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01

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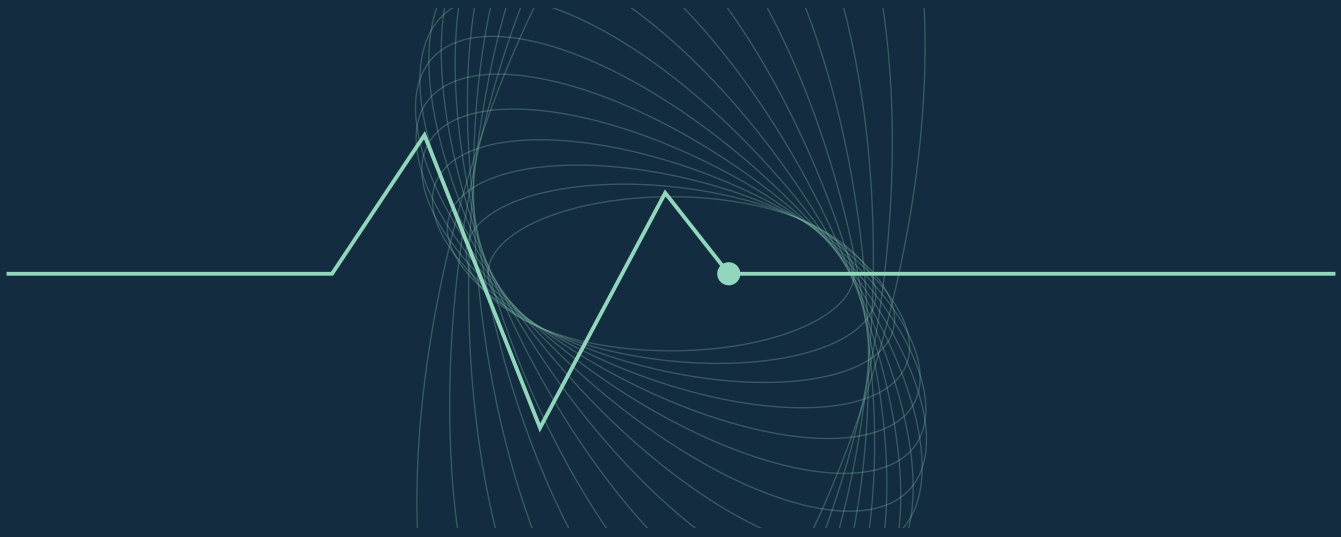
PATIENT ACCESS



A better first conversation

A practical voice AI playbook for US healthcare front offices

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US HEALTHCARE & DENTAL

Map scheduling, patient intake, referral follow-up, and staff handoffs into a measurable administrative workflow.

01 / PATIENT ACCESS

Design around the next step

Start with a call map, not a list of features.

Review a representative sample of calls with the front-office team. Group them by the action the patient needs: arrange a visit, change an appointment, ask an approved office question, check an administrative referral status, or reach a person. Record where staff must switch systems or ask someone else for help. These observations become the pilot scope.

For each included call type, document the permitted information, authoritative system, completion signal, and accountable staff role. The workflow below is an original operating model. It draws on the importance of clear accountability and follow-through emphasized in the IHI/NPSF referral safety guide summarized by AHRQ [1]. It is not a clinical triage protocol.

01	> 02	> 03	> 04
Identify the request	Use approved rules	Verify the result	Assign the next owner

New patient intake	Collect only practice-approved administrative details. Explain whether the next step is staff review or scheduling. Do not promise eligibility, coverage, or acceptance.
Appointment changes	Use the permitted visit type, location, and provider rules. Say confirmed only after the scheduling system reports success; otherwise create a clearly labeled request.
Referral coordination	Help a coordinator identify missing administrative steps or a callback request. Staff verify clinical completeness and decide the care pathway.

BRING THIS TO YOUR TEAM

Write a one-sentence completion rule for every workflow: who does what next, in which system, and by when.

02 / PATIENT ACCESS

A handoff needs an owner

A saved message is only the beginning of a handoff.

Agree on the transfer destination, staffed hours, callback expectation, and fallback when nobody answers. A caller asking for a person should have a clear route. Clinical questions and reports of symptoms move into the practice-approved escalation process; the assistant should not assess severity, interpret results, or recommend treatment. An emergency instruction must follow an approved script, not an improvised clinical judgment.

Separate patient identification from permission to disclose information. Before enabling account-specific answers, have the practice approve identity checks, authorized-representative handling, and what can be shared. HHS permits certain patient messages while emphasizing limited disclosure and reasonable confidential communication requests [2]. That guidance does not replace a review of calling, recording, or consent requirements.

01 Recognize a boundary > 02 Explain the handoff > 03 Route limited context > 04 Confirm staff receipt

One accountable queue	Assign a named team role to each request category. Record receipt, status, and closure so requests do not disappear between front desk and clinical staff.
A useful summary	Capture the administrative request, permitted callback details, actions attempted, and unresolved question. Avoid an unfiltered transcript in every notification.
An honest fallback	If a connection fails, describe what was captured and what remains pending. Never say an appointment changed or a team was notified before verifying it.

BRING THIS TO YOUR TEAM

Test an unanswered transfer, a system outage, and a patient declining AI before inviting live patient calls.

03 / PATIENT ACCESS

Measure useful work, not just calls

Keep service quality and financial value in the same view.

Choose a narrow cohort, such as routine scheduling requests at one location during a defined period. Establish a comparable baseline. Count eligible calls separately from all calls; a clinical escalation is not a failed administrative booking. Review outcomes with the staff who receive the work, and record corrections and repeat contacts as well as completions.

The example below is arithmetic, not a Voicesis result or forecast. If 600 eligible calls each release 2 minutes of staff handling, the potential capacity is 20 hours. At a loaded labor value of $30 per hour, that is $600 of modeled monthly capacity. Subtract the subscription and incremental operating costs to estimate net modeled value. Salaried time released is not automatically a cash saving; document how that time is used.

01 Baseline the cohort > 02 Review pilot outcomes > 03 Count staff rework > 04 Decide whether to expand

Verified completion	Verified completed administrative tasks divided by eligible tasks attempted. Document which system event proves completion.
Handoff follow-through	Track the share of requests acknowledged and resolved within the practice's agreed window. Review aged items daily during the pilot.
Net capacity	Baseline staff minutes minus remaining staff handling, review, and correction time. Compare similar call types, locations, and time periods.

BRING THIS TO YOUR TEAM

Set acceptance criteria before launch. Expand only when the practice can explain the exceptions as clearly as the successful calls.

SOURCES & METHODOLOGY

Research, with its limits visible.

A patient calling a practice is trying to move something forward. The useful measure of an AI conversation is whether that next step is accurate, understandable, and owned. This playbook proposes a small, supervised administrative pilot, with clinical questions kept in the practice's established human workflows.

[1] Institute for Healthcare Improvement / National Patient Safety Foundation

Closing the Loop: A Guide to Safer Ambulatory Referrals in the EHR Era

Original 2017 report, summarized by AHRQ Patient Safety Network. Referral accountability and follow-through; not validation of a voice AI product.

https://psnet.ahrq.gov/issue/closing-loop-guide-safer-ambulatory-referrals-ehr-era

[2] U.S. Department of Health and Human Services

May providers leave messages for patients?

Privacy considerations for patient messages and confidential communications.

https://www.hhs.gov/hipaa/for-professionals/faq/may-health-care-providers-leave-messages/index.html

How to use this whitepaper

This paper combines the listed sources with original operational recommendations by Vatsal Patel. It is not a systematic review, clinical study, or report of measured Voicesis outcomes. Diagrams are proposed workflows; calculations are illustrative.

It is operational education, not clinical or legal advice. Capabilities, integration access, contracts, and safeguards must be verified for the proposed deployment. No endorsement by the cited organizations is implied.

Sources reviewed September 24, 2026. External guidance may change.

Turn the next conversation into a useful next step.

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