

THE ACCESS GAP

Why Scheduling Template Integrity (Not Just Provider Supply) Determines Whether Patients Can Get Care

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Executive Summary

The dominant narrative about limited access to care is a supply narrative: there are not enough primary care physicians, psychiatrists, or obstetricians, and the fix is to train more of them. That narrative is not wrong — the workforce shortfalls documented later in this paper are real and well quantified by the Association of American Medical Colleges (AAMC) and the Health Resources and Services Administration (HRSA). But for a health system leader deciding where to spend the next dollar of operational attention, treating supply as the whole story is incomplete, and can be actively misleading. A large, directly actionable share of the access problem sits not in how many providers a system employs, but in the integrity of the scheduling templates that determine how much of that provider's time actually reaches a patient.

Template integrity, as used in this paper, describes whether a provider's scheduling template — the pattern of visit types, holds, blocks, and slot lengths that governs how many patients can be seen and when — is deliberately designed around real demand and the organization's stated access goals, consistently applied, and routinely audited, or whether it has instead drifted into an accumulation of individual provider preference, unmanaged holds, and legacy convention that no one actively owns. Where template integrity is weak, a health system can be sitting on real, uncaptured capacity even in specialties widely described as short-staffed. Industry benchmarking indicates that schedules operating at a typical 70% utilization rate leave approximately 30% of available capacity unrealized¹. This gap exists not because provider time is unavailable, but because the scheduling template was not strategically designed using historical daily and seasonal demand trends alongside future growth objectives—or because it has not been regularly optimized to reflect evolving patient demand.

This paper uses three specialties — primary care, mental health, and maternal care — as case studies, because each shows a different face of the same underlying problem: templates that have lost integrity over time, that no one is accountable for, and that quietly convert existing provider capacity into apparent scarcity. It closes with a set of strategies built around the lever health system leaders can pull immediately and without waiting for a new hire: taking ownership of how templates are designed, governed, and audited.

**30%**

of scheduled capacity can go uncaptured when templates run at an industry-typical 70% utilization rate

26 days

average new-patient wait time in major U.S. metros — even where provider capacity technically exists

<7%

no-show rate achievable with disciplined template management, versus far higher rates in unmanaged templates

¹Impact Advisors, "Surgical Block Utilization," Impact Advisors Insights, May 7, 2025, <https://www.impact-advisors.com/article/surgical-block-utilization/>.

Is It a Supply Problem, or a Capture Problem?

Ask a health system leader why patients are waiting weeks or even months for an appointment, and the answer is almost always framed as a supply problem: not enough behavioral health providers, not enough OB-GYNs, not enough primary care physicians. That framing is comfortable because it points to a cause outside the organization's direct control — a national workforce pipeline, a residency-funding formula, a demographic wave of aging patients. It is also, this paper argues, only half the story. The more useful and more immediately answerable question is a capture question: of the provider capacity a health system already has on staff today, how much of it is actually reaching patients, and how much is being lost to a scheduling template that was never designed, or has quietly stopped reflecting, real demand?

The distinction matters because the two problems call for entirely different responses on entirely different timelines. Fixing a genuine supply shortage requires years: a new residency slot, a new hire, a new graduate. Fixing a template integrity failure requires weeks: an audit, a redesign, a governance policy, and the discipline to enforce it. Every specialty examined in this paper — primary care, mental health, and maternal care — shows both problems layered on top of each other. This paper does not deny that real shortages exist; the workforce statistics later in this document are accurate and consequential. But it argues that health system leaders have been trained to reach for the supply-side lever first, when the template-integrity lever is faster, cheaper, fully within the organization's control, and, in many markets, larger than most leaders assume



Primary Care: When the Front Door Is a Template Problem

① The Supply Backdrop

There is a genuine primary care shortage in parts of the country: HRSA has designated 7,488 health professional shortage areas for primary care alone, covering nearly 74 million people, and AAMC projects a national primary care physician shortfall of roughly 20,000 to 40,000 by 2036². Those numbers are real, and they matter for national workforce policy.

② The Template Problem Underneath It – Why the Front Door Still Matters

Inside most existing primary care practices, including many that are not in a designated shortage area at all, the more immediate constraint on patient access is not the physician's total capacity; it is how that capacity has been carved up. Practice-management consultants have documented primary care templates with well over a thousand distinct appointment types, a level of complexity that reflects years of individual provider customization rather than any actual difference in what patients need. One widely cited example found a single practice operating with 1,100 appointment types — a scheduler's logistical nightmare that added no value for patients, who simply wanted to be seen³. While there is no magic number for visit types, standardizing to a small number, by contrast, has been shown to dramatically simplify scheduling without reducing quality of care.

The same pattern shows up in how templates allocate time between visit categories. It is common for a primary care template to devote a disproportionate share of daily slots to short, low-acuity follow-ups — sometimes on the order of 40% of the schedule — while comprehensive new-patient visits, which represent a much larger share of practice growth and revenue, are left with a small fraction of available slots. That imbalance is a template design problem, not a demand problem: the demand for new-patient access exists, but the template was never rebuilt to reflect it. Left unaddressed, this is precisely why national new-patient lag time has climbed to roughly 26 days on average⁴, even in metro markets that are not formally designated shortage areas.

When a primary care template loses integrity — when its visit-type mix, hold structure, and new-patient allocation no longer reflect real demand — the effect does not stay contained to primary care. Patients who cannot get a timely primary care appointment delay the referrals that connect them to mental health and maternal care in the first place. A template failure at the front door compounds every access problem behind it, which is why this paper treats primary care template integrity as the upstream multiplier for the two case studies that follow.

²Association of American Medical Colleges, The Complexities of Physician Supply and Demand: Projections from 2021 to 2036 (Washington, DC: AAMC, 2024); Health Resources and Services Administration Health Professional Shortage Area designations, as reported in AAMC, "Addressing the Physician Workforce Shortage," <https://www.aamc.org/advocacy-policy/addressing-physician-workforce-shortage>

³Joanne Tetrault, "Simplify Your Scheduling," Physicians Practice, March 1, 2003, <https://www.physicianspractice.com/view/simplify-your-scheduling>.

⁴AMN Healthcare and Merritt Hawkins, 2022 Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates (Dallas: AMN Healthcare, 2022).

Mental Health: Templates That Hide Capacity Behind a Full Caseload

① The Supply Backdrop

As of late 2025, roughly 137 million Americans — 40% of the U.S. population — lived in a federally designated Mental Health Professional Shortage Area, according to HRSA's most recent workforce brief, and federal workforce models project the gap will widen substantially through 2038⁵. These figures describe a genuine, well-documented national shortfall, concentrated most severely in rural counties.

Provider Type	Projected 2037–38 Shortfall	Notes
Mental health counselors	~88,000–99,800	Status quo to baseline scenario
Addiction counselors	~114,000–123,000	Lowest projected adequacy (~21%) of any discipline
Psychologists	~99,800	Baseline 2038 projection
Adult psychiatrists	~36,800 (status quo); ~86,400 (elevated need)	More than double under improved-access scenario
Child & adolescent psychiatrists	~7,000	Compounds pediatric behavioral health gaps



⁵Health Resources and Services Administration, Bureau of Health Workforce, State of the Behavioral Health Workforce, 2025 (Rockville, MD: HRSA, 2025).

② The Template Problem Underneath It

The headline statistic most often cited to describe behavioral health access — that roughly six in ten⁶ behavioral health providers nationally are not accepting new patients — is as much a description of template design as it is a description of true capacity. Most behavioral health templates do not separate a protected block for new-patient intake evaluations from the recurring block of established-patient therapy sessions that fills a clinician's calendar week after week. Once a caseload of ongoing therapy patients fills a template, the template itself has no mechanism for surfacing a new-patient opening, regardless of whether the clinician's total weekly capacity could, in principle, accommodate one. The clinician is not unavailable; the template has simply never been built to make availability visible.

This is a distinct failure from a true workforce shortage, and it responds to a different fix. A true shortage requires more clinicians. A template integrity failure requires the organization to decide, deliberately, what share of every clinician's weekly template is protected for new-patient intake regardless of how full the therapy caseload becomes — and then to govern that decision centrally rather than leaving it to each provider's individual scheduling habits. Where that discipline is absent, wait times of three weeks to six months for a new evaluation reflects the template's design at least as much as they reflect the region's true clinician-to-population ratio.

③ The Human and Clinical Cost

Whatever the cause, the consequence is the same large treatment gap: in 2024, an estimated 62 million U.S. adults experienced mental illness, yet close to half received no treatment⁷. Left untreated, behavioral health conditions do not stay contained to behavioral health. Patients with a comorbid mental health or substance use condition generate medical costs two to three times higher, on average, than patients without one, and behavioral health diagnoses are present in roughly half of all frequent emergency department users nationally.⁸

⁶American Psychological Association, 2022 COVID-19 Practitioner Impact Survey (Washington, DC: APA, 2022).

⁷Substance Abuse and Mental Health Services Administration, 2024 National Survey on Drug Use and Health (Rockville, MD: SAMHSA, 2025).

⁸American Hospital Association, Care Delivery Transformation Framework: Integrated Behavioral Health (Chicago: AHA, n.d.).



Maternal Care: Where Template Integrity Ends and True Supply Failure Begins

Maternal care is the case study in this paper where the distinction between a supply problem and a template problem must be drawn most carefully and honestly. In a true maternity care desert, there is no template to fix, because there is no clinician or birthing facility in the county at all. Roughly 35% of U.S. counties fall into this category, representing more than 2.3 million women of childbearing age and over 150,000 births annually in places with zero local obstetric infrastructure⁹. No amount of scheduling discipline changes that outcome; it requires actual investment in clinicians, training pipelines, and facilities, discussed further in Reserve Workforce and Infrastructure Investment (p. 19).



2.3M+

women of childbearing age live in a true maternity care desert with zero local OB infrastructure

267

rural hospitals closed OB services between 2011–2021 alone

18.6

U.S. maternal deaths per 100,000 live births — far above peer nations



⁹March of Dimes, Nowhere to Go: Maternity Care Deserts Across the U.S. (Arlington, VA: March of Dimes, 2024).

① Where Template Integrity Still Matters

Outside true deserts, however — in the much larger set of counties with limited but non-zero obstetric access, and in the urban and suburban practices that retain OB capacity — template integrity determines whether that remaining capacity reaches patients in time. Prenatal care follows a well-established, gestational-age-driven visit cadence, yet many OB templates are built around a generic visit-length standard that does not flex to match that cadence, causing early low-acuity visits to consume the same slot length as a late-term visit that requires closer monitoring. Templates in many OB practices also lack a protected same-day triage block for urgent but non-emergent prenatal concerns — bleeding, reduced fetal movement, blood pressure spikes — which means patients with real but non-catastrophic concerns default to the emergency department not because no obstetric provider exists, but because the existing provider's template has no mechanism for same-day access.

② The Outcomes Consequence

Where the underlying cause is genuine infrastructure loss, the consequences are severe: women in rural America are roughly 60% more likely to die of pregnancy-related causes, Black women's maternal mortality rate remains about 2.6 times that of White women, and the CDC estimates that roughly 80% of U.S. maternal deaths are preventable¹⁰. That last figure is worth sitting with. It means the maternal mortality crisis is fundamentally a systems and access failure, not a clinical-knowledge one, and systems failures include both true infrastructure gaps and the template failures that squander the infrastructure that remains.

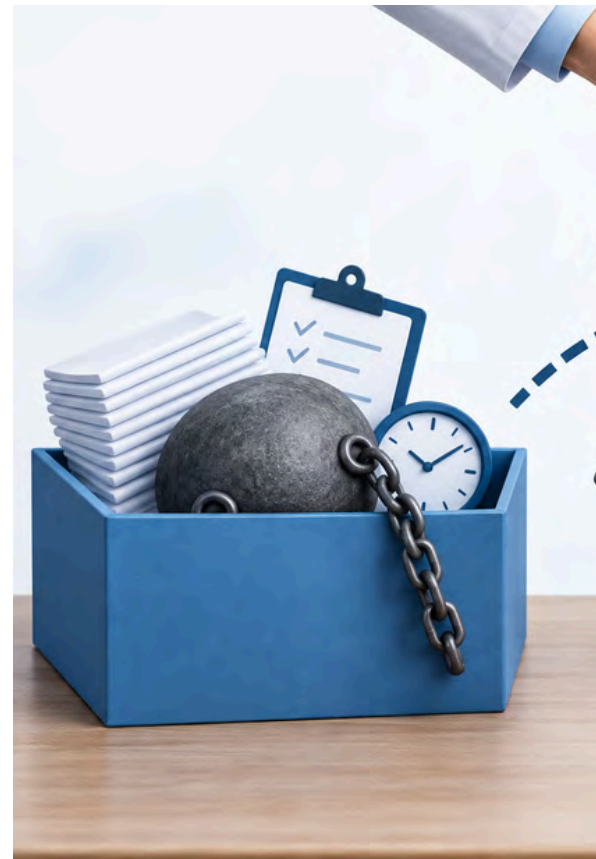
¹⁰Centers for Disease Control and Prevention, "Working Together to Reduce Black Maternal Mortality," April 8, 2024, <https://www.cdc.gov/womens-health/features/maternal-mortality.html>; CDC National Center for Health Statistics, Maternal Mortality Rates in the United States, 2023 (Hyattsville, MD: NCHS, 2024).

The Constraint Doesn't Disappear, It Moves

The three case studies above address demand that is already trying to reach an existing provider. But fixing a primary care template does not end the story. It starts a new one. A patient who finally gets a timely primary care appointment is a patient who eventually generates volume in the procedural areas that follow a diagnosis: an operating room, a cath lab, an infusion chair, a radiology suite. These are not incidental downstream effects. Surgery, cardiac catheterization, infusion, and imaging are among the highest revenue-generating service lines in a health system, and they are where an access initiative's financial return is actually realized. Two distinct dynamics follow from that, and health system leaders should not conflate them. The first is a cascading demand effect: front-door capacity improvements increase downstream procedural volume, straining departments that were never the target of the original access initiative. The second is independent of the first. The departments absorbing that increased volume, including operating rooms, cath labs, infusion centers, and imaging suites, have scheduling integrity problems of their own, unrelated to whatever happens upstream in primary care.

① A Cascading Effect: Where Referrals Go When the Front Door Opens

Improving access to primary care is, by design, supposed to increase downstream utilization. That is the clinical goal, and it is also where much of an access initiative's financial return is realized. A patient who is finally seen for a persistent symptom is a patient who may be referred for imaging, a cardiac catheterization, an infusion regimen, or a surgical consult: the procedural service lines that generate a disproportionate share of a health system's revenue. What is less often planned for is the operational consequence. A health system that fixes its clinic templates without examining capacity in the departments those referrals feed will simply relocate its access problem, and defer the revenue it was counting on, rather than resolve it. This is the same dynamic industrial and process engineers describe in constraint theory: relieving one bottleneck in a system does not eliminate the constraint, it moves it to the next-tightest resource in the chain. In a health system, that next resource is frequently the operating room, the cath lab, the imaging suite, or the infusion center, and in most systems, none of them is being managed with the same template discipline this paper recommends for primary care, mental health, and maternal care.



② The Same Failure, Different Setting

Independent of any upstream referral effect, procedural and ancillary capacity shows the identical template integrity failure described throughout this paper: a resource that is not actually scarce, sitting behind a schedule that was never built, or has stopped being maintained, to reflect real demand. Operating rooms are a clear example. Industry benchmarks target roughly 80% utilization, yet most U.S. health systems operate their ORs at 65% to 75%, with the shortfall driven overwhelmingly by block-time allocation, first-case start delays, and turnover time rather than a true shortage of surgeons or rooms.¹¹ Infusion centers show a nearly identical pattern. A 2019 national survey of infusion center operations found a median scheduled chair utilization of 80% against a median actual utilization of 70%, a ten-point gap attributable to no-show rates, cancellations, and cycle-time variability rather than a shortage of chairs or nursing staff. Imaging tells the same story¹². Workflow studies of MRI operations have found effective scanner utilization during operating hours in the 77% to 85% range, with the gap traced to patient punctuality, same-day cancellations, and IV-access delays, process failures rather than equipment scarcity¹³. Across these three, the number is close enough to the 70% utilization rate this paper documents in primary care that it should not be read as a coincidence. Cardiac catheterization labs, measured differently, tell the same story in a different unit. A published efficiency initiative at one large cath lab found the share of days running at full lab utilization starting near 8% and reaching over 77% after disciplined block scheduling and turnaround-time management were introduced, with no additional rooms, staff, or equipment added.¹⁴ Whatever the metric, the underlying failure is identical across all four service lines: a schedule template with no owner, no audit cadence, and no mechanism for surfacing the capacity that already exists, recurring in every resource a health system schedules, not just the ones a physician's name is attached to.

③ Why Sequencing Matters

This has a direct implication for how health system leaders sequence capacity investment. An access initiative that succeeds in primary care but ignores downstream template integrity does not create the value it promises. It simply exposes the next constraint, often at greater cost, since an OR minute, a cath lab hour, or an infusion chair-hour typically carries a higher fully loaded cost than a clinic visit. The strategies outlined in A Path Forward for Health System Leaders (p. 17–19) apply with equal force to a surgical block schedule and an infusion chair template as they do to a primary care panel. Treating capacity management as a single discipline that spans the full care continuum, rather than a series of disconnected initiatives in different departments, is what determines whether an access investment compounds in value or simply relocates the bottleneck to a more expensive part of the system.

¹¹Narges Hosseini and Kevin M. Taaffe, "Allocating Operating Room Block Time Using Historical Caseload Variability," *Health Care Management Science* 18, no. 4 (2015): 419–30, <https://doi.org/10.1007/s10729-014-9269-z>; A. Macario, "The Limitations of Using Operating Room Utilisation to Allocate Surgeons More or Less Surgical Block Time in the USA," *Anaesthesia* 65, no. 6 (2010): 548–52, <https://doi.org/10.1111/j.1365-2044.2010.06374.x>.

¹²National Home Infusion Association, 2019 Infusion Center Volumes, Staffing, and Operations Survey (Alexandria, VA: NHIA, 2019).

¹³Ulrike Streit et al., "Analysis of Core Processes of the MRI Workflow for Improved Capacity Utilization," *European Journal of Radiology* 138(2021): 109648, <https://doi.org/10.1016/j.ejrad.2021.109648>.

¹⁴Grant W. Reed et al., "Operational Efficiency and Productivity Improvement Initiatives in a Large Cardiac Catheterization Laboratory," *JACC: Cardiovascular Interventions* 11, no. 4 (2018): 329–38, <https://doi.org/10.1016/j.jcin.2017.09.025>

Beyond These Three: A Capture Problem Hiding Inside the Shortage Numbers

AAMC projects a national physician shortage of **13,500 to 86,000 physicians by 2036**, affecting both primary care and specialty care¹⁵. This projected gap is driven in large part by an aging population with increasing healthcare needs, creating greater demand for specialties such as cardiology, oncology, surgery, and neurology—areas that are already experiencing workforce shortages. These projections are built from current utilization patterns, meaning they measure the gap between demand and the types of patients a template currently allows a provider to see, not the gap between demand and a provider's true working capacity. If scheduling templates across specialty care are operating at the same industry-average utilization rate of approximately 70% observed in primary care, a significant portion of the projected physician shortage may reflect unrealized capacity rather than a true lack of clinical supply.

Specialty Category	Projected 2036 Shortfall Range	Primary Demand Driver
Primary care	~20,200 – 40,400	Population growth, aging, front-door demand
Surgical specialties	~10,100 – 19,900	Aging population, procedural volume growth
Mental health / psychiatry	Included in behavioral health projections above	Rising diagnosed prevalence, workforce attrition
Medical & other specialties (aggregate)	Up to several tens of thousands	Chronic disease burden in an aging population
Total physician workforce	~13,500 – 86,000	Compounding demographic and workforce-attrition trends

This does not mean the shortage is not real. The equity-adjusted analysis, in which AAMC estimates that closing current utilization gaps for underserved populations would require on the order of 100,000 to 200,000 additional physicians¹⁶, shows genuine unmet demand well beyond anything a template fix alone could close. But it does mean health system leaders should not treat every specialty's reported wait time or apparent unavailability as proof that headcount is the binding constraint. In market after market, the diagnostic step that is skipped is the simplest one: auditing whether the templates governing existing specialists are capturing the capacity that is actually there before concluding that the answer is another hire.

¹⁵Association of American Medical Colleges, Complexities of Physician Supply and Demand.

¹⁶Association of American Medical Colleges, Complexities of Physician Supply and Demand, equity-adjusted health care utilization scenario.

The Common Thread: Templates Without an Owner

Primary care, mental health, and maternal care look like distinct clinical domains, but the template integrity failures inside each one share a nearly identical anatomy:



No clear ownership:

In most practices, the scheduling template is treated as the individual provider's personal domain rather than an organizational asset. There is often no single role accountable for whether a given template still reflects current demand.



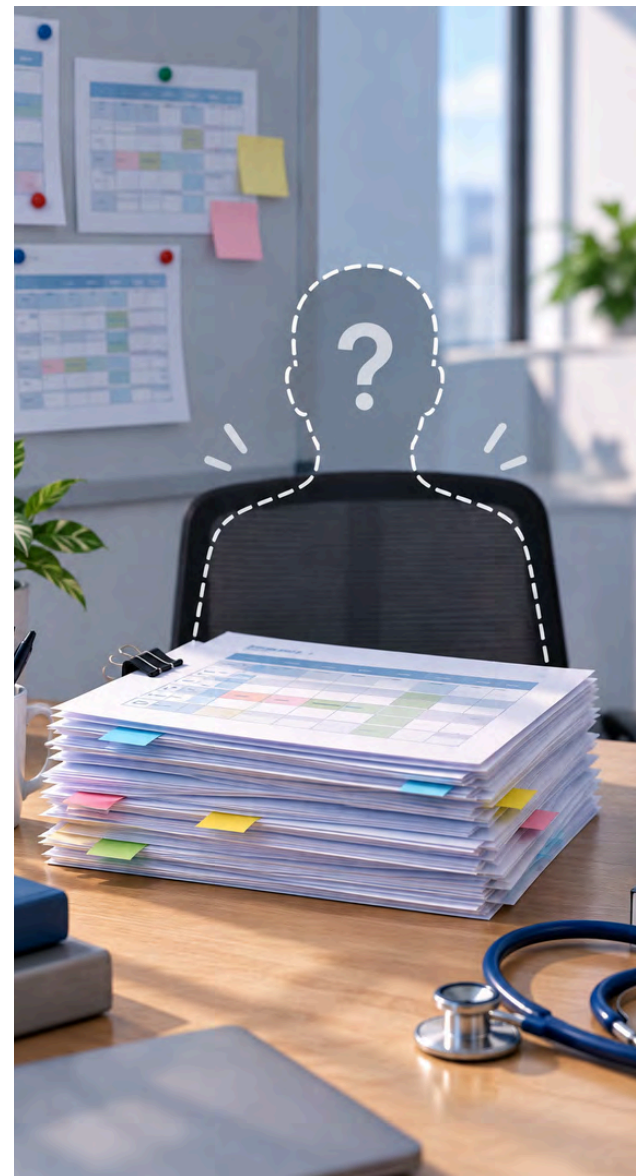
Drift by accretion, not design:

Templates rarely start broken. They accumulate exceptions — a hold added for one recurring meeting, a custom visit type created for one referring physician, a block protected for one provider's preferred lunch hour — until the original design logic is unrecognizable and no one remembers why any given piece exists.



No audit cadence:

Best practice calls for quarterly reviews of scheduling performance, including fill rates, no-show rates, and visit-type mix, with template adjustments driven by actual patient demand and historical volume data. In practice, this review is one of the first things to lapse when clinical operations teams are stretched thin, which means the templates most in need of attention are often the ones reviewed least.





Visit-type sprawl that obscures the demand signal:

When a template carries dozens or hundreds of appointment types, it becomes nearly impossible for scheduling staff or operational leadership to see whether the mix of slots offered actually matches patient needs.



Conflation of new-patient and follow-up demand:

Across behavioral health, primary care, and obstetrics, scheduling templates often allow recurring established-patient demand to consume available capacity before new-patient demand is strategically allocated. As a result, providers may appear fully booked when, in reality, it is the template — not the provider's true clinical capacity — that has reached its limit

None of this is to say the structural forces documented elsewhere in this paper — reimbursement misalignment, training pipeline bottlenecks, geographic maldistribution, and rising demographic demand — are not real. They are, and Reserve Workforce and Infrastructure Investment (p. 19) addresses them directly. But they operate on a multi-year timeline. Template integrity failures operate on the timeline of the next scheduling cycle and are the more immediate lever available to any health system leader reading this paper today.



The Cost of Inaction

Orientation alone is not enough. Coding education should continue throughout all years of the program, reaching first-, second-, and third-year residents alike. A combination of in-person sessions and supplementary channels works best, and no program for health system leaders determining where to focus limited operational resources, the financial case for auditing and optimizing scheduling template integrity is both immediate and measurable, whereas the impact of broader workforce initiatives often takes longer to realize. A practice running at the industry-typical 70% utilization rate is leaving 30% of its billable, already-staffed capacity uncaptured — capacity the organization is already paying for in salary and overhead whether or not a patient fills the slot. That is a pure operating loss, distinct from and additive to the clinical cost of delayed care.

The clinical cost compounds on top of it. Untreated behavioral health conditions drive avoidable utilization: roughly half of high-frequency emergency department users carry a mental health diagnosis¹⁷, and a portion of that utilization reflects patients who could not get a timely appointment with a clinician who, on paper, had an opening that a poorly governed template never surfaced. In maternal health, a patient triaging a non-emergent prenatal concern in the emergency department because her OB's template has no same-day slot generates a far more expensive and lower-continuity encounter than the same visit would have been inside her existing OB relationship — a cost the health system bears regardless of whether the underlying cause was a true shortage or an uncaptured opening. Conversely, organizations that have brought discipline to specialty scheduling and case management report measurable returns: collaborative care models for behavioral health have been documented to save roughly six dollars for every dollar invested¹⁸, and intensive outpatient models for complex patients have cut total health care spending by double-digit percentages within two years¹⁹ — returns that depend on the underlying scheduling infrastructure being capable of delivering the access those models promise.



¹⁷American Hospital Association, Care Delivery Transformation.

¹⁸Jürgen Unützer et al., “Long-Term Cost Effects of Collaborative Care for Late-Life Depression,” *American Journal of Managed Care* 14, no. 2 (2008): 95–100.

¹⁹Jaewhan Kim et al., “Impact of an Intensive Outpatient Clinic Model on Health Care Utilization and Cost,” *American Journal of Managed Care* 32, no. 7 (2026): 406–412, <https://doi.org/10.37765/ajmc.2026.89915>

A Path Forward for Health System Leaders

No single intervention will eliminate every patient access challenge, but the order of operations matters. Scheduling template integrity is an operational lever that health systems control today, while workforce expansion and infrastructure investments typically require years to produce meaningful gains in capacity. The strategies below are ordered accordingly.



Establish clear ownership and governance over every scheduling template

The single highest-leverage change available to most health systems costs nothing and requires no new hire: assign a named owner — typically a clinical operations leader working jointly with the provider — to every scheduling template, with explicit authority to review and revise it. Sustained performance depends on clear ownership. Without it, the solutions outlined in this section are unlikely to produce durable, long-term improvements. Even the most thoughtfully redesigned scheduling templates are unlikely to sustain their performance if no individual or team is responsible for their ongoing governance. Without active management, they typically return to legacy patterns over time.



Audit and rebuild templates around actual demand, not legacy convention

A quarterly review of fill rates, no-show rates, and visit-type mix against actual demand data — an operational discipline already practiced by high-performing medical groups — helps organizations maintain target performance levels, including 90%–95% fill rates and no-show rates below 7%. ²⁰This approach transforms template management from a one-time optimization effort into an ongoing standard of operational excellence. Where a template shows a mismatch between the visit types it offers and the visit types patients are actually requesting, that mismatch is the fix, not a call for more staff. Standardizing appointment lengths and consolidating an unmanaged sprawl of custom visit types into a small, clinically coherent set the same simplification that turned one documented practice's 1,100 appointment types into a workable handful — routinely surfaces capacity that already existed but was never visible to scheduling staff or patients.



²⁰Medical Group Management Association, Restoring Balance to Patient Access and Medical Practice Operations (Englewood, CO: MGMA, August 2023); MGMA, DataDive Practice Operations benchmarking data.



Protect new-patient, intake, and triage capacity explicitly inside the template

Recurring established-patient visits will continue to fill available appointment capacity unless proactively managed. Ensuring timely access for new patients and urgent needs requires deliberate structural allocation within scheduling templates — not reliance on residual capacity after existing demand has been accommodated. In practice, this means a primary care template that reserves same-day or near-term new-patient slots, a behavioral health template that separates new-evaluation intake capacity from ongoing therapy blocks, and an OB template that carves out same-day triage capacity for urgent but non-emergent prenatal concerns. Capacity-based panel design, aligning each provider's share of patient assignments with their proportion of available clinical capacity, has demonstrated the ability to reduce wait times and unnecessary patient redirections without adding providers. By better matching existing capacity to actual demand patterns, organizations can improve access using resources already in place.



Extend template discipline into virtual and hybrid capacity

Once in-person templates reflect real demand, virtual visits, e-consults, and hybrid models become genuine capacity multipliers rather than an added layer of scheduling complexity. Permanent Medicare telehealth flexibilities, expanding multistate licensure compacts, and payer parity requirements in most states make virtual behavioral health, virtual prenatal check-ins, and specialist e-consults a realistic way to extend a well-governed template's reach, but they must inherit the same integrity requirements as any other visit type. Bolting virtual capacity onto an already-undisciplined template compounds the underlying problem rather than solving it.





Reserve workforce and infrastructure investment for where a template fix cannot substitute

Some access challenges are the result of true supply constraints, and no amount of scheduling optimization or template discipline can fully resolve a shortage of available providers. True maternity care deserts with zero local obstetric infrastructure, HPSA-designated counties with no behavioral health provider within 100 miles, and the demographically driven, AAMC-projected shortfalls in surgical and medical specialties all require real investment: sponsoring residency positions in underserved regions, building mobile and hub-and-spoke care models where a fixed site cannot be sustained, and layering loan repayment and rural incentive programs onto training investment. The purpose of auditing template integrity first is not to eliminate the need for workforce investment; it is to ensure that investment is directed toward areas where provider supply is truly the limiting factor rather than applied broadly as a default response to every access challenge.



Target case management toward the highest-risk, highest-utilization patients

Risk-stratified, intensive outpatient and care-management programs for medically and behaviorally complex patients have demonstrated some of the clearest utilization and cost reductions in the data reviewed for this paper. This strategy works within existing clinical infrastructure — it is a capture strategy, not a supply strategy — and is often the fastest-to-deploy lever for health systems already operating under value-based arrangements, particularly once the underlying templates that these programs depend on have the integrity to deliver the access they promise.



70%

typical schedule utilization rate
— meaning up to 30% of
capacity is available before any
new hire is needed

90–95%

appointment fill rate achievable
with disciplined, regularly
audited template management

1,100

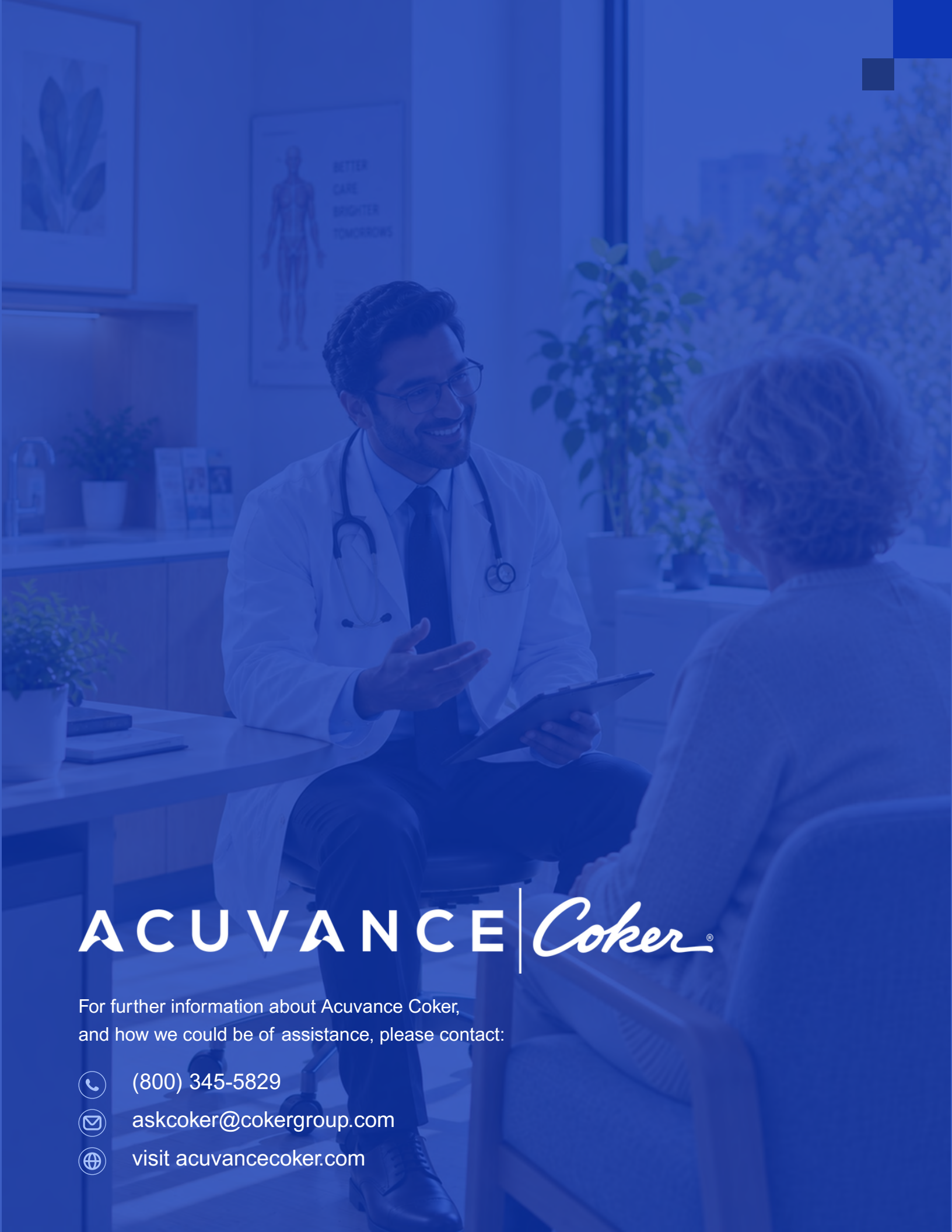
distinct appointment types
found in one documented
practice before template
consolidation

Conclusion

The workforce shortage projections discussed in this paper are real, and no level of scheduling discipline can replace the residency expansion, rural workforce incentives, and infrastructure investments required to address true supply constraints. However, pursuing those solutions before assessing whether existing clinical capacity is being fully and effectively deployed reverses the appropriate sequence of action. Template integrity — clear ownership, routine audit, protected new-patient and triage capacity, and disciplined governance — is the lever every health system already controls, that pays off in weeks rather than years, and that determines whether the provider capacity already on staff shows up as patient access or as apparent scarcity.

The organizations best prepared to navigate the next decade of access challenges will be those that make template integrity a permanent operating discipline. Before concluding that more supply is the answer, they will ensure existing capacity is reaching patients effectively — across primary care, mental health, maternal care, and every specialty where demand continues to rise.





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