

MON
TUES
WED
AVAILABILITY: NONE



The Waiting Game: New-Patient Appointment Access for US Physicians

Table of Contents

Why Is This Important?	4
Our Methodology	5
What We Learned: Access Is Not as Easy (or Fast) as It Could Be	7
How Can We Prepare for the Future?	12
Potential Solutions for Organizations	15
Adopting a Consumer-Centric Culture	16
Appendix A: Detailed Findings	17
Appendix B: Methodology Detail	25
References	27

Navigating the US healthcare system can be an exercise in frustration, whether you interact with it once a day or once a year. Its inherent complexity is compounded by a problematic supply-and-demand equation: the population is aging and utilizing more healthcare services, while physicians are retiring at a rate faster than new ones are being trained. Mix in operational and financial pressures, such as decreasing margins and staffing shortages, and the result is that access to care has never been more difficult.

Sometimes the biggest barrier to receiving care is the first step—making an appointment. Obtaining an appointment as a new patient is especially challenging. First you need to identify a potential physician, a process that may include gathering recommendations from other providers, coworkers, or neighbors; using physician locator options from health system or health plan physician directories; or turning to online data sources (e.g., WebMD, ZocDoc).

Then you have to navigate the oft-labyrinthine channels for scheduling an appointment—assuming you can reach the right person in a practice, answer screening questions correctly, and clear the barrier of insurance acceptance. Only then does the wait begin for an initial new-patient appointment—and it may be a lengthy one.

While alternative means exist for obtaining more rapid access to physicians (e.g., direct referrals, expedited access due to acute conditions), the reality is that many patients wait weeks or even months to access care for routine or nonemergent conditions. Health systems are acutely aware of these challenges and often ask us questions such as:

?

“How do our wait times compare to other organizations?”

?

“Is that how long it usually takes this specialty to see new patients?”

?

“What should our wait time goal be?”

Unfortunately, meaningful wait time data is uncommon—partly because access is always changing, and partly because true access is dependent on so many variables (e.g., patient condition, time of year). As such, we conducted our own consumer research—putting ourselves in the shoes of the average patient in large cities across the US—to determine how long a typical new patient seeking care for common conditions might wait for an appointment. The result is a realistic view of where and in what specialties patients face the most significant challenges to accessing routine care.



Why Is This Important?

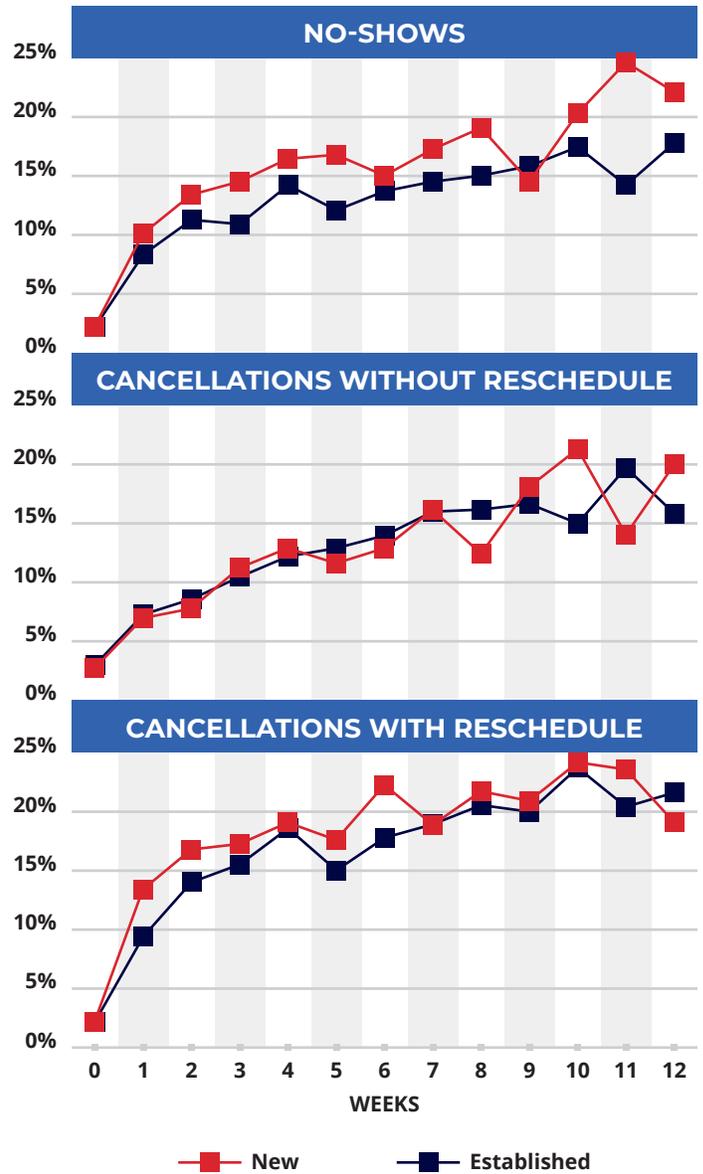
First and foremost, delayed care is inferior care. Even seemingly routine or nonurgent symptoms can signal something more serious that could be exacerbated without timely care. As such, there needs to be a way to address patients' queries effectively and promptly.

Additionally, consumer expectations have evolved significantly in all industries. From buying a plane ticket to making a restaurant reservation, the consumer experience has been highly optimized, and customers in turn have become accustomed to information and services being available at their fingertips.

They bring the same expectations about speed and convenience to healthcare. Numerous studies^{1,2,3} have shown that patients are significantly less likely to show up for appointments that are scheduled further out. Many health systems use a benchmark of 14 days from the scheduled date to the date of service, as this is when no-show rates drop precipitously, as seen in figure 1.⁴

As evidenced by the figure, there is a positive correlation between the increase in no-shows and cancellations and the increase in appointment wait time, ultimately affecting patient outcomes, provider productivity, and organizations' financial performance.⁵

FIG 1 | APPOINTMENT-KEEPING BEHAVIOR BY PATIENT TYPE



Customers have become accustomed to information and services being available at their fingertips.

That means hospitals and physicians’ offices—historically slow to adopt innovative patient-facing technology—must consider the consumer-first approach that other industries have embraced. And because scheduling an appointment with a provider is typically where the consumer experience begins, it is a critical starting point. Just as some consumers may prefer to buy their groceries at Whole Foods instead of Kroger based on their perceptions and experience, they will choose a healthcare organization based on how well their expectations are met. In other words, today’s patients are empowered to “shop around,” which they’ll do if they have trouble getting in or encounter a long wait. Health systems that fail to acknowledge this reality will lose business.

Our Methodology

ECG Management Consultants sought to understand the challenges a typical patient might face when establishing care with a new physician—specifically, to find out how long the wait is for the third next available appointment (TNAA), a commonly used access benchmark. We included 11 common medical specialties (see table 1) in 23 metropolitan statistical areas (MSAs) across the US (see figure 2) to better understand the experience a commercially insured consumer might have in securing a new-patient appointment. We selected general, nonemergent conditions that typically do not require a physician referral and utilized a “secret shopper” approach, posing as a new patient trying to book an appointment with selected area practices.

TABLE 1 | SCENARIOS BY SPECIALTY

SPECIALTY	CLINICAL SCENARIO
Cardiology	General cardiac workup
Dermatology	Full-body skin check
Family Medicine	Establish care
Gastroenterology	Stomach ulcer
General Surgery	Femoral hernia irritation
Neurology	Headache
Obstetrics/Gynecology	Well-woman visit
Orthopedic Surgery	Hip pain
Ophthalmology	Routine diabetic patient eye care
Pediatrics	Establish care prior to school year
Rheumatology	Establish care for rheumatoid arthritis and biologic prescription management



WHAT IS TNAA?

TNAA represents the number of calendar days to the third next nonurgent appointment available to new patients. For practices that indicated their physicians were accepting new patients, callers were directed to ask how soon they could schedule an appointment to document TNAA. TNAA is a commonly tracked metric used to gauge true patient access, as the number of days to the first or second available appointment may be artificially short in the event of a late cancellation or other event. In the callers’ scripts, they prompted schedulers to offer a handful of appointments to document the third next available.

- 1** First, we identified potential physicians in each MSA through basic internet searches, as a typical patient would. Our goal was to identify at least 10 physicians in unique practice groups per specialty.
- 2** We then called the practice, sometimes navigating several menu options and usually waiting on hold to reach someone who could schedule appointments.
- 3** Once we reached a scheduler, which often took several minutes, we presented as a potential new patient looking to schedule an appointment for the defined specialty scenarios. We told schedulers we had commercial health insurance to remove access barriers that are sometimes present for patients with other insurance types (e.g., Medicaid, Medicare, self-insured).
- 4** When potential dates were offered, we declined the first and second date and recorded the TNAA date.

FIG 2 | MSAs

It is important to note that we did not actually schedule any appointments; as our research will show, those are often scarce resources.

What We Learned: Access Is Not as Easy (or Fast) as It Could Be

GETTING THROUGH TO A HUMAN IS HALF THE BATTLE

To achieve the desired sample size in each specialty, our research led us to telephone encounters with 3,712 physician practices. But we were only able to secure responses from 3,078—meaning we hit dead ends with almost 1 in 5 physician practices.

634

practices could not provide appointment availability information for a variety of reasons, all roadblocks consumers might commonly face when attempting to secure care.

45%

directed callers to leave a message but did not return the call.

31%

placed callers on hold for over five minutes.

11%

did not answer the call, did not offer the ability to leave a message, or were no longer open.

We were able to reach the remaining 13% of practices, but they were unable to provide availability information without first registering us or were too narrowly subspecialized to accommodate our indicated condition. For example, in neurology we frequently encountered physicians who only saw specific types of patients or a select range of diagnoses. Those limitations were not readily apparent to us when selecting physicians.

Some schedulers were able to recommend a different physician in the practice with availability, but many schedulers either did not have the practice knowledge necessary to make such a recommendation or did not have another physician to recommend.

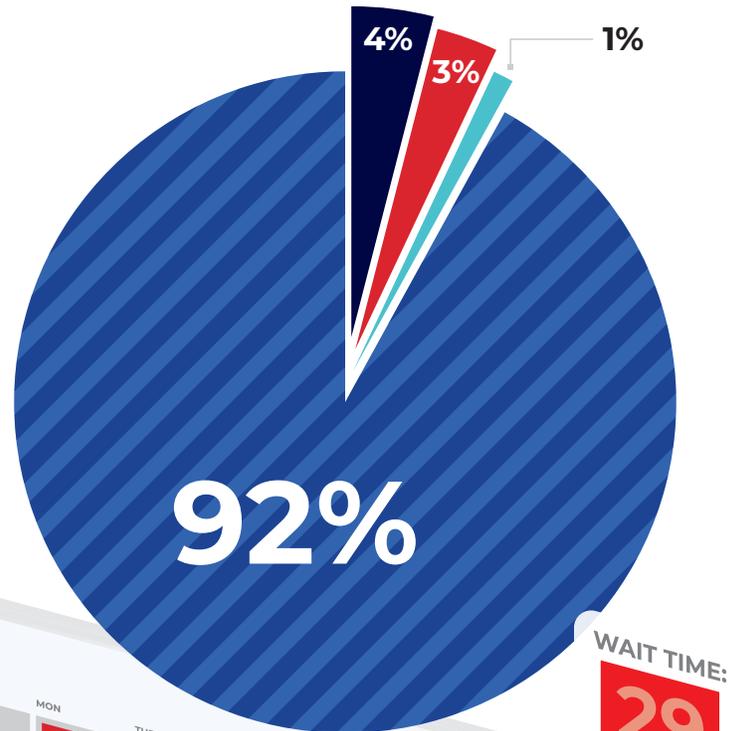
Despite our limited sample size, it is clear our struggles to get through to practices were not isolated incidents. We can estimate that millions of patients experience the same dead ends we did, given that US physicians conduct more than one billion office visits annually.⁶ And that's the opposite of what today's savvy consumers expect.

AND THEN THE WAIT BEGINS

Getting on the schedule is a battle of its own. Some waiting period is to be expected, as several steps may need to occur between the scheduling of an appointment and the appointment itself (e.g., registration paperwork, prior records requests, insurance verification, diagnostic exams). But these steps do not warrant waiting several weeks or even months.

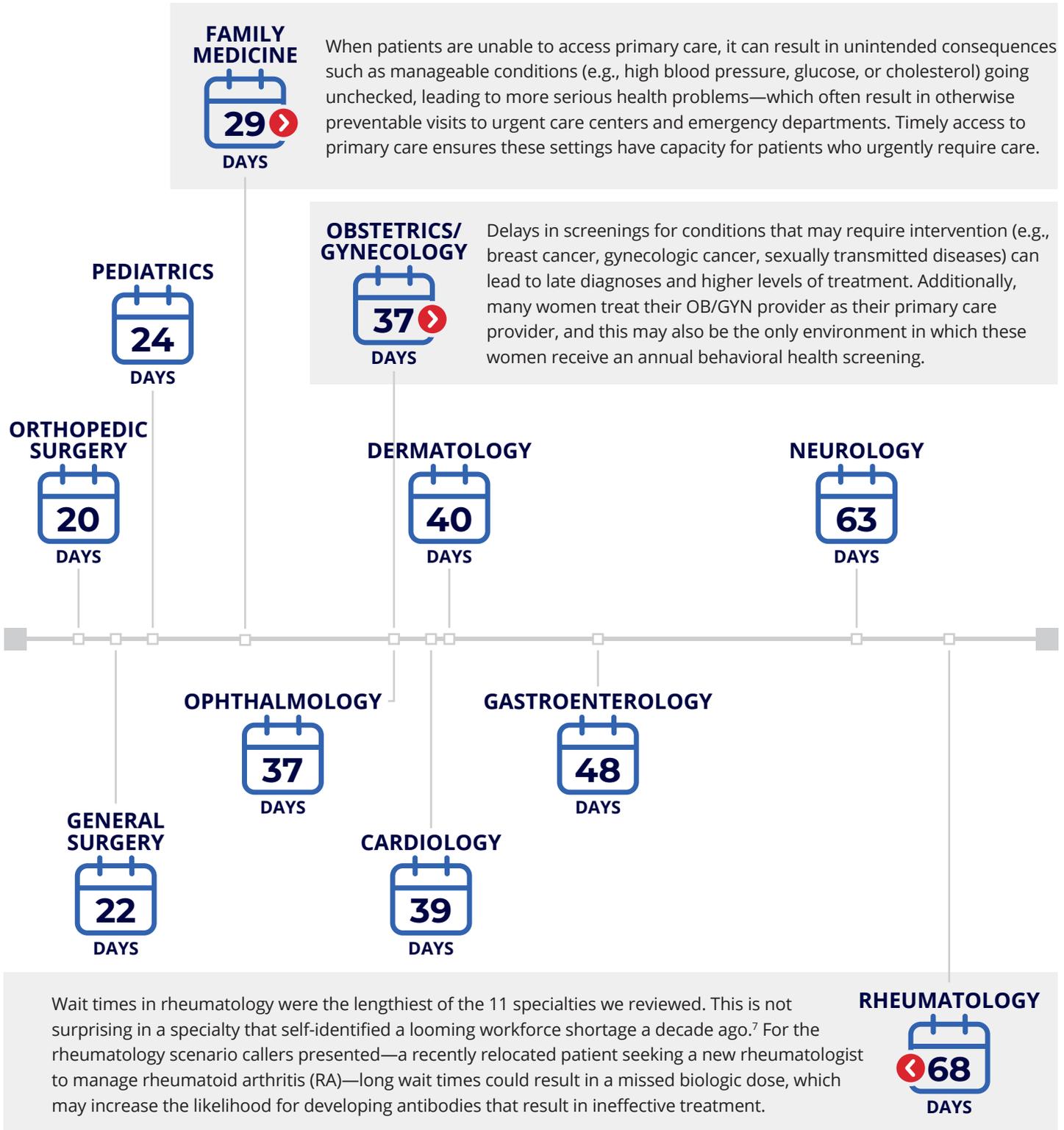
Of the total practices that responded (3,078), 8% (232) were unable to share wait time information due to registration and referral requirements, or they indicated they were not accepting new patients. The remaining 92% (2,846) provided estimated wait times for the TNAA for new patients.

- Wait times provided
- Referral required to schedule
- Practice closed to new patients
- Registration required to schedule



KEY FINDINGS AND TAKEAWAYS

SPECIALTY FINDINGS The average wait time for all specialties and metro areas was 38 days. Individual specialty wait times are summarized below. See appendix A for detailed wait times for each MSA.



METROPOLITAN MARKET FINDINGS

Across all specialties and metropolitan markets, the average TNAA was 38 days. Boston had the longest individual specialty wait times in 6 of the 11 researched specialties, as well as the highest overall average wait time across all specialties (70 days). Boston has one of the highest physician densities in the country at 577 per 100,000 population (compared to 326 per 100,000 population nationally),⁸ but many are focused solely on research and teaching due to the large academic medical center presence. More doctors does not necessarily mean more, or better, access.

Cincinnati had the second-highest wait time across all specialties (48 days). It should also be noted that Cincinnati had the fewest number of

complete practice responses. This may be due to a variety of factors, including increased health system consolidation in the metro area. This suggests Cincinnati's high wait times may stem from, in part, to a shortage of access points for patients. Houston had the lowest overall wait times on average (27 days).

Las Vegas had the lowest percentage of completed calls to researched practices. It is our experience working in this area that there is a higher rate of physician turnover compared to other regions, so online searches for providers reflected a higher degree of physicians who no longer practice in the market.

See appendix A for detailed results for each of the 23 MSAs.

FIG 3 | AVERAGE TNAA FOR ALL RESEARCHED SPECIALTIES



DISCUSSION

Population density and ratio of physicians to population do not necessarily have an impact on appointment access, and some states have significantly higher ratios of physicians per 100,000 residents than others.⁹ It should also be noted that if significantly populated MSAs have access challenges, smaller cities and rural areas may be experiencing even more troubling access trends.

Because there are so many nuances when it comes to physician availability and practice operations, it is difficult to define a benchmark for the ideal number of days patients should expect to wait for a new-patient appointment. Our research is not, and should not be interpreted as, a benchmark of any kind; rather, it is a small snapshot of what patients across the country are experiencing.

In the absence of accurate benchmarks, many organizations (ECG included) have used general metrics, such as two weeks, as a barometer for determining whether specialties have reasonable or lengthy wait times. Of the 253 metropolitan market and specialty combinations included in this research, just 16 (6%) had an average wait time less than or equal to 14 days. Average wait times for each metropolitan market and specialty are in appendix B.

These measurements are but one metric, albeit an important one, by which a healthcare organization might consider the degree of consumer friendliness or robustness of its physician network. And it is important to note that not all specialties—or all health conditions—warrant the same wait time to access physicians.

One factor our study does not account for is that in many markets and specialties, commercially insured patients typically have the lowest wait times and fewest barriers to care. Patients with Medicare/Medicaid or who are uninsured will often face more challenges locating a physician who will accept them into their practice, and those patients will often wait longer for care. In our experience, it is not unusual for practices to have one wait time for commercially insured patients and a second, much lengthier wait time for Medicare/Medicaid patients. As many health systems focus their efforts on health equity, defined as the optimal scenario where every patient has the opportunity to reach their fullest health potential despite differences such as socioeconomic status, this dynamic represents one of the more common barriers faced by patients with differing circumstances.

We acknowledge this research is not perfect; a secret-shopper approach comes with its limitations (see appendix B for additional detail). We particularly want to emphasize that the specialty scenarios we conveyed were for nonurgent appointments; practices commonly have policies in place to fast-track patients with time-sensitive symptoms or a referral for a specialist evaluation, and many also have same-day appointment blocks built into physicians' scheduling templates for this express purpose. For our research, we intentionally developed specialty scenarios that were nonurgent to gauge availability for the typical patient looking for a new physician.

How Can We Prepare for the Future?

Now that we have an idea of what appointment access looks like across the country, the next step is to understand the implications for patients and organizations moving forward, particularly because some market factors will continue to put strain on the system (e.g., higher utilization of healthcare services, decreasing supply of providers).

ADOPT AUTOMATION AND SELF-SERVICE TOOLS

Maintaining a virtual “24-hour, one-stop shop” for consumers is not only a patient satisfier but also helps providers and staff stay organized and informed about patient needs. When the appropriate tools are in a single, easily navigable platform, consumers will find it intuitive to access more of their care needs in a way that is convenient for all. This may include:

- Patient portal to review past medical records and follow-up items, referrals, and lab results, with care team messaging capabilities..
- Online scheduling and registration.
- Telehealth visits.
- Care coordination and navigation.
- Preventive health maintenance.



WHAT THIS MEANS FOR CONSUMERS

Become familiar with virtual tools available through local healthcare organizations and when appropriate, use them. Many organizations have invested in self-service software to make accessing care easier but do not always do a great job marketing them to consumers.



WHAT THIS MEANS FOR ORGANIZATIONS

Make scheduling an appointment as easy as buying groceries. Strategically invest in consumer self-service tools as well as automation. Make sure the functionality is easy to use and integrates with key organizational technology (e.g., EHR). Self-service tools can also lead patients to avoid long wait times by either solving their care needs virtually (eliminating the need for an in-person appointment) or, as appropriate, finding earlier availability, either at your organization or another one.

ENSURE PROVIDERS ARE UTILIZED APPROPRIATELY AND AT THE TOP OF THEIR LICENSE

Given the growing physician shortage, the use of advanced practice providers (APPs) as well as effective support from nursing staff will become not only more prevalent but necessary.



WHAT THIS MEANS FOR CONSUMERS

Depending on the need, be open-minded when seeking care providers. Nurse practitioners and physician assistants, who can often appropriately diagnose and treat a patient's needs, may have more or earlier availability, reserving scarcer physician time to care for patients with more complex conditions.



WHAT THIS MEANS FOR ORGANIZATIONS

Optimal use of APPs and nurses results in well-managed and well-maintained patient panels and a positive patient, provider, and staff experience, in addition to being a cost-effective method for organizations to meet patient needs. APPs may be eligible (subject to state regulations) to have their own patient panels in some primary and specialty care settings; they otherwise can support physician panels (e.g., APP intake clinic or APP follow-up clinic). Furthermore, nursing staff can be trained to triage patients based on approved protocols to ensure the patient sees the right provider at the right time.

ENHANCE OPERATIONAL EFFICIENCY

As consultants, we often find operational improvement opportunities at the organizations we work with, sometimes due to ineffective initial design and sometimes due to years of changing workflows that may have been implemented to address uncommon scenarios. From our experience, organizations that develop and adhere to shared goals, standardization, and clearly defined protocols are most effective in overcoming the various barriers to access that exist in the market.



WHAT THIS MEANS FOR CONSUMERS

Save a step wherever possible. Schedule future appointments at the time of checkout, follow up on preventive care maintenance after the first communication attempt, and follow prompts (whether on the phone or web) to get to the right place at the right time.



WHAT THIS MEANS FOR ORGANIZATIONS

Make things simple. Schedule future visits at the point of care, automate proactive preventive health maintenance reminders, and simplify consumer communication where possible. This means clear and concise language in a phone tree or a web decision tree and easy-to-understand options.

IMPROVE HEALTH EQUITY BY ADDRESSING ACCESS

As more organizations strive to tackle inequities in healthcare, access to services is a key component to consider. Lack of timely access for new-patient appointments or other barriers to access can often be signs that inequity is building—or already exists.

WHAT THIS MEANS FOR CONSUMERS

Recognize that in some scenarios, access challenges may be addressed in alternative ways. Rural patients, for example, may receive scarce specialty care through telemedicine or physicians rotating through a satellite or time-sharing practice rather than from a provider embedded in the community full time.

WHAT THIS MEANS FOR ORGANIZATIONS

Routinely engage in health equity impact assessment, identifying areas where specific patient populations (a geography, a demographic group, or a marginalized identity) face gaps in access to care, particularly outside the immediate span of medical group control. Regularly identifying access trouble spots, and working with community partners to mitigate them, can be a straightforward way to tackle health equity issues before they become quality-of-care or outcome gaps.

Lack of timely access for new-patient appointments or other barriers to access can often be signs that inequity is building—or already exists.



Potential Solutions for Organizations

DEVELOP A COMPREHENSIVE ACCESS STRATEGY

Components of a well-rounded access strategy are noted in figure 4. While all components are important, organizations should prioritize template optimization, a capacity analysis and plan (including the effective usage of APPs), and the introduction or enhancement of a virtual intake clinic. Together, these strategies support the provision of appropriate appointment availability for each patient request.

FIG 4 | COMPONENTS OF A COMPREHENSIVE ACCESS STRATEGY



CONDUCT A PROVIDER NEEDS ANALYSIS

Analyze provider need to identify where gaps exist and how they can be filled. This may include ensuring that the needs of the community are met with well-distributed services, and understanding the referral relationships within the area to prevent patient leakage and decreased market share. An assessment of the market supply of physicians, including how they are geographically situated and aligned with health networks, can be a valuable tool for identifying access gaps that can be addressed through physician recruitment, redistribution of ambulatory entry points, and areas where health equity can be improved.

Adopting a Consumer-Centric Culture

As the old saying goes, you only get one chance to make a first impression. And if a consumer's first impression of your organization involves outdated technology, long waits, or voicemails that don't get returned, they'll do the same thing they do when they're dissatisfied with any other service—bring their business elsewhere (and probably air their complaints online).

It's true that getting medical advice isn't the same as having groceries delivered or ordering an Uber, and the supply-demand problem in healthcare may inhibit even the most determined consumer's options. But that doesn't absolve any organization from seeking ways to optimize their operations. Because for patients, the first step of the care journey shouldn't be the hardest.



For patients, the first step of the care journey shouldn't be the hardest.

APPENDIX A: DETAILED FINDINGS

AVERAGE NEW-PATIENT APPOINTMENT WAIT TIMES BY METRO AREA AND SPECIALTY

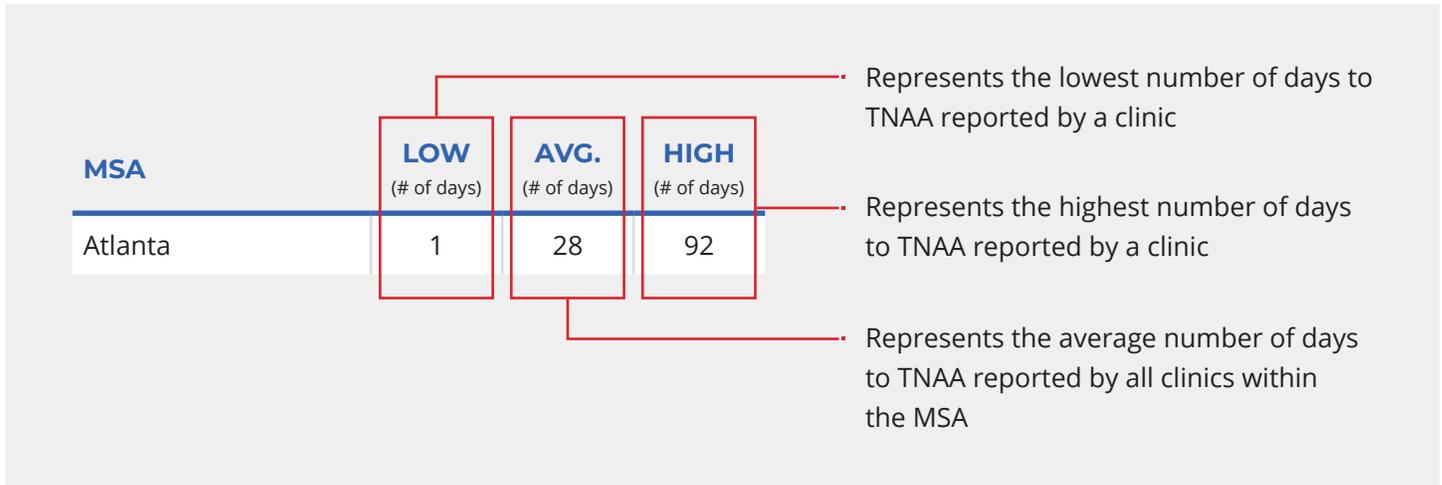
MSA	FAMILY MEDICINE	PEDIATRICS	CARDIOLOGY	DERMATOLOGY	GASTROENTEROLOGY	GENERAL SURGERY	NEUROLOGY	OBSTETRICS/ GYNECOLOGY	OPHTHALMOLOGY	ORTHOPEDIC SURGERY	RHEUMATOLOGY	AVERAGE
Atlanta	28	21	39	57	33	16	88	64	49	20	64	45
Boston	43	42	74	94	186	44	64	85	56	34	113	70
Charlotte	41	6	58	58	79	21	21	48	56	15	84	46
Chicago	27	24	47	37	59	27	74	25	35	21	73	39
Cincinnati	24	37	56	110	16	14	101	39	57	11	77	47
Dallas/Fort Worth	30	33	33	16	52	10	40	33	35	17	55	32
Denver	27	25	33	75	32	18	90	30	33	14	54	39
Detroit	45	37	37	39	57	32	42	32	42	18	44	38
Houston	15	23	18	12	31	13	54	31	57	14	39	27
Las Vegas	20	12	33	30	42	19	46	40	40	14	124	38
Los Angeles	31	28	32	25	25	39	87	39	22	21	69	37
Miami	16	18	34	17	31	19	47	19	51	13	43	28
Minneapolis/St. Paul	16	27	35	36	41	25	107	31	23	22	152	45
Nashville	14	12	49	34	66	14	53	38	22	19	67	35
New York	18	27	28	26	19	14	71	26	37	19	42	28
Philadelphia	27	14	39	18	114	40	24	37	21	28	75	36
Phoenix	32	9	16	27	42	15	82	46	30	18	33	31
San Diego	30	28	40	31	52	28	94	44	48	23	42	41
San Francisco	20	27	63	41	33	15	91	27	20	23	64	38
Seattle	58	31	37	72	39	35	33	51	29	26	55	44
St. Louis	33	33	25	43	50	15	96	31	32	30	70	40
Tampa	16	13	39	36	42	31	42	41	32	19	68	33
Washington, DC	47	21	33	21	71	14	38	29	34	23	62	36
Average	29	24	39	40	48	22	63	37	37	20	67	38

APPENDIX A

RESPONSE RATE BY MSA

MSA	TOTAL PRACTICES CONTACTED	COMPLETED RESPONSES (# AND %)	
Atlanta	145	122	84%
Boston	154	135	88%
Charlotte	155	122	79%
Chicago	163	133	82%
Cincinnati	154	118	77%
Dallas/Fort Worth	165	145	88%
Denver	168	127	76%
Detroit	163	145	89%
Houston	167	122	73%
Las Vegas	168	122	73%
Los Angeles	164	141	86%
Miami	165	144	87%
Minneapolis/St. Paul	164	142	87%
Nashville	159	129	81%
New York	165	145	88%
Philadelphia	154	136	88%
Phoenix	165	135	82%
San Diego	158	134	85%
San Francisco	162	138	85%
Seattle	167	129	77%
St. Louis	157	140	89%
Tampa	165	135	82%
Washington, DC	165	139	84%
Total	3,712	3,078	83%

WAIT TIME RANGES FOR EACH MSA BY SPECIALTY



FAMILY MEDICINE

MSA	LOW (# of days)	AVG. (# of days)	HIGH (# of days)
Atlanta	1	28	92
Boston	3	43	150
Charlotte	11	41	95
Chicago	5	27	90
Cincinnati	7	24	60
Dallas/Fort Worth	1	30	60
Denver	10	27	60
Detroit	2	45	150
Houston	7	15	30
Las Vegas	7	20	35
Los Angeles	3	31	180
Miami	3	16	45

MSA	LOW (# of days)	AVG. (# of days)	HIGH (# of days)
Minneapolis/St. Paul	7	16	30
Nashville	3	14	40
New York	3	18	30
Philadelphia	14	27	75
Phoenix	5	32	90
San Diego	7	30	90
San Francisco	5	20	60
Seattle	5	58	180
St. Louis	2	33	150
Tampa	5	16	60
Washington, DC	2	47	150
Aggregate	1	29	180

APPENDIX A

PEDIATRICS

MSA	LOW (# of days)	AVG. (# of days)	HIGH (# of days)
Atlanta	7	21	60
Boston	10	42	150
Charlotte	3	6	14
Chicago	14	24	45
Cincinnati	7	37	120
Dallas/Fort Worth	5	33	90
Denver	5	25	60
Detroit	2	37	120
Houston	5	23	180
Las Vegas	4	12	45
Los Angeles	7	28	120
Miami	7	18	60

MSA	LOW (# of days)	AVG. (# of days)	HIGH (# of days)
Minneapolis/St. Paul	10	27	45
Nashville	3	12	30
New York	10	27	60
Philadelphia	3	14	60
Phoenix	3	9	45
San Diego	7	28	45
San Francisco	5	27	45
Seattle	14	31	60
St. Louis	7	33	90
Tampa	3	13	41
Washington, DC	3	21	60
Aggregate	2	24	180

CARDIOLOGY

MSA	LOW (# of days)	AVG. (# of days)	HIGH (# of days)
Atlanta	10	39	97
Boston	21	74	240
Charlotte	11	58	112
Chicago	14	47	90
Cincinnati	3	56	140
Dallas/Fort Worth	6	33	78
Denver	7	33	90
Detroit	7	37	90
Houston	5	18	45
Las Vegas	7	33	90
Los Angeles	7	32	90
Miami	14	34	90

MSA	LOW (# of days)	AVG. (# of days)	HIGH (# of days)
Minneapolis/St. Paul	14	35	60
Nashville	7	49	110
New York	14	28	60
Philadelphia	14	39	60
Phoenix	5	16	50
San Diego	14	40	90
San Francisco	10	63	150
Seattle	7	37	90
St. Louis	7	25	60
Tampa	5	39	160
Washington, DC	7	33	120
Aggregate	3	39	240

DERMATOLOGY

MSA	LOW (# of days)	AVG. (# of days)	HIGH (# of days)
Atlanta	5	57	187
Boston	10	94	210
Charlotte	7	58	170
Chicago	7	37	120
Cincinnati	14	110	180
Dallas/Fort Worth	3	16	45
Denver	7	75	380
Detroit	7	39	90
Houston	3	12	60
Las Vegas	7	30	60
Los Angeles	7	25	90
Miami	3	17	50

MSA	LOW (# of days)	AVG. (# of days)	HIGH (# of days)
Minneapolis/St. Paul	14	36	75
Nashville	2	34	90
New York	3	26	70
Philadelphia	7	18	32
Phoenix	7	27	80
San Diego	7	31	60
San Francisco	7	41	150
Seattle	21	72	180
St. Louis	2	43	120
Tampa	3	36	120
Washington, DC	3	21	60
Aggregate	2	40	380

GASTROENTEROLOGY

MSA	LOW (# of days)	AVG. (# of days)	HIGH (# of days)
Atlanta	21	33	49
Boston	90	186	270
Charlotte	10	79	111
Chicago	14	59	145
Cincinnati	5	16	30
Dallas/Fort Worth	14	52	120
Denver	5	32	60
Detroit	7	57	180
Houston	7	31	110
Las Vegas	7	42	150
Los Angeles	10	25	45
Miami	10	31	90

MSA	LOW (# of days)	AVG. (# of days)	HIGH (# of days)
Minneapolis/St. Paul	10	41	60
Nashville	30	66	120
New York	5	19	45
Philadelphia	35	114	400
Phoenix	7	42	180
San Diego	14	52	90
San Francisco	14	33	60
Seattle	21	39	60
St. Louis	14	50	210
Tampa	7	42	100
Washington, DC	7	71	120
Aggregate	5	48	400

APPENDIX A

GENERAL SURGERY

MSA	LOW (# of days)	AVG. (# of days)	HIGH (# of days)
Atlanta	7	16	27
Boston	14	44	60
Charlotte	10	21	45
Chicago	3	27	100
Cincinnati	3	14	70
Dallas/Fort Worth	7	10	14
Denver	7	18	60
Detroit	7	32	60
Houston	7	13	45
Las Vegas	7	19	70
Los Angeles	7	39	150
Miami	14	19	30

MSA	LOW (# of days)	AVG. (# of days)	HIGH (# of days)
Minneapolis/St. Paul	14	25	45
Nashville	7	14	26
New York	4	14	21
Philadelphia	21	40	62
Phoenix	3	15	30
San Diego	14	28	30
San Francisco	3	15	30
Seattle	13	35	75
St. Louis	3	15	75
Tampa	3	31	100
Washington, DC	3	14	30
Aggregate	3	22	150

NEUROLOGY

MSA	LOW (# of days)	AVG. (# of days)	HIGH (# of days)
Atlanta	21	88	182
Boston	30	64	180
Charlotte	7	21	30
Chicago	14	74	180
Cincinnati	40	101	233
Dallas/Fort Worth	14	40	60
Denver	21	90	180
Detroit	14	42	60
Houston	7	54	90
Las Vegas	3	46	225
Los Angeles	2	87	180
Miami	14	47	120

MSA	LOW (# of days)	AVG. (# of days)	HIGH (# of days)
Minneapolis/St. Paul	60	107	240
Nashville	10	53	158
New York	5	71	157
Philadelphia	7	24	60
Phoenix	7	82	290
San Diego	14	94	150
San Francisco	7	91	270
Seattle	14	33	90
St. Louis	30	96	240
Tampa	14	42	120
Washington, DC	14	38	90
Aggregate	2	63	290

OBSTETRICS/GYNECOLOGY

MSA	LOW (# of days)	AVG. (# of days)	HIGH (# of days)
Atlanta	25	64	145
Boston	7	85	365
Charlotte	7	48	400
Chicago	7	25	90
Cincinnati	14	39	80
Dallas/Fort Worth	7	33	90
Denver	3	30	75
Detroit	7	32	90
Houston	7	31	90
Las Vegas	3	40	90
Los Angeles	5	39	150
Miami	3	19	50

MSA	LOW (# of days)	AVG. (# of days)	HIGH (# of days)
Minneapolis/St. Paul	10	31	60
Nashville	14	38	120
New York	7	26	120
Philadelphia	7	37	90
Phoenix	3	46	180
San Diego	7	44	135
San Francisco	7	27	60
Seattle	14	51	90
St. Louis	14	31	90
Tampa	7	41	100
Washington, DC	7	29	60
Aggregate	3	37	400

OPHTHALMOLOGY

MSA	LOW (# of days)	AVG. (# of days)	HIGH (# of days)
Atlanta	8	49	100
Boston	7	56	150
Charlotte	10	56	117
Chicago	7	35	110
Cincinnati	14	57	75
Dallas/Fort Worth	7	35	90
Denver	7	33	90
Detroit	7	42	150
Houston	21	57	150
Las Vegas	3	40	100
Los Angeles	7	22	90
Miami	3	51	270

MSA	LOW (# of days)	AVG. (# of days)	HIGH (# of days)
Minneapolis/St. Paul	7	23	45
Nashville	7	22	55
New York	10	37	120
Philadelphia	7	21	60
Phoenix	7	30	120
San Diego	7	48	240
San Francisco	3	20	60
Seattle	7	29	120
St. Louis	14	32	120
Tampa	3	32	70
Washington, DC	14	34	90
Aggregate	3	37	270

APPENDIX A

ORTHOPEDIC SURGERY

MSA	LOW (# of days)	AVG. (# of days)	HIGH (# of days)
Atlanta	10	21	45
Boston	7	34	90
Charlotte	5	15	30
Chicago	7	21	30
Cincinnati	3	11	50
Dallas/Fort Worth	6	17	26
Denver	5	14	21
Detroit	2	18	30
Houston	7	14	21
Las Vegas	7	14	30
Los Angeles	14	21	30
Miami	3	13	45

MSA	LOW (# of days)	AVG. (# of days)	HIGH (# of days)
Minneapolis/St. Paul	14	22	34
Nashville	5	19	71
New York	5	19	30
Philadelphia	7	28	60
Phoenix	3	18	60
San Diego	14	23	30
San Francisco	14	23	30
Seattle	13	26	51
St. Louis	7	30	60
Tampa	7	19	50
Washington, DC	2	23	60
Aggregate	2	20	90

RHEUMATOLOGY

MSA	LOW (# of days)	AVG. (# of days)	HIGH (# of days)
Atlanta	10	64	142
Boston	30	113	180
Charlotte	30	84	120
Chicago	30	73	120
Cincinnati	18	77	149
Dallas/Fort Worth	14	55	170
Denver	21	54	136
Detroit	7	44	90
Houston	10	39	70
Las Vegas	7	124	346
Los Angeles	30	69	120
Miami	7	43	90

MSA	LOW (# of days)	AVG. (# of days)	HIGH (# of days)
Minneapolis/St. Paul	21	152	270
Nashville	28	67	102
New York	7	42	120
Philadelphia	7	75	180
Phoenix	3	33	90
San Diego	2	42	120
San Francisco	7	64	150
Seattle	14	55	180
St. Louis	14	70	120
Tampa	7	68	250
Washington, DC	14	62	180
Aggregate	2	67	346

APPENDIX B: METHODOLOGY DETAIL

During the summer of 2023, ECG Management Consultants researched and contacted physician practices in 11 specialties across 23 major metropolitan markets. We researched and made calls to 3,712 unique practices; the final data set consisted of 3,078 completed practice responses. Of those, we were able to record TNAA for 2,846 practices.

SAMPLING METHODOLOGY

We contacted physicians in practices who ranged from solo practitioners to employees of integrated health system medical groups. Practices were identified randomly via search engine. As best we could, we aimed to compile an initial database of 10 to 15 unique practices per specialty per MSA with a goal of collecting at least 10 complete responses.

The sampling methodology we employed to compile the practice database emulates the way most patients research and contact medical practices:

- A 2022 patient access survey found that over 70% of consumers went to the internet to find their most recent healthcare provider, service, or location.¹⁰
- A 2020 survey reported 92% sometimes or always conduct their own specialist research, even when they have a referral from a healthcare professional.¹¹
- 89% of consumers say appointment availability is extremely or very important when selecting care.¹²
- Approximately 60% of baby boomers prefer to schedule appointments via telephone, and healthcare demand from the country's aging population is expected to reach its peak by 2030. Individuals 65 and older now account for 34% of healthcare demand and by 2034 will account for 42% of the demand.^{3,13}

SPECIALTIES

We selected 11 specialties based on perceived success scheduling a new-patient appointment without a referral. To ensure consistent data collection methods,

we followed a script posing as patients who had recently moved to the area looking to establish care with a new physician. Depending on the specialty, we tailored the script to the clinical scenarios outlined in table 1. Again, these scenarios were chosen based on the anticipated likelihood of a new-patient self-scheduling without a physician referral.

TABLE 1 | SCENARIOS BY SPECIALTY

SPECIALTY	CLINICAL SCENARIO
Cardiology	General cardiac workup
Dermatology	Full-body skin check
Family Medicine	Establish care
Gastroenterology	Stomach ulcer
General Surgery	Femoral hernia irritation
Neurology	Headache
Obstetrics/Gynecology	Well-woman visit
Orthopedic Surgery	Hip pain
Ophthalmology	Routine diabetic patient eye care
Pediatrics	Establish care prior to school year
Rheumatology	Establish care for rheumatoid arthritis and biologic prescription management

METROPOLITAN MARKETS

The geographic definitions for each of the selected metropolitan markets are based on their MSA definition. MSAs are urban areas with a population of at least 50,000 that represent a "core area containing a substantial population nucleus, together with adjacent communities having a high degree of economic and social integration with that core." There are 387 MSAs in the United States; the selected MSAs displayed in figure 2 fall in the top 10% of most populated MSAs.¹⁴

APPENDIX B

TABLE 2 | METROPOLITAN MARKET MSAS

US RANK	METROPOLITAN AREA	MSA NAME
1	New York	New York-Newark-New-Jersey, NY-NJ
2	Los Angeles	Los Angeles-Long Beach-Anaheim, CA
3	Chicago	Chicago-Naperville-Elgin, IL-IN
4	Dallas/Fort Worth	Dallas-Fort Worth-Arlington, TX
5	Houston	Houston-Pasadena-The Woodlands, TX
6	Washington, DC	Washington-Arlington-Alexandria, DC-VA-MD-WV
7	Philadelphia	Philadelphia-Camden-Wilmington, PA-NJ-DE-MD
8	Atlanta	Atlanta-Sandy Springs-Roswell, GA
9	Miami	Miami-Fort Lauderdale-West Palm Beach, FL
10	Phoenix	Phoenix-Mesa-Chandler, AZ
11	Boston	Boston-Cambridge-Newton, MA-NH
13	San Francisco	San Francisco-Oakland-Berkley, CA
14	Detroit	Detroit-Warren-Dearborn, MI
15	Seattle	Seattle-Tacoma-Bellevue, WA
16	Minneapolis/St. Paul	Minneapolis-St. Paul-Bloomington, MI-WI
17	Tampa	Tampa-St. Petersburg-Clearwater, FL
18	San Diego	San Diego-Chula Vista-Carlsbad, CA
19	Denver	Denver-Aurora-Centennial, CO
21	St. Louis	St. Louis, MO-IL
23	Charlotte	Charlotte-Concord-Gastonia, NC-SC
29	Las Vegas	Las Vegas-Henderson, North Las Vegas, NV
30	Cincinnati	Cincinnati, OH-KY-IN
35	Nashville	Nashville-Davidson-Murfreesboro-Franklin, TN

LIMITATIONS

We acknowledge that the research methodology has some limitations that could not be easily eliminated through our design parameters.

SAMPLING

We sought to identify 10 to 15 unique physician practices per specialty in each metropolitan market. In some instances, we had hundreds of providers to choose from, meaning our data, while representative of more practices than the typical patient might research

and contact to successfully schedule an appointment, may not represent all consumer experiences. In more consolidated markets, we sometimes were challenged to identify 10 distinct practices in select specialties. Consumers in those markets may have fewer alternatives to turn to when access is limited.

The sampling methodology did not guarantee that each practice would be compatible with the specialty scenario, an experience consumers also face when

selecting a physician. When we identified practices with restrictions (e.g., an orthopedic surgeon who sees only spine surgery cases), we excluded it and sought to identify an alternative practice instead.

RESEARCH SCENARIOS

Some practices required a patient to be registered in their system before a visit could be confirmed. In those cases, we were unable to collect a wait time on those calls.

Some practices required new-patient referrals (not an uncommon scenario with some health plans or specialty types) and would not reveal wait time data without that referral secured.

We sought to collect data exclusively for physicians, so nonphysician options were excluded from our data. Practices that use APPs to either comanage patients in partnership with a physician or maintain their own patient panels may have shorter wait times for new patients.

The nonurgent patient scenarios we utilized may not meet the criteria for access pathways some practices may have in place that expedite certain patients and/or conditions. For example, cardiology practices commonly offer appointments within 48 hours for patients with a referral from aligned primary care practices or for patients exhibiting time-sensitive symptoms.

REFERENCES

1. Rosenbaum JI, Mieloszyk RJ, Hall CS, Hippe DS, Gunn ML, Bhargava P. Understanding Why Patients No-Show: Observations of 2.9 Million Outpatient Imaging Visits Over 16 Years. *J Am Coll Radiol*. 2018;15(7):944-950. doi:10.1016/j.jacr.2018.03.053. <https://pubmed.ncbi.nlm.nih.gov/29755001/>
2. Shaw T, Metras J, Ting ZAL, Courtney E, Li ST, Ngeow J. Impact of Appointment Waiting Time on Attendance Rates at a Clinical Cancer Genetics Service. *J Genet Couns*. 2018;27(6):1473-1481. doi:10.1007/s10897-018-0259-z. [Impact of Appointment Waiting Time on Attendance Rates at a Clinical Cancer Genetics Service - PubMed \(nih.gov\)](https://pubmed.ncbi.nlm.nih.gov/30811111/)
3. Rodríguez-García, Miguel et al. Managing Waiting Times to Predict No-Shows and Cancelations at a Children's Hospital. *Journal of Industrial Engineering and Management*, [S.l.], v. 9, n. 5, p. 1107-1118, dec. 2016. ISSN 2013-0953. [Managing waiting times to predict no-shows and cancelations at a children's hospital | Rodríguez-García | Journal of Industrial Engineering and Management \(jiem.org\)](https://www.jiem.org/)
4. Managing Waiting Times to Predict No-Shows and Cancelations at a Children's Hospital: Scientific Figure on ResearchGate. https://www.researchgate.net/figure/Plot-of-patient-no-show-cancelation-without-reschedule-and-cancelation-with-reschedule_fig1_312429304
5. Jain, Sachin H, Missed Appointments, Missed Opportunities: Tackling the Patient No-Show Problem. *Forbes*. Oct. 6, 2019, <https://www.forbes.com/sites/sachinjain/2019/10/06/missed-appointments-missed-opportunities-tackling-the-patient-no-show-problem/?sh=7a5136e2573b>
6. Santo L, Kang K. National Ambulatory Medical Care Survey: 2019 National Summary Tables. [National Ambulatory Medical Care Survey: 2019 National Summary \(cdc.gov\)](https://www.cdc.gov/nchs/data/ambulatory/2019-national-summary-tables).
7. Battafarano DF, Ditmyer M, Bolster MB, et al. 2015 American College of Rheumatology Workforce Study: Supply and Demand Projections of Adult Rheumatology Workforce, 2015-2030. *Arthritis Care Res (Hoboken)*. 2018;70(4):617-626. doi:10.1002/acr.23518 2015 American College of Rheumatology Workforce Study: Supply and Demand Projections of Adult Rheumatology Workforce, 2015-2030.
8. Clarivate Market Overviews published October 2023.
9. National Center for Health Statistics (US). Health, United States, 2019. Hyattsville (MD): National Center for Health Statistics (US); 2021. Data table for Figure 16, Number of physicians in patient care per 100,000 resident population, by state: United States, 2018.NIH National Library of Medicine, National Center for Biotechnology Information, <https://www.ncbi.nlm.nih.gov/books/NBK569310/table/ch2.tab16/>.
10. Kyruus 2022 Patient Access Journey Report.
11. Kyruus 2020 Patient Access Journey Report.
12. Kyruus 2023 Care Access Benchmark Report.
13. Janus, Shawn. Colliers Report: Demand for Healthcare Grows as Baby Boomers Age. *Colliers*. July 1, 2022.
14. United States Census Bureau, [About \(census.gov\)](https://www.census.gov/).



THE AUTHORS



JENNIFER MOODY

Partner

jmoody@ecgmc.com



STEVE MCMILLEN

Principal

smcmillen@ecgmc.com



NIKI PETROFF

Manager

napetroff@ecgmc.com



ANNA BERENBEYM

Manager

aaberenbeym@ecgmc.com

RESEARCHERS



ANN HERRLE

Analyst



SAVANNAH LAUX

Analyst



LATASHA LOVE

Senior Analyst



WANDA SADLER

Project Coordinator

For more insights from ECG, visit www.ecgmc.com/thought-leadership.



A Siemens Healthineers Company