



A TALK ON VOICE AI IN HOME-BASED CARE

AI on the Front Lines: How Voice Automation is Changing Home Care Operations

Jay Gopal | Kyron Medical | July 2026

50-minute session

Educational, not a pitch

Q&A at the end



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BEFORE WE START

Who I am, and why I see both sides of this



Jay Gopal

CEO & Co-founder, Kyron Medical

- Builds voice AI used by medical practices across 36 states and 15 specialties
- Works daily with front-office and billing teams on real deployments, real failures, and real wins
- Focus areas: patient access, revenue cycle automation, and safe AI in clinical settings



Full disclosure

I run a company in this space.
Today's goal is to explain the technology honestly, including its limits, so you can evaluate any vendor, not just mine.

ROADMAP

Where we're going in the next 50 minutes

01



The home health moment

Demand, workforce, and why the phone is the bottleneck

02



Voice AI, explained

What it actually is, why it works now, and where it breaks

03



Use cases in home health

Front office, patient communication, billing, after-hours

04



Adopting it well

Economics, compliance, and questions to ask any vendor

05



What's next

Where the technology is heading over the next few years

Kyron Medical

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01

The home health moment

More patients, fewer hands, and a phone line holding the whole operation together.

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Demand is compounding faster than the workforce



73M

Americans 65+ by 2030, as the last boomers reach retirement age



#1

home health aide ranks among the fastest-growing U.S. occupations this decade



~80%

of older adults say they want to age in place, at home, not in facilities

The squeeze: care is moving into the home while agencies struggle to recruit clinicians and office staff. Every administrative hour you can give back to a human is an hour of capacity you didn't have to hire.

In home health, the phone is still the operating system



Referrals arrive by phone and fax

Hospital discharge planners and physician offices still call. Speed-to-answer decides who gets the referral.



Every visit is a scheduling event

Patients, caregivers, and field clinicians reschedule constantly. Each change is a call, or three.



Clinicians call in from the field

Nurses and aides phone the office for directions, orders, supplies, and documentation questions.



Care doesn't stop at 5 PM

After-hours lines cover wound issues, missed visits, and anxious caregivers, usually via an answering service.

What an unanswered call actually costs

1

A referral call rings out

The discharge planner moves to the next agency on the list. That's an entire episode of care lost.

2

A reschedule goes to voicemail

The visit is missed, the plan of care slips, and a recert or LUPA problem starts forming.

3

A caregiver can't get through

Frustration becomes a complaint, a bad survey score, or an unnecessary ER visit.

A single home health episode is worth roughly

\$2-3K+

in reimbursement. Miss a few referral calls a week and the math gets ugly fast.

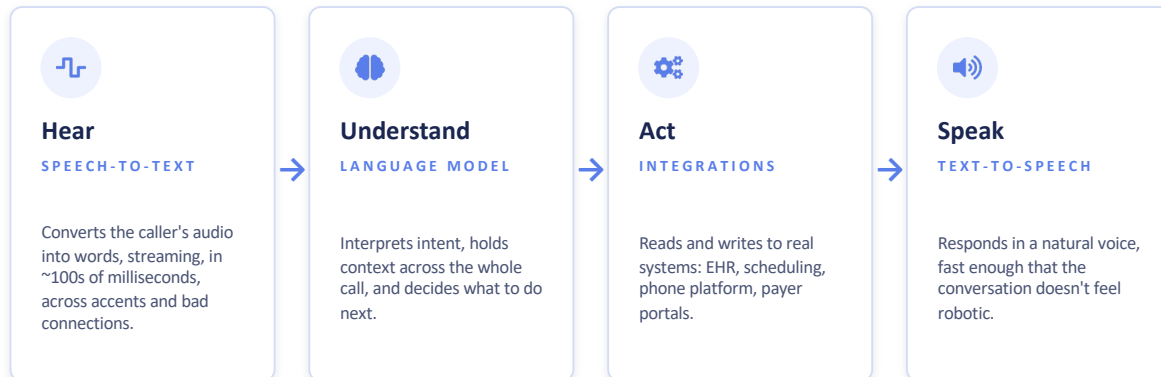


02

Voice AI, explained

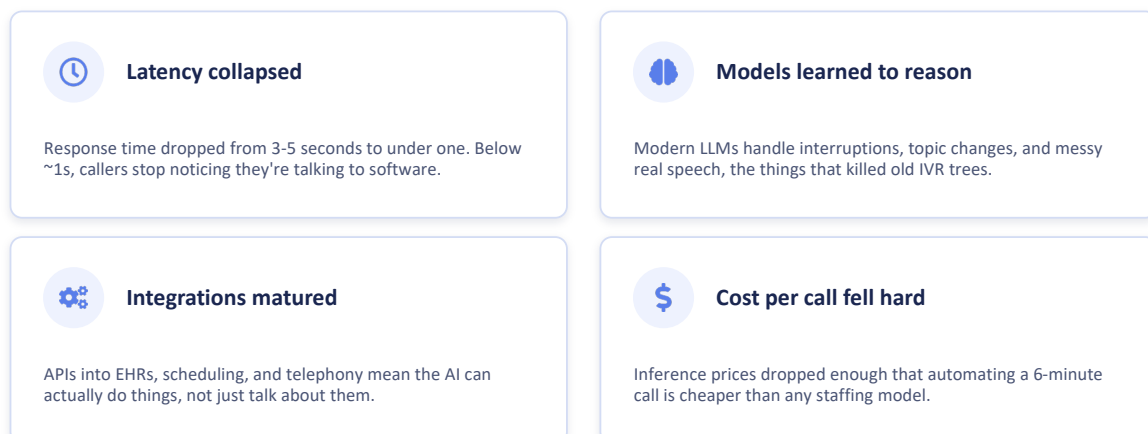
What's actually inside a voice agent, why it suddenly works, and where it still breaks.

Under the hood: four layers working in real time



The loop runs continuously: hear → understand → act → speak, dozens of times per call. The "agent" is the orchestration, not any single model.

Why 2026 is different from every past 'AI phone' wave



If you evaluated this technology in 2023 and walked away, it is worth looking again. The category changed underneath you.

An honest scorecard: strong today vs. still hard



Reliably strong today

- Structured conversations: scheduling, confirmations, intake, FAQs
- High-volume repetitive calls, hundreds at once, 24/7
- Multilingual conversations without staffing interpreters
- Payer phone trees: eligibility, claim status, prior auth follow-up
- Perfect documentation: every call transcribed and logged



Still hard, design around it

- Clinical judgment: triage decisions belong with licensed staff
- Emotionally charged calls: grief, complaints, escalations
- Highly novel situations with no script or precedent
- Very poor audio plus heavy accents plus background chaos
- Anything where a wrong answer is a safety event

Anatomy of one call, start to finish



The handoff is a feature, not a failure. Well-designed agents resolve the routine 70-80% and hand the rest to your team with full context, so the human starts the call already knowing what's going on.

03

Use cases in home health

Where voice AI is earning its keep today, from referral intake to the billing office.

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USE CASES · FRONT OFFICE

Referral intake and scheduling: the front door, always open



Referral intake

Answers referral lines instantly, captures demographics, insurance, and diagnosis, and starts the intake packet before a human touches it.



Scheduling & rescheduling

Books SOC visits, moves recurring visits when patients or clinicians need changes, and writes directly to the schedule.



Confirmations & reminders

Outbound calls and texts confirm tomorrow's visits, cutting no-shows and missed-visit documentation work.

Why it matters here: referrals are won on speed-to-answer. The agency that picks up first, at 7 PM on a Friday, often gets the patient.

Communication that meets patients where they are



Voice-first by necessity

Home health patients skew older. Many will never use a portal or app, but everyone can answer a phone call.



Any language, any time

Conversations in the caller's preferred language without scheduling an interpreter or making family translate.



Routine check-ins at scale

Post-visit follow-ups, satisfaction checks, and medication reminders that would be impossible to staff by hand.



Caregivers in the loop

Adult children coordinating a parent's care can call at 9 PM and actually get things done.

The billing office: where the hold music goes to die



Eligibility & benefits

Verifies Medicare, MA plan, and Medicaid coverage before start of care, so authorization surprises don't surface at billing.



Prior auth & follow-up

Initiates and chases authorizations with MA plans, the calls your billers dread most, and logs every reference number.



Claim status & denials

Works payer phone trees for claim status, reads denial codes, and queues appeals while your team sleeps.

Home health twist: PDGM, NOAs, face-to-face documentation, and Medicare Advantage growth have made home health billing more call-intensive, not less. A biller can spend half a day on hold; software doesn't mind.

After-hours coverage, with hard boundaries around triage



What the AI handles at 2 AM

- Answers instead of an answering service reading from a card
- Handles routine matters: visit times, directions, non-urgent messages
- Collects structured symptom information using your protocols
- Documents everything for the morning team automatically



The non-negotiable line

- Clinical decisions stay with the on-call nurse. Full stop.
- Red-flag symptoms trigger immediate warm transfer or 911 guidance
- Escalation rules are written by your clinical leadership, not the vendor
- When in doubt, the system is designed to over-escalate

What a real deployment looks like: one example from the field

Customized, not generic

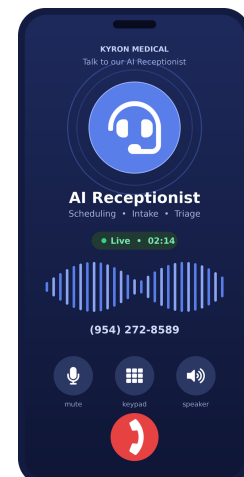
The agent is configured to the agency's service lines, territories, payers, and phone tree, so it sounds like the agency, not like software.

Wired into real systems

Reads and writes to the EHR and scheduling platform. A booking on the call is a booking in the system, no re-keying.

Live alongside staff

Rings through to the AI first or overflows from humans, and every practice tunes that mix differently.



Scripting that adapts to the caller, not the other way around



Protocol-driven questions

The agent asks what your clinical and intake teams decided it should ask, in the order they decided, per service line.



Adapts in real time

Follow-ups change based on answers. A wound question branches differently than a scheduling question, mid-sentence if needed.



Built with your team

Clinicians and office leads review scripts, listen to calls, and request changes, and the changes ship in days, not quarters.

Trust is built on transparency: see every call, fix anything fast



Every call, transcribed

Speaker-labeled transcripts the moment a call ends. Nothing the AI says or hears is invisible to you.



Dashboards, not vibes

Call volumes, resolution rates, escalations, and outcomes in real time, so performance is measured, not assumed.



Flag → fix → verify

Staff flag any call they don't like; the behavior gets corrected and the fix is verifiable in the next transcripts.

Rule of thumb: if a vendor can't show you full transcripts of your own calls, walk away. Auditability is the difference between automation and abdication.

04

Adopting it well

The economics, the compliance homework, and the questions that separate real from demo-ware.

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ADOPTING IT WELL

What the numbers tend to look like

PATIENT ACCESS

50-70%

lower cost on calls the AI handles vs. staffed answering

24/7

answer rate on referral and patient lines, zero hold time

5-12%

revenue lift reported from captured referrals and fewer no-shows

REVENUE CYCLE

25-40%

reduction in average handle time on payer work

20-30%

improvement in first-pass resolution on worked claims

\$3-5M

net annual gain per \$100M of managed revenue cycle

Ranges reflect deployments across the industry. Your mileage depends on call mix, payer mix, and how much of the workflow you automate.

The compliance homework: four things to get right



HIPAA & data handling

Signed BAA, encryption in transit and at rest, and clear answers on where audio, transcripts, and PHI live, and for how long.



Recording & consent

Call-recording consent varies by state; two-party-consent states need disclosure language built into the greeting.



AI disclosure

A growing set of state laws require telling callers they're speaking with an AI. Do it anyway: it's cheap and it builds trust.



Escalation & override

Documented rules for when the AI must hand off, plus a human override path your staff can trigger at any time.

Ten questions that separate real platforms from demo-ware

1. Can I listen to live production calls from a customer like me?

2. What percentage of calls resolve without a human, and how do you measure it?

3. How does the AI decide to escalate, and who defines those rules?

4. Does it write directly into my EHR and schedule, or just take messages?

5. Who builds and maintains the scripts, and how fast do changes ship?

6. What happens on your worst day: outage plan, fallback routing?

7. Where does PHI live, who can access it, and will you sign a BAA?

8. How do you handle two-party consent and AI-disclosure requirements?

9. What does month 3 look like: tuning cadence, reporting, success metrics?

10. Can I exit cleanly, and take my data and phone numbers with me?

WHAT'S NEXT

Where this is heading over the next few years



From reactive to proactive

Agents that don't wait for the phone to ring: outbound recert reminders, missed-visit recovery, and gap-closure calls.



Deeper clinical context

Tighter EHR integration means the AI knows the plan of care and episode timeline, and routes accordingly.



One AI across every channel

Voice, text, fax intake, and portal messages handled by the same agent with the same memory of the patient.



From cost saver to growth lever

Early adopters treat this as capacity: taking more referrals and growing census without growing overhead first.



Thank you. Questions?

Hear a production voice agent yourself: (954) 272-8589

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36 states live

15 specialties

90+ custom workflows

100M+ in claims