CHG Healthcare

Solutions for a future-ready workforce



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The great workforce recalibration

From silver bullets to designed capacity

Physician capacity is tightening, and most organizations feel it before they see it in a report. It shows up in next week's schedule: fewer open templates, longer waits for specialty visits, slower ramp-up after a hire, and more frequent coverage scrambles. In a market where hospital margins remain thin and workforce costs remain the largest operating pressure, even small disruptions in physician availability now carry clinical, financial, and access consequences.

The Association of American Medical Colleges (AAMC) has projected a physician shortage of up to 86,000 by 2036.[1] Independent modeling from the federal Health Resources and Services Administration (HRSA) predicts an even greater shortage of 141,160 by 2038, with significant gaps across primary care, cardiology, OB-GYN, anesthesiology, and other specialties.[2] However, these future projections don't capture the dire straits health systems are experiencing right now. In fact, analysis by CHG Healthcare points to physician shortages already at or above AAMC's projection.

"We have to stop talking about the physician shortage as if it is a future event," says Austin Chatlin, managing director of Advisory Services. "When you look across the data, including HRSA's more severe projections, the message is clear: the shortage is not coming. It is already here."

The industry didn't arrive here all at once. It got here through compounding pressures that moved faster than the physician pipeline could respond. The need for care is growing as the population ages and more patients live longer with complex conditions, while the physician workforce itself is aging and expectations around work, flexibility, and sustainability continue to shift. Nearly one in five physicians is expected to retire within the next decade, accelerating an already constrained supply, while burnout and disengagement erode retention among those still in practice.[1]

> ***"We have to stop talking about the physician shortage as if it is a future event. It is already here."***
>
> ***—Austin Chatlin, managing director, Advisory Services, CHG Healthcare***

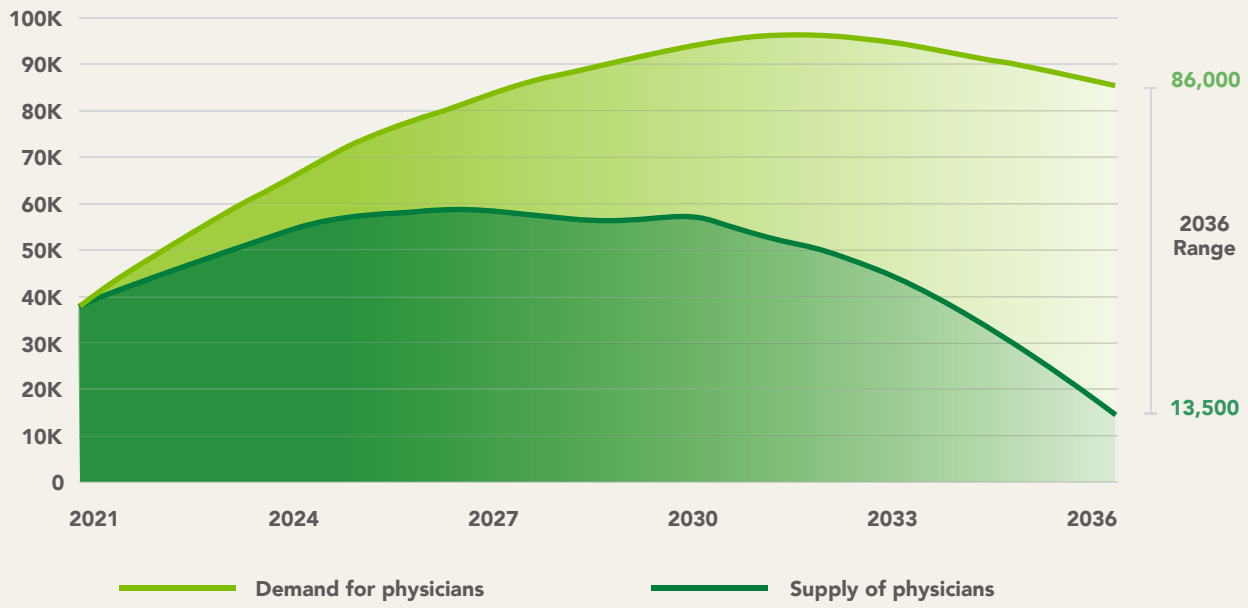
"A lot of hospital-based physicians, are saying, 'I'm not sure I want to deal with 24/7 call and all of these sicker patients.' Then you throw in the fact that the physician workforce is nearing retirement. We have about 20% that are 65 and older and 22% that are 55 to 64. So 42% of our docs are 55 and older. That's a little nerve-racking," says Scott Polenz, chief executive officer, Oakleaf Surgical Hospital.

This combination of tight supply, inconsistent deployment, and rising demand has reshaped the leadership challenge. Health systems making progress are moving away from one-off staffing fixes and building physician and APP workforces designed to adapt under pressure—strengthening the full-time core, expanding flexible capacity, and improving how quickly providers move from hire to impact.

> ***The shortage of physicians is very real. The financial pressures on organizations are very real. The inability to access care at times when you need it the most is very real."***
>
> *— Allan Cacanindin, vice president, Physician and Provider Recruitment, SSM Health*

Projected Physician Shortfall

The AAMC projects a shortage of up to 86,000 physicians by 2036[1], but the effects are already visible in today's operations, from access gaps to coverage instability and extended time-to-fill.



Source: AAMC, The Complexities of Physician Supply and Demand: Projections From 2021 to 2036

The future-ready answer

Across health systems, the response to these pressures is starting to converge. Outdated, ineffective approaches are being replaced by more deliberate strategies that focus on how the physician workforce is built, deployed, and sustained day to day:

Strengthen core full-time physician capacity
Recruitment, retention, and engagement each require distinct strategies, but together they define the stability of the full-time core.



Design a flexible physician workforce
This includes workforce design, advanced practice provider (APP) integration, float pool models, virtual coverage, and strategic use of external coverage.

Enable workforce performance through technology
Tools that improve access to the right physicians and APPs, accelerate credentialing, improve visibility, and streamline deployment turn hiring decisions into usable clinical capacity.



> ***With so many external market forces, it's more critical than ever for health systems to adopt a strategy and an approach to help protect profitability and ensure continuity of care."***
>
> *— Melinda Giese, senior vice president, Enterprise Client Solutions, CHG Healthcare*

Future-ready opportunities

The following sections outline how health systems are implementing each of these approaches in practice.

1. Strengthening core physician capacity
2. Designing a flexible physician workforce
3. Accelerating workforce performance through technology

Strengthening core physician capacity

How physicians experience the organization after they arrive determines whether they stay, continue contributing, and remain part of the system's workforce over time.

Physician capacity often looks like a hiring problem. But it starts earlier, in shifts that go uncovered and capacity that never fully shows up. Recruitment is becoming more competitive, but it should be treated as a different problem from retention and engagement. Recruitment determines whether the organization can attract the right physician or APP in a constrained market. Retention and engagement determine whether that capacity remains available, productive, and willing to flex when demand changes.

"Provider shortages, increased demand, shifting care models—they're all important when it comes to access growth and financial stability of a system like ours," says Allan Cacanindin, vice president of Physician and Provider Recruitment at SSM. "A great recruitment function adds millions in stabilized revenue and reduces millions in expenses. And so, the role of recruitment and how the trends are shaping our recruitment teams today, we're definitely moving from order taking to strategic workforce planning."

Recruitment capability has to move beyond posting jobs and waiting for the market to respond. Healthcare systems need a clearer view of which candidates are clinically aligned, licensable, and ready to be credentialed and deployed on the timeline the service line requires. A wrong fit creates a capacity problem: leaders lose time, schedules remain open, and the organization still has to stabilize care while the search continues.

Physicians are also evaluating opportunities differently. Compensation still matters, but leadership opportunities, flexibility, workload design, and the organization's ability to support sustainable practice are playing a larger role in how physicians judge whether an opportunity is worth joining.

Recent CHG Healthcare research highlights the retention side of the same challenge: While 75% of physicians report being satisfied in their roles, far fewer feel meaningfully engaged, and more would discourage others from joining their organization than recommend it.[3] Hiring is only the first test. How physicians experience the organization after they arrive determines whether they stay, continue contributing, and remain part of the system's workforce over time.



Retention: Where capacity is lost before it's measured

Most organizations underestimate the risk tied to physician retention, not because physicians are leaving all at once, but because capacity begins eroding long before a resignation ever happens. They start to pull back in ways that are easy to miss—less willingness to take on additional coverage, less flexibility when schedules tighten, and a change in how much of themselves they are willing to give to the organization. That erosion does not always show up in the way organizations track the workforce.

"Engagement is a major performance driver. We know that when physicians are engaged, they are more productive.[3] They actually generate more revenue for the health systems and are much more productive from a wRVU perspective," says Matt Brown, vice president, Advisory Services and Enterprise Solutions, CHG Healthcare.

While most physicians report satisfaction, according to the CHG Physician Sentiment Research, only 18% are highly engaged, and that difference plays out operationally.[3] Engagement shapes how much discretionary effort exists in the system, how consistently coverage holds when pressure builds, and how much variability the workforce can absorb as patient flow changes. When engagement is low, the same number of physicians produces less consistent capacity.

Few organizations are structured to manage that risk. Only 23% of healthcare organizations have a formal retention strategy, and fewer than one in three maintains a comprehensive succession plan.[3] Without a defined approach, turnover, leadership gaps, and declining physician contribution often go unmanaged until the impact is already visible.

> ***"More than a quarter of physicians say they intend to leave their practice within two years. 13% ultimately do."***
>
> **— Scott Polenz, chief executive officer, Oakleaf Surgical Hospital**

The cost is often framed as the loss of a physician, but the larger impact builds earlier and more gradually. A single departure can exceed $1 million when recruitment costs, onboarding time, and lost clinical revenue are fully accounted for, but long before that point, capacity has already been thinning.[4] Coverage becomes harder to sustain, reliance on higher-cost staffing increases, and the system begins absorbing inefficiencies that compound over time.

What leaders can control is the operating environment physicians practice in. According to the CHG Physician Sentiment Research, they can make leadership more visible and responsive, give physicians meaningful input into decisions that affect their work, protect time for complex care, use APPs and locums to remove avoidable pressure from the core team, and build retention and succession planning into the workforce strategy before a departure forces the issue.[3] In environments like that, physicians are more likely to keep stretching with the system instead of looking for a way out.

"More than a quarter of physicians say they intend to leave their practice within two years. 13% ultimately do. An engaged physician is 26% more productive than a disengaged colleague. So that's about $460,000 more in additional revenue every year when you have an engaged physician," Scott Polenz, chief executive officer, Oakleaf Surgical Hospital told Becker's Healthcare Podcast.



Reclaiming control of physician services

Many health systems have relied on external physician management groups to stabilize operations and reduce administrative burden. Over time, that distance made performance harder to see clearly, incentives drifted from system priorities, and leaders had fewer ways to intervene when cost, quality, or access began to slip.

Across the landscape, organizations are pulling these services back in-house in response to inconsistent performance and limited control over clinical operations. Bringing these functions closer to the system improves visibility into performance and gives leaders more direct influence over how physician capacity is deployed. Gaps are addressed earlier, staffing decisions reflect real-time demand, and adjustments happen before they compound into access or margin issues.

Turning new physician capacity into performance

Even after hiring, capacity doesn't immediately translate into increased care delivery. The transition from onboarding to full contribution rarely moves as quickly as expected. Credentialing, payer enrollment, scheduling alignment, and workflow integration advance on different timelines, leaving physicians clinically ready but still weeks or months away from operating at full capacity.

In a market where adding new physicians is increasingly difficult, performance depends less on hiring volume and more on how fully existing capacity is used. When physicians move quickly from onboarding into active schedules, service lines maintain momentum and revenue is captured as intended. When that transition lags, access tightens and teams absorb additional strain to stabilize coverage.

Designing a flexible physician workforce

Organizations are implementing new, more flex-oriented approaches to expand the capacity of full-time physicians.

Most systems feel the strain before they can explain it. It shows up in clinics, specialties, and schedules that don't line up with how demand actually moves. It cuts across how work is structured, how coverage is assigned, and how physicians are expected to operate day to day. Addressing it requires a more flexible approach to workforce design, where physician time can be reallocated, extended, and supported in ways that match how care needs to be delivered.

Defining a virtual care strategy that expands capacity

Virtual care should be designed as a capacity lever, not a stand-alone access channel. The strategic question is where physician time is constrained by location rather than clinical need—and where a virtual model can safely extend that time across sites, specialties, and demand patterns.

That starts by mapping the demand type. Some gaps are episodic: a cardiology consult needed a few days a week at one site, behavioral health demand across several clinics, or oncology follow-ups crowding out new-patient access. Other gaps are geographic: rural or satellite sites that cannot support a full-time specialist but still need reliable coverage. In each case, the solution is not simply adding virtual visits. It is deciding which work can be delivered virtually, which requires on-site presence, and where escalation needs to be built into the model.

"We are never not trying to replace this terrestrial [in-person] care model. The in-person care is always going to be part of advanced illnesses like cardiac disease. The key is you only want to use that when you really need to," Dr. Geoffrey Wessler, chief executive officer of Heartbeat Health, recently said in a Becker's Healthcare Webinar. "And that's so, so important for us to get to a sustainable system because if we're using our terrestrial cardiologists to care for patients that could be managed with telehealth, then that means that they're blocking a spot that someone who really needs it can't get in. And that's what's caused this wait time across the country of, you know, 50, 60 days in some markets."

A practical virtual care strategy should answer five questions:

- Which specialties or visit types are appropriate for virtual coverage?
- Which physicians are licensed, credentialed, and scheduled to support those sites?
- How will virtual coverage integrate into referral, scheduling, documentation, and handoff workflows?
- What clinical escalation path moves the patient from virtual to in-person care when needed?
- How will leaders measure impact on access, leakage, throughput, and physician workload?

Used this way, virtual care becomes part of the broader capacity architecture. It extends coverage before gaps widen, keeps more volume in the system, and gives leaders another way to match physician time to demand without overcorrecting with a full-time hire that the market may not support.



Redistributing clinical work through advanced practice providers

Advanced practice providers (APPs) are one of the fastest-growing segments of the clinical workforce, now representing around 41% of the provider workforce.[5] Even with that growth, many health systems still faced overbooked physicians and lengthening specialty wait times.

Typically, APPs are placed where the pressure is most visible: overflow clinics, fragmented coverage support, or wherever the schedule is breaking. That provides short-term relief, but physician time remains tied up in visits that don't require physician-level expertise, and throughput stays constrained.

When clinical work is deliberately redistributed, capacity starts to change. Physician time is reserved for complex decisions and procedures, while lower-acuity care moves through structured APP-led pathways.

41%

That's how much of the provider workforce that advanced practice providers (APPs) represent. They're one of the fastest-growing segments of the clinical workforce.

SOURCE: Advisory Board. "APPs Make Up 41% of the Provider Workforce. Here's Why It Matters." May 19, 2025

What this looks like in practice

In a traditional urology practice model, a physician may see the patient at each stage, from consult through follow-up and ongoing management. In a redesigned model, consult preparation, pre-operative education, and routine follow-ups evolve to APP-led pathways with clear protocols and escalation triggers. Physician time concentrates on procedures and complex decisions where it has the greatest operational and clinical impact.

As lower-acuity work moves through a structured team model, physician time shifts toward higher-value care. That same physician supports more procedural volume, access improves, and bottlenecks ease.

A similar pattern shows up in outpatient neurology, where a virtual rapid-access clinic reduces wait times by about 15 days and increases monthly patient throughput by more than 50 visits without adding physician headcount. The gains come from clearer pathways and better-defined roles, not additional staffing.

Scaling without losing control

Expanding APP roles introduces a different kind of complexity. Experience levels vary, scope-of-practice rules change by state, and subspecialty care often requires training beyond general certification.

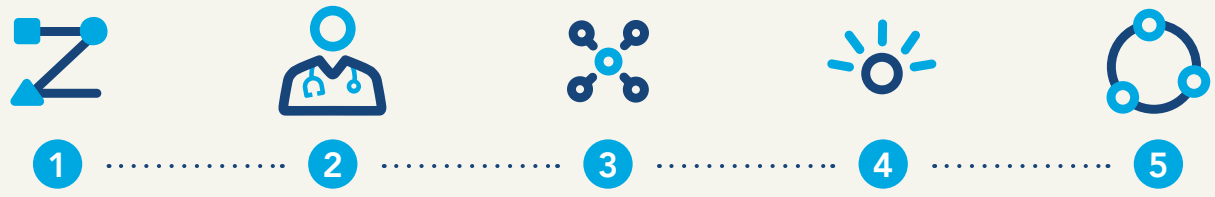
Organizations that sustain performance gains approach APP integration as care-model design rather than staffing expansion. They define where APPs operate, how care flows, and how decisions escalate, so capacity expands without introducing new friction.

That discipline shows up in a few consistent ways:

- Clear delineation of care pathways
- Subspecialty training aligned to service-line needs
- Defined supervision models with physicians
- APP autonomy aligned with regulatory and clinical expectations
- Intentional integration into service-line strategy, not parallel to it

When those models are fully implemented, the effect is more durable. Throughput becomes more predictable, access holds as demand fluctuates, and the system relies less on constant adjustment to keep pace.

Scaling APP roles



Designing coverage that holds under pressure

Redistributing clinical work addresses how care is delivered, but coverage determines whether that care holds when demand flexes and staffing does not keep pace.

Physician supply has tightened while expectations around call, flexibility, and sustainability continue to change. Under those conditions, coverage built around a single staffing approach begins to fracture.

What looks stable most days can unravel quickly when volume spikes, a specialist steps away, or growth outpaces hiring timelines.

Designing for flexibility changes how that pressure can be handled through a few distinct demand-driven coverage and hybrid capacity architecture.

Two workforce design models to consider

Model 1: Demand-driven coverage

Most staffing templates are structured around historical averages. That's a comfortable place to begin. It's also where hidden strain starts: the ED gets backed up at predictable hours, ICU beds tighten at predictable times, discharges lag in predictable patterns—while the schedule stays fixed.

Demand-driven coverage treats staffing as a variable input. Leaders use admission timing, day-of-week patterns, seasonal surges, and discharge flow to shape coverage windows that expand during predictable peaks and taper during known lulls. This is especially powerful in hospital-based specialties where volume is driven by external demand.

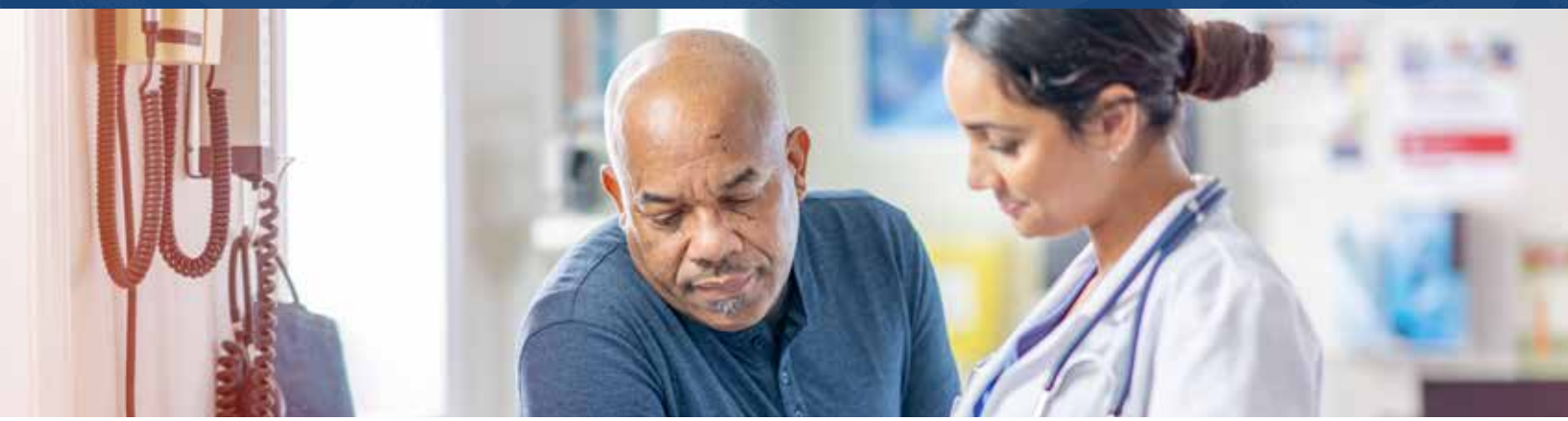
Model 2: Hybrid capacity architecture

In a tight market, coverage built on a single staffing structure limits sources for capacity. When a specialist search stretches into multiple quarters, growth stalls. When volume shifts across sites, traditional models can't flex effectively.

A more complete hybrid model layers multiple sources of capacity with clear roles:

- **Employed physicians:** core continuity, complex cases, and service-line leadership
- **Virtual physicians:** coverage extension, specialty access, and overflow
- **APPs:** scope-appropriate volume and care team efficiency
- **Locums:** surge capacity, gap coverage, and new service-line testing

This hybrid design is an intentional capacity architecture—matching the right care delivery mechanism to the right demand type. Locums are one tool in that kit. For many health systems, virtual care and APP deployment can also be more cost-effective and operationally sustainable levers when used in the right place.



Making physician capacity move with float pools

A single unexpected leave can trigger weeks of phone calls, contract reviews, and credentialing delays before coverage stabilizes. Each gap triggers the same sequence of steps—finding coverage, confirming credentials, verifying enrollment, and rebuilding the schedule—while time and access erode in the background. Successful organizations remove that repetition upfront by building mobility into the workforce and with physicians already credentialed, enrolled, and able to practice across sites, allowing capacity to grow without restarting the process.

An integrated float pool creates that mobility. It creates a pre-cleared layer of physicians and APPs who can be deployed across defined sites and settings as demand changes, supported by shared standards, centralized visibility, and a consistent way to place providers where they are needed most.

That foundation creates operational flexibility. As needs change, coverage can be reassigned, which allows service lines to maintain momentum and steady patient access. The regular escalation of staffing stressors that can slow operations and negatively affect engagement and retention over time is smoothed out to a predictable and manageable level.

How leading systems structure float capacity

There is no single model, but high-functioning systems tend to organize float capacity in ways that balance predictability with responsiveness. Here are a few examples:

- **Rotational hub-and-spoke models** that distribute coverage across satellite sites
- **Specialty or region-based teams** deployed where demand concentrates
- **Virtual or fractional FTE float pools** that extend coverage across multiple sites simultaneously
- **Internal marketplaces** that connect W-2 and independent clinicians to short-term, additional shifts across the enterprise
- **Enterprise teams** designed for longer-term, high-impact coverage

While there's a variety of structure with each of these models, each can support and stabilize physician capacity when applied to the right department, service line, or enterprise organization.

Sequencing coverage with intention

Each of these examples falls in line with a solutions-oriented and structured framework to guide more deliberate coverage decisions: order of utilization. Rather than defaulting to reactive, last-minute staffing solutions, this model encourages organizations to move through available options in a strategic sequence based on cost efficiency, continuity of care, and patient access.

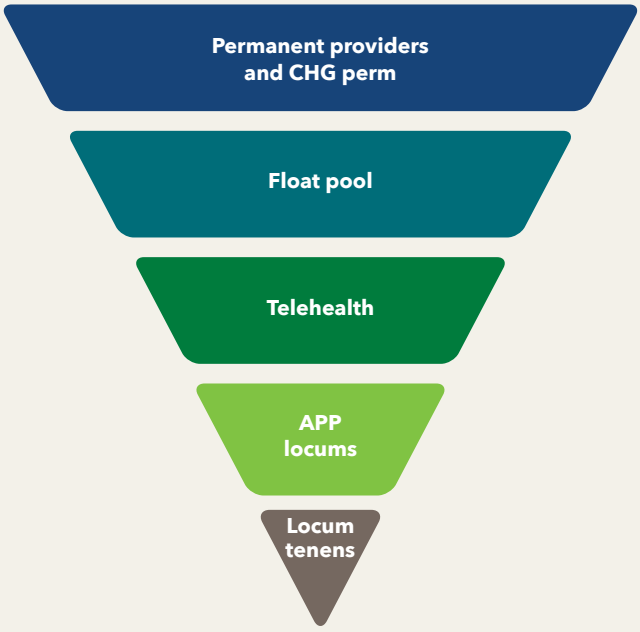
Developed by CHG Healthcare and grounded in its experience managing flexible clinical labor, order of utilization shifts coverage decisions away from ad hoc, department-level decisions toward enterprise-wide, data-informed deployment—a playbook for thinking proactively about provider coverage.

By sequencing staffing options thoughtfully, organizations can better balance quality, continuity, and cost. Technology, including a vendor management system, can serve as the operational backbone for centralizing staffing data, supporting decision logic, and helping leaders know when to move resources into the right place at the right time.

Why physicians opt in

A float pool depends on participation, and the appeal is straightforward when friction is removed. Physicians gain flexibility without taking on additional administrative burden, since there are opportunities to pick up additional work in ways that fit their schedules.

CHG Healthcare research shows that roughly 60% of physicians report strong interest in picking up additional coverage beyond their core responsibilities, averaging several additional days per month. Nearly 80% say they would join a float pool offered by their existing employer, with interest rising even further when cross-site or telehealth options are included.



Implementing an Order of Utilization Model

Instead of reacting to vacancies with ad hoc solutions, organizations following this model adopt a stepwise approach:

1. **Assess internal resources:** Can existing employed providers cover demand?
2. **Prioritize permanent recruitment:** If not, begin sourcing permanent hires (noting that filling specialty roles can take 200+ days).
3. **Bridge gaps strategically:** Use temporary staffing solutions such as locum tenens, telehealth, or advanced practice providers (APPs), timed to complement long-term workforce goals.
4. **Integrate technology:** A vendor management system can serve as the operational backbone of centralizing staffing data and supporting decision logic.

Why physicians opt in (continued)

"There's an immense burnout problem in clinicians facing all clinicians across all specialties and areas of practice. There are so many headwinds that make people look for alternative practice environments," Dr. Geoffrey Wessler, chief executive officer, Heartbeat Health told a recent Beckers Webinar. "Within the last two years, we started being less of an alternative sort of innovative practice and more of a cardiology practice that happens to do a lot of telehealth as our modality."

80%

Nearly 80% of physicians say they would join a float pool if offered by their employer. Interest rises even further—into the mid-to-high-80% range—when cross-site or telehealth options are included.

SOURCE: CHG Healthcare

> ***"There are so many headwinds that make people look for alternative practice environments."***
>
> *— Dr. Geoffrey Wessler, chief executive officer, Heartbeat Health*

CASE STUDY

In practice:

Float pools at enterprise scale

In one of the nation's largest radiology practices, backlogs were delaying diagnoses and slowing downstream treatment decisions across multiple markets. Traditional locum requests offered temporary relief but required repeated credentialing and onboarding cycles that couldn't keep pace with fluctuating demand. Rather than chasing individual gaps, the system built enterprise readiness with a float pool model to reduce time from hiring to credentialing.

Scenario:
Enterprise-wide diagnostic backlog and variable imaging demand

Challenge:
Radiology backlogs were delaying diagnoses and downstream care. Traditional locum deployment couldn't flex fast enough to meet fluctuating demand across care sites.

Solution:
Partnered with CHG Healthcare to design an enterprise-wide float pool model:

- Aggregated 1099 providers across the organization
- Pre-credentialed and pre-enrolled clinicians
- Matched clinicians to coverage needs with AI-enabled tech platform
- Deployed care remotely with telehealth

Outcome:

- Float pool providers increased output equivalent to 8–10 FTEs
- Providers hired within 78 days in a hard-to-fill specialty, with a typical average of 6–10 weeks
- Credentialing time reduced from 6 months to 3 months

Expanding capacity through strategic locums

Locum tenens is already embedded in most health systems. Across the U.S., locums physicians now support care for as many as one in three patients each year, with utilization continuing to rise as organizations contend with persistent gaps in physician supply.[6] Those gaps reflect an operating environment shaped by longer recruitment timelines, newer physician expectations, and sustained pressure on specialty access.

Despite that, many organizations still use locum tenens the same way they did years ago: reacting to vacancies as they appear. Over time, that growing dependence on reactive decisions created its own strain through repetitive onboarding and limited visibility into performance.

In high-demand specialties, the impact extends beyond staffing. As coverage gaps lengthen, the system experiences slower throughput, deferred care, and increasing reliance on higher-cost coverage to maintain baseline operations.

Organizations that perform differently have changed how locums operate within the system. Clinical coverage options through credentialed and payer-enrolled locums remain in place as a standing layer of capacity while recruitment continues, rather than cycling in and out with each gap.[6]

In higher-performing systems, locum tenens is used strategically and leveraged in ways that maximize continuity and performance. Characteristics of locum tenens in these higher-performing systems include:

- Longer-term relationships and repeat assignments
- Predictable schedules that allow clinicians to integrate into care teams
- Clear expectations for continuity, documentation, and handoffs
- Established credentialing and payer enrollment to avoid repeated delays

With that structure, coverage becomes stable enough to plan around.

CASE STUDY

In practice:

From short-term coverage to strategic capacity

For rural hospitals, specialty instability shapes both patient access and whether procedural revenue stays within the community. A large multi-state health system saw prolonged vacancies in cardiology, OB-GYN, gastroenterology, and orthopedics beginning to erode both access and procedural revenue across its 60-hospital footprint. Vacancies were stretching longer each year.

The organization needed a coverage model that could perform during extended searches.

Scenario:
Sustained specialty shortages across a multi-state rural system

Challenge:
60 community hospitals, many rural, facing prolonged shortages in high-margin procedural specialties.

Solution:
A long-term locums model engineered for continuity—not emergencies—with locums embedded into care teams while permanent recruitment continued

- Dedicated 1099 physicians
- Fixed, repeat schedules
- Multi-month commitments
- Centralized enrollment and oversight

Outcome:

- Sustained specialty access across vulnerable markets
- Preserved procedural revenue during extended searches
- Reduced disruption compared to episodic coverage
- Structured bridge to permanent hires

Accelerating workforce performance through technology

Strategic technology and AI use is helping realize a future-ready physician workforce.

Vendor fragmentation is a major source of administrative inefficiency for health systems managing multiple staffing relationships. The right platform can help health systems find, credential, schedule, and deploy the providers they need before access gaps widen into heavier workloads and lost volume.

"A trend that I'm seeing right now is organizations looking carefully at infrastructure and technologies to make things better. So there's a lot in motion born from the challenges and pressures we face today. We're definitely moving from order taking to strategic workforce planning. A lot of what I would say is greater integration with our analytics and automation, from pipeline intelligence to process efficiencies," said Allan Cacanindin, vice president of Physician and Provider Recruitment at SSM Health on the CHG Healthcare Podcast.

A next-gen vendor management system (VMS) can go beyond pulling from wide-ranging agencies for best-market rates to powering internal float pools. Locumsmart, CHG Healthcare's leading VMS, connects health systems to a broad ecosystem of vetted locum tenens agencies through a single, integrated platform. That access matters because fragmented vendor management often leaves leaders without a clear view of spend, provider readiness, vendor performance, or where coverage gaps are forming across the enterprise.

Locum tenens physicians generate an average of 3.6x gross billables relative to cost, with top-performing systems reaching closer to 8.6x, depending on how quickly clinicians are scheduled, integrated, and utilized once they enter the system.[6] That difference reflects how effectively physicians are deployed, scheduled, and supported once they enter the system. Technology is central to that outcome.

> ***"What it looks like on the other side is centralized, efficient, electronic, and digitally enabled."***
>
> *—Matt Brown, vice president, Advisory Services and Enterprise Solutions, CHG Healthcare*

CASE STUDY

> ***Before partnering with Modio, credentialing issues were costing us up to $400,000 annually in lost revenue."***
>
> *—Director of physician services, national health system focused on community health*

One source of lost physician and APP capacity often sits in the gap between recruitment and deployment. Each step has its own friction—recruiting to credentialing, credentialing to payer enrollment, enrollment to scheduling, and scheduling to operations. When those handoffs are disconnected, physicians may be clinically ready but still weeks or months away from full contribution.

"Before partnering with Modio, credentialing issues were costing us up to $400,000 annually in lost revenue. Since our partnership, we've seen a dramatic improvement in our payer enrollment and claim processing, directly impacting our bottom line," a director of physician services at a national health system focused on community health told CHG Healthcare.

In practice:

From fragmented delays to enterprise acceleration

Scenario:
Multi-vendor locum management across one of the largest health systems in the country.

Challenge:
The organization managed its locum tenens processes through spreadsheets and de-centralized tracking. This limited forecasting capability, complicated invoice validation, and reduced visibility into total spend.

Solution:
A next-generation vendor management system (Locumsmart) to centralize sourcing, standardize processes, automate invoice validation, and consolidate reporting across the enterprise.

Outcome:

- Centralized oversight across multiple vendors
- Automated invoice validation and consolidated billing
- Streamlined candidate tracking and reduced administrative burden
- Approximately $15 million reduction in total locum spend year over year

Four steps to reduce time from recruitment to care delivery

1. **Prioritize deployable physicians and APPs**
   In a constrained physician market, time spent recruiting the wrong candidate carries real cost. Readiness-based matching—driven by AI and informed by multi-dimensional physician, APP, and facility data—shifts recruitment toward providers who can enter practice on the required timeline, factoring in licensure, work eligibility, scope alignment, and start-date certainty earlier in the process.
2. **Reduce delays in credentialing and payer enrollment**
   Credentialing sets the pace for everything that follows, and physician credentialing is notoriously difficult and lengthy. AI is pushing credentialing technology forward by leaps and bounds with its ability to automate and detect issues across a large volume of files. Technology can automate verification, surface missing information earlier, and maintain data integrity so progress does not reset every time a provider moves into a new setting.
3. **Activate physicians and APPs without delay**
   Credentialing and enrollment do not automatically create patient access. Technology can reduce that lag by linking provider readiness to scheduling, site needs, and service-line demand so cleared providers move into active care faster.
4. **Manage physician and APP contingent workforce decisions at the enterprise level**
   Without centralized visibility, physician and APP contingent labor decisions become local, urgent, and expensive. A next-generation VMS centralizes sourcing, standardizes workflows, automates invoice validation, and consolidates reporting. At that level of visibility, it's also more cost effective to discover a high-quality physician workforce. A VMS can also give leaders a clearer view of expenses, return on spend, vendor performance, and where locum tenens should be used more deliberately across the enterprise.

When these capabilities operate together, the impact is a physician and APP workforce that can be activated, governed, and redeployed with far less friction as conditions change.



AI impact on physician retention

Efficiency is essential to the physician experience and a strategic lever for workforce retention. And AI has incredible potential on this front. Even small improvements—streamlined EHR workflows and automated scheduling, for example—can yield outsized benefits, including reduced burnout. As an Advisory Board researcher has put it: "Fewer clicks can mean higher retention."

Physicians additionally see AI as valuable for reducing workload and aiding clinical decisions, when they have transparency and input. According to the 2024 AMA Physician AI Sentiment Report[7], 93% of physicians want to be involved in AI decision-making. However, according to CHG Healthcare research, only 30% of physicians believe they have input into the technologies their organization invest in. Adoption of ambient AI documentation is already high in health systems. In fact, according to an AJMC study, ambient AI tools capturing patient-clinician conversations to support documentation were used by nearly two-thirds of U.S. hospitals on Epic electronic health record systems in 2025.

This is likely just the start. Burnout and attrition warnings can be generated based on PTO trends, schedule deviations, and even EHR login patterns. Although there is rightful caution around using AI for clinical support, over time it will likely help reduce cognitive load on physicians around complex cases.

AI impact on physician recruitment

In addition to the potential for AI to accelerate credentialing mentioned earlier, AI advancements across the path to physician recruitment have the potential to improve what has long been a laborious, difficult, costly, and sometimes fraught process.

AI-powered matching is one capability that is already gaining traction in physician recruitment. In the simplest terms, these AI matching tools discover "matches" between physician capabilities and preferences to organizational needs. And they're increasingly successful in measurable ways—reducing the time and effort required for permanent or locum tenens placements, as well as finding physicians who are optimal fits for specific roles inside health systems.

The current generation of matching increasingly goes beyond the obvious—specialty and existing credentialing, for example—to finding providers who match across more personal dimensions, such as their geographic preferences, cultural fit indicators, work-life preference alignment, and career stage needs.



AI impact on physician scheduling

AI is also starting to be leveraged to optimize scheduling. This can benefit physicians in ways as minor as reducing perceived unfairness in call schedules or as potentially critical as chronic overload. It can also assist health systems schedule more effectively for the delivery of care.

"We were able to use AI in a way to do data analysis by CPT code to find out how to really drill down and find just this handful of providers who actually had done this procedure," said Andrea Leland with Dartmouth Health. "It saved hours of trying to source and market to just find these people who actually could do this type of procedure."[8]

> ***"We were able to use AI in a way to do data analysis by CPT code to find out how to really drill down and find just this handful of providers who actually had done this procedure."***
>
> *—Andrea Leland, chief healthcare executive, future of physician staffing, Dartmouth Health*



CONCLUSION

From reactionary to future-ready

Physician scarcity is now part of the operating environment. Growth, access, and service-line performance increasingly depend on how deliberately health systems build, manage, and redeploy physician and APP capacity week after week.

Across CHG Healthcare's partnerships with health systems, we see a consistent progression. Some organizations remain vacancy-driven: a resignation triggers a scramble and the burden lands on the same core physicians. Others are beginning to build structure—strengthening full-time capacity, designing more flexible coverage, and using technology to reduce the friction between workforce decisions and care delivery.

More advanced systems align strategy and execution. They manage APP usage with clear pathways and guardrails, build provider float capacity that can sequence coverage decisions through an order of utilization model and reduce deployment delays with better credentialing, scheduling, and workforce governance.

At the leading edge, physician and APP capacity is treated like an enterprise asset—forecasted, redeployed, and protected with intention. Most organizations recognize elements of themselves somewhere along that spectrum. The practical question is what lever can they pull to move performance forward next: strengthening the full-time core, building a flexible strategic workforce, or enabling both through workforce technology.

CHG Healthcare's partnership across the workforce spectrum

Pressure on physician and APP capacity is not easing. For health systems, the question is whether they are ready to move before disruption affects access, revenue, and care team stability. That readiness requires a different kind of workforce strategy.

CHG Healthcare partners with more than 85 percent of health systems to offer comprehensive workforce solutions with technology and advisory services centered on the physician. As a physician and APP workforce expert, we help health systems attract and retain full-time physician staff, build a flexible strategic workforce, and enable it all through the right healthcare staffing technology and advisory capabilities. CHG Healthcare brings the scale, expertise, and operational know-how to help organizations move from reactive staffing to more intentional workforce design.

We partner with health systems to:

- Attract and retain full-time physician and APP staff through smarter recruitment, stronger match quality, and workforce strategies that support engagement.
- Build flexible, strategic workforce models using order of utilization planning.
- Improve workforce performance through technology that supports enterprise-level decision-making.
- Strengthen workforce governance so coverage decisions align across service line and system priorities.
- Turn temporary coverage into a strategic lever for access and long-term resilience.

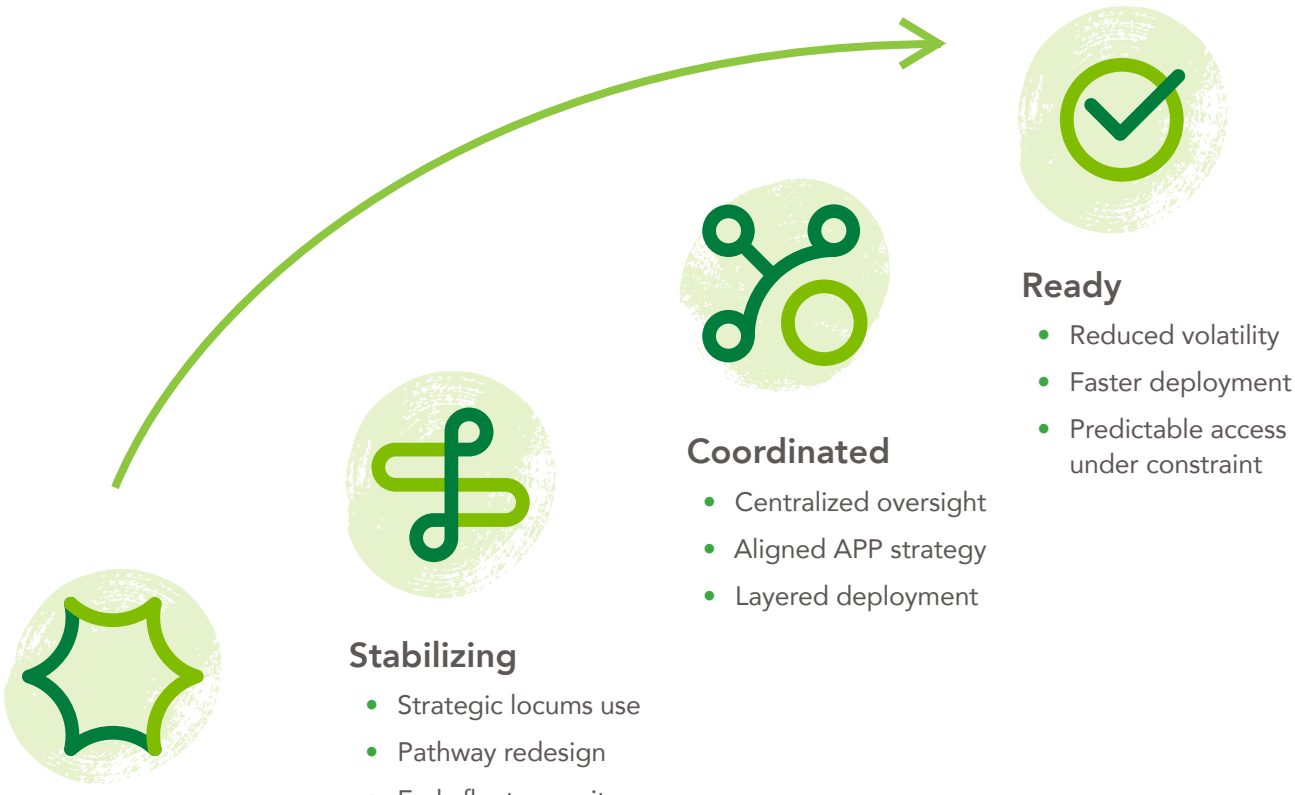
CONCLUSION

The value shows up in the moments like service lines opening on schedule and physicians and APPs being deployed where their expertise creates the greatest clinical and financial value. CHG Healthcare helps our clients move toward a future where administrative friction is reduced and leaders get a clearer view of where capacity exists and how quickly it can be activated.

That is what future readiness requires now: a workforce operating model built to hold under pressure. CHG Healthcare's advanced workforce solutions help health systems define how physician and APP capacity performs today—and how it will hold up as demand continues to change.

The maturity arc: From reactionary to future-ready

A simple progression toward more resilient workforce planning



Reactive

- Vacancy-driven decisions
- Premium coverage spikes
- Siloed governance

Stabilizing

- Strategic locums use
- Pathway redesign
- Early float capacity

Coordinated

- Centralized oversight
- Aligned APP strategy
- Layered deployment

Ready

- Reduced volatility
- Faster deployment
- Predictable access under constraint

CONCLUSION

Future-ready workforce assessment

A future-ready workforce is built through clearer governance, smarter deployment models, stronger operational infrastructure, and a broader view of physician and APP capacity. Health systems that score higher on the maturity arc are typically better positioned to respond to demand shifts, reduce disruption, and maintain more predictable access even under pressure.

Scoring guide

Rate yourself in the following six capability areas by scoring 1–4, then add them up to get your total score and see where you currently stand.
Total possible score: 6–24

6–9 = Reactive
Your organization is still operating largely in response mode. Coverage decisions are often triggered by disruption, and workforce flexibility is limited.

10–14 = Stabilizing
You have begun to put more structure around workforce planning and are starting to reduce some of the volatility.

15–19 = Coordinated
Your workforce strategy is becoming more connected, deliberate, and enterprise-oriented. You have stronger alignment across staffing levers.

20–24 = Ready
Your organization is operating with a future-ready workforce model built for agility, visibility, and more predictable performance under constraint.

Capability Area	Reactive | 1	Stabilizing | 2	Coordinated | 3	Ready | 4
1. Workforce governance	Coverage decisions are made locally and reactively, often after disruption begins.	Some recurring gaps are reviewed centrally, but oversight is still inconsistent.	Workforce decisions are guided by centralized oversight and clearer escalation paths.	Governance is enterprise-wide, proactive, and aligned to system priorities, service lines, and future demand.
2. Staffing model design	Workforce planning is focused mainly on filling vacancies.	The organization is beginning to use a broader mix of staffing approaches.	Permanent staff, APPs, float capacity, virtual care, and locums are used in a more deliberate way.	The staffing model is layered and flexible, designed to shift capacity based on need, acuity, and access goals.
3. Locums and contingent labor strategy	Locums are used mainly as a last-minute fix and are viewed primarily as a cost.	Locums are used more intentionally for predictable gaps or recruiting lag.	Locums are incorporated into workforce planning and support continuity, access, and operational stability.	Contingent labor is treated as a strategic lever for resilience, revenue protection, service line continuity, and growth.
4. APP and float capacity deployment	APPs and float resources are deployed inconsistently and often without systemwide alignment.	Early efforts are underway to build float capacity and define APP roles more clearly.	APP strategy and float capacity are coordinated across service lines and used to improve coverage flexibility.	APPs and float capacity are integrated into enterprise workforce design and deployed where they create the most value.
5. Operational infrastructure and technology	Credentialing, payer enrollment, and staffing workflows are manual, fragmented, or slow.	Some processes are standardized, but visibility is still limited.	Technology supports more consistent credentialing, enrollment, staffing workflows, and workforce visibility.	Workforce infrastructure is integrated and data-enabled, allowing faster deployment, better visibility, and stronger decision-making.
6. Performance measurement and resilience	Success is measured mainly by whether an immediate gap gets filled.	Some operational measures are tracked, but not consistently across the enterprise.	Leaders track workforce metrics such as time-to-fill, coverage utilization, onboarding speed, and access impact.	The organization uses workforce data to reduce volatility, improve predictability, and support sustained access under pressure.

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Let's connect

Schedule a workforce strategy session or risk assessment consult with a CHG Healthcare physician workforce strategist. We'll evaluate your physician workforce, capture unrealized care opportunities, and provide insights on how to better manage your provider pool.

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