LEGISLATIVE COUNCIL STUDY COMMITTEE ON THE USE OF ARTIFICIAL INTELLIGENCE IN HEALTH CARE

Artificial Intelligence in Practice:
A Community Health Center Perspective

Outreach Community Health Centers

Federally Qualified Health Center | Milwaukee & Racine, Wisconsin

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INTRODUCTION

About the Presenter

Nicole Mubanga, MD

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A Wisconsin native, educated in Wisconsin, and board-certified in Family Medicine, I continue to maintain an active clinical practice today. Since completing residency in 2016, I have worked in community health centers across Milwaukee, Kenosha, and Racine — helping patients with barriers to resources and low health literacy navigate complex health conditions within complex social circumstances, including lack of insurance, food, housing, transportation, education, and trust in the health care system as a whole.

Financial Disclosure

I have no financial conflicts of interest to disclose related to this testimony or any of the technologies discussed.

Outreach Community Health Centers

A federally qualified health center (FQHC) — a HRSA-funded, community-based provider offering primary care on a sliding-fee scale regardless of ability to pay — serving the most vulnerable patients in Greater Milwaukee and Racine for more than 40 years.

WHO WE ARE

6+
Care sites across Milwaukee & Racine + Mobile Health Unit

Sliding-Fee
Income-based — most patients uninsured or on Medicaid

40+ Years
Serving Greater Milwaukee & Racine

Small Team
180 staff — lean staff and budget vs. large health systems

2025 AT A GLANCE

~25,000
Patients Served

99%
Below 200% FPL

68%
Medicaid

18%
Uninsured

Most legislative testimony on health care AI comes from large systems and vendors. We bring the perspective of a resource-constrained safety-net clinic using these tools with real patients, every day.

Fully Integrated Services

Behavioral Health:

- Psychiatry
- Therapy
- AODA and SUD Services
- School-based therapy

Medical:

- Primary Care
- OB/GYN & Prenatal Care Coordination
- Podiatry
- Nutrition

BH Case Management:

- CCS - Comprehensive Community Services
- CSP - Community Support Program
- TCM - Targeted Case Management
- CCM - Crisis Care Management

Homeless Services:

- Street Outreach & Homeless Teams
- Benefits Enrollment
- Rapid Rehousing Program

Pharmacy:

- Onsite Pharmacy
- 340B discount program

Community Partnerships

Ascension Dental

Onsite dentistry + Smart Smiles (110+ schools)

Medical College of Wisconsin

Onsite family medicine residency

CH Mason Community Clinic

Medical & behavioral health services

St. Ben's & Salvation Army

Primary care & behavioral health

Wellpoint Clinics (2026)

BH, PT, OT & speech therapy

Milwaukee County Access Clinics

BH crisis services for the uninsured

STATEWIDE CONTEXT

Wisconsin’s Community Health Centers: The Bigger Picture

18

Community Health Centers statewide

300,000+

Patients served statewide (2025)

9 in 10

Patients earn under 200% FPL

$2,679/mo

200% FPL income limit, family of four

STATEWIDE PAYER MIX (2025)

56%
Medicaid

17%
Uninsured

18%
Commercial Insurance

Community Health Centers primarily serve patients with barriers to care — often with low health, financial, or legal literacy, and limited awareness of their rights and protections.

SECTOR CONTEXT

AI Adoption in the FQHC Setting: Where We Stand

Community health centers across Wisconsin are at very different stages of AI adoption — and for good reason. Both the promise and the caution are real.

Reasons to Adopt

- Improves speed and accuracy of documentation
- Allows more direct engagement with patients during the visit
- Improves patient and provider satisfaction — more focus on care, less on documentation
- Improves provider work-life balance by cutting down charting time

Reasons for Hesitancy

- **Cost** — progressively narrowing margins amid reduced grant funding, rising personnel expenses, and changing reimbursement
- **Trust** that information is secure, safe and accurate — for organizations, providers and patients

The biggest trust concern is specific to ambient AI: the risk of unintentional sharing of recorded dialogue. If that dialogue reveals information of a politically or judicially charged nature, exposure has the potential for catastrophic consequences — potentially exposing a patient to persecution. Our first obligation as clinicians is to do no harm.

A Particular Concern: Consent Itself Can Do Harm

For a behavioral health provider treating a patient experiencing paranoia, even raising the topic of AI-assisted recording can compromise the therapeutic relationship itself. As FQHCs, our first duty is to protect patients who may already carry deep mistrust of the health care system.

OVERVIEW

AI Tools at Outreach

Ambient AI

DAX AI Scribe

Ambient dictation & note generation

Our most deeply adopted AI tool — live since January 2025.

Clinical References

OpenEvidence

Point-of-care clinical evidence search

UpToDate AI

AI-assisted clinical reference & guidance

OCHIN Epic Built-In AI

MyChart Response Suggestions

Draft replies to patient messages

Chart Summaries

AI-generated pre-charting summaries

Coding Recommendations

AI-assisted billing/coding support

AI Beyond Patient Care

Also supports our operations — helping address staffing challenges and cost pressures:

- Draft communications & policies
- Summarize meetings
- Create reports & presentations
- Support project management
- Develop procedures & workflows

SPOTLIGHT

DAX AI Scribe: Our First — and Deepest — Adoption

First FQHC

in Wisconsin to adopt DAX AI Scribe

Live since

January 2025

Provider satisfaction

The primary, most consistent gain — less time on documentation, more attention on the patient.

Documentation clarity & accuracy

Marked improvement for clinicians whose notes were previously minimal — now capturing fuller clinical detail.

Quality review & care coordination

Richer notes strengthen our quarterly random chart reviews and give nurses and care teams a clear record of what was discussed and next steps.

PATIENT TRUST

Consent in Practice, Not Just on Paper

For DAX AI Scribe, consent is built into two touchpoints:

At registration

Included as part of the standard consent-to-treat at the front desk.

At every visit

The provider asks again, verbally, before each visit begins — every single time.

In the room, standard language isn’t enough

We have standard language to explain the software — but as a practicing clinician, I typically translate it into terms that make sense for that individual patient. Most patients are comfortable once it’s explained. A few are not.

When a patient declines: the provider dictates without AI processing, or writes the note manually. The choice stays with the patient — every time.

SPOTLIGHT

Clinical Reference AI: OpenEvidence & UpToDate

OpenEvidence — adopted organically, provider by provider, over the past year.

UpToDate AI — launched June 2026; used for differentials, treatment planning, and patient-specific guidance.

A real example

A patient with heart failure, diabetes, chronic kidney disease, and lactose intolerance needs dietary guidance. UpToDate AI can generate recommendations tailored to all four conditions at once — a synthesis that used to take significant provider time to work out manually.

Why this matters

- Curated, current evidence — not everything searchable, including outdated information
- Every answer links to source references, supporting our own ongoing learning
- Replaced ad-hoc use of general chat tools to keep the data entered safe and the output accurate

OCHIN EPIC BUILT-IN AI

Not Every Built-In Tool Delivers Equal Value

OCHIN Epic ships several AI features by default — MyChart response suggestions, chart summaries, coding recommendations. Their real-world value varies widely. MyChart AI-Suggested Responses is a representative example:

AI drafts suggested replies to patient MyChart messages for providers to review and send.

Where it helps

A useful starting point for routine, lower-complexity messages — saving a few minutes of drafting time.

Where it falls short

More often than not, providers rewrite the suggestion to be patient-specific — especially with patients they know well. The AI draft is a starting point, not a replacement for that relationship.

OUR TAKEAWAY

AI tools vary widely in real-world value — even within the same EHR. Policy should account for that range rather than treat "AI in health care" as one thing.

GOVERNANCE

How We Decide to Adopt a Tool

1. Clinical Review

OCHIN Epic specialist, CMO, and clinical directors review before go-live.

We evaluate impact on clinical practice:

- Expected provider/clinician adoption
- If, and how, it improves quality of care
- Impact on clinician satisfaction and burnout

2. Operational Review

For clinical and non-clinical tools, we ask:

- What roles will it support
- Which staff are using it currently
- How it integrates with systems already in place
- Ease of use/learning — training & staff buy-in
- Whether it adds to or replaces an existing system

3. Fiscal Review

Tools with added cost — like DAX — are reviewed for:

- start up cost
- cost of maintenance and sustainability
- Expected return on investment

Important context: not every AI feature goes through this process.

Some Epic-embedded AI tools are opt-in at the point of care — a provider must actively click to activate them. Of the clinical tools, only DAX AI and UpToDate AI received formal advance review.

THE SAFETY-NET REALITY

What This Looks Like Without Enterprise Resources

Challenges to building robust, sustainable internal AI governance

Limited staff & budget

Our people already carry full patient loads, administrators are often managing the work of multiple roles; there’s no dedicated AI governance team or budget line.

Largely OCHIN Epic-driven

Most features arrive by default from our EHR vendor rather than a clinic-led rollout plan.

Leaning on our network

The Wisconsin Primary Health Care Association and OCHIN Epic have shared templates and guidance we’re now evaluating to build our own formal process.

THE REGULATORY BALANCING ACT

Why Flexible, Scalable Regulation Matters

Preserve Room to Adopt

AI can extend a lean workforce — reducing administrative burden and helping us meet community need despite wait lists and staffing shortages.

Overly burdensome requirements risk making beneficial technology accessible only to the largest health systems, leaving community-based providers behind.

The economics of AI are still evolving — as computational costs fall and value rises, flexible rules today preserve room for smaller providers to benefit as the technology matures.

Risks We Can't Ignore

Publicly available AI tools have already been shown to give inaccurate or harmful health information — with real consequences when patients rely on them for health decisions.

Many operate entirely outside HIPAA, and patients may not understand how their health data is collected, used, or monetized.

Health data is among the most personal information a person has. The exam room is designed to be a place where one can share their most deeply personal thoughts, feelings and concerns; patient safety and privacy must remain central to any AI framework, particularly with Ambient listening tools.

THE CENTRAL QUESTION

How do we ensure AI tools used by Wisconsinites are safe, effective, transparent, and worthy of public trust — while preserving the ability of smaller practices, lean nonprofits, Community Health Centers, and independent providers to use these technologies in service of better care?

FOR THIS COMMITTEE

What Safety-Net Providers Need From AI Policy

TOP PRIORITY

Absolute Protection for Vulnerable Patients

When ambient AI captures a visit, patients may disclose information — about immigration status, reproductive health, substance use, or political beliefs — that could expose them to political or judicial persecution if it left the exam room. That information must be absolutely protected. This cannot be optional or left to discretion.

Capacity-aware standards

Compliance timelines and documentation requirements that a small clinic can realistically meet — not just large systems with dedicated AI teams.

Flexible, plain-language consent

Preserve room for clinicians to explain AI use in terms that fit the patient in front of them, not just a fixed disclosure script.

Protect clinical judgment

Any standard should keep the human decision-maker in charge — providers must be able to override, edit, or decline AI output.

Support, not just require

Fund or facilitate shared resources — templates, technical assistance, peer networks like WPHCA — so small and safety-net providers can meet new standards.

Thank You

AI is already improving care at Outreach Community Health Centers — but any statewide standard must work for clinics like ours, not just the largest systems in the room.

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