ADVANCING INTEGRATED HEALTHCARE

A PRIMARY CARE GUIDE TO AI: EVIDENCE, QUESTIONS, AND PRACTICAL INSIGHTS FOR RHODE ISLAND PRACTICES

Featuring Insights from Dr. Atin Jindal of Brown University Health

Every week brings another vendor email promising AI will save time, reduce burnout, or transform care. Dr. Atin Jindal, hospitalist and Director of Medical Informatics at Brown University Health, offered something more useful at CTC-RI's May Clinical Strategy Committee meeting: an honest look at what AI in health care has actually proven — and a practical way to size up the next tool that lands in your inbox.

But the evidence only tells part of the story. Most AI tools on the market today were not built with primary care in mind — and that gap has real consequences for patients and practices.

What The Evidence Shows

Evidence drawn from "Implementing AI in Primary Care: Evidence Based, Actionable Insights," Atin Jindal MD MS, Brown University Health, May 15 2026. Full citations available upon request.

To hear the full presentation and discussion, listen here.

AMBIENT SCRIBES

52% → 39%

Clinician burnout reduction

Strongest evidence of any AI category. Also yields 13 fewer minutes in the EHR and 16 fewer minutes on documentation per day.

Benefits only hold when every note is actively reviewed before signing.

CLINICAL DECISION SUPPORT

28.4% → 22.4%

Adenoma detectio after AI removed

AI performs best alongside clinicians. Two consistent risks: automation bias and deskilling — where reliance on AI erodes independent clinical skill over time.

No robust randomized trials yet in primary care settings.

PATIENT MESSAGING

84%

faster message resolution (triage tools)

Only ~20% of AI drafts are used as-is. But 35–45% of error-containing drafts were sent completely unedited.

Human review before any patient-facing send is essential.

The Gap Nobody's Solving Yet

SOCIAL CONTEXT IS BEING STRIPPED OUT

Most ambient AI tools remove patient social context — a design choice built for hospital settings that quietly erodes the trust primary care depends on.

AI will likely arrive in primary care long before consensus standards do. The practices asking thoughtful questions now will be best positioned to improve care while protecting trust.

COMMUNITY HEALTH TOOLS ARE LAST IN LINE

Investment follows revenue. CHW workflows, multilingual support, and care coordination tools are not priorities for major vendors right now.

NO LONGITUDINAL MEMORY

These tools are optimized for a single encounter. They cannot carry the relational and clinical context that builds across years of primary care.

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Five Questions Worth Asking Before You Adopt Any AI Tool

1. **Is it staff-facing or patient-facing?** Staff-facing tools carry lower risk because a person can catch a mistake before it reaches a patient. Patient-facing tools carry higher risk, but demand for them is real: patients are already turning to tools like ChatGPT on their own, with or without guidance from their care team.
2. **What's the actual evidence?** AI clearance often relies on a much lighter evidentiary bar than people assume. Ask specifically where the evidence comes from and on what patient population the tool was validated. Evidence from a large academic hospital system may not translate to a community health center or independent primary care practice.
3. **How does it fail?** Ask the vendor to walk you through a real false positive and a real false negative, not just the best-case demo.
4. **Is there a rollback plan?** Know how to turn the tool off before you turn it on.
5. **Does it preserve what makes primary care work?** Continuity, social context, and trust rarely show up in AI benchmarks, but they belong in your evaluation.

> *When a tool has a built-in bias or blind spot, that flaw doesn't affect one patient. It gets applied at scale across every patient who interacts with it.*

Why This Matters For Equity

When a tool has a built-in bias or blind spot, that flaw doesn't affect one patient. It gets applied at scale across every patient who interacts with it. Pair that with the fact that small, independent, and safety-net practices, many of the practices CTC-RI stakeholders represent, are the least likely to have a information technology team or AI department to evaluate a tool before rolling it out. That makes the five questions above more important here, not less.

Why this matters for Rhode Island

AI will likely arrive in primary care long before consensus standards do. The practices asking thoughtful questions now, and not simply buying tools first, will be best positioned to improve care while protecting trust. CTC-RI is not here to recommend AI products. Our role is to help Rhode Island's primary care community ask better questions, learn from one another, and distinguish meaningful innovation from noise.

What's next

CTC-RI's Clinical Strategy Committee will keep building on this conversation in the coming months and draft a series of priorities to identify next steps. Looking further ahead, our second annual payer panel on **Friday, July 17** will bring health plans together to share how they are approaching AI, administrative burden, and advanced primary care. Join us for this conversation.

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