AMPLIFY

Amplify, Not Automate: A 7-Layer AI Playbook for Waits, Burnout, and Margin

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A 7-Layer AI Playbook for Waits, Burnout, and Margin

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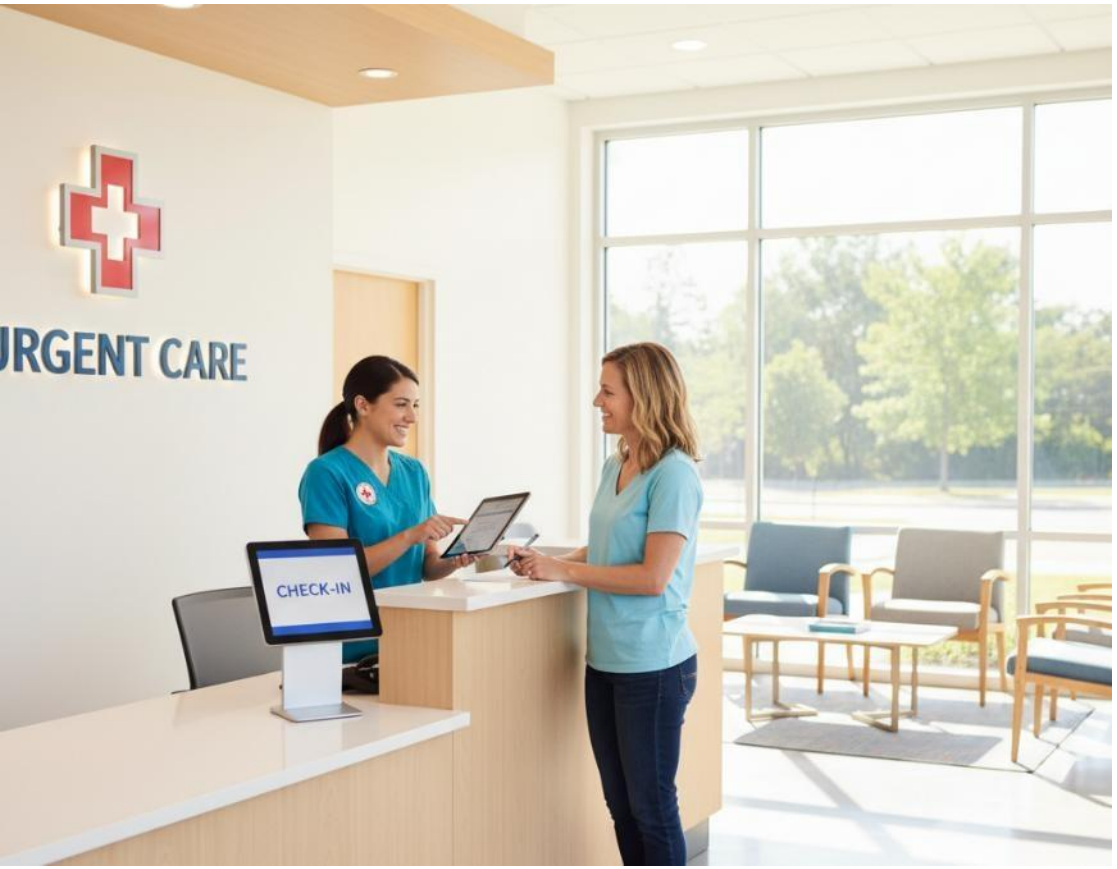
I've spent 20+ years solving the operational, financial, and clinical problems that urgent care faces — now AI is the fastest-moving variable in that equation.

AI Scales What Already Works in Urgent Care



- Urgent care already excels at fast, convenient, community-based care.
- AI now touches the whole visit journey — from intake to documentation and follow-up — removing friction for patients and care teams.
- But…***if AI doesn't improve outcomes or deliver the same outcomes with less burden and cost, it's just a gadget.***

The Seven Layer Framework

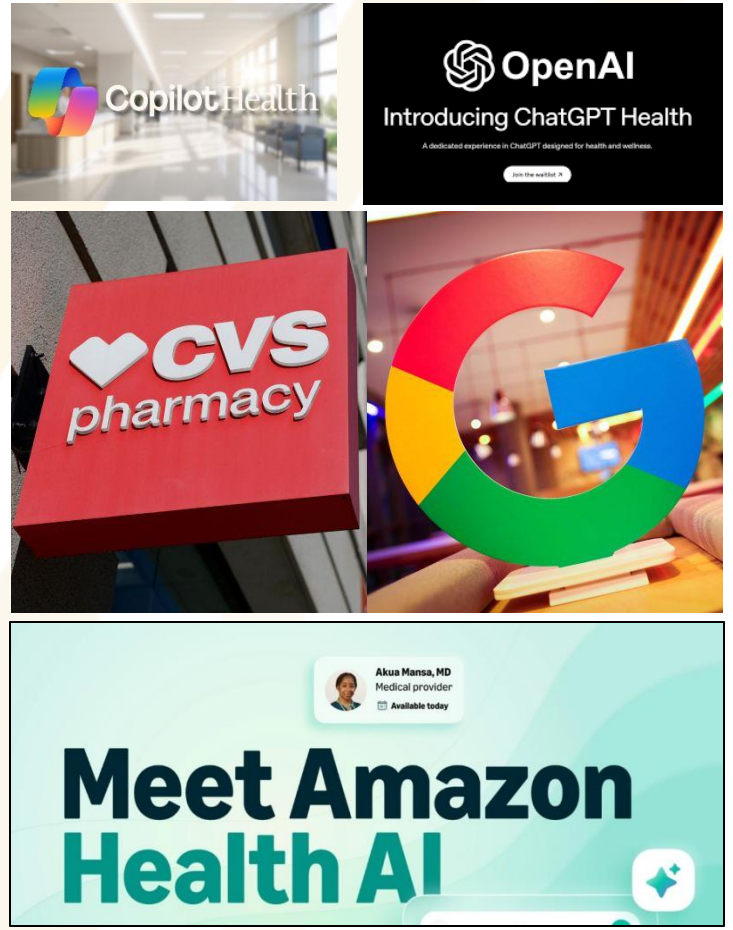
- Layer 1 — Your New Competition Is Amazon
- Layer 2 — Own the Digital Front Door Before Big Tech Does
- Layer 3 — Set the Rules Before Your Staff Sets Their Own
- Layer 4 — Clean the House Before You Automate It
- Layer 5 — Put AI in the Exam Room, Not in Charge of It
- Layer 6 — Fight Back: Move Towards Touchless RCM
- Layer 7 — AI Writes the Note. You Practice the Medicine.

Layer 1: Your New Competitor is Amazon

- **Predictive Staffing:** AI forecasts volume using weather, school calendars, and flu trends — and staffs accordingly.
- **Real-Time Visibility:** Patients expect to track their visit like a delivery. Live updates, no surprises.
- **Frictionless or Forgotten:** One clunky experience ends the relationship.
- **Price at the Door:** AI gives patients their exact out-of-pocket cost at check-in — before they ask.

Layer 2: Intercept the Patient Before Big Tech Does

- **Patients are actively choosing Big Tech over their doctor**
  - 32% of U.S. adults have used AI health chatbots
  - 20% turn to AI because of cost or access barriers
  - 42% skip professional follow-up after receiving AI health advice
  - 41% have uploaded PHI directly into consumer AI tools
- **The Trust Transfer:** While health chatbot usage doubled to 32% in one year, physician trust simultaneously *collapsed* from 65% to 26%
- **The Volume Hit:** Consumer AI is deflecting 15–25% of low-acuity visits — costing clinics 4–8 patients per day — and accelerating as trust continues to shift



Sources: Stanford Medicine (2026); KFF Health Tracking Poll (March 25, 2026)

AI at the Digital Front Door

BEFORE THE VISIT

- Symptom triage directs patients to the right level of care — urgent care, ER, or self-care
- Smart scheduling fills slots in real time based on predicted volume and acuity
- Online check-in captures reason for visit and flags high-acuity cases before arrival
- Pre-visit intake collects demographics, insurance, history, consents, and payment — before the patient walks in
- Intercepts patients before Big Tech platforms capture the visit entirely

DURING THE VISIT

- Ambient scribes capture the encounter in real time — clinician stays focused on the patient, not the keyboard
- Clinical Decision Support (CDS) surfaces relevant protocols, drug interactions, and order sets at the point of care
- Computer vision assists with imaging — a second set of eyes on X-rays for fractures, reducing callbacks and liability

AFTER THE VISIT

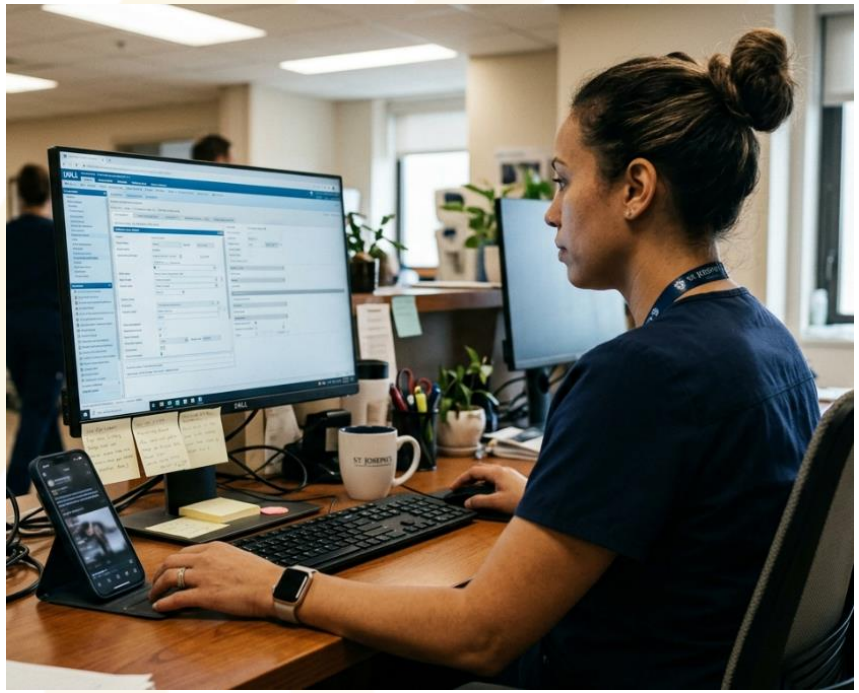
- Automated discharge instructions tailored to the diagnosis — sent by text or app within minutes Lab result notifications delivered directly to the patient with plain-language explanations
- Follow-up check-ins at 24 and 48 hours identify complications early and reduce unnecessary return visits
- Re-engagement campaigns bring patients back before they drift to a competitor or a chatbot

Layer 3: Set the Rules Before Your Staff Sets Their Own

The Reality
- ~50% of workers use unapproved AI tools; in healthcare, only ~50% follow their organization's AI policy
- 93% admit to pasting company data into unauthorized tools
- 52% would break AI rules if it makes their job easier
- Staff aren't being reckless — they're 20–80% more productive with these tools, and they know it

The Risk
- Pasting PHI into a free LLM is a HIPAA violation — mandate Business Associate Agreements (BAAs) from every AI vendor to guarantee data is sandboxed and never used for training
- The EMR must remain the Stadium of Record — all AI outputs flow back into it, not into shadow systems

The Fix
- Provide approved, secure tools so staff don't have to improvise
- Elevate "power users" —share workflows openly



Sources: Microsoft Work Trend Index (2024); Cyberhaven Data Security Report (2024); Salesforce Trends in AI (2025); MIT Sloan/Stanford productivity research

Layer 4: Clean the House Before You Automate It

- Automate a broken process and you just break it faster — the mess doesn't disappear, it multiplies
- Garbage in, garbage out: inconsistent intake, coding, or documentation produces bad predictions and untrustworthy AI outputs
- Map and clean first: document current workflows, cut redundant steps, and standardize templates before any vendor goes live
- Pay for outcomes, not features — measure before vs. after, and link contract renewals to the metrics you actually care about

Proof: Better Targeting, Better Outcomes, Lower Costs

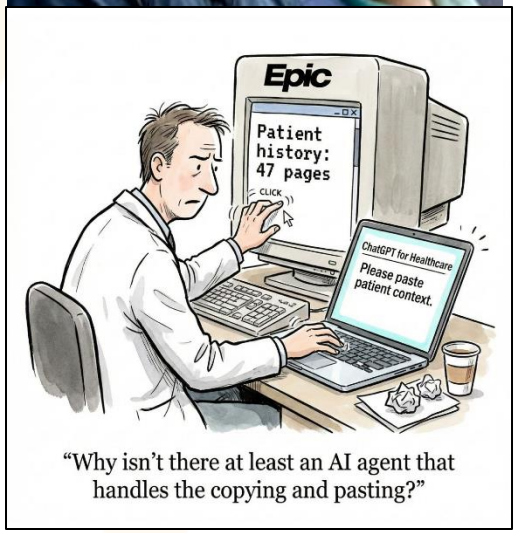
Rutgers capstone simulation data:

- AI-Optimized Standing Orders: Increases share of visits with results ready before the clinician from ~20–30% to 60–80%.
- Cycle Time: AI cuts door-to-door time by ~7–10 minutes vs. 57-min baseline (12–18% faster) and adds ~3–4 patients/day/clinic.
- Revenue Uplift: Net revenue per visit rises ~$16–$19/visit → ~$375–$550 extra revenue per clinic per day.
- Stewardship: Inappropriate antibiotics for sore throat drop from ~49% to ~27–35% (20–45% reduction) by enforcing “test-before-treat.”

Source: Ayers AA. AI for Standing Orders in Urgent Care. Rutgers Business School Capstone. Fall 2025.

Layer 5: Put AI in the Exam Room, Not in Charge of It

- **Exam-room agent:** ambient scribe captures the encounter in real time; clinical co-pilot surfaces relevant protocols and order sets at the point of care
- **Imaging assistant:** computer vision provides a second set of eyes on X-rays for fractures — reducing callbacks and liability
- **EMR:** the Stadium of Record — every agent's output flows back into it; rules, documentation, and audit trail live there and nowhere else
- **If a tool requires a separate login, cut/paste, or double-entry, it does NOT make the team**



Layer 5, cont'd: Ambient Scribes

- **Scribes evolving into structured-data generators**: powering autonomous coding, making it up to 55.1% faster.
- **Time savings:** 8.5% less total EHR time, 15% less note-writing; ~1 hr/day less after-hours documentation.
- **Capacity & connection:** 18% more patients per clinician; 84% say it improves interactions. Burnout dropped from 52% to 39%.
- **The Upcoding Risk:** Vendors justify high fees ($300-$500/mo) by tying AI to billing. Beware of algorithms artificially inflating E/M codes (e.g., pushing a Level 3 to a Level 4).
- **Malpractice Guardrail:** AI = "Clinical Decision Support" (CDS). A licensed provider must verify every output. Not having scribes in 2026 will hinder recruiting.

Sources: KLAS Research (2025); AMA Physician Burnout Survey (2025); ONC Clinical Decision Support Guidance)

Layer 6: Fight Back: Move Toward Touchless RCM

The Threat: Zero Sum Game of Provider AI vs. Payer AI

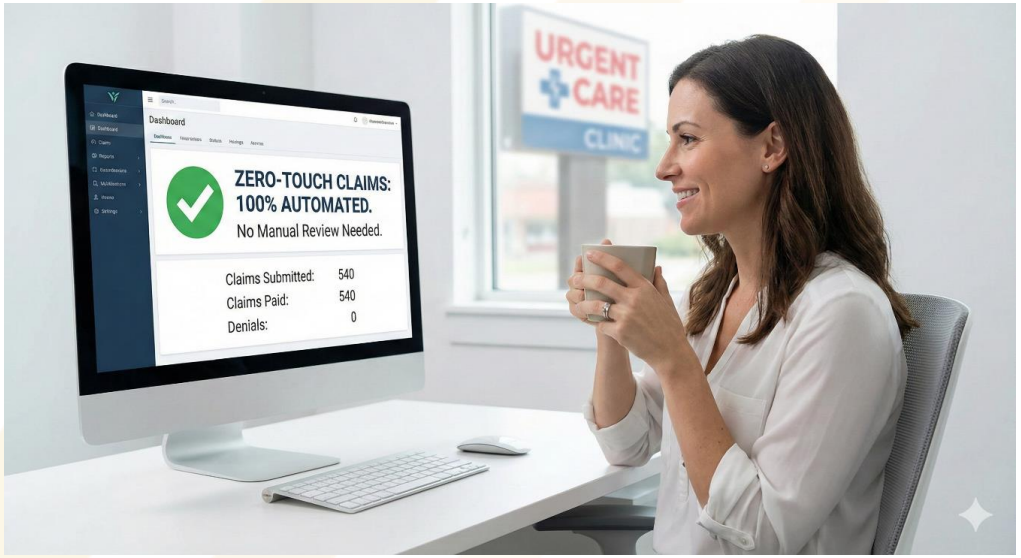
- AI scribes drive a 5.8% increase in RVUs
- Payers cannot afford the revenue bump; they're Insurers are deploying their own AI to downcode and deny claims
- For every $10B in revenue, payers expect AI to save $150M–$300M in admin costs alone.

The Opportunity You're Leaving on the Table

- ~20% of urgent care claims are denied; up to 60% are NEVER appealed — not because they're wrong, but because staff lacks the bandwidth to fight them
- Fully autonomous agents resolve denials, code claims, and scrub submissions with zero human touchpoints

Govern AI strictly:

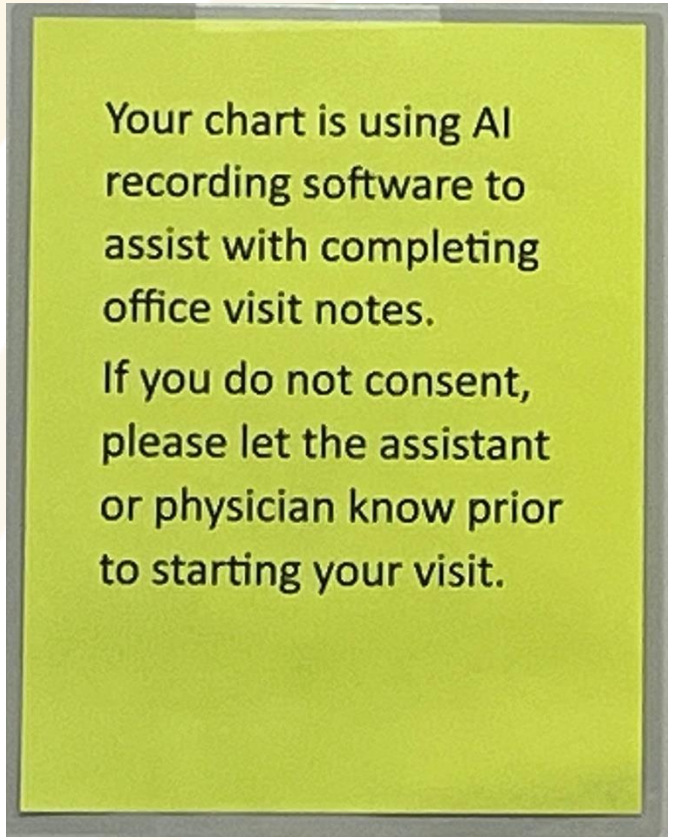
- Do not use AI to artificially inflate codes — use it to build a bulletproof documentation defense against payer audits
- A human must remain in the loop to verify outputs



Sources: UCSF Department of Medicine (2024); McKinsey Global Institute (2024); American Medical Association Prior Authorization Survey (2024)

Layer 7: AI Writes the Note. You Practice Medicine.

- **The Legal Threshold:** When does an algorithm's output cross from a harmless web search into the unlicensed practice of medicine? This is the defining liability question of the AI era.
- **The Precedent Is Already Here:** A life insurance company recently sued OpenAI for the unauthorized practice of law. Clinical operators face the same risk if AI output — without physician review — influences patient decisions.
- **The Trust Gap Is Real:** When physician ads explicitly mentioned AI, patients perceived providers as less competent, less trustworthy, and less empathetic.
- **Lead with Care, Not Tech:** Tell patients when and why AI is used. AI drafts the chart — the licensed provider practices the medicine. Always offer opt-out with no impact on care.
- **The ultimate safeguard isn't technical. It's human.**



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The Financial Case: What AI Is Worth Per Clinic

+$16–$19 per visit

REVENUE UPLIFT

~$375–$550 extra/clinic/day → $135K–$200K/year

Source: Rutgers Business School capstone simulation

+18% patients per clinician

CAPACITY & BURNOUT REDUCTION

~1 hr/day recaptured; burnout drops 52% → 39%

Source: Published ambient scribe studies; KLAS research

60% of denials never appealed

DENIAL RECOVERY & RCM DEFENSE

~20% of claims denied; AI autonomously resolves & resubmits

Source: McKinsey; UCSF RVU data

7–10 min faster door-to-door

THROUGHPUT & CYCLE TIME

+3–4 billable visits/day; 10-clinic group: +$1.5K–$4K/day

Source: Rutgers simulation

10-clinic operator deploying full-stack AI: conservatively $1.5M–$2.5M in combined annual uplift

Through recovered denials, additional visits, and reduced documentation overhead.

Results vary by clinic size, EHR, payer mix, and implementation maturity.

UCA Vendor Checklist

🛡️ 1. Security & Data Governance

•[ ] **The BAA Mandate:** Will the vendor sign a Business Associate Agreement (BAA) to guarantee that patient data is securely sandboxed?

•[ ] **Shadow IT Prevention:** Does this tool eliminate the temptation for your staff to paste PHI into unauthorized, public consumer LLMs?

•[ ] **Clear Data Rules:** Does the platform allow you to set clear rules on data use and provide secure tools for your team?

⚙️ 2. Workflow & EMR Integration

•[ ] **The Double-Entry Rule:** Does the tool operate without requiring double-entry?

•[ ] **Bi-Directional Sync:** Does the AI offer seamless bi-directional integration with your current EMR?

•[ ] **No Separate Logins:** Can your staff use the tool without a separate login, or having to cut and paste patient context?

•[ ] **Stadium of Record:** Does the vendor respect your core EMR as the ultimate "Stadium of Record" for all rules, documentation, and audit trails?

⚖️ 3. Clinical & Billing Integrity

•[ ] **Transparent Pricing:** Is the vendor transparent about costs, rather than justifying high fees by tying their AI to billing increases?

•[ ] **Upcoding Guardrails:** Does the tool have safeguards against algorithms artificially inflating E/M codes?

•[ ] **Clinical Decision Support (CDS):** Is the AI legally positioned as Clinical Decision Support, ensuring that a licensed provider must verify every output before the chart is closed?

Thank You — Q&A

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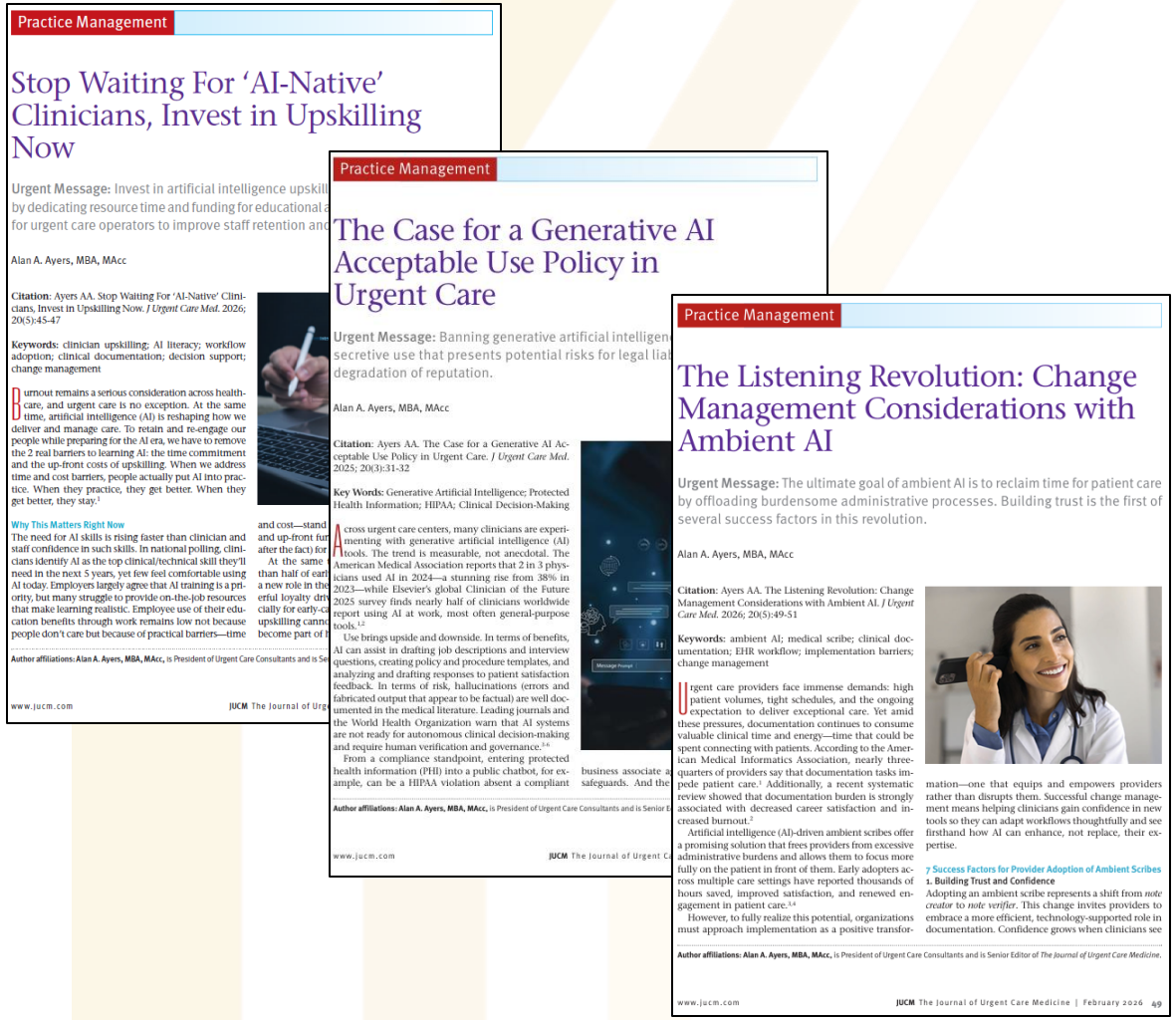

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