

NCCHCA 2026 · ANNUAL PRIMARY CARE CONFERENCE

DAY ONE · THURSDAY, JUNE 4

AI in the FQHC cuts through the noise.

A two-day curriculum for ambulatory C-suite leaders on what's real, what's worth funding, and what to do in the next 90 days.

WHERE

Durham, NC · June 4–5, 2026

PRESENTERS

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Day 1 · agenda

Four sessions. One arc — from naming the technology to a 90-day plan you can take back to the board.

01	AI in healthcare · cutting through the noise	9:50 – 10:45 AM
02	Where AI creates value in the FQHC	10:45 – 11:40 AM
03	Evaluating, governing, and funding AI	1:30 – 2:25 PM
04	From priorities to your 90-day action plan	2:25 – 3:20 PM

99%+

THE COGNITIVE REVOLUTION

**of all physical work on Earth is
already done by machines.
Cognition is next.**

A DAY IN THE LIFE · THE FQHC PRIMARY-CARE PROVIDER

Today's provider spends most of the shift on the keyboard, not the patient.

6.4hrs

of an 11-hour shift spent on administrative and EHR tasks per primary-care provider.

Source: Annals of Family Medicine, 2017 (Sinsky et al., commonly cited)

59%

of clinician shifts dedicated to administrative work — not clinical care.

Source: AMA Burnout Survey (figure attributed in workshop brief)

1 in 5

FQHC clinical positions unfilled — the workforce gap AI has to plug or expose.

Source: NACHC Workforce Survey, 2024

01

SESSION ONE • 9:50 – 10:45 AM

AI in healthcare

Cutting through the noise. We name the technology, separate what's real from what's still aspirational, and ground the conversation in the FQHC operating reality.

Can we use AI here?

What's our AI strategy?

We have to use Machine Learning here

Just throw AI at it

How about large language models?

Let's automate with AI

Can AI write this report?

Will AI replace us?

We're behind on AI

This is perfect for Generative AI

Is this all agentic AI?

ChatGPT can do this, right?

LLMs are the next best thing

Is this a neural network thing?

We need to be AI-first

Do we need a data scientist?

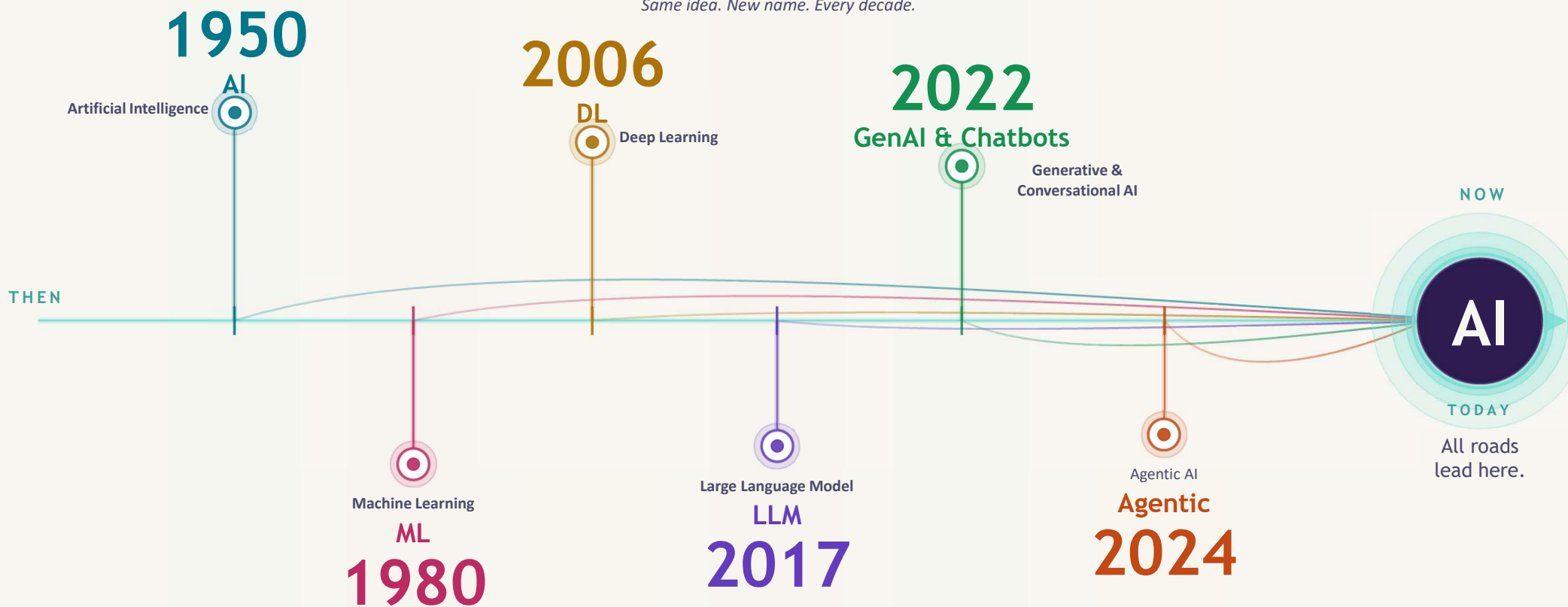
This screams deep learning

Let the model decide

Our competitors use AI

The Evolution of AI Terminology

Same idea. New name. Every decade.



One concept. The vocabulary just kept evolving.

REAL TODAY · HYPE TOMORROW

Four use cases are working in production. Four still belong in vendor pitch decks.

● Real today

Ambient documentation

— ~30 min/day saved per clinician; 8.6 percentage-point reduction in work-outside-

work
Network Open, Oct 2025 · PMC12492056

Revenue cycle automation

— 83% of orgs report ≥10% drop in denials.

Black Book Research, Feb 2025

No-show prediction

— 86–92% accuracy in production deployments.

Vendor case-study median (Phreesia, Relatient)

Care-gap identification

— 10–15 point UDS / HEDIS quality lift.

FQHC consulting engagement avg

● Still hype

"Autonomous" diagnostic AI — the brochure version doesn't exist; the FDA versions are narrow and tightly supervised.

Plug-and-play EHR integration — there's no "plug." Every integration is a 6–12 week project, even for big vendors.

AI replaces the front desk — works for triage, breaks at edge cases, often shifts work rather than eliminates it.

Self-improving AGI in the EHR — not a real product roadmap; not a near-term capital plan.

30min

THE ONE WITH HARD, REPEATABLE EVIDENCE

Ambient documentation is the only AI use case with a published, peer-reviewed time-saving for primary care.

Average ~30 minutes per provider per day; 8.6 percentage-point reduction in pajama-time across three large primary-care networks.

Source: JAMA Network Open, October 2025 · PMC12492056

THE CONSTRAINTS AI HAS TO LIVE INSIDE

FQHCs are running this AI conversation on a -2.4% margin.

-2.4%

Average operating margin across FQHCs in the most recent UDS reporting cycle.

Source: NACHC Chartbook (figure cited in brief)

60%

of FQHC executives cite cost as the primary barrier to AI adoption.

Source: NACHC AI Readiness Survey (figure cited in brief)

\$1.6M

Median 340B net revenue per FQHC — and one of the few flexible levers for AI funding.

Source: HRSA 340B Program data, 2024

SESSION 1 · KEY TAKEAWAYS

Three things to carry into Session 2.

01**Don't let "AI" confuse you.**

There are multiple options under your sleeve. You need to understand what works best when.

02**Four use cases are real. Don't over-buy the rest.**

Ambient docs, RCM, no-show prediction, care-gap ID.
Everything else gets a pilot — not a multi-year contract.

03**Negative margins shape every AI decision.**

If it doesn't pay back inside a year or unlock new funding, it doesn't make the FY27 budget.

02

SESSION TWO · 10:45 – 11:40 AM

Where AI creates value

Four concrete use cases with sourced numbers, the vendor landscape FQHCs can actually afford, and the build-vs-buy decision with a fourth option in the middle.

RANKED BY TIME-TO-MEASURABLE-RETURN

Four use cases — same calendar year payback, very different sequencing.



Ambient documentation

Real-time scribe captures the visit; clinician edits, not writes. Live this quarter.

~30 min/day saved · payback < 6 mo



Revenue cycle

Denial prediction, auto-coding, prior auth automation. Highest-confidence ROI in the stack.

≥10% denial drop · 83% of adopters



Patient access & triage

No-show prediction with SDOH-enriched outreach. Conversational AI deflects 40–45% of calls.

86–92% no-show accuracy



Population health & UDS

Care-gap identification, risk stratification, panel management. Direct UDS quality lift.

10–15-point quality improvement

REAL CLIENT EXAMPLE · EARLY TREATMENT PLAN IDENTIFICATION

Managing population health



Challenge

An organization serving communities in West Virginia sought a proactive solution to identify patients with a rising risk of lung cancer diagnosis to provide earlier treatments to improve patient outcomes and decrease the total cost of care.



Approach

Reviewed billions of claims records to find significant service patterns and associated diagnosis serving as predictors for onset of specific disease states. These patterns are used to identify patients who are at risk or trending towards risk.

- Diagnosis confirmed within patients identified by risk model
- Conversion of patients identified into clinically appropriate care pathways within the network
- In conjunction with network leakage reduction, increased system revenue by 18%

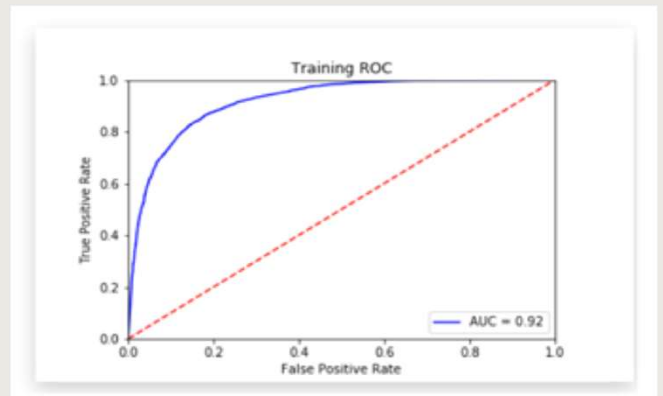
811

Number of undiagnosed patients identified with lung nodules present within first 12 months

Lung Cancer AUC Chart

- 50/50 Non-Patient/Patient split Dataset
- 70/30 Train vs Test Validation Dataset
- Area Under Curve (AUC) : **0.918**
- Model Confidence: **0.863**

		Predicted	
		0	1
Actual	0	3,756	879
	1	773	5,215



THE DECISION MOST BOARDS DEFAULT ON

Build, buy, or co-build — and a fourth option in the overlap.

Build

Hire a team, own the IP.
Most FQHCs can't carry
\$2M+/yr in AI talent — and
the talent often won't
relocate.

Buy

Pick a vendor, sign a long
contract. Fast to start;
expensive lock-in; rarely
tuned to FQHC
populations.

Co-build

Partner deeply with one
vendor. Slow; politically
heavy; works only if the
vendor is already FQHC-
fluent.

+AI as a Service

A shared AI team on
subscription — the option
we'll explore in detail on Day
2.

SESSION 2 · KEY TAKEAWAYS

Three things to carry into Session 3.

01

Lead with an operational challenge

Address a pain point with technology.

02

Population Health Management is key to the success of patient care.

Real word example.

03

The build-vs-buy dichotomy is false.

There's a fourth path in the overlap. Day 2 unpacks it.

03

SESSION THREE · 1:30 – 2:25 PM

Evaluating, governing, funding

Before you spend a dollar — the readiness assessment, the vendor questions, the bias guardrails, and the six funding sources you can stack.

AI READINESS ASSESSMENT

Readiness has four pillars. One hollow pillar sinks the project.



Data infrastructure

One source of truth for patient data; clean UDS reporting; documented data-sharing agreements; basic interoperability in place.

Test: can you produce a year of clean UDS in < 1 day?



EHR maturity

On a supported version, current on patches, with API/FHIR endpoints enabled. AI without API access is just a screen scraper.

Test: can your EHR vendor name three live AI integrations?



Staff capacity

A named clinical champion, protected training time, a change-management lead who isn't also doing four other jobs.

Test: who owns this on Monday at 9 AM?



Security posture

BAA template ready, incident response plan exists, MFA on EHR access, recent HIPAA risk assessment on file.

Test: when was your last HIPAA risk assessment?

5 questions every AI vendor must answer before the contract gets signed.

01

Will this tool conflict with our billing rules?

Your 340B drug program has strict compliance boundaries. Make sure the vendor has mapped their data flows around it.

340B COMPLIANCE

02

Can you map your outputs to our annual report?

Every FQHC files UDS data with HRSA each year. Ask the vendor to point to exactly which measures their tool touches.

UDS MAPPING

03

Does this tool treat every patient equally?

FQHCs serve everyone regardless of ability to pay. A tool that gates or steers by payer type creates access and equity risk.

SLIDING FEE SCALE

04

What will a federal auditor actually see?

HRSA can show up for an Operational Site Visit. You need logs, overrides, and audit trails ready — not scrambled together after the fact.

HRSA / OSV READINESS

05

Talk to a health center like ours.

Not a hospital system. Not a national IDN. A federally qualified health center within 25% of your size, same EHR, willing to talk on the phone.

FQHC REFERENCE

If a vendor can't answer all five clearly, **that is your answer.**

HUMAN-IN-THE-LOOP GOVERNANCE

Every clinical AI gets a human review layer. No exceptions.

A**The clinician signs the note — not the AI.**

Ambient scribes draft; clinicians edit and attest. The signing clinician is always legally and clinically accountable.

B**Override is the metric you watch.**

Override rate, override reason, and override outcomes go into your monthly QA review — not the model's confidence score.

C**Risk-stratify the use cases.**

An auto-coding suggestion is low-risk. A care-management flag is medium. A diagnostic recommendation is high. Different review depths.

D**The committee is named, not implied.**

AI Governance Committee: medical director, compliance, IT, frontline clinician, finance. Meets monthly.

FUNDING LANDSCAPE · SIX STACKABLE SOURCES

Six funding sources stack. Plan the stack, not the single grant.

RHTP — Rural Health Transformation Program	\$50B over five years; ~\$10B/yr; funds begin Oct 1, 2026. 5% EHR cap pushes funding to AI overlays. NC allocation est. ~\$213M.	\$213M NC next year alone
HRSA Section 330 grants	Operational base grant — limited but stackable with capital and quality improvement supplements.	Operational base
340B net revenue	Most flexible internal lever; median ~\$1.6M/yr per FQHC; can fund AI infrastructure that supports access.	~\$1.6M median
USDA DLT grants	Distance Learning & Telemedicine — eligible for telehealth-adjacent AI infrastructure in rural service areas.	Up to \$1M / award
FCC Rural Health Care Program	Subsidized broadband / connectivity costs — the backbone every cloud-based AI tool runs on.	\$685M annual cap
NACHC / CHAI partnership	Coalition for Health AI guidance + NACHC GPO procurement. Lower per-site cost via shared evaluation.	Procurement leverage

SESSION 3 · KEY TAKEAWAYS

Three things to carry into Session 4.

01**Readiness is the cheap stuff to fix first.**

An honest four-pillar score takes a week and tells you whether the AI project can succeed before you sign anything.

02**Preparation for AI requires thought.**

We always need a human touch regardless of the type of technology we throw into our organization. Choose vendor partners as a long-term strategy.

03**The funding stack is your real budget.**

Stop chasing one grant. Sequence RHTP + 330 + 340B + DLT + FCC across the project plan.

04

SESSION FOUR · 2:25 – 3:20 PM

Priorities to action

Pressure-test the pitfalls, lock in the change-management essentials, and leave with a one-page AI priority map and a 90-day playbook.

PITFALLS THAT DERAIL MOST FQHC AI ROLLOUTS

Three failure modes show up in nine out of ten projects.

**Vendor scope limitations.**

Leveraging vendor solutions that are focused to a limited scope. Partner with vendors who approach solutions for the entire organization as opposed to singular pain points / challenges..

**Data-readiness gaps that surface.**

The pilot can't run because the UDS data isn't where the vendor needs it. Run a one-week data audit before signing.

**Staff resistance treated as a comms problem.**

Resistance is a workflow problem. If the AI adds clicks, it loses. Time the workflow before and after — every time.

CHANGE MANAGEMENT FOR FQHCS

Keys to success

**Clinical champions beat vendor reps.**

A named clinician advocate moves adoption faster than any vendor success team. Pay them protected time.

**One workflow, then expand.**

Pick one visit type, one provider cohort. Prove the workflow before you scale by site or department.

**Protected training time is a budget line.**

If training comes out of clinical hours, the rollout fails. Block calendar; backfill productivity targets.

**Transparent communication about what AI does — and doesn't.**

Tell patients and staff what the AI sees, what it suggests, and who decides. Trust is the rollout's gating factor.

A 90-DAY PLAYBOOK WITH CLEAR GO/NO-GO GATES

Three phases, three decisions, ninety days to a defensible recommendation.

30

DAYS 1–30 • DIAGNOSE

**Pick the use case.
Confirm the data.**

Four-pillar readiness score; one-week data audit; named clinical champion; vendor shortlist of three.

60

DAYS 31–60 • DESIGN

**Workflow mapped
before contract signed.**

Time-in-motion baseline; override workflow drafted; sliding-fee impact reviewed; governance committee chartered.

90

DAYS 61–90 • DELIVER

**Pilot one site, one
workflow, one
cohort.**

Go/no-go gate at day 90: time saved, denial rate or no-show rate, override rate, clinician NPS. Roll forward or stop.

What AI opportunities most likely to move the needle at *your* health center.

A · DOCUMENTATION

Ambient documentation

30 min/day saved per provider; lowest-risk entry point.

B · REVENUE

Denial prediction

83% of adopters see $\geq 10\%$ denial drop in year one.

C · REVENUE

Auto-coding

Coder productivity lift; query rate reduction.

D · ACCESS

No-show prediction

SDOH-enriched outreach; 86–92% accuracy in production.

E · ACCESS

Conversational call deflection

40–45% of inbound calls handled without a live agent.

F · POPULATION

Care-gap identification

UDS / HEDIS lift; ties directly to quality reporting.

G · WORKFORCE

Scheduling optimization

Reduce agency spend; smooth panel coverage.

H · WORKFORCE

Retention prediction

Early signal on turnover; targeted intervention.

Leave Day 1 with your one-page AI Priority Map

1

Your top three opportunities — named.

From the eight options on the previous slide — one sentence on why each made your shortlist.

UDS EXAMPLE

UDS example: ① Cervical cancer screening, Table 6B — 54% today, target 65%, tied to SAC grant score. ② Colorectal screening — 38% completion, 400+ open gaps closeable before year-end. ③ Hypertension control, Table 6A — 61% controlled; VBC bonus triggers at 70%.

YOUR ANSWERS

OPPORTUNITY 1

Name the use case · Why it made your shortlist

OPPORTUNITY 2

Name the use case · Why it made your shortlist

OPPORTUNITY 3

Name the use case · Why it made your shortlist

2

The readiness gap that has to close first.

Which of the four pillars (data, EHR, staff, security) is most likely to block your top pick — and who owns it.

UDS EXAMPLE

UDS example: Data pillar — cervical screening status is in free-text notes, not a discrete EHR field. The AI model produces 30% false positives without structured data. Owner: IT Director + CMO. Fix: 3-week Epic field build, must start by Nov 1.

YOUR ANSWERS

THE PILLAR BLOCKING YOU

data / EHR / staff / security · Describe exactly what breaks

WHY IT BLOCKS YOUR TOP PICK

Specific consequence — what fails if this isn't fixed first?

OWNER + RESOLUTION DATE

Full name · Title · Fix-by date

3

The funding stack you'll go after.

Which two-to-three funding sources you'll pursue in FY27 — and which one funds the pilot in the next 90 days.

UDS EXAMPLE

UDS example: ① HRSA Quality Improvement Grant — FY27, ~\$75K, apply by March 15. ② Blue Cross VBC bonus — +\$18/member if cervical screening hits 65% by Dec 31. ③ Pilot now: redirect 0.15 FTE care coordinator time (~\$9K). No new budget needed.

YOUR ANSWERS

FY27 SOURCE 1

Grant or contract name · Estimated amount · Application deadline

FY27 SOURCE 2

Grant or contract name · Estimated amount · Application deadline

90-DAY PILOT FUNDER

Who pays for the test? · Amount · Approved by

4

The first 30-day move.

One concrete action, one named owner, one calendar date. Walk out with it written down.

UDS EXAMPLE

UDS example: Action: Build discrete Epic field for cervical screening status across all eligible records. Owner: James Park, IT Director — sign-off from Dr. Lin by Friday. Date: November 1. Nothing else in this plan moves until this is done.

YOUR ANSWERS

THE ONE ACTION

Specific and concrete — not 'explore' or 'consider' · What exactly happens?

THE NAMED OWNER

First name · Last name · Title · Their verbal commitment

THE CALENDAR DATE

Month · Day · Year · What does 'done' look like?

All four complete → you leave with a one-page AI priority map for your health center.

Day 2 · agenda

Three sessions, ending with the capstone — where the curriculum becomes a plan.

05	Operational AI · access, revenue, workforce	9:50 – 10:45 AM
06	AI risk, compliance, and the legal landscape	10:45 – 11:40 AM
07	Building your AI future · capstone workshop	1:30 – 2:45 PM

See you tomorrow.

Day 2 turns priorities into operations — and explores a fourth path most FQHCs haven't seen yet.

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Day 2 · agenda

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05

SESSION FIVE • 9:50 – 10:45 AM

Operational AI

Three operational domains — access, revenue, and workforce — where AI has clear evidence and short payback. The problem, the solution, the vendor, the gotcha.

THREE DOMAINS · SUB-12-MONTH PAYBACK

Three operational domains, each with a year-or-less ROI signal.

A**Patient access**

No-show prediction, SDOH-enriched outreach, conversational AI for call deflection (40–45% of inbound), online scheduling. Visible to patients on day one.

B**Revenue cycle**

Auto-coding, denial prediction, prior authorization automation (CMS-0057 mandate, 2026), sliding-fee automation. Highest-confidence financial ROI in the stack.

C**Workforce**

Scheduling optimization, retention prediction, virtual training, reducing agency spend. Slowest visible ROI; largest cumulative impact on margin.

DOMAIN 1 · PATIENT ACCESS

No-shows, calls, and online scheduling — three plays, one access strategy.



No-show prediction + SDOH outreach

Score each visit; pair high-risk slots with transportation, language, or reminder support. Outreach is the AI — the prediction is just the trigger.

86–92% accuracy · payback in 3–6 mo



Conversational AI · call deflection

Handles refills, scheduling, basic triage. Watch handoff quality — bad handoffs lose more trust than they save staff time.

40–45% of inbound · staff retention lever



Online self-scheduling

Not technically AI — but the precondition for it. Without online scheduling, your conversational AI has nowhere to send patients.

Foundation, not feature

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FQHC-specific gotcha

If the system steers high-cost or no-show-prone patients away, you've automated an access barrier. Audit triage rules quarterly.

Compliance · sliding-fee impact

DOMAIN 2 · REVENUE CYCLE

CMS-0057 lands in 2026. Prior auth automation is the first AI to fund.



Prior authorization automation

CMS-0057 mandates electronic prior auth (FHIR-based) for impacted payers, effective 2026. The infrastructure pays for itself.

Mandate-driven · ROI by 12 mo



Denial prediction

Catches denial risk before submission; routes to a human for fix. 83% of adopters see $\geq 10\%$ denial drop.

Black Book, Feb 2025



Auto-coding

Coder productivity lift; query rate down; downstream denial drop. Pairs naturally with ambient documentation.

Coder hours / encounter ↓



FQHC-specific gotcha

Sliding-fee scale calculation must remain transparent and auditable. Any AI in the front-end charge flow is in scope for HRSA review.

HRSA OSV · sliding-fee

DOMAIN 3 · WORKFORCE

Workforce AI's ROI shows up in the agency line item — and the retention rate.



Scheduling optimization

Match panel coverage to demand patterns.
Direct line to agency spend reduction within two quarters.

Agency spend ↓ · margin lever



Retention prediction

Surface attrition risk before notice is given.
Targeted retention intervention is dramatically cheaper than recruitment.

Cost-of-turnover lever



Virtual training

AI-assisted onboarding, just-in-time clinical refreshers. Lowers time-to-productivity for new hires.

Onboarding time ↓



FQHC-specific gotcha

Predictive retention models are bias-prone — adverse-action and EEOC implications. Keep these advisory; never automated.

Governance · HITL mandatory

GROUP EXERCISE

What is your biggest bottleneck to one AI capability?

1

Name the bottleneck.

One sentence. The thing that's eating clinical or admin hours this quarter.

2

Map it to a capability.

Access · revenue · workforce. Be specific — "denial prediction," not "RCM."

3

Name one gotcha.

What's the FQHC-specific reason this might fail at your health center?

4

Share one out per table.

We'll capture them for the capstone exercise this afternoon.

SESSION 5 · KEY TAKEAWAYS

Three things to carry into Session 6.

01**Access is the most patient-visible win.**

No-show + call deflection move the needle in the first quarter. Just watch the equity audits.

02**Prior auth is mandate-driven, not optional.**

CMS-0057 effective 2026. Use the compliance budget to fund the AI.

03**Workforce AI compounds slowly.**

It's the agency-spend line that shrinks — twelve months in. Don't pitch it as a quick win.

06

SESSION SIX · 10:45 – 11:40 AM

Risk, compliance, legal

HIPAA, HRSA, bias, shadow AI, HTI rules, governance, 340B. The compliance map that determines whether an AI project survives its first site visit.

HIPAA + AI

Three things your AI vendor's BAA must cover before the data flows.

1

Cloud BAA with explicit AI training scope.

Does the vendor train models on your PHI? If yes, under what conditions, with what de-identification, and is opt-out written into the agreement?

2

Data residency and subprocessor list.

Where is the data stored? Who's the actual inference provider (OpenAI, Anthropic, Google, in-house)? List every subprocessor with PHI access.

3

De-identification standard for any training use.

Safe Harbor or Expert Determination? Re-identification testing? If the vendor can't name the standard, the data shouldn't move.

HRSA OVERSIGHT · OPERATIONAL SITE VISITS

The OSV reviewer will ask three questions about your AI tools.

1

Are AI-driven decisions logged and reviewable?

Triage routing, sliding-fee determinations, scheduling steers. If a HRSA reviewer can't reconstruct the decision, it's a finding.

2

Who is accountable for each AI use case?

One name per tool. BPHC expects governance you can point to, not committee minutes you have to assemble retroactively.

3

How is access equity monitored?

Outcome metrics by language, race, payer, and visit type. Quarterly. Documented. Acted on.

SHADOW AI · THE USE YOU DON'T SEE

Your staff are already using an AI tool. Channel it or ignore it.

● Ignore it

PHI flowing into consumer AI tools without a BAA — a HIPAA breach waiting to be reported.

Staff sharing prompts and outputs that include patient details across personal accounts.

No audit trail. No incident response. No defensible position when the breach surfaces.

The talented staff use shadow AI anyway. You just don't get the upside.

● Channel it

Sanctioned enterprise AI (Copilot, ChatGPT Enterprise, or org-deployed LLM) with a real BAA.

Acceptable-use policy with concrete examples — what's in bounds, what isn't, what to do when unsure.

Detection: simple DLP rules that flag PHI patterns being copy-pasted out of the EHR.

An "AI champion" per department — the person staff ask before they paste.

HTI-1 + HTI-5 · WHAT YOUR EHR VENDOR OWES YOU

The HTI rules give you procurement leverage you didn't have two years ago.

1

HTI-1 · algorithm transparency requirements.

Certified EHR developers must disclose key information about decision-support interventions — including AI-driven ones — to customers. Ask for the source attributes.

2

HTI-2 / HTI-5 · expanded disclosures and information blocking.

Subsequent rules extend disclosure and tighten information blocking. The pattern: vendors must show, not just assert.

3

Your procurement move.

For every AI tool: request the source attributes document, attestation history, and the vendor's information-blocking compliance posture. Make it part of the master agreement.

PRACTICAL GOVERNANCE · THREE ARTIFACTS

An AI governance program is three documents and one meeting cadence.



AI Committee charter

Membership, mandate, decision rights, escalation path. One page. Reviewed annually.

Owns model inventory + risk register



Incident response plan

What constitutes an AI incident. Who's notified. How patients are informed if affected. Drills twice a year.

Plug into existing IR plan



Model inventory

Every model in production: owner, use case, vendor, BAA on file, last bias review, override rate, last validation date.

Quarterly review · open spreadsheet OK

07

SESSION SEVEN · 1:30 – 2:45 PM · CAPSTONE

Building your AI future

The capstone. We recap the arc, frame three doors most FQHCs see, review added options and strategize committee roles.

THE ARC · AWARENESS → ACTION

What have we learned so far

1-2

AWARENESS

What's real, what's hype

The taxonomy, the four real use cases, the vendor landscape.

3

EVALUATION

Ready, governed, funded

Four-pillar readiness, vendor framework, funding stack.

4

OPERATIONS

Access, revenue, workforce

Where the dollars are; where the workflow actually changes.

5-6

RISK

Compliance, bias, 340B

HIPAA, HRSA, HTI, governance. The guardrails.

7

ACTION — NOW

Your AI priority map

Translate everything above into a plan you'll execute.

THE THREE DOORS MOST FQHCS SEE

Build, buy, or ignore.

DOOR 1

Build

\$2M+ / yr fully loaded

Hire an AI team. Most FQHCS can't carry the burn — and the talent often won't relocate to your service area.

UNAFFORDABLE

DOOR 2

Buy

Vendor lock-in · 3–5 yr contracts

Pick a tool, sign the contract, hope it fits.
Generic to your population; expensive to leave;
rarely best-of-class twice running.

WRONG FIT

DOOR 3

Ignore

Status quo · zero capex

Wait for the technology to mature. The window closes — your competitors won't wait, and the regulatory and funding picture is moving now.

FALLING BEHIND

THE DECISION MOST BOARDS DEFAULT ON

Co-build & AI-as-a-Service may be more feasible

Build

Hire a team, own the IP.
Most FQHCs can't carry
\$2M+/yr in AI talent — and
the talent often won't
relocate.

Buy

Pick a vendor, sign a long
contract. Fast to start;
expensive lock-in; rarely
tuned to FQHC
populations.

Co-build

Partner deeply with one
vendor. Slow; politically
heavy; works only if the
vendor is already FQHC-
fluent.

+AI as a Service

A shared AI team on
subscription — the option
we'll explore in detail on Day
2.

+AI DEPARTMENT AS A SERVICE · SIX EMBEDDED ROLES

Six roles, one goal — the team an FQHC would hire if margin allowed.



AI Strategist

Sets the priorities, owns the roadmap, sits in your leadership cadence.



Solutions Architect

Chooses the stack, designs the integrations, owns the vendor relationships.



Clinical Informaticist

Bridges workflows and tools; the translator between clinicians and the model.



Grants & Funding Lead

Sequences RHTP, HRSA, 340B, DLT, FCC; writes the narratives; tracks the awards.



ML Engineer

Builds, evaluates, and monitors the models in production. The bias-watcher.



Change & Training Lead

Owns adoption. Champion network, training cadence, override tracking.



AI does not replace people, it makes us better, more creative, creates opportunity for us to use our time wisely.

The Workforce Reinvestment Covenant

+AI DEPARTMENT AS A SERVICE · FOUR TIERS

Four tiers, matched to scale — and a consortium model for multi-FQHC alliances.

ESSENTIAL**Single-site or small org****1-2 sites**

Strategy + 1 use case + governance baseline. Quarterly cadence.

GROWTH**Mid-size FQHC****3-6 sites**

Full six-role team, 2–3 active use cases, monthly cadence, funding pursuit included.

ENTERPRISE**Large FQHC system****7+ sites**

Full team plus dedicated ML capacity, on-site cadence, multi-region rollouts.

CONSORTIUM**Multi-FQHC alliance****Custom****NCCHCA-scale cohort**

Shared team across member orgs; pooled procurement; per-org governance preserved.

~213M

NCCHCA IS A NATURAL COHORT

**~\$213M est. in North Carolina
RHTP allocation, same EHRs,
same payer mix, same
constraints.**

The conditions for a shared-services AI cohort already exist in this room. The economics work better the more centers participate.

RHTP NC allocation estimate based on per-state formula assumptions; confirm with current NOFO

Let's Continue the Conversation

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