Healthcare Automation Playbook

A step-by-step guide to automating scheduling, intake, follow-up, and reporting in independent healthcare organizations.

Independent healthcare organizations run on people, not platforms. Every no-show, every intake form filled out twice, every report built by hand at 9pm costs staff time that should go to patients.

Automation fixes that. But only if you build it in the right order, gate it with the right checks, and know ahead of time where it tends to break. This playbook covers all three.

01 READINESS CHECK

Automating a broken process just breaks it faster. Confirm these four things before you touch a scheduling tool, an intake form, or a reporting dashboard.

- ☐ You have one documented process for each workflow, not three unwritten ones.
  If scheduling works differently depending on which front desk person answers, write down the real process first.
- ☐ You know which systems already talk to each other, and which ones do not.
  EHR, billing, scheduling, messaging. Map the gaps before you paper over them with automation.
- ☐ You have a named owner for each automated workflow.
  Someone has to watch it after launch. "The team" is not an owner.
- ☐ You have budget and time for a pilot, not just a full rollout.
  Test on one provider or one location before every workflow, everywhere, at once.

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02 SCHEDULING

1. Map your current booking channels before you automate any of them.
   Phone, web form, walk-in, referral. List every path a patient uses to get on the calendar.
2. Pick one calendar as the system of record.
   Every channel writes to it. No exceptions, no side spreadsheets.
3. Automate reminders before you automate booking.
   Reminders cut no-shows fast and touch nothing clinical. Easiest win, do it first.
4. Build the cancellation and reschedule path with the same care as the booking path.
   A patient who cannot reschedule easily calls the front desk anyway, and you have automated nothing.
5. Connect a waitlist to your cancellation flow.
   A canceled slot should refill itself before staff notice it is open.
6. Set a no-show follow-up rule before you go live.
   Decide now whether that is a call, a text, or a waitlist fill. Do not decide it live.

03 INTAKE

1. Separate clinical intake from administrative intake.
   Insurance and demographics can automate faster and with less risk than symptom history.
2. Send intake forms on a fixed schedule relative to the appointment.
   48 hours out is the standard. Test it against your own no-show and completion data.
3. Route incomplete forms back automatically, once.
   One automated nudge. After that, a human calls.
4. Sync intake data to your EHR on submission, not on arrival.
   Front desk staff should never retype what a patient already typed.
5. Flag high-risk answers for human review before the appointment, not during it.
   Automation surfaces the flag. A clinician makes the call.

04 FOLLOW-UP

1. Define what counts as a follow-up trigger.
   Visit type, diagnosis, lab result, referral. Write the list down before you automate any of it.
2. Automate the routine follow-ups first.
   Annual reminders, prescription refill checks, satisfaction surveys. Low risk, high volume.
3. Keep clinical follow-up decisions with a clinician.
   The system can queue the task. It should not decide the next step in care.
4. Track follow-up completion, not just follow-up sent.
   A message sent is not a message read. Measure response, not delivery.
5. Set an escalation path for follow-ups that go unanswered.
   Two unanswered messages should mean a phone call, not a third message.

05 REPORTING

1. Decide who reads each report before you build it.
   A report nobody reads is a maintenance cost with no return.
2. Automate the reports tied to compliance and billing first.
   Fixed formats, hard deadlines. They are the easiest to templatize.
3. Pull from one source of truth, not from staff memory.
   If a report requires someone to "check with the front desk," it is not automated yet.
4. Build an audit trail into every automated report, and review it quarterly against manual spot checks.

Automation drifts. Catch it before a regulator or auditor does.

06 90-DAY ROLLOUT

Run all four workflows on the same timeline and you will not be able to tell which automation broke what. Stagger it.

PHASE	FOCUS	WHAT SHIPS
Days 1–30	Foundation	Reminders live. Booking calendar consolidated to one system of record. First intake form automated.
Days 31–60	Expansion	Full intake automation across visit types. Routine follow-ups automated. EHR sync confirmed and spot-checked.
Days 61–90	Reporting & Review	Compliance and billing reports automated. First quarterly audit run against manual spot checks. Pilot expanded past one location.

07 WHERE THIS BREAKS

- Automating around a broken process instead of fixing it first.
  The workflow just fails faster and with less visibility into why.
- Letting the system make a clinical judgment call it was never built to make.
  Automation should surface the decision point. A clinician should still make the call.
- No named owner once the person who built it moves on.
  Unowned automation is the first thing that goes stale, and nobody notices until it fails.
- Treating “message sent” as the finish line instead of “message answered.”
  Delivery is not engagement. Measure the thing that actually closes the loop.
- Running every workflow live on day one instead of staggering the rollout.
  One broken automation is a fix. Four broken automations at once is a full-time job for a week.

Scheduling and intake automate fast. Follow-up and reporting are where organizations stall.

Both involve judgment calls that look automatable and are not, at least not fully. Build the routine layer with automation. Keep the judgment layer with your team. That split is what makes the system trustworthy enough to actually use.