



A conversation with an investor who has been building AI since the mid-1980s.

AI, LEVERAGE, AND THE CARE LOOP

Picked up on the first ring

Why the point of AI in healthcare isn't autonomy — it's leverage. A conversation on standardizing the data, scripting the guardrails, and quantifying the risk of doing nothing.



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FEATURED VOICES

Dr. Mark Adams

A career spanning AI, technology, and life sciences: chief operating officer and chief technology officer at Adaptive Biotechnologies, a decade of work with the federal government, and a founder, innovator, and investor. Now a partner at Two Bear Capital, which led Rainfall Health's Series A.

Eddie Qureshi

Founder and CEO of Rainfall Health, and host of the Rainfall Health Podcast. Spends most of his time with health system executives and the policy changes shaping care for underserved communities.

INTRODUCTION

The question isn't what AI replaces. It's what it makes possible.

Mark Adams has been working on artificial intelligence since the mid-1980s, when the goal was to understand how minds work by replicating them. That perspective makes him unusually calm about the current moment and unusually specific about where it matters.

His argument is not that AI will run healthcare. It's that healthcare is short on people, drowning in paperwork, and missing a common language between providers — and that these are precisely the problems large language models turn out to be good at. The value shows up as leverage: one care coordinator on top of a whole panel instead of one call, and a patient whose call gets picked up on the first ring.

He is also sympathetic to the sector's caution. Healthcare is conservative because mistakes are existential. His challenge to the holdouts isn't to be braver — it's to price the risk of standing still, which is a decision too.

THE THROUGH-LINE

“Human beings are intrinsic to the care loop. So the question should be how we generate leverage, so those people can be more effective in their jobs.”

Dr. Mark Adams

A note: this is an edited conversation from the Rainfall Health Podcast. It reflects the participants' own views and is not legal, financial, investment, or clinical advice.

Quality of care rests on groups that can't exchange a sentence

Ask where AI matters most in healthcare and Mark doesn't start with diagnosis. He starts with the paperwork, the complication, and the absence of a common language among providers — particularly in the United States. The burden for quality sits on disparate organizations, staffed by disparate people, without shared data standards for exchanging what they know about a patient.

The consequence is repetition. Every handoff means finding out all over again what is going on with this person, instead of giving them the care they actually need.

THE OLD FIX

Hire people: medical transcriptionists, data entry staff, experts to review records. Costly, slow, and never cheap or fast enough to actually affect a patient's care.

WHAT CHANGED

Translation between formats, done quickly and cheaply enough to reach the point of care — from discovery all the way through to the bedside.

Two jobs AI is unusually well suited to

- 1 Standardize the data** moving in and out of healthcare, so a record means the same thing to everyone who reads it.
- 2 Absorb the routine** collection and translation work, in a labor market with real nursing shortages and a shortage of healthcare data experts.

Mark's read on timing: we are right at the edge of a transformational point — and healthcare, being conservative, will be the last to use it. Fortunately or unfortunately, that's just how it goes.

Eight of ten grand challenges, mostly in the last few years

When Mark was an undergraduate, the field had a list of grand challenges — the problems that defined what artificial intelligence could not yet do. Something on the order of eight of the ten have since been knocked over, and most of that happened recently.

8 / 10

grand challenges
knocked over

The conclusion he draws isn't about capability. It's about calibration: the time frame of what constitutes a long time is shortening. He has grown more hesitant to say anything is decades away — “who knows?” is now the honest answer.

Then and now

Mid-1980s

The point was to recapitulate a human mind — can we learn what makes minds work by replicating them with machines? Less about what business use it might have.

Today

The tools exist and the constraint has moved. AI is only as good as the data it's trained on — and in healthcare, the new discoveries and workflows often aren't in a digital format at all.

Which is why, on both sides of this conversation, the same conclusion lands: humans aren't going anywhere for the time being. As Eddie put it — even though you can't spell Rainfall without AI.

One call at a time, or the whole panel at once

Making sure people get better is a responsibility of people. Accept that, and the design question becomes narrow and answerable: how do you generate leverage so those people are more effective at the part only they can do?

WITHOUT LEVERAGE

One conversation

A care coordinator is on top of the single call they're making right now. Everyone else in the panel waits.

WITH LEVERAGE

Nine at once

A patchwork of conversations running in parallel, flipping over to the human the moment somebody needs to intervene.

What the AI does, in order

COLLECT

Gather and translate the data into a format the care team can actually use on their calls.

CALL

Make the routine outbound calls itself — the ones that follow a known script and a known form.

RECORD

Capture the outcome consistently, so the next person in the loop starts informed rather than from scratch.

ESCALATE

Bring the human care coordinator into the conversation when the moment calls for it — then move on.

Note where the human ends up: not removed from the loop, but pointed at the interventions. Which is where they were always most valuable.

Don't underestimate the first ring

The leverage argument is usually made in operator terms. The more interesting half is what it feels like from the other end of the phone — because from the patient's perception, the quality of the interaction goes up, not down.

First ring

A patient calls their care coordinator and somebody picks up. Not a queue, not a callback window.

~80%+

of the time they get the answer they need and can move forward. The rest escalate to a human, consistently and deterministically.

Two things that are easy to confuse

The old phone tree

Press six for this, five for that, then wait half an hour. Automation as a wall between the patient and the answer.

A guardrailed conversation

A reasonable, human exchange with very clear limits: no hallucination, no AI operating outside its mandate, and a human available the moment one is needed.

Mark's view is that this is not one option among several. It is, in some sense, the only way these tools have the kind of impact healthcare needs — because confidence, for both the company and the patient, is the precondition for using them at all.

Humans write the process. AI merely implements it.

Asked what makes Rainfall's approach different from what he sees broadly in the industry, Mark points at a design decision rather than a model: the care coordination pattern comes from well-established best practices, with human experts driving it. The AI is not asked to figure out good care.

HUMANS DEFINE

The script, the process, and the form — customizable per site or hospital where they have something particular.

AI EXECUTES

Runs the conversation, knocks and nudges it back on track, and gets the form properly filled out.

DEPARTURE HANDS OFF

Leave the script and it goes to a human. The guardrail is structural, not a prompt.

Why this is easier to trust than it sounds

Instead of carefully guardrail against hallucination in open-ended conversation, the problem is restated: here is the form, here is the information we need from this interaction, here is the process likely to get there. That is a task current models handle reliably — and it works across a variety of languages, which Mark calls frosting on the cake.

“You're not depending on the AI to figure that out. Human beings have developed this. AI is merely implementing it.”

Dr. Mark Adams

Eddie's framing of the same choice: in healthcare it has to reach the same conclusion every time, so we had to go narrow in order to go broad.

No decision is also a decision

Mark spent a decade working with the federal government, so he has limited patience for the Silicon Valley complaint that clinicians, regulators, and the military simply won't move. Walk a hundred miles in their shoes: a mistake costs a lot. It can be painful, deeply problematic, or cost someone their livelihood or their savings.

But there is a corresponding error on the cautious side. Business as usual gets characterized as risk-free, when in fact that risk was simply accepted a long time ago — while the consequences of no decision go unpriced.

THE RISK THAT GETS COUNTED

Adopting something new in a setting where mistakes are existential. Real, and worth quantifying carefully.

THE RISK THAT DOESN'T

The trend line you're on: a nursing shortage, an aging population, and demographic pressure on the supply of trained clinicians.

The Waymo comparison

Autonomous taxis have certainly been in accidents. But the number of those accidents against the number involving human rideshare drivers is, in his words, probably not even comparable — because the automation is slow, cautious, and confined to limited, well-mapped routes. The guardrails are doing the work, and if you manage around them cleverly there is a net saving.

The challenge he puts to holdouts: don't hesitate to use new technology where it lets your staff be more effective at the parts of the job that only they can do — and be willing to accept a quantified risk when you've compared it honestly against the risk of doing nothing.

And the cheapest first step: ask your clinicians what the least favorite part of their job is. He guarantees the answer involves typing into the EHR.

Start on a few well-mapped streets

You don't have to argue for full autonomy to make the case. Limited self-driving on a few very well-mapped streets is enough — because the moment you start operating, you start generating the data that makes the next place easy.

CONSTRAIN

A deliberately limited footprint with clear guardrails. Slow and cautious is a feature at this stage, not an apology.

ACCUMULATE

Operating produces training data about the process itself — the thing nobody can buy and everybody needs.

EXPAND

Model the next city from what you learned in the first one. Mark watched exactly this happen around him — San Francisco for years, then suddenly self-driving cars all over Denver.

THE SAME STORY IN HEALTHCARE

Run a few procedures across a limited set of hospitals and what you're really learning is the process. That knowledge is what allows rapid expansion — and improvement in lives well beyond the original narrow guardrails.

Note who wins the next phase: the companies that have already been generating data. Compounding here is not linear.

Eddie's addition to the analogy is about who holds the wheel. If clinicians and physicians are in the conversation early, they get to drive the technology toward where they actually need help — rather than have technologists arrive with limited solutions that don't fit the bill. Or, as Mark added, plain old bad ideas.

What an investor is actually looking at

Mark is explicit that his firm is like every other venture firm — committed to large returns for its limited partners. What made this a standout, by his account, is a confluence that rarely appears together.

01

Innate social good

Quality care for underserved Americans — good for patients, and by extension for families, communities, and the economy.

02

Near-term customer economics

Customers see substantial economic benefit, so they're incentivized to buy — which shows up as a short sales cycle and recurring revenue.

03

Data unavailable elsewhere

Comparable data on care across the most impactful health episodes, across many hospital systems — something he believes has essentially never been done.

Why the third one compounds

The collection, aggregation, and management of episode data creates the ability to compare and contrast care across the country. Mark's view is that this has substantial potential value going forward — in medical device work, in drug development, and in the other places that badly need exactly this kind of information.

“It is very rare that you find the confluence between something that has a really innate social good and the potential for driving real economic advantage.”

Dr. Mark Adams

The practical takeaway for founders in this space: you can do good and do well at the same time, and the data you generate by operating is often the most durable asset you build.

The enabler is available to everybody

Mark used to tell people we would soon see the first billion-dollar single-person company. He now thinks that threshold has passed, and wonders whether the number should be higher. The point isn't the valuation — it's how much leverage is sitting unused.

VELOCITY, OBSERVED TWICE

Then

At Adaptive Biotechnologies they were among the earliest to put AI into development teams — early enough that the tooling was primitive by today's standards, and it still produced substantial acceleration.

Now

Watching an engineering team take feature requests through categorization, specification, tickets, QA review, and release in timeframes he would have considered unbelievable a couple of years ago.

His advice to new innovators, in full

- 1 If you have a good idea, you probably can go do it. This is a unique moment for that to be true.
- 2 The tooling advantage isn't confined to life sciences. It applies to anyone in any business willing to use it.
- 3 The constraint is willingness, not access. "I can show you the door, but you have to walk through it."

It's the same challenge he gives every entrepreneur his firm meets, and the same one he gives as a mentor: walk through that door.

Where else could this move the needle?

Mark's closing question was addressed to Rainfall, but it generalizes to anyone running a narrow, well-guardrailed program: what are the proximate values nearby? Where else could this be deployed to move the needle for patients, and particularly for underserved ones?

Beyond Medicare

The population that needs accountable follow-through is much larger than one payer's roster.

Rural care

Distance makes the first-ring problem worse, which makes leverage matter more, not less.

Distant military

Another population where coordination happens across distance and handoffs are the weak point.

And the mechanism for getting there

Eddie's answer was about who does the teaching. Health systems guiding health systems, clinicians guiding clinicians — helping each other find the use cases that are most impactful, then partnering to execute them. The annual conference exists for that reason: everyone gets a lot further, a lot faster, together.

“It's funny to have the VCs say, hey, how can we go improve public health? But the truth is, there's substantial opportunity there too.”

Dr. Mark Adams, in closing

Take the learnings, the training, and the data, and turn them into something deployable more broadly for underserved communities. That's the assignment he leaves behind.

Narrow by design, so it can go broad

Rainfall Health is an accountability and accessibility platform powered by AI — the first and only company certified for these Medicare-mandated programs. The architecture Mark describes is the product: human-authored care coordination patterns, AI executing them at scale, and a deterministic handoff the moment a person is needed.

Leverage for the care team

Routine outbound calls, data collection, and translation handled by AI, so coordinators work the whole panel and spend their attention on interventions.

Guardrails that hold

Scripted processes drawn from best practice, customizable per site, with departures escalating to a human every time.

Data that compounds

Comparable episode data across many hospital systems — the asset that makes the next deployment faster than the last.

FROM THE HOST

“We bring humans in at the juncture where they have the most impact, and let AI answer what's routine — reliably, the same way every time. In healthcare, it can't go off the rails.”

Eddie Qureshi, founder & CEO, Rainfall Health

GET CONNECTED

Find the leverage in your own care loop

If you're weighing where AI belongs in care coordination — and where a human has to stay in the loop — we'd like to help. Rainfall is the end-to-end solution, technology and services, for hospitals and health systems.

LEARN MORE

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START A
CONVERSATION

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Watch for the next episode of the Rainfall Health Podcast.



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