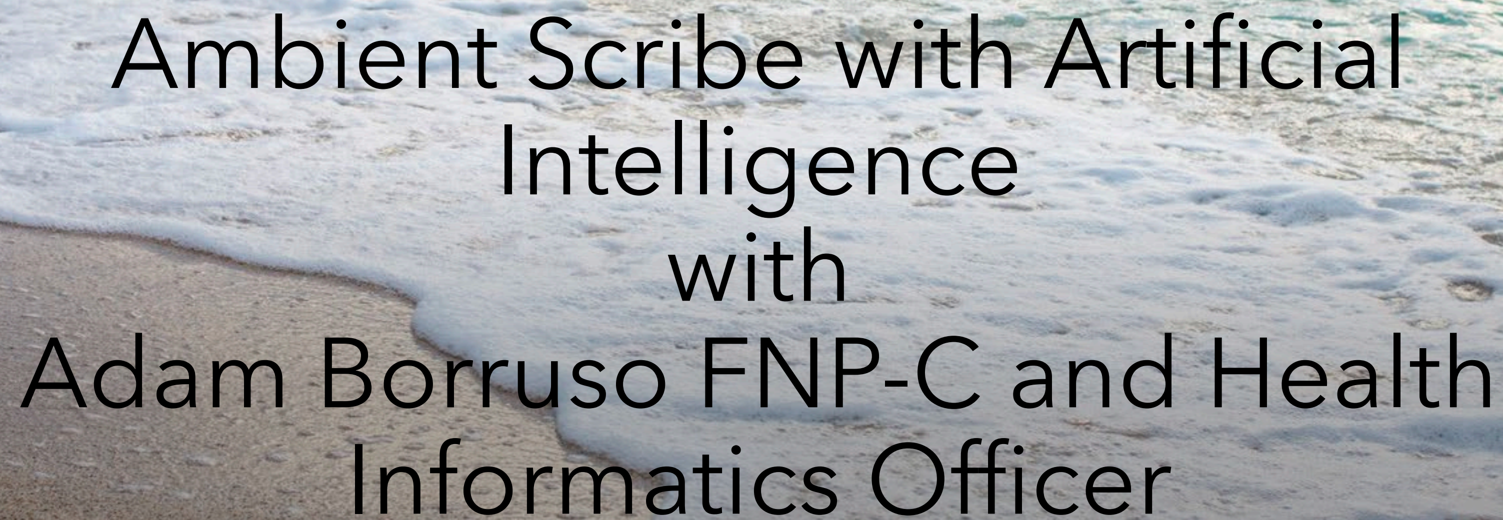


Ambient Scribe with Artificial Intelligence
with
Adam Borruso FNP-C and Health Informatics Officer

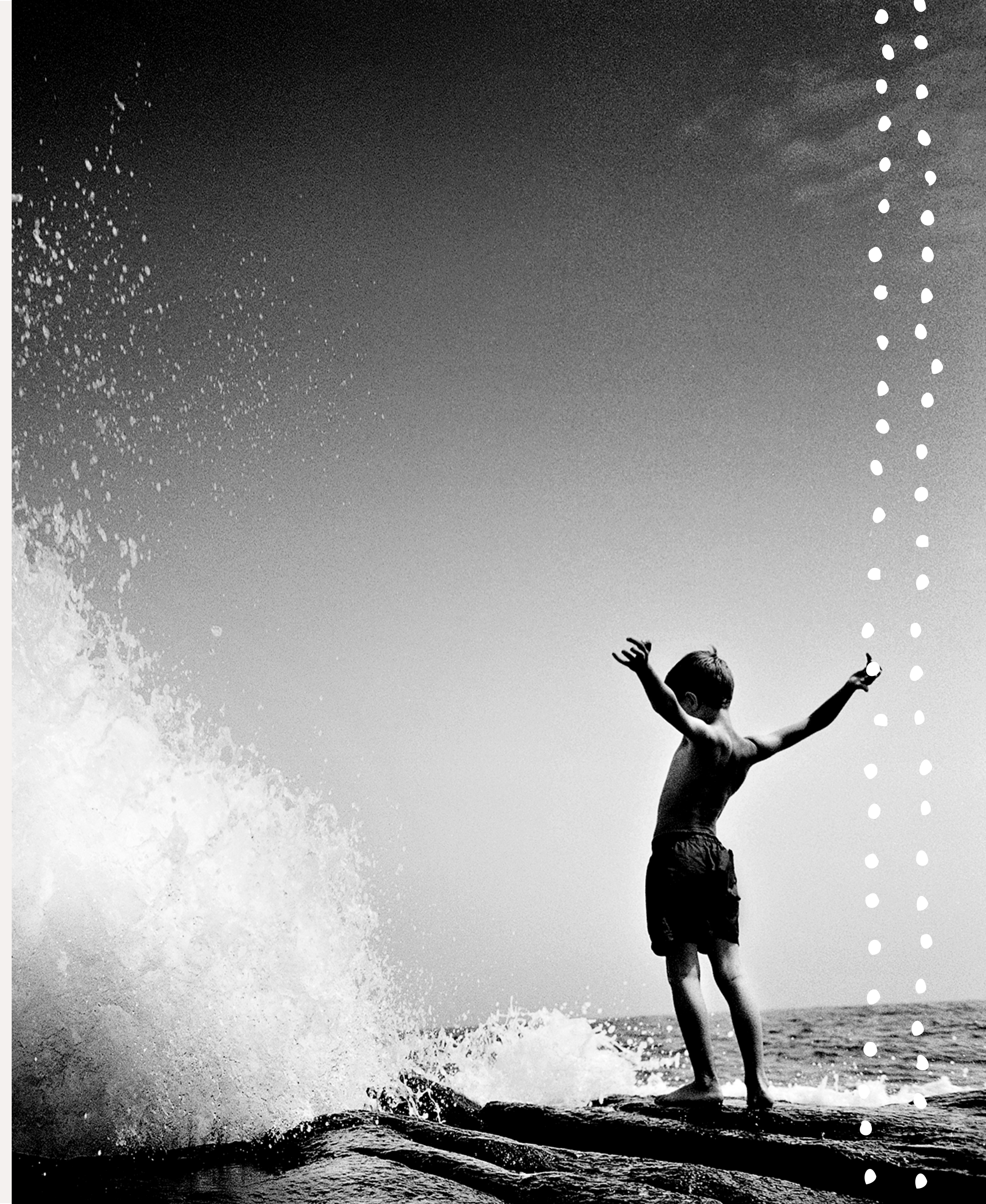
- No financial or relationship disclosures

Agenda

- Introduction
- What is it?
- Our Journey and Experience
- Final tips & takeaways

Who am I?

- Registered Nurse
- Family Nurse Practitioner
- Health Informatics Officer
- Over 20 years of experience
- Worked on multiple EHR



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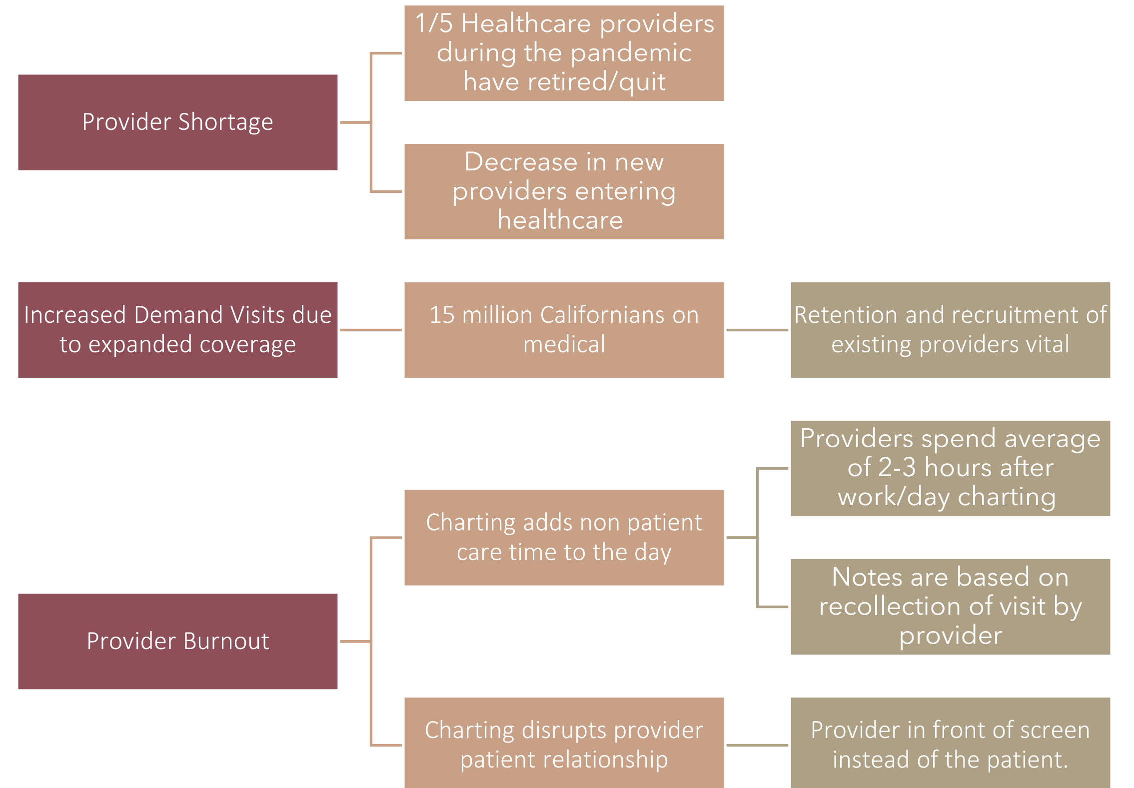
What Electronic Health Record has done to medicine:

Less time with patients and more time behind the computer serving the needs of billing



What is it?

- Real-Time Audio Capture
  - Records conversations during the visit using phone, tablet, or desktop

  Automatic Note Generation
  - Transcribes and structures notes based on clinical context (e.g., SOAP format)
  - EHR Integration (varies by product) allows importing of notes, ICD codes, orders, and referrals
  - Customizable Output
  - Learns provider's documentation style over time
- Bring in device and turn on recording
- After dictation done time to import information from programing

Process for us

- Due diligence done with evaluation team of CIO, Medical Director and Health Informatics Officer
- Evaluation of at least three different options of products present on the market
- Multiple products with different advantages including more robust charting and integration within our EHR
- After evaluation and demonstration, a decision to bring to our Steering Committee and Board for approval and monetary decisions

Pilot Process

- Picked a variety of providers including tech savvy providers and providers behind on charting over one week (Started with five providers)
- Survey completed before start to get baseline including information on quality of current note, worries about using AI Scribe, hours spent outside of normal work hours weekly, and burnout

Pilot Process continued

- Training with Health Informatics Officer with daily check in to work out problems for the first week
- Clinical Support rounding and support as well
- Post Survey taken after six weeks to see how pilot was affecting

Survey Results

I am producing a note that I feel represents what happened in the visit and is done well – Improved from 7/10 to 9/10

Hours I spend outside of normal work hours charting weekly – Improved from 6.4 hours to 2.8 hours

I am able to get my non charting tasks done (Jellybeans, paperwork, etc.) in the hours of work – Improved from 1.8/10 to 4.6/10 (we are still doing primary care people)

Burnout scale improved from 5/10 to 2.4/10

Comments

- Thank you for the opportunity to improve quality of notes and quality of life for me and my family. this has given me hope for the future of primary care and reducing burnout.
- The AI Scribe has been a game changer. I honestly was thinking about reducing to 60% and this has made it possible to continue at 80%. I feel happier at work. I feel less stressed. I feel more connected to my patients. I feel like I am providing better care.

Comments continued

- The biggest Suprise from AI scribe is the amount of cognitive load that it has reduced. I'm better able to focus on what patients are saying, consider diagnoses and treatment plans and look for the data I need while in the room with patients. I feel confident that even if the scribe result isn't perfect, it will contain enough to create a note that represents the different aspects of our discussions. This opens me up to be able to address more individual problems in the visit and tackle some of the bigger problems in an acute visit.
- Has allowed for better eye contact and empathetic listening. There is clearer communication and ability to focus more on the plan and education.

- Roll out to the entire medical team with support from Health Informatics Officer and CAS team
- Regular check in with providers and support from Pilot Team
- Discussion with Behavioral Health and selling them on options and benefits

Behavioral Health Expansion

- Worked closely with Health Informatics Officer on tricks for success
- Does not work well with structured data or templates (yet)
- AI Scribe programs that work for medical are catered to medical and not as good for BH
- Partnered with one of the companies to figure out how to improve documentation
- Gathering regular feedback from BH providers on how to improve

Why consider AI Scribe?

- Burnout prevention
  - More efficient charting
- Retention of providers
  - How can you leave when we have made your quality of life EVEN BETTER
- Recruitment
- Overall cost savings
- Improved quality of documentation – locked charts on time matter
  - Risk reduction of legal implications

- Some patients will not want recording
- Still some manual entry in notes (15min->3min)
- Import ICD codes, order meds/labs/referrals/procedures – for non integration
- 2 patients in the room at one time in the same visit
- Exam is less than hoped for
- Plan can be less than robust
- Time investment by provider in beginning while AI learns documentation style
- Costs
    - Offset with retention/possibly added patient

What is required?

Interface set up with programs

Devices for recording

Approval from Steering/Board for recording

Consent from patient to document

Training for providers

Tips and Tricks

- **Educate Your Team and Patients**
  - Inform staff and patients about the purpose and benefits of ambient scribing
  - Use simple language like: "This tool helps us document your visit more accurately so we can focus more on you"
- **Choose the Right Environment**
  - Ensure quiet, private spaces with minimal background noise
  - Use high-quality microphones and position them optimally
- **Understand the Technology's Capabilities and Limitations**
  - Know what your ambient scribe can and cannot do (e.g., does it auto-populate SOAP notes, handle orders, or require manual review?)

Tips and Tricks continued

- **Speak Clearly and Naturally**
  - Avoid overlapping speech with the patient
  - Use clinical keywords like “diagnosis,” “treatment plan,” “follow-up,” and “medication” to help the AI structure notes
- **Include Specifics**
  - Be precise with prescriptions: “I’m prescribing amoxicillin 500 mg three times daily for sinusitis”
- **Maintain Eye Contact and Engagement**
  - Let the scribe handle the note-taking so you can focus on building rapport

Tips and Tricks continued

- **Review and Edit Promptly**
  - Validate the generated notes immediately after the visit while the context is fresh
- **Use Templates and Smart Phrases**
  - Customize templates to align with your clinical style and specialty
- **Monitor for Errors or Omissions**
- Ambient scribes may miss nuances—always double-check for clinical accuracy

Tips and Tricks Continued

- **Track Metrics**
  - Monitor time saved, note quality, and patient satisfaction to assess ROI
- **Provide Feedback to Vendors**
  - Share usability insights to improve tool performance and customization
- **Stay Updated on Regulations and Privacy**
  - Ensure compliance with HIPAA and institutional policies
- **Join a Community of Practice**
  - Engage with other clinicians using ambient scribes to share best practices and troubleshoot issues

What does a day in the life look like for our future