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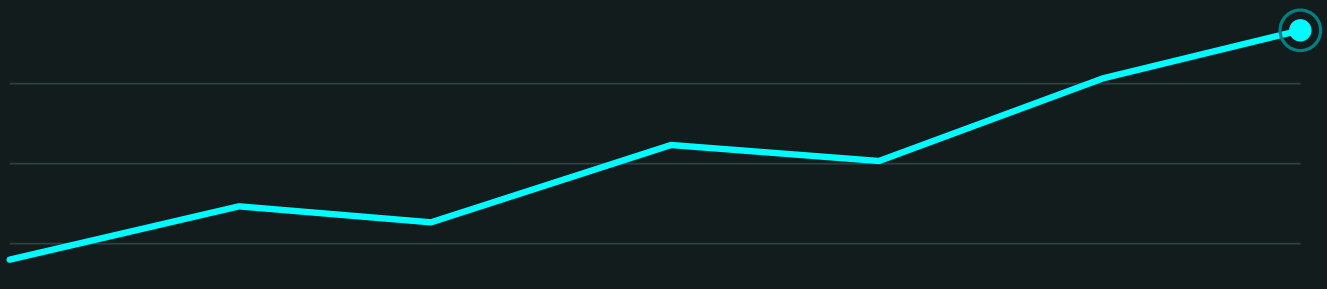
FIELD GUIDE NO. 02 · 2026 EDITION

The Clinic Occupancy Playbook

What it takes to keep provider schedules full across a multi-location medical group: the breakeven math, the patient demand benchmarks, and the marketing system that fills the slots you are already paying for. Written for independent OB/GYN, primary care, and specialty practices.

SCORING CLINICS BY HEADROOM · THE NO-SHOW P&L · THE NEW-CLINIC CREDENTIALING CALENDAR



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ABOUT THIS FIELD GUIDE

Written for the physicians who own the P&L

You run a medical group with more than one location. Some schedules are full weeks out and some have Tuesday afternoons that echo, and the difference between those two states decides whether the group makes money. This guide is about that difference. It is written for owners and administrators of independent multi-location practices: OB/GYN and women's health, primary care, and the specialty clinics that live on an appointment book.

We use the word occupancy because it is the honest name for what a clinic sells: provider time. A bookable slot is inventory that expires the moment the hour passes, and payroll, rent, malpractice, and the EHR bill all arrive whether the slot was filled, no-showed, or never booked.

One promise about the numbers

Every statistic here is drawn from a named third-party source: AMN Healthcare's wait-time survey, MGMA benchmarks, KFF polling, Experian Health and Kyruus patient-access research, the March of Dimes, and peer research on lead response and reviews, each with a numbered citation listed at the back. Where we model a scenario instead of citing one, we label it an illustrative model in plain sight. If a number cannot survive being asked about on a call, it does not belong in a document with our name on it.

What's inside

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CHAPTER 01

The schedule is the building

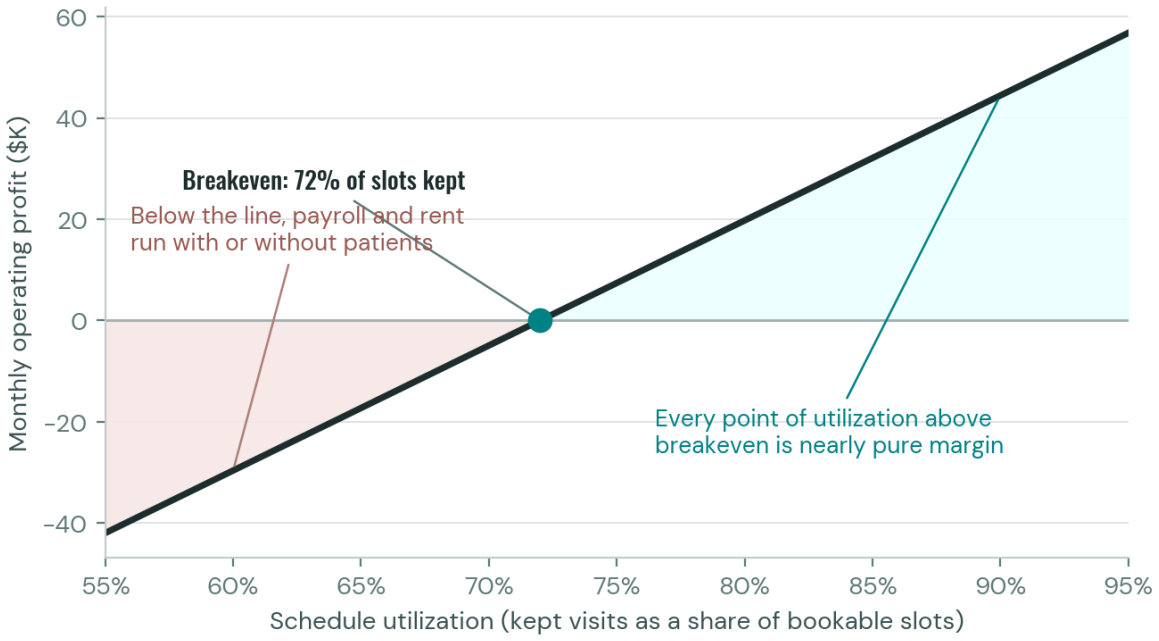
01

A medical practice has the financial personality of a hotel with a stethoscope: heavy fixed costs, thin variable costs. Provider compensation, clinical staff, rent, malpractice coverage, the EHR, billing, insurance overhead. Those bills are committed months in advance. What changes with one more kept visit is small: some supplies, some incremental admin. The cost of the visit was mostly paid before the patient walked in.

That structure creates a line. Below it, every month quietly burns cash. Above it, each additional kept visit contributes almost entirely to profit, because the fixed costs are already covered. Real estate calls the concept the breakeven occupancy ratio;[29] in a clinic the unit of occupancy is the bookable slot, and the metric is schedule utilization: kept visits as a share of the slots your providers offer. Operators feel the line before they can name it. It is why one location booked three weeks out feels calm while its sibling with gap-toothed Tuesdays feels like a slow leak.

The math, in one worked example

Take a three-provider clinic offering 60 visit slots a day, about 1,260 a month. Use $245 per completed visit, the typical initial-visit reimbursement providers report,[14] assume roughly 20% variable cost, and set fixed costs where breakeven lands at 72% utilization. This is an illustrative model, built to show the shape of the curve, not any specific practice. Here is what that P&L does as the schedule fills.



Monthly operating profit vs. schedule utilization for a modeled 3-provider clinic. Illustrative model: 1,260 slots, $245 per kept visit, ~20% variable cost, breakeven set at 72%.

Visit value anchored to provider-reported reimbursement figures. See sources 14, 29.

In this model, one point of utilization is about 12 to 13 kept visits a month, worth roughly $2,500 of contribution, or close to $30,000 a year. Ten points is the difference between a clinic that loses money and one that funds the next opening. That is why this guide treats the schedule as a marketing metric, not just an operations metric. Operations can protect the slots. Only demand can fill them.

UPRYT POV

Most groups manage the cost side of this curve obsessively: staffing ratios, supply contracts, billing yield. The demand side gets whoever answers the phone. We think that is backwards. Costs have a floor. Utilization has headroom, and the headroom is where the margin lives.

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CHAPTER 02

The multi-location clinic trap

02

Here is the pattern we see over and over in medical groups. One location is booked out and carries the P&L. The others coast or lose. Clinical quality is consistent everywhere, often with the same rotating providers. So why is the flagship full while the newest office has gaps in every column?

When care is consistent and outcomes are not, the variable left standing is demand. And demand, at the location level, is a marketing output: map rank, provider reviews, referrals, response speed, online booking. One reputation in the exam room, a separate battle on every map pin.

How the fragmentation happens

Nobody plans it. The website came from the EHR vendor's template program, the ads from a local shop, reviews from whatever the front desk remembers, and a booking marketplace fills gaps while quietly owning the patient relationship. Some groups even split each location onto its own separate domain, dividing their search authority exactly where it needs to compound. Growth multiplied the vendors, and the vendors never met.

The discipline gap is measurable. 94% of high-performing multi-location brands run a dedicated local marketing strategy, versus about 60% of average performers,[25] and location-specific pages convert up to 50% better than a generic homepage,[24] because a patient searching in one suburb wants the door in that suburb. 76% of near-me searchers visit a business within 24 hours.[23] The demand is there, address by address. What varies is who captures it.

94% vs 60%
high performers vs. average with a dedicated local strategy [25]

+50%
conversion lift, location pages vs. one generic homepage [24]

76%
of near-me searchers visit a business within 24 hours [23]

The tell

A fragmented group has a signature: every vendor's report says they are winning, and the schedule says otherwise. If the reporting you receive cannot name kept visits, new patients, or utilization by location and by provider, it is measuring the vendor's activity, not your practice.

UPRYT POV

One firm in the stack usually figured out long ago that a fragmented client is a client who never leaves. Making yourself hard to replace is a skill. It is not the same skill as filling schedules, and a physician-owner owes loyalty to the utilization number, not to whoever holds the website logins.

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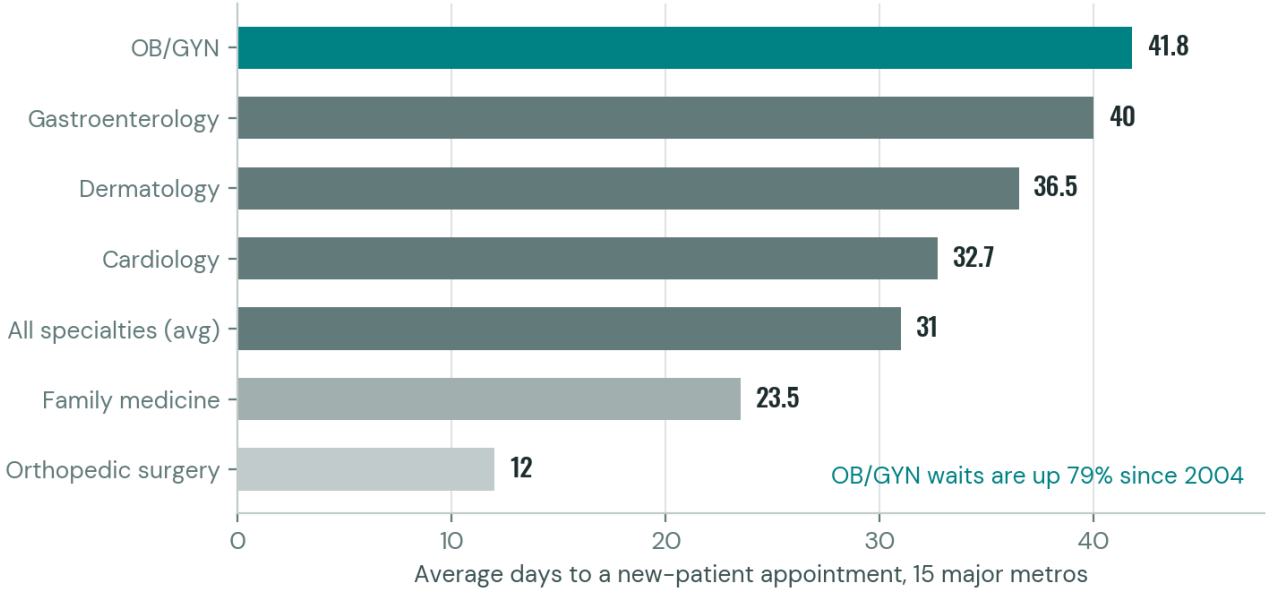
CHAPTER 03

How patients choose a clinic now

03

The patient journey moved online and got impatient, and the access math moved in your favor if you can capture it. Average wait for a new-patient appointment in major metros hit 31 days in 2025, up 48% since 2004. In OB/GYN it is 41.8 days, up 79% over the same period.[1] Every week of wait time in your market is demand looking for a faster door.



Average days to a new-patient appointment by specialty, 2025.

Source 1. AMN Healthcare 2025 Survey of Physician Appointment Wait Times, ~1,400 physician offices across 15 metro areas.

Reviews decide the shortlist

84% of patients check online reviews before choosing a new provider, and more than half read at least six before deciding.[10] The referral you have counted on for decades now gets fact-checked: 61% of patients say they prioritize online reviews over recommendations from friends and family,[10] and 72% will only consider providers rated four stars or higher.[11] Reviews are read per provider and per location, which means every physician and every address in your group has its own reputation to build or bleed.

Booking is a deciding factor, not a convenience

89% of patients say they want to schedule anytime from a phone or computer, and 61% would consider switching to a provider that offers a digital front door.[18] When choosing a new provider, 61% call online scheduling extremely or very important, and 75% of millennials booked their most recent appointment online.[19] The discovery layer is shifting too: consumers using AI tools for local recommendations jumped from 6% to 45% in a single year,[26] and those tools read the same

structured data and reviews your human patients do.

For women's health, the map is being redrawn

Access to OB care is contracting nationally: 34.6% of U.S. counties are maternity care deserts, and at least 96 hospital labor and delivery units closed across 35 states between January 2024 and May 2026.[20] In roughly 60% of the affected counties, the unit that closed was the only local birthing facility.[21] Every closure reroutes families toward the groups that remain visible, credible, and easy to book. For an independent OB/GYN group, being findable is not vanity. It is how displaced patients find their next medical home.

84%
of patients check reviews before choosing a provider[10]

41.8 days
average OB/GYN new-patient wait in major metros[1]

61%
would consider switching for a digital front door[18]

UPRYT POV

Long waits at the big systems are the independent group's opening. You can move faster than a hospital marketing department ever will: answer today, book this week, and show 200 recent reviews that say so. Speed and proof are the whole pitch.

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CHAPTER 04

The quiet leak

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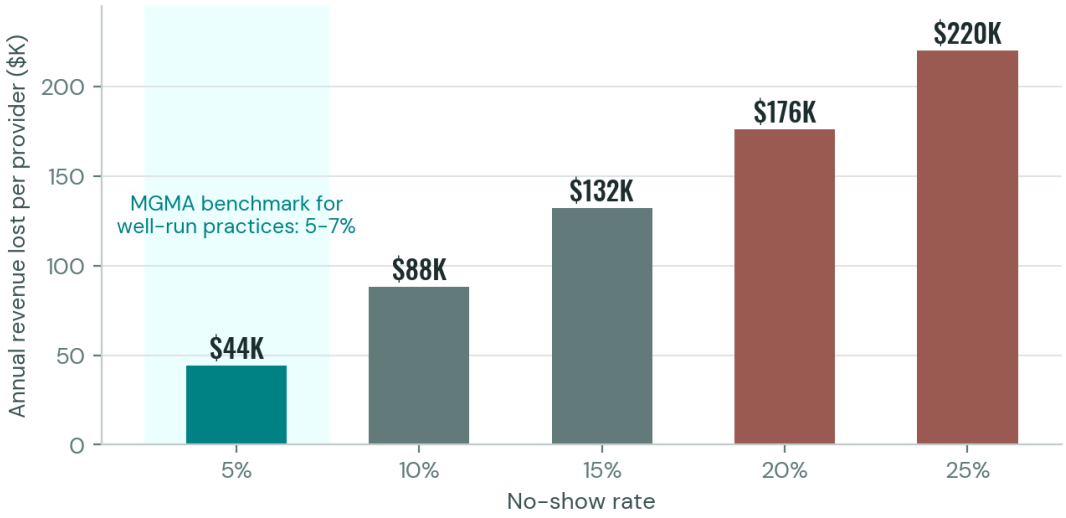
Before a group spends another dollar acquiring patients, it should measure what happens to the ones already trying to get in. Two leaks drain most clinic P&Ls: appointments that evaporate, and phones that ring out.

The no-show tax

Missed appointments cost the U.S. system an estimated $150 billion a year, at roughly $200 of lost revenue per empty slot.[3] No-show rates run 5% to 30% depending on specialty and population, while MGMA-benchmarked, well-run practices hold 5% to 7%.[5] For an independent practice the gap is worth $150,000 or more a year,[6] and the damage compounds: a patient who no-shows once has an attrition rate near 70%, versus 19% for patients who never miss.[4] One empty Tuesday often costs the entire lifetime of the relationship.

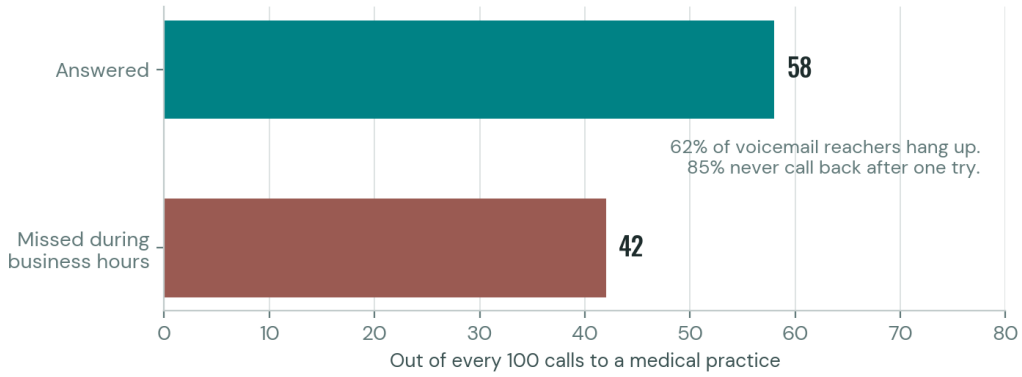


Annual revenue lost per provider by no-show rate. Model: 20 slots per day, 220 clinic days, $200 per missed visit.

Sources 3, 5. Slot value per Artera; benchmark band per MGMA-referenced practice data.

The phones are the front door, and the door is half closed

About 80% of appointments are still scheduled by phone, and a study of 7,000 calls across 22 practices found that 42% of business-hour calls go unanswered.[7] Of callers who reach voicemail, 62% hang up,[8] and 85% never call back after one unanswered attempt.[9] They do not disappear. They dial the next practice on the map.

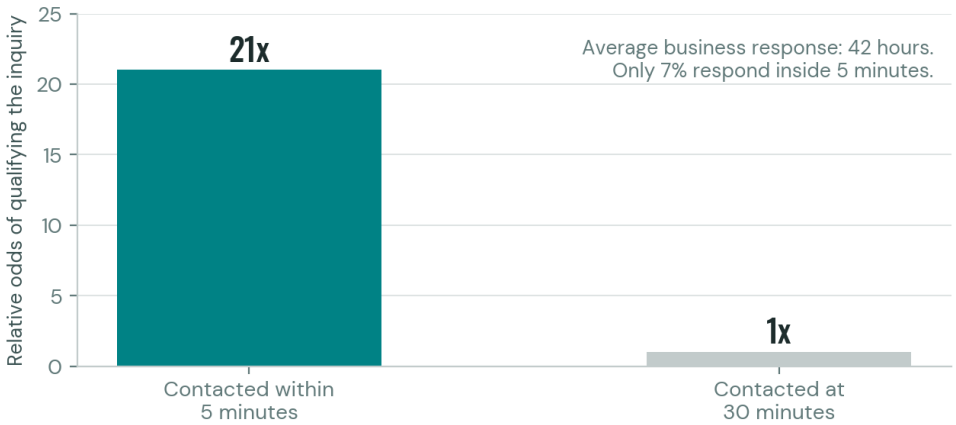


The front-door leak: what happens to 100 inbound calls at a typical practice.

Sources 7, 8, 9.

Speed decides who gets the patient

For web inquiries the window is minutes, not hours. Contacting a new inquiry within 5 minutes makes you 21 times more likely to qualify it than waiting 30,[15] responding within the first hour is 7 times better than waiting longer,[16] and 78% of customers choose whoever responded first.[17] In a market where the incumbent answer is a 41.8-day wait, the practice that responds in five minutes is playing a different sport.



Relative odds of qualifying a new-patient inquiry by response time.

Sources 15, 16, 17. MIT/InsideSales lead response research; HBR response study; industry response-time surveys.

UPRYT POV

Groups measure marketing on new-patient volume and treat no-shows and phones as front-office problems. They are the same problem: demand density. A clinic with a waitlist does not have a no-show problem, it has a backfill routine. Plug the leaks first; every acquisition dollar works harder afterward.

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CHAPTER 05

Scoring clinics by headroom

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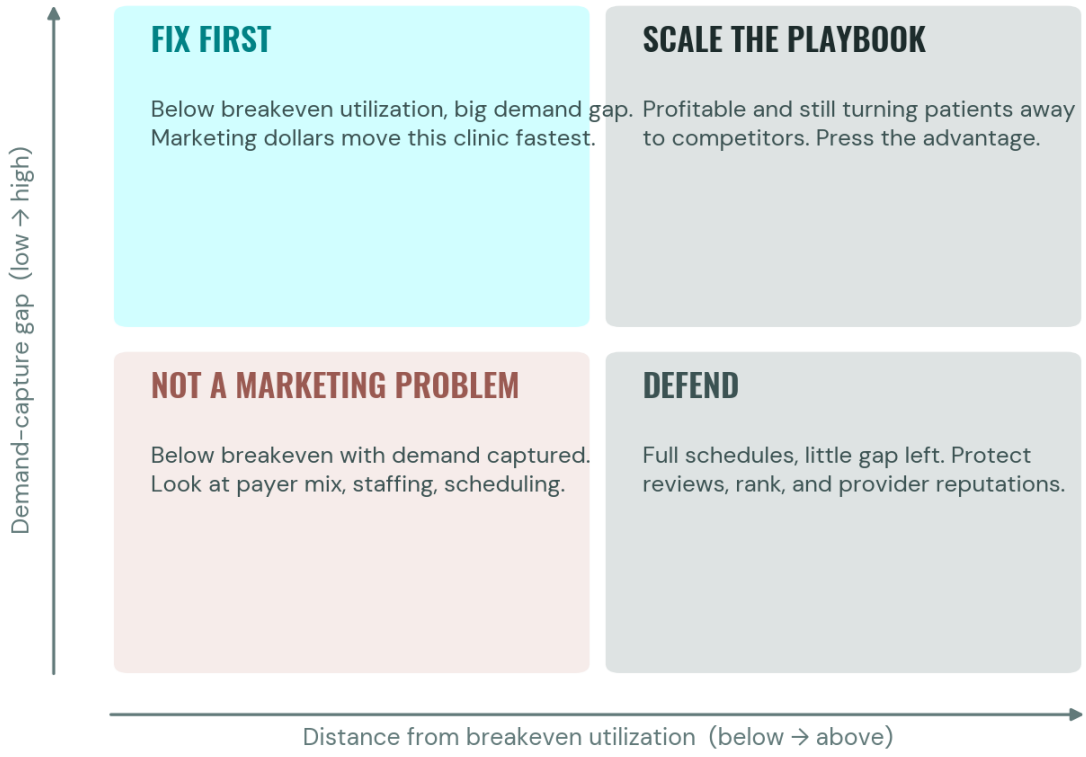
Marketing budgets in medical groups usually get allocated one of two bad ways: evenly, because it feels fair, or loudly, toward whichever office manager escalates best. Headroom scoring replaces both with two questions per location.

Question one: how far is this clinic from breakeven utilization? That is a finance number you already have, or can build with the Chapter 1 math. Question two: how much demand is this clinic failing to capture? That is a marketing audit: map rank against nearby competitors, review count and rating gap by provider, share of calls answered, response time on web inquiries, dependence on paid booking marketplaces. Score both, place every location on the grid, and the budget argument usually ends itself.



The headroom matrix. Plot every clinic by distance from breakeven utilization and by unclaimed demand in its market.

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How to run it

Signal	Where it comes from	What it tells you
Distance from breakeven	Location P&L: fixed costs, contribution per kept visit, current utilization	Urgency. Below the line, every month compounds the problem.
Local rank gap	Map pack position vs. top 3 competitors on money keywords	Visibility at the decision moment; 76% of near-me searches convert to a visit within a day [23]
Review gap	Rating and volume vs. the local leader, per provider and per location	Credibility; 72% of patients filter at 4 stars and up [11]
Answer rate and speed	Share of calls answered; minutes to first response on web inquiries	Conversion; 21x qualification odds inside 5 minutes [15]
Marketplace dependence	Share of new patients arriving through paid per-booking platforms	Cost structure; marketplace fees commonly run $35 to $110 per new booking [12]
New-patient wait time	Days to third-next-available appointment, by provider	Capacity signal; the metro average is 31 days and rising [1]

The matrix also protects you from the classic mistake: pouring marketing into a clinic whose problem is not demand. An office below breakeven that already captures its market has a payer-mix, staffing, or scheduling problem, and more ad spend will only document the fact faster. Say so out loud. Marketing dollars belong where unclaimed demand exists.

UPRYT POV

We run this scoring in week one of every engagement and show the grid to the whole leadership team, physicians included. Half the value is the budget logic. The other half is that the office managers stop arguing with each other and start arguing with the grid.

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CHAPTER 06

Service lines and offers

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Clinics rarely discount, but they make the equivalent mistake: treating every slot as identical and every service as unschedulable. The discipline is the same one hotels learned: know your contribution per unit of capacity, and design offers that fill the capacity that would otherwise expire. One guardrail first: your clinicians decide what care is appropriate, and marketing never promises outcomes. The economics apply to how you package and schedule what your providers already offer.

Three moves that fill dead capacity

01 Reactivate before you acquire

The cheapest kept visit is a lapsed patient with an overdue well visit, screening, or follow-up. They already chose you, their chart is on file, and recall outreach costs postage and minutes, not marketplace fees. Run recall campaigns as a standing system with its own weekly number, not a once-a-year cleanup.

02 Build committed revenue into the book

Memberships, wellness plans, series-based care, and prepaid packages convert one-time decisions into defaults, the clinic version of the committed revenue every subscription business prizes. A patient on a plan books ahead, shows up more, and smooths the utilization curve that Chapter 1 says pays for everything.

03 Point self-pay lines at the valleys

Demand for cash-pay services is real and measurable: 12% of U.S. adults are currently taking a GLP-1 medication, double the share of 18 months earlier, and usage among women runs 15%.[22] Weight management, aesthetics, and wellness visits are schedulable, insurance-light, and perfect for the dayparts your core schedule leaves empty. Fill the 2pm valley with the service line patients are already searching for.

And one rule about vendor incentives. Percentage-of-spend pricing means your marketing partner earns more when your ads cost more, and per-booking marketplace fees mean your acquisition cost never falls no matter how strong your reputation gets. However you buy marketing, make sure the person recommending the budget does not get a raise for inflating it.

UPRYT POV

Our test for any offer or service line: would the practice's CFO (or the physician who plays one) sign it after seeing the contribution math on one page? If the answer requires a story about brand awareness, it is not ready.

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CHAPTER 07

The new-clinic calendar

07

Most groups start marketing a new location the week it opens. In healthcare that mistake is expensive twice, because revenue has a second gate: payer credentialing and enrollment take 90 to 120 days on average, and complex cases run 180 or more,[27] and a late start creates a 30-to-90-day billing gap after the doors open.[28] The fix is one calendar that starts at lease-signed and runs credentialing and demand in parallel.

Window	What ships	Why it cannot wait
Day -150 (lease signed)	Payer enrollment and CAQH submissions filed for every provider. Location page live with an offer to join the list. Google Business Profile created and verification started. Tracking numbers provisioned.	Commercial credentialing averages 90 to 120 days;[27] starting at -150 is the minimum that protects day-one billing.[28]
Day -120 to -75	Provider bios, photography, and intro content produced. Referral outreach to nearby practices, employers, and community groups begins. Citations and data consistency locked across the map.	Search engines and AI assistants need weeks to trust a new address, and referral relationships need coffee before they need brochures.
Day -75 to -30	Online scheduling live to a pre-open waitlist. Paid local campaigns on. Phone coverage and 5-minute web-inquiry response rehearsed with real test leads.	Inquiries answered inside 5 minutes qualify at 21x the rate of slow ones;[15] the habit must exist before the volume does.
Day -30 to open	Waitlist converted to booked first appointments. Opening-week schedule built to meaningful utilization. Review engine armed to fire on the first kept visits.	A clinic that opens at real utilization resets the whole ramp curve, and early reviews compound from day one.
First 90 days	Weekly one-page readout: utilization, kept visits, cost per booked and kept, answer rate, review velocity, rank movement. Recall and service-line offers pointed at the dayparts that reveal themselves.	The first quarter sets the location's local rank, review base, and habit loops that every later quarter inherits.

The calendar is boring on purpose. New clinics fail from sequencing, not from a lack of ideas: the payer application that sat in a drawer, the profile that was not verified in time, the ads pointed at a page that was not live. A written calendar converts the opening from an event into a system, the only version that repeats at clinic 4 and clinic 14.

UPRYT POV

We treat a signed lease as the starting gun for both demand and credentialing. If either plan starts at the ribbon cutting, the ribbon is cutting into the first year's P&L.

CHAPTER 08

Metrics that map to a full schedule

08

Marketing reporting fails medical groups in a specific way: it measures activity that is easy to count instead of outcomes that cover payroll. Impressions, clicks, even raw leads all flatter the vendor. The chain that matters has four links: demand captured, appointment booked, appointment kept, slot filled.

Cost per booked and kept

Cost per lead is the most manipulable number in local marketing. Cheap inquiries that never book are not cheap, and booked patients who never arrive are worse. The honest unit is cost per booked and kept new patient, by channel, by clinic. Marketplaces make the arithmetic vivid: at $35 to $110 per new booking, charged whether or not the patient shows,[12,13] and with providers reporting that about 7 of 10 booked patients arrive,[14] the real cost per kept new patient can run 40% above the sticker. Owned channels with faster response and reminder discipline usually win that math, but only the practices that measure it ever find out.

Track the leak metrics like revenue

Answer rate, response time, no-show rate, and review velocity are leading indicators of next quarter's utilization, and every one of them should be reported weekly, per location, per provider. A physician whose rating drifts below the four-star filter line[11] is a schedule that will thin out two quarters from now, whatever this month's production says. A location whose answer rate slips is buying ads to feed a voicemail box.

Utilization, by provider, by daypart

The Chapter 1 curve runs on one number: kept visits as a share of bookable slots. Cut it by provider and by daypart and the marketing to-do list writes itself: the associate with Thursday valleys needs profile and review investment, the 2pm trough across all providers needs a service-line offer, the location with strong booking but weak keeps needs reminder and confirmation work, not more ad spend.

UPRYT POV

Our reporting rule: every weekly readout ends at a booked, kept, or filled slot, and every number is per location and per provider. If a metric cannot be traced to the schedule, it goes in an appendix, not a headline.

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CHAPTER 09

The operator's diagnostic

09

Ten questions to put to your current marketing setup, whether it is in-house, outsourced, or a pile of both. Score one point for every confident yes.

01 Do you know each clinic's breakeven utilization?
Not the group's. Each location's. If finance cannot produce it, Chapter 1 can.

02 Can anyone on your marketing team name kept-visit utilization by location?
If the people spending the demand budget do not know the demand number, they are optimizing something else.

03 Does your reporting end at booked, kept, or filled slots?
Impressions and leads are inputs. The schedule is the output.

04 Do you know your cost per booked and kept new patient, by channel, by clinic?
It is the only acquisition number that survives contact with the P&L.

05 Do you know your answer rate, and have you tested it?
42% of practice calls go unanswered in business hours.[7] Call your own front desk on a Monday at 8am and find out.

06 Is a human responding to web inquiries inside 5 minutes?
The 21x window.[15] Submit a lead to your own site on a Saturday.

07 Can a new patient book online without calling?
61% of patients would consider switching providers for a digital front door.[18]

08 Does every location and every provider have its own page, profile, and review engine?
84% of patients read reviews first,[10] and they read them per doctor, not per brand.

09 Does a written new-clinic calendar start at credentialing, not at opening day?
90 to 120 days of payer enrollment[27] means the ribbon cutting is far too late to begin.

10 Could you fire any single vendor or marketplace without losing your own accounts?
If someone else owns the domain, the ad accounts, the booking flow, or the profile logins, you have a landlord, not a partner.

Scoring: 8 to 10, your system is ahead of most of the market; press the advantage. 5 to 7, the leaks are findable and probably concentrated in two or three questions above. 4 or below, the good news is that nothing here requires more budget to fix. It requires an owner.

THE NEXT STEP

Ready when you are. No rush on our end.

Everything in this guide works whether or not we ever meet. Run the breakeven math, score your clinics, call your own front desk on a Monday morning, submit a test inquiry on a Saturday, and put the diagnostic in front of whoever runs your marketing today. If the answers come back clean, you are in better shape than most of the market and you should keep doing exactly what you are doing.

If they do not, that is usually not a people problem. It is a fragmentation problem, and it is fixable.

WHERE UPRYT FITS

UPRYT is the embedded growth team for multi-location operators, medical groups included. We replace the pile of vendors with one team that plugs in like in-house, owns the number, and runs everything in this playbook as a system: the headroom scoring, the new-clinic calendar, the phone and 5-minute response machine, the review engine per provider and per location, and the weekly one-page readout that ends at kept visits. When you grow, we do not tax it. Your spend going up does not make us cost more, and a new clinic does not restart the relationship.

THE FIRST STEP IS FREE. We audit what you are running today, per location and per provider, against every benchmark in this guide, and hand you the findings. Keep them either way. **upryt.io/audit**

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SOURCES

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marchofdimes.org/maternity-care-deserts-report

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