is not switching tools. **It is rebuilding everything it learned from scratch.** For a practice that owns its capability, that same day is an inconvenience.

ASK YOURSELF

- If your primary AI vendor announced it was shutting down or being acquired next month, **what would your practice actually keep?**
- Could your team reconstruct your current AI-assisted workflows in a new tool **without starting from zero?**



When you rent AI capability instead of owning it, every vendor disruption costs your practice everything you built.

WHY THIS MATTERS FOR HEALTHCARE PRACTICES

Most practices run lean on the administrative and IT side. Unlike a tech company with an internal development bench, **a typical practice has no one to rebuild clinical or billing workflows from scratch when a vendor relationship ends.**

Acquisition-heavy market. Healthcare IT is one of the most acquisition-heavy segments in technology. Vendors that practices depend on today are regularly absorbed, rebranded, or sunset, often with little notice and limited data portability.

Rebuilding costs real money. Rebuilding billing and coding workflows from scratch is not a neutral cost. It means retraining staff, re-documenting payer-specific logic, and absorbing the productivity loss during the gap.

No margin for disruption. Practices operating under fee-for-service reimbursement models have no margin buffer for that kind of disruption. Every week of reduced billing efficiency shows up directly in collections.

Portability is a design choice. An orchestration layer sits between your workflows and whichever model is currently best. When a better model ships, that is a configuration change rather than a rebuild.



2 Buying before thinking buries your best use cases

THE PROBLEM

A license tells a practice what it is allowed to use. **It does not say which problems are worth solving with AI**, which tools fit which jobs, or how to spot a thin wrapper on a model everyone already has.

THE COST

The next year brings a steady stream of AI pitches. Without a way to evaluate them, every pitch sounds equally good, and **practices are at risk of buying on confidence instead of fit.**

ASK YOURSELF

- *If a new AI vendor pitched your practice tomorrow, does your team have a **defined set of criteria** to evaluate whether it actually fits your clinical and billing operations?*
- *Do you know which of your current AI licenses are **actively used, by whom, and for what?***



Buying the tool and checking the box before assessing the right applications gives you just surface-level capabilities.

WHY THIS MATTERS FOR HEALTHCARE PRACTICES

The healthcare AI vendor market is expanding faster than most practice leaders can track. Scribes, prior-auth bots, RCM tools, and clinical decision support platforms are all competing for the same budget line, and many of them are built on the same underlying models.

HIPAA claims require scrutiny. Practices without an evaluation framework are especially exposed to vendors who overstate their HIPAA compliance posture or clinical validation. “HIPAA-compliant” is not a certification; it is a claim, and it requires scrutiny.

Unused licenses auto-renew anyway. A license purchased without a use-case rationale is rarely adopted at scale. Staff default to workarounds, and the investment sits unused while the vendor relationship auto-renews.

High-value use cases stay hidden. In a fee-for-service environment, the highest-value AI applications tend to be in claims, denials, and prior authorization. A practice without a prioritization framework is unlikely to find its way there on its own.



Five questions that separate a real tool from a wrapper

A license tells you what you are allowed to use. It does not tell you what is worth buying. These five questions do most of the work, and four of them are about what you are left holding.

1

Where does our data live, and **whose tenant is it sitting in?**

2

If we leave in two years, **what comes with us, and in what format?**

3

What is underneath this. Which model, and **what happens when a better one ships?**

4

Is “HIPAA compliant” a certification here, or a claim? **Who audited it?**

5

What breaks if this **vendor is acquired next quarter?**

If a vendor cannot answer four of these in a first meeting, that is the answer.



3 Waiting on the EHR vendor's roadmap keeps you a step behind

THE PROBLEM

In a lot of groups, if a capability is **not on the records vendor's release schedule, it does not happen.** That puts the practice's pace in someone else's hands.

THE COST

Payers don't time their contract changes for your EHR updates. When a payer changes a contract, the practice waiting on a quarterly vendor release is **always a step behind, negotiating from data it does not control.**



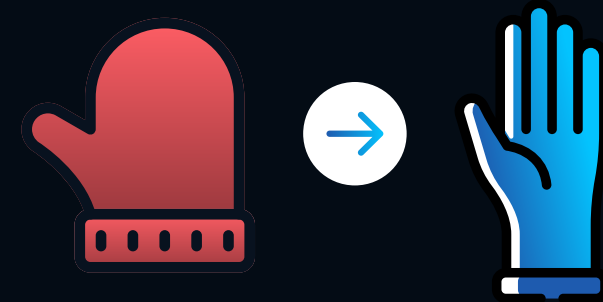
WHY THIS MATTERS FOR HEALTHCARE PRACTICES

The glove is the layer you build on top of it. That one fits your hand, and it is yours.

There is usually more available than practices realize. A group on a community-hosted records arrangement can pull its own clinical and financial data into a repository it controls, then query that repository directly, rather than waiting for a reporting feature to appear on a release schedule or for an analyst to build another static report. The records system stays the records system. The layer built on top of it is yours.

ASK YOURSELF

- When your largest payer last changed a contract term, **how long did it take your practice to understand the financial impact?**
- Is there a workflow your team has been waiting on your EHR vendor to build **for more than six months?**



EHR-embedded AI fits like a mitten. It covers you, but nothing fits your hand.

Fee-for-service reimbursement contracts are not static. Payers adjust rates, add prior-auth requirements, and shift billing rules on timelines that do not align with a vendor's quarterly release cycle.

Time is money. Practices that can model the impact of a new payer contract in days, rather than waiting on an EHR update, negotiate from a fundamentally stronger position.

Value-based care overlays keep getting layered onto fee-for-service arrangements. Practices that depend on their EHR vendor to surface that data are last to see it.

People & Personnel Mistakes

Every specialty group runs on a handful of people who are genuinely hard to replace. When one of them moves on, their knowledge walks out the door with them.

The practices getting ahead use AI to hold onto what those people know, not to replace the people themselves. Your people are your real asset, and the knowledge they carry is worth protecting.





4

Not building an institutional memory means starting from scratch every time someone leaves

THE PROBLEM

When the most experienced biller in a practice gives notice, **everything that person knows leaves too**. The replacement spends the better part of a year relearning what the last person already figured out, and the practice carries the cost of that gap the entire time.

THE COST

Every experienced person who leaves takes years of hard-won judgment with them, and **the practice pays to rebuild it from zero**.

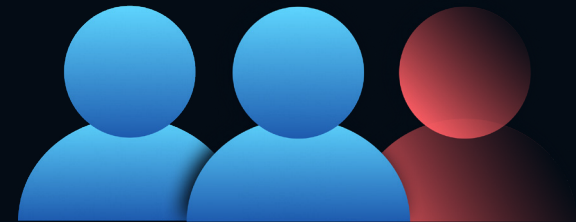


WHY THIS MATTERS FOR HEALTHCARE PRACTICES

Healthcare billing and coding is a specialized skill set, and the labor market for experienced staff is tight. **Turnover in revenue cycle roles is consistently high across the industry, and the knowledge lost is rarely documented.**

ASK YOURSELF

- If your most experienced biller gave notice today, **how much of what they know exists anywhere in writing?**
- How long did it take your last revenue cycle hire to reach full productivity, **and what did that gap cost?**



Losing a key person means losing everything they knew.

Institutional memory walks out. An experienced biller carries payer logic, prior-auth patterns, and denial strategies that exist nowhere in writing. When they leave, so does your reimbursement performance, unless that logic was captured into something the practice owns.

The gap hits collections. Replacing a skilled coder takes months. In fee-for-service, that productivity loss isn't absorbed by a contract, it's absorbed by the practice.

Specialty nuance takes years. Oncology drug billing, modifier logic, payer-specific prior-auth, none of it can be onboarded from a job description.



5 Overlooking physician burnout will stall every other AI initiative

THE PROBLEM

Clinician burnout doesn't just threaten your AI initiative, **it threatens everything**. Better care, healthier populations, lower cost. None of it survives when the people delivering it are running on empty. Most practices treat burnout as an HR problem. It's actually the most expensive operational risk on the balance sheet.

THE COST

When clinicians burn out, the downstream effects dwarf any technology investment: **turnover, reduced patient volume, quality gaps, and reputational damage**. An AI effort that adds to their load, rather than removing it accelerates the problem it was supposed to solve.

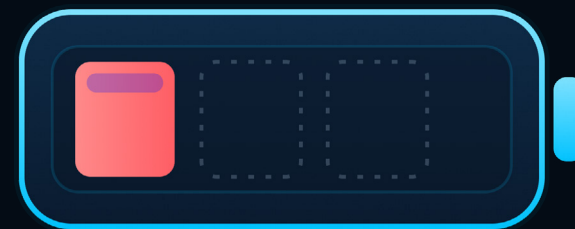


WHY THIS MATTERS FOR HEALTHCARE PRACTICES

Physician burnout is not a future risk. It is a documented, present condition across specialties, with **administrative burden consistently cited as the leading driver**.

ASK YOURSELF

- Does your current AI plan reduce the administrative load on physicians, or does it **ask them to carry more of it?**
- If the physician most involved in your AI efforts stepped back tomorrow, would the initiative **continue or stall?**



Better care, healthier populations, lower cost. None of it survives clinician burnout.

Documentation eats clinician time. Studies across the industry show that clinicians spend a significant portion of their working hours on documentation and administrative tasks rather than patient care. Any AI initiative that adds to that load, rather than reducing it, is working against itself.

Fragile by design. An AI effort that depends on a physician to champion, train, and sustain it is especially fragile in a workforce already reporting burnout at high rates. When that physician cuts back or leaves, the effort goes with them.

Sequence matters. Practices that use AI to reduce documentation burden first, before asking physicians to lead broader adoption, create the capacity that makes everything else possible.



6 Parking AI on one person's desk stalls AI progress

THE PROBLEM

In a lot of practices, AI became one capable younger staffer's job, handed over with **no budget, no mandate, and no authority to change how anyone else works**. Predictably, it stalled.

THE COST

One person can run a pilot. No one person can change how an entire practice operates. While good intentions stall on a desk, denied claims go unfought, prior-auth bottlenecks stay manual, and physician time stays buried in documentation **These are costs the practice absorbs without ever seeing them on a report.**

ASK YOURSELF

- *Who in your practice is currently responsible for AI, and **do they have the budget, authority, and cross-departmental access** to actually change how clinical and billing operations work?*
- *If that person left tomorrow, would your AI efforts continue or **disappear with them**?*



AI is complex and should permeate every layer of your institution. Parking it on one person's desk confines AI to one corner of your practice or limits its effectiveness.

WHY THIS MATTERS FOR HEALTHCARE PRACTICES

In a HIPAA-covered environment, an ungoverned AI effort is not just an operational problem. It is a compliance exposure. **One person running AI experiments without a governance structure is a different risk category** than the same situation in an unregulated business.

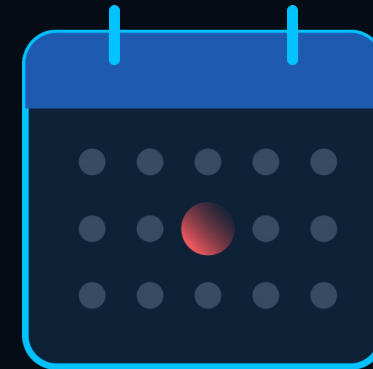
Workflows cross department lines. Clinical and billing workflows cross department lines by definition. Prior authorization touches the clinical team, the billing team, and often the front desk. No single person has the authority or visibility to improve that workflow alone.

No governance, no guardrails. Without a framework, there is no standard for which tools are approved, which data can be used, and who is accountable when something goes wrong. In a practice handling PHI, that gap has regulatory consequences. Governance here is the same work as a security risk assessment or a HIPAA readiness review, pointed at a new category of tool. The structure already exists.

Single points of failure. AI adoption that lives on one desk does not scale and does not survive turnover.



7 Treating AI learning as a one-time event widens the literacy gap



A single workshop is not literacy. It is a vocabulary people forget in a month.

THE PROBLEM

The most common version of “we are handling AI literacy” is one lunch-and-learn. **People leave with terms they lose inside a month**, because knowledge without steady practice fades.

THE COST

AI moves faster than anything most leaders have lived through. Every month learning is treated as a one-time event, the gap between what a leader is expected to know and what they actually know gets wider.



WHY THIS MATTERS FOR HEALTHCARE PRACTICES

Healthcare-specific AI tools are evolving faster than the typical CME or compliance training cadence most practices run on. **A team that completed an AI overview six months ago is already working from an outdated picture.**

ASK YOURSELF

- Does your practice have a defined strategy for keeping leadership and staff continuously current on AI developments, or **does your team's knowledge stop at the last training event?**
- When payers or vendors shift how they use AI, **how quickly can your team recognize the change and adjust?** Do you have a process for that, or does it happen by chance?

Payer AI keeps moving. Payer AI is not static. The tools insurers use to automate prior-auth decisions and flag claims for denial are updated continuously. A billing team whose AI literacy stopped at last year's lunch-and-learn is not equipped to respond to what payers are doing today.

Annual training isn't enough. Most practices run one annual compliance review. That cadence was designed for regulatory requirements that change slowly, not a technology environment where shifts happen quarterly.

Stale knowledge is expensive. Leaders who treat AI literacy as a one-time event make vendor and tool decisions based on stale understanding.

The cadence that works is monthly and short. Thirty minutes on what changed, what it means for your payer mix, and whether anything on your list just got easier.

Timing Mistakes

For the first time, someone on your team can describe what they need in plain English and have a tool help build it. No waiting on a vendor's roadmap. No sitting in a developer's queue.

The practices pulling ahead have shifted posture. When a problem shows up, their first move is not “who do we buy this from.” It is “what would it take to build this ourselves?”





8 Moving slow means payers gain an advantage

THE PROBLEM

Payers are using AI to review and dispute claims faster than human teams can respond. **Automated denials arrive at a speed and volume that manual appeals cannot match.**

THE COST

The denials come faster than a billing team can appeal them, **and the practice absorbs the loss.** In oncology, where the dollars per claim are high, that gap hits hardest.



WHY THIS MATTERS FOR HEALTHCARE PRACTICES

The shift to AI-driven claims review by major payers is not a future trend. It is already the operating reality for most fee-for-service practices, and the volume and speed of automated denials have outpaced what manual billing teams can absorb.

ASK YOURSELF

- How quickly can your billing team **identify and appeal AI-driven claim denials from payers?**
- Does your practice have tools in place to **triage denials and focus on the claims most worth fighting?**



While debating an AI policy, the payers already automated against you.

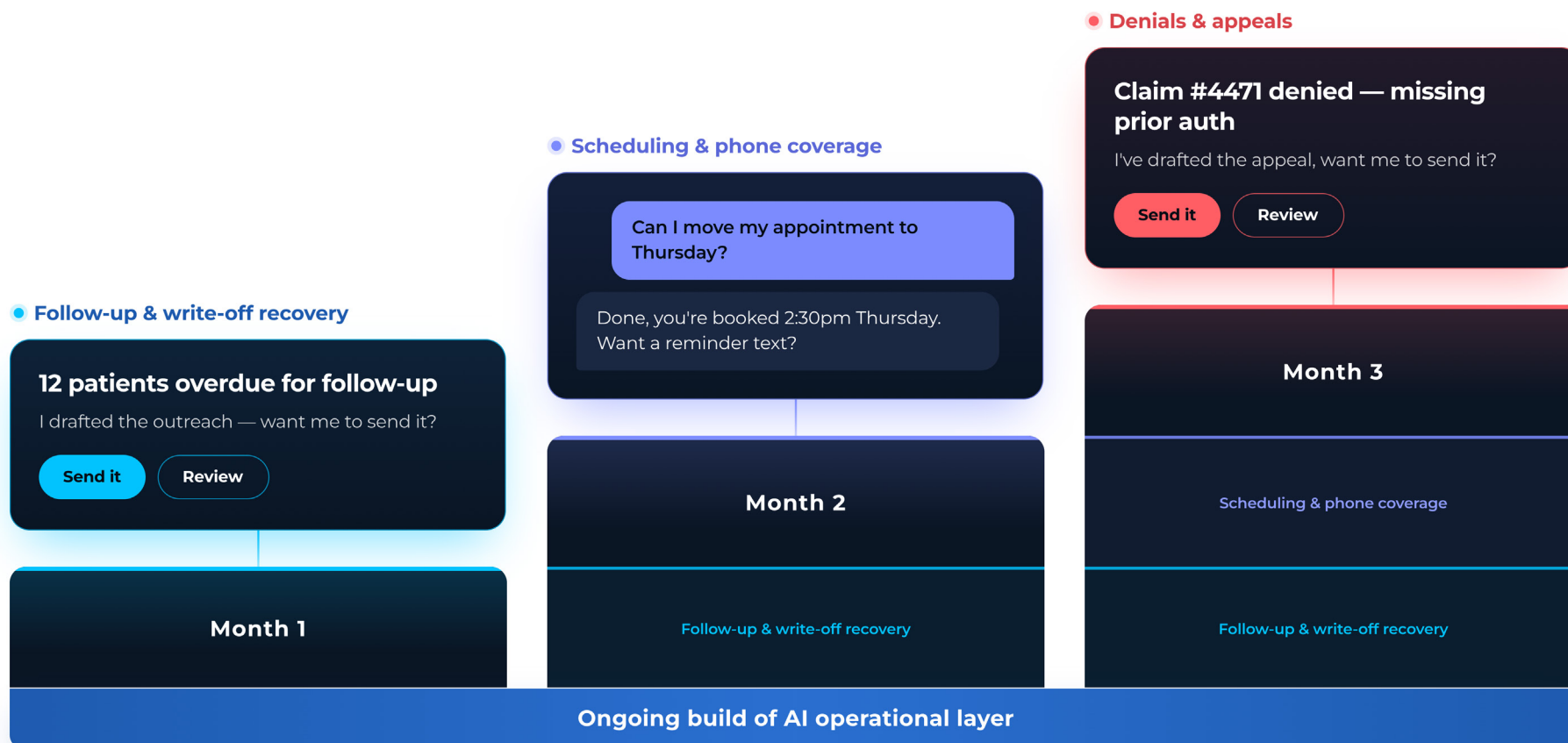
Denials are rising. Prior-authorization denial rates have climbed across specialties, with AI-assisted review cited as a factor. Manual appeals processes are structurally disadvantaged.

High stakes per claim. In oncology and other high-cost specialties, the dollar value per claim is high enough that a single denied treatment authorization can represent a material revenue impact. The speed at which payers can now issue those denials means the window for appeal is narrower than it has ever been.

Triage or lose. Fee-for-service reimbursement depends on winning the claims that are worth fighting. A practice without the tools to triage denials quickly and respond at scale is leaving reimbursement on the table by default. The shape of the fix is not theoretical. An agent can work payer portals directly to assemble and submit authorizations, then surface only the ones that need a person. It pays back fastest where authorization volume is highest.

Start owning your AI

Real use cases from your owned AI layer start in month one. As Path Forward builds out the full layer, more digital teammates come online, covering patient follow-up, scheduling, denials and appeals, and practice insights. None of them are siloed agents. Each digital employee is a different way of using the same central layer.



What owning AI actually looks like

The three ideas on the last page are easy to agree with and hard to picture. Here's what they look like inside a practice that's actually doing it.

Path Forward's AI Operating Program doesn't stop at governance and literacy. It builds digital teammates: AI agents trained on your practice's own workflows, running inside your systems, owned by you rather than rented from a platform.

Most practices lose ground in the same few places: clinical follow-through slips when physicians run out of hours, patients wait on hold when front-desk staff are stretched thin, denials pile up faster than a billing team can appeal them, and quality measures drift out of range without anyone seeing it until the reporting year closes.

Three teammates, one system, built for exactly those gaps.

Meet your practice's AI team

Catches what's costing your practice before it's a write-off

Monitors the patient panel, flags overdue follow-ups, and drafts the outreach, so care gaps don't slip through because a physician's day got full.

Addresses Mistakes #5, #6

12 patients overdue for follow-up

I drafted the outreach — want me to send it?

Send it

Review

Answers the calls the front desk cannot get to

Handles scheduling, reminders, and rescheduling around the clock, so patients aren't on hold and staff aren't buried in phone tag.

Addresses People & Personnel Mistakes

Can I move my appointment to Thursday?

Done. You're booked for 2:30pm Thursday with Dr. Rogers. Want a reminder text 24 hours before?

Patient

AI Agent

Every claim, fully fought for

Tracks denials as they land, drafts and resubmits appeals, and keeps payer-specific logic in one place, so it doesn't walk out the door when a biller does.

Addresses Mistakes #4, #8

Claim #4471 denied — missing prior auth

I've drafted the appeal and resubmission — want me to send it?

Send it

Review

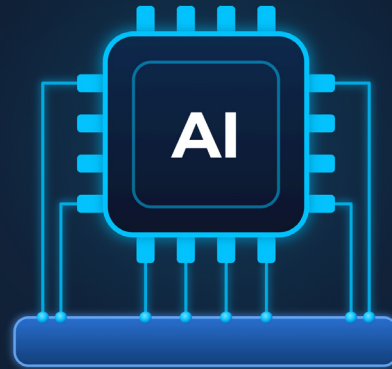
Next steps



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