

Helping
Physicians
& Nurses



AI Capacity Decision Playbook

How to Turn Efficiency into Clinical Impact



AI is already changing the mechanics of healthcare work. It can draft notes, assemble information, route requests and flag risk. The more consequential question is what healthcare gains once the work itself changes.

RECENT AMBIENT-DOCUMENTATION STUDIES SHOW WHY:



A randomized trial published in NEJM AI found **0.36 fewer hours per day** spent on notes and lower work exhaustion, but no significant improvement in professional fulfillment.



A Providence study found **less documentation burden** without a sustained increase in appointments or relative value units.

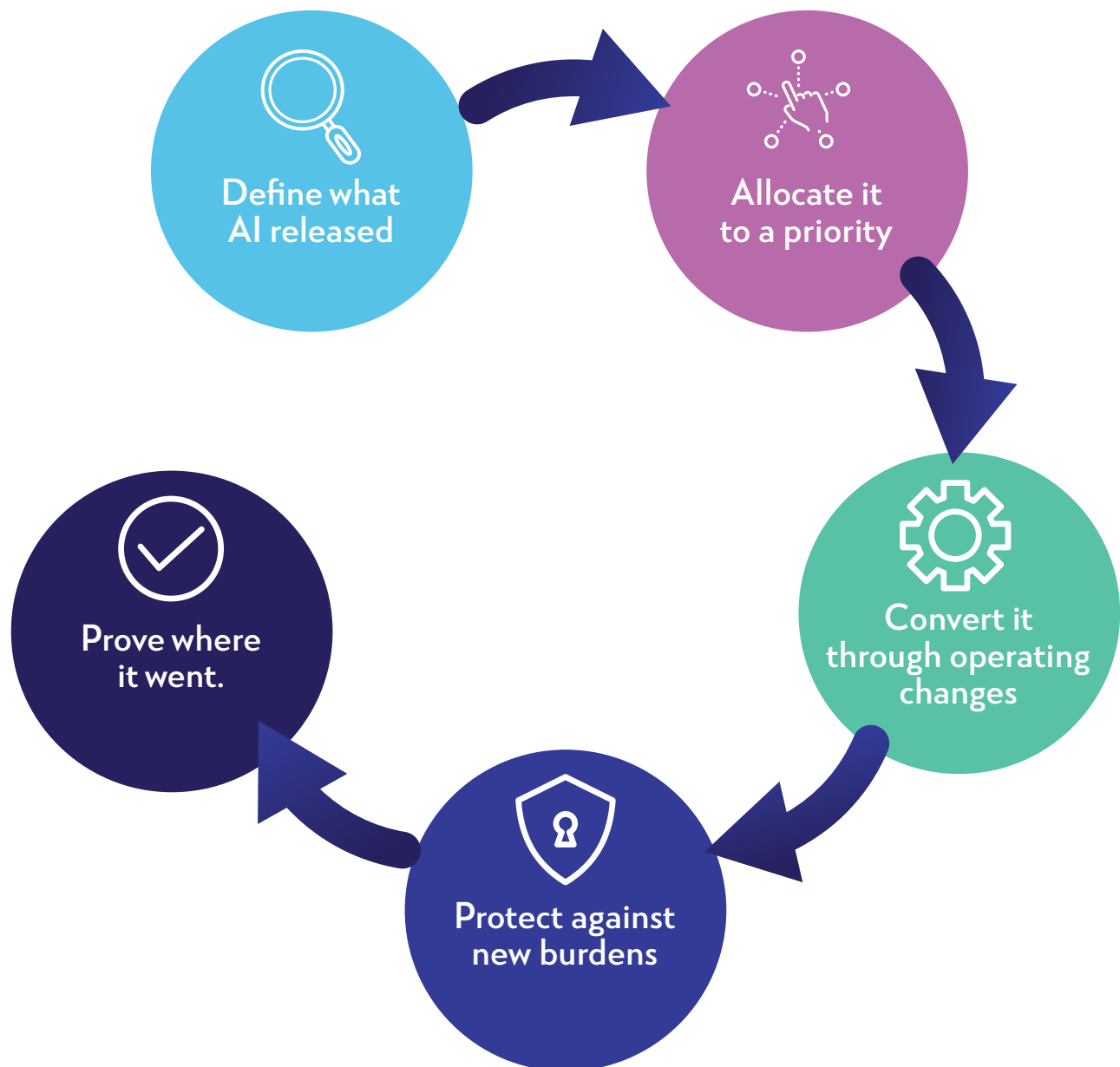


A UCSF Health study linked ambient-scribe access to **2.8% more encounters** and **5.8% more relative value units**.

The stakes are rising as adoption spreads. More than 80% of physicians responding to the [American Medical Association's 2026 survey](#) reported using AI professionally. Federal data shows that 71% of nonfederal acute-care hospitals used predictive AI integrated with their electronic health records in 2024. Adoption was uneven: 86% of system-affiliated hospitals reported use, compared with 37% of independent hospitals, according to the [ASTP/ONC hospital data brief](#).

The leadership challenge now reaches beyond deployment. When AI releases time, attention or operational capacity, leaders must decide what that capacity becomes—and design the conditions that get it there.

THE CAPACITY DECISION

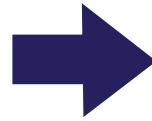


THE CHOICE AFTER EFFICIENCY

Two HIMSS26 speakers framed the choice differently. In *Transforming Clinical Workflows With AI Apps and Agents*, Tamara Moores Todd, MD, Chief Health Informatics Officer at Intermountain Health, linked capacity to faster disposition for a rural patient. In *Beyond ROI: What AI Is Really Worth in Healthcare*, Bryon Frost, MD, Chief Medical Informatics Officer at McLeod Health, linked it to protected clinician time.

“If I can compress that time cycle from seeing the patient to disposition and get them the care that I would give to my own family, that’s what winning looks like from a clinical lens.”

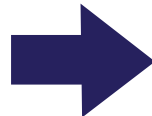
– Tamara Moores Todd, MD



DESTINATION:
Faster clinical coordination

“If you get time back in your day, do not see more patients with that time.”

– Bryon Frost, MD



DESTINATION:
Protected clinician time

Both priorities are defensible. The risk is leaving the destination undefined. Existing pressures will decide, and the gain can disappear into schedules, queues and workload.

1



DEFINE WHAT AI ACTUALLY RELEASED

Capacity is often used as shorthand for value. A tool can save time without freeing a schedule, increase task completion without reducing workload or surface a decision before anyone can act.



Form of capacity

What may be freed or improved



Time and attention

Documentation time, information search, data entry and cognitive effort



Workforce and service

Staff effort that can support more people or higher-value work



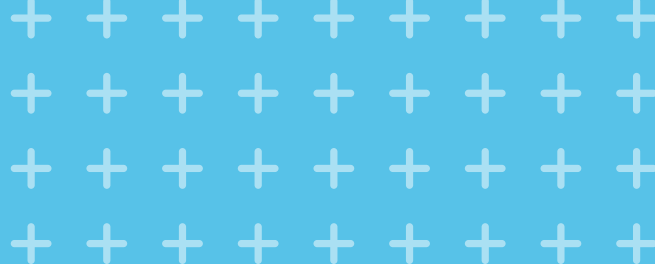
Flow and physical operations

Queue and routing time; bed, room or equipment availability



Decision and financial

Time to identify risk or prepare a decision; revenue captured or cost avoided



During *Beyond ROI: What AI Is Really Worth in Healthcare*, Craig Lavoie, MD, a family physician and clinical informatics leader, explained that Community Health Systems' ambient-documentation effort began with a human question:

“What is going to actually improve the lives of our clinicians?”

The *Interoperability and AI: Industry Perspectives and Best Practices* session showed how released capacity might change payer outreach. Hiren Thakkar of Blue Cross Blue Shield of Massachusetts described nurse case managers spending 20 to 25 minutes preparing for a member call; AI-assisted preparation could shift time from information assembly to member outreach. In Moore's Todd's clinical-workflow session, Intermountain Health reported that an agent triaged approximately 150,000 support tickets during a seven-EHR consolidation, relieving an operational bottleneck.

These organization-reported examples clarify the intended use of capacity. Whether the gains became member reach, routing accuracy or usable time remains an evidence question.

BEFORE YOU CALL IT CAPACITY

Establish the evidence:

Set the baseline, period and affected work; separate observed results from projections.

Name the recipient and test usability:

Who received the gain, and was it concentrated enough to become an appointment, staffing change or meaningful recovery time?



2



ALLOCATE IT TO A CHOSEN OUTCOME

Capacity rarely remains unclaimed. Scheduling templates, staffing shortages, payment models and unmet demand pull it toward existing priorities. A clinician might see another patient, spend more time with the people already scheduled or finish within the normal workday. A nurse might reach more members, investigate complex cases or inherit more administrative work.

Choose the Destination



FASTER ACCESS

Name the population, service or delay that should improve.



MORE PATIENT PRESENCE

Protect the interaction time created by less administrative work.



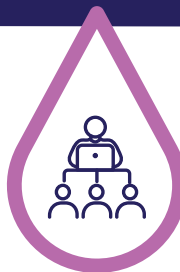
WORKFORCE SUSTAINABILITY

Choose the burden, after-hours work or retention measure that should change.



QUALITY AND SAFETY

Define the decision, intervention or outcome that should improve.



OPERATIONAL RESILIENCE

Target the backlog, bottleneck or staffing vulnerability that should shrink.



FINANCIAL PERFORMANCE

State the expected result and the downstream effects to watch.



Involve the People Who Will Live With the Choice

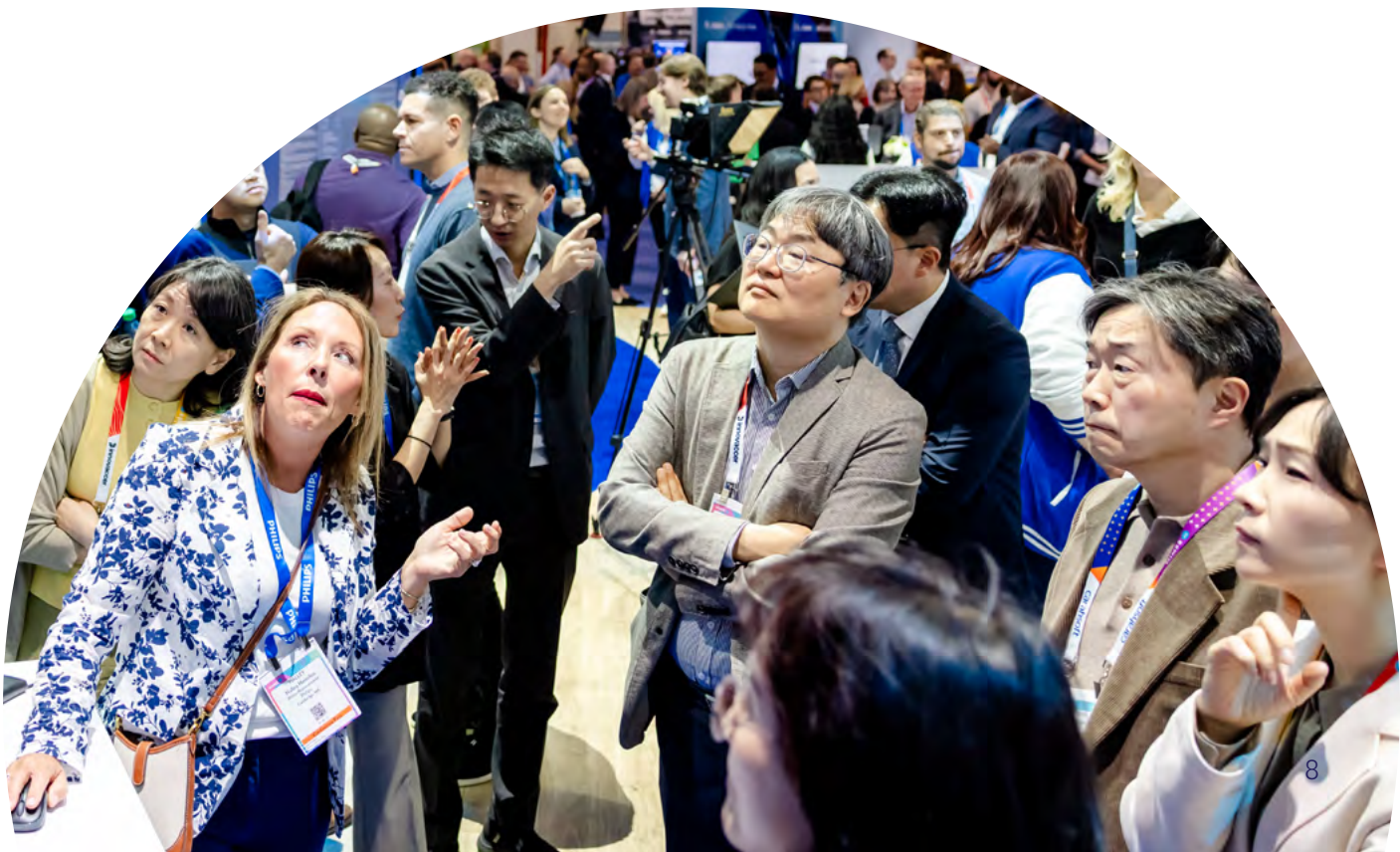
The HIMSS26 session *Executive Perspectives on AI-Assisted Intelligent Hospital Rooms and Care Delivery Models* examined how room-level technology could remove friction while preserving bedside judgment. Jennifer Crews, Nurse Administrator for Practice and Digital Transformation at Mayo Clinic, described designing intelligent-room capabilities around bedside pain points and patient and family input. Examples included one-touch language interpretation and virtual connections to care teams and relatives. Valerie McKinnis, MD, Chief Medical Information Officer at AdventHealth, described a possible pain-reassessment workflow that could prompt the patient and alert the nurse when attention was needed.

The design goal is more nursing capacity for communication, assessment and direct care.

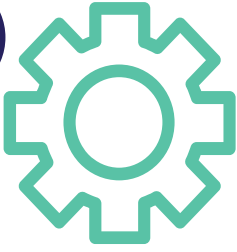
During *From the Bedside to the Boardroom: The Physician's Role in Healthcare AI Strategy*, Micky Tripathi, Chief AI Implementation Officer at Mayo Clinic, framed workforce participation as a progression:

***“No one likes to have things done to them ...
start moving more toward things done FOR them,
things done WITH them and things done BY them.”***

Patients experience the choice, too. A [multinational study of 13,806 hospital patients found](#) that 72.9% preferred physician-led decision-making and only 4.4% preferred fully autonomous AI diagnosis. A separate [U.S. study](#) found that visible clinician involvement increased the likelihood of choosing an AI-enabled visit by 18.4 percentage points.



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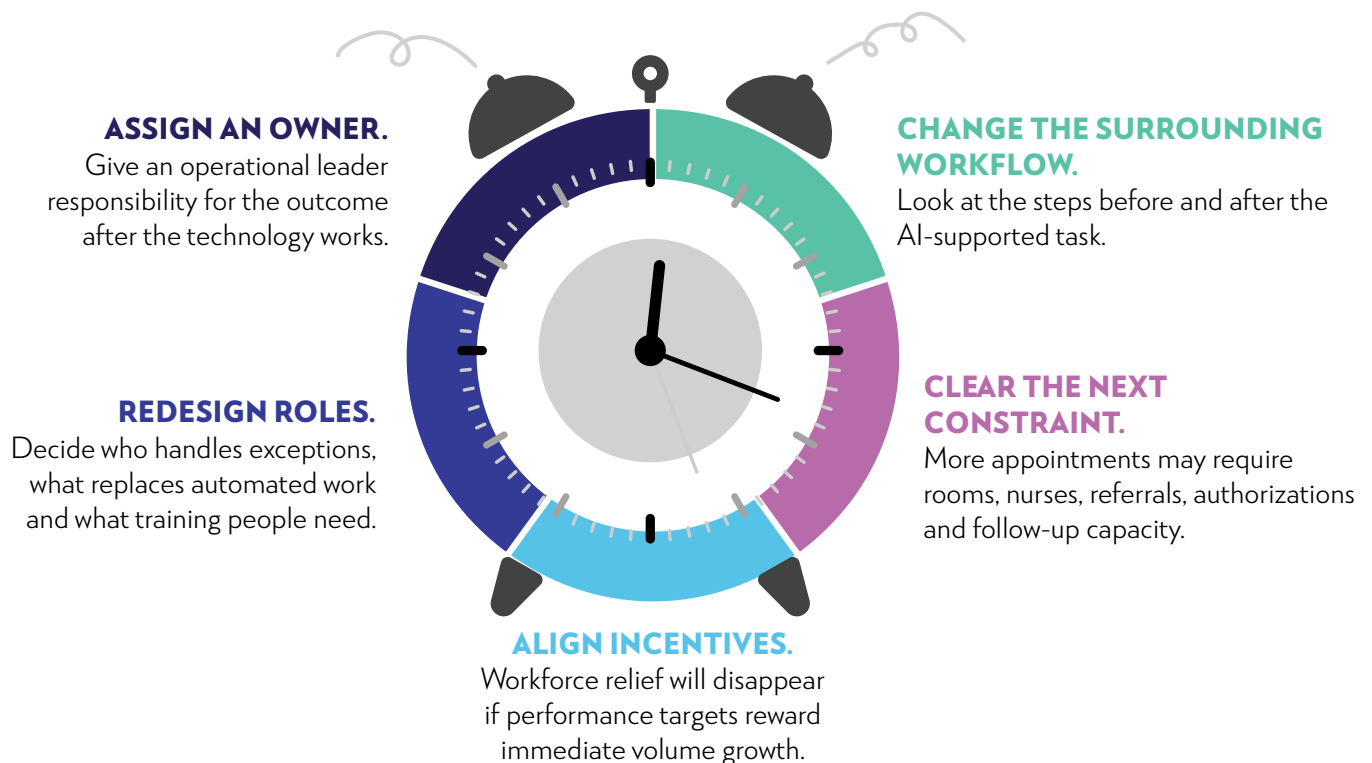


CONVERT CAPACITY THROUGH THE OPERATING MODEL

Time savings can coexist with the same handoffs, staffing limits and incentives. During *Transforming Healthcare: AI, Cloud, and the Future of Patient and Provider Experience*, Lisa Bari, Vice President of Policy and Partnerships at Innovaccer, captured that gap:

*“[Time savings are] amazing, that’s wonderful.
But then you still have a lot of the underlying workflow problems.
We still haven’t solved that.”*

Change the Work Around the Gain





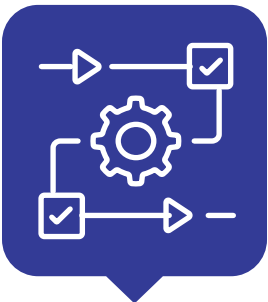
City of Hope illustrates what sits between a promising model and a clinical result. During *Delivering Real Impact With AI in Healthcare Operations*, Nasim Eftekhari, MS, described an early model that identified sepsis risk among bone-marrow-transplant patients. Retrospective modeling found a useful signal; the organization still needed real-time data and a clinical workflow that placed the prediction in front of people able to respond. City of Hope has also [described that development path](#) publicly.





PROTECT AGAINST BURDEN AND UNEXAMINED AUTHORITY

Efficiency in one workflow can shift work, delay, cost or risk elsewhere.



WORK AND TIME

Tasks shift to another team or create a new queue.



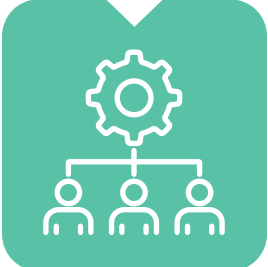
COST

Savings here increase expense elsewhere.



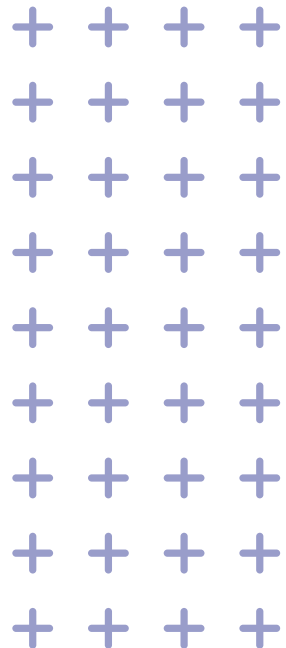
COGNITIVE LOAD AND RISK

Alerts and exceptions become review work.



CAPABILITY

Skills may weaken when people stop practicing them.



Automation often handles predictable cases first and leaves people with the hardest exceptions. Review, correction and escalation may consume more capacity than the business case anticipated.



Burden can also move between organizations. A provider may automate an authorization request while a payer automates review. Either organization can become more efficient without reducing the patient's wait or the system's administrative burden.

Make Human Oversight Real

- Specify who reviews an output and when.
- Give reviewers enough information and time to make a real decision.
- Define their authority to override, pause or stop the system.
- Track review time, corrections and whether employees feel able to challenge AI.



During the HIMSS26 session *Recognizing the “Value Proposition” Criteria While Selecting AI Applications*, Isaac Kohane, MD, PhD, Chair of the Department of Biomedical Informatics at Harvard Medical School, compared how language models responded to clinical scenarios involving patient autonomy and intervention. The models repeatedly differed in how strongly they favored intervening or waiting. Kohane described those patterns as a form of embedded value judgment:

***“Consistent repeated behaviors that show a value proposition
... and we are completely unaware of that.”***

Organizations may therefore delegate more than a task. A model can influence which risks receive attention, when intervention appears warranted and how patient autonomy is weighed. Leaders need to test those tendencies in relevant populations and workflows, preserve human accountability and define where the system may influence or act.

The AMA's 2026 survey also found that 88% of physicians expressed at least some concern about AI-related skill loss. Protect the capabilities healthcare will still need: independent judgment for consequential decisions, training that covers failure patterns, opportunities for trainees to practice without automation and recovery procedures when technology is unavailable.

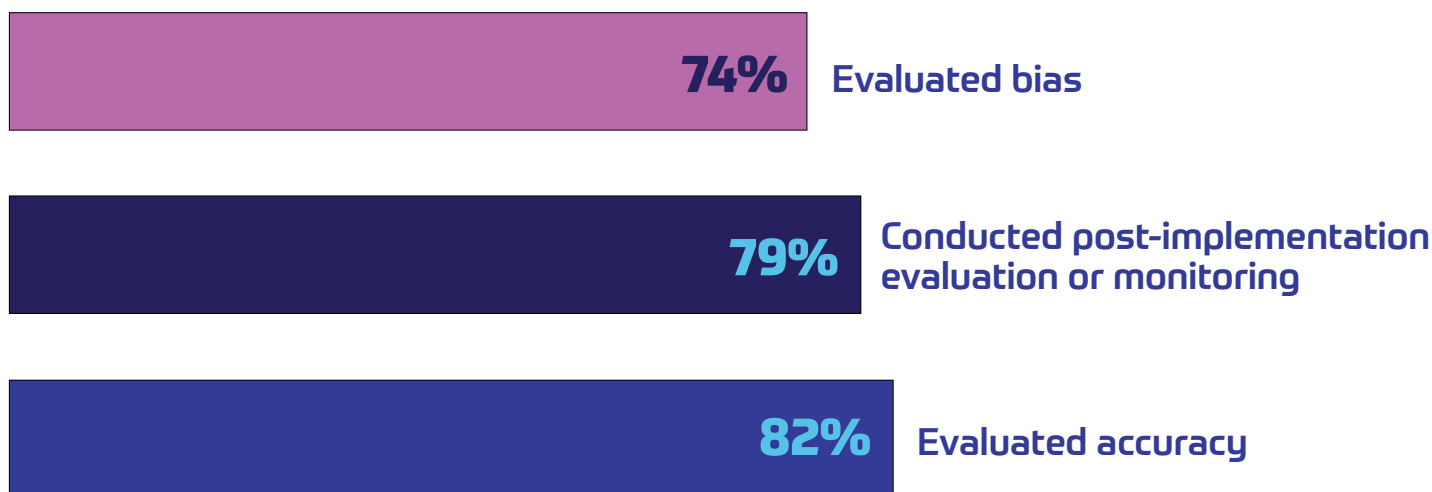


PROVE WHERE THE CAPACITY WENT

Time saved is a starting metric. A credible measurement plan connects three things: the task actually changed, the intended outcome improved, and any new work, delay, or risk elsewhere is visible and addressed.

During the HIMSS26 session *AI We Can Trust: Ensuring Clinical AI Applications Are Fit for Purpose*, Peter Embí, MD, MS, a Physician-Informatician at Vanderbilt University Medical Center, and Rebecca Mishuris, MD, Chief Health Information Officer at Mass General Brigham, used a patient-portal prioritization example to show why technical metrics needs a balancing measures.

Precision and recall can show whether the model identifies urgent messages accurately. Response time can show whether urgent messages move faster. Balance matters: track whether nonurgent messages start waiting longer or whether commitments to respond to every patient slip. The federal [Hospital Trends in the Use, Evaluation, and Governance of Predictive AI brief](#) found that many hospitals evaluated at least some predictive AI models in 2024:



Fewer hospitals applied those practices to all or most models. Leaders need portfolio-level visibility into what is monitored, which populations and sites are covered, who sees the results and who can require a change.

Before deployment, leadership should define which findings support expansion, which can be addressed through revision and which require limitation, suspension or retirement.

CAPACITY DECISION SCORECARD

Use this decision summary during approval, implementation planning and post-deployment review.

STAGE	DECISION	EVIDENCE
Define	Is the released capacity specific and usable?	Baseline task time or volume, affected roles and observed versus modeled gain.
Allocate	What outcome should the capacity serve?	Named beneficiary, priority measure, trade-offs and input from affected people.
Convert	Are the necessary operating changes ready?	Workflow map, accountable owner, staffing or incentive changes and the next constraint.
Protect	Are transferred burden and delegated authority acceptable?	Burden map, human review and stop rules, and workforce and patient safeguards.
Prove	Should the use case expand, change, pause or end?	Outcome and balancing measures, site and population results, review period and decision thresholds.

THE VALUE IS IN WHAT HAPPENS NEXT

AI can save time, accelerate decisions and remove friction. The organizational questions determine value: where the capacity goes, what changes around it and how leaders know the result held.

Clear answers allow organizations to expand AI with purpose instead of treating technical performance as the finish line.

When AI gives capacity back to healthcare, leaders must be able to show where it went.

Continue the Conversation at HIMSS27

The ideas in this playbook grew from HIMSS26 leaders working through these questions in clinical and operational settings. At HIMSS27, the global health community will carry the conversation forward with new evidence, practical case studies and candid discussion about responsible AI at scale.

Bring the questions that matter most to your organization. Learn how peers are measuring impact, redesigning work and keeping people at the center of AI-enabled care.



SAVE THE DATE

HIMSS GLOBAL HEALTH CONFERENCE & EXHIBITION

April 5–8, 2027 | McCormick Place | Chicago

HIMSS26 SESSION SOURCES

- *Transforming Clinical Workflows With AI Apps and Agents* — Tamara Moores Todd, MD, and fellow panelists
- *Beyond ROI: What AI Is Really Worth in Healthcare* — Bryon Frost, MD; Craig Lavoie, MD; and fellow panelists
- *Interoperability and AI: Industry Perspectives and Best Practices* — Hiren Thakkar and fellow panelists
- *Executive Perspectives on AI-Assisted Intelligent Hospital Rooms and Care Delivery Models* — Jennifer Crews; Valerie McKinnis, MD; and fellow panelists
- *From the Bedside to the Boardroom: The Physician's Role in Healthcare AI Strategy* — Micky Tripathi and fellow panelists
- *Transforming Healthcare: AI, Cloud, and the Future of Patient and Provider Experience* — Lisa Bari and fellow panelists
- *Delivering Real Impact With AI in Healthcare Operations* — Nasim Eftekhari, MS, and fellow panelists
- *Recognizing the "Value Proposition" Criteria While Selecting AI Applications* — Isaac Kohane, MD, PhD, and fellow panelists
- *AI We Can Trust: Ensuring Clinical AI Applications Are Fit for Purpose* — Peter Embí, MD, MS; Rebecca Mishuris, MD; and fellow panelists

