

From cost center to growth engine

Redefining the role of physician locum tenens



CHG[®]
Healthcare

Unlock hidden revenue

Most health systems don't lose revenue because they use locums; they lose it because of how they use them. Stop waiting for perfect hires. Top-performing organizations are using locums strategically to maintain care access, lower physician turnover, and generate stronger gross billables.

In this playbook, you'll learn how to:

Identify operational pitfalls blocking locums ROI

Solve payer enrollment challenges to avoid missed billing

Measure your system's locums maturity—from reactive to strategic

Quantify revenue potential across key specialties

Learn from real-world systems outperforming peers

Follow a step-by-step guide to turn locums into a growth strategy

You're likely leaving money on the table. This playbook shows how to reclaim it.

The cost of waiting for the perfect hire

Across health systems, the scenario is familiar: A specialist leaves, the search begins, and the time-to-fill clock starts ticking. As weeks become months, patient access erodes, teams absorb the strain, and losses accumulate.

In the background, a locum tenens physician is available—a doctor who could step in on short notice. But many systems hesitate. The paperwork feels burdensome. The optics feel uncertain. And there's a persistent belief that it's better to wait for the “right” full-time hire.

This approach isn't the exception; it's the norm, and it's costing health systems millions, leaving billable hours on the table.

The missed opportunities begin with how healthcare systems categorize locum tenens physicians. They're often grouped with travel nurses or allied contract labor—and therefore, viewed as another expense.

From that vantage point, they're always too something: too expensive, too temporary, too complex to be a reliable, long-term staffing strategy.

This perception gap limits far more than staffing options; it also affects revenue, growth, and operational resilience.

Physician locums aren't just support staff—they're physicians. They *are* a key component of a revenue cycle engine, even if it's an alternative source of energy. Every patient encounter they manage directly contributes to hospital income. When those encounters go unstaffed, systems lose money.

But not every system is making that mistake.

While some remain stuck in reactive staffing cycles, high-performing organizations are weaving locum tenens into their long-term workforce strategy.

They're using locum tenens as a revenue-preserving tool—not just a break-glass-in-case-of-emergency fix. Locum physicians at high-performing health systems generate patient revenue at a comparable or even higher rate of return as full-time hires,¹ particularly when factoring in revenue preservation during workforce gaps.

Introduction

In today's hyper-competitive market, reactive staffing is a vulnerability that your competitors are already exploiting successfully. This is what happens when locums are brought in at the last minute:



Short-term coverage that fails to address long-term access challenges



Brief support for overextended teams that know the relief is temporary, accelerating burnout, patient leakage, and delayed care



Coverage decisions that feel financially safe but are operationally expensive

One unfilled year in a key physician role can cost a hospital more than \$2.4 million in missed revenue.² That's before factoring in the downstream impact on patient trust, throughput, and long-term loyalty. At worst, locums are seen as a temporary fix for holes like these. At best, they're an ROI multiplier

hiding in plain sight, ready not just to plug but prevent vacancies like these from happening in the first place.

Every C-suite leader is focused on a different lever: revenue, labor, care delivery, or culture. But the lack of a sustainable staffing strategy affects them all. Health systems that aren't evaluating locums deployment every day are taking an enormous risk, especially in an industry without forgiving margins.

This playbook challenges the legacy framing of locums that got us here. We'll unpack the most common misconceptions, spotlight what high-performing systems do differently, and introduce a step-by-step maturity model to help health systems capture the full ROI of strategic locum tenens coverage.

When built into a systemwide workforce design, locums enable something beyond temporary fixes. They stabilize service lines, preserve access in high-acuity or rural areas, and extend clinical reach. In this unpredictable era of healthcare, that's a multiplier that matters more than ever.

What we heard from the C-suite

Many leaders still view locum tenens as a short-term rental, not as a strategic asset that can expand and strengthen the organization over time.



Section 1

The myth of expensive physician locum coverage

The financial conversation around locum tenens often begins and ends with hourly rates. But this narrow view obscures the real cost of delayed coverage: missed care opportunities, follow-up failures, and patient attrition to competing systems.

When staffing decisions are made in the 11th hour, the downstream effects are rarely tracked—let alone quantified—yet, this is what happens when locums are brought in at the last minute:

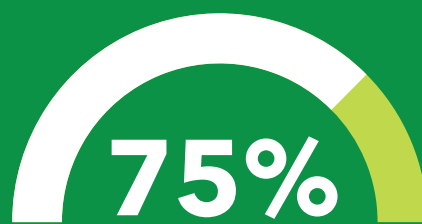
- **Burnout accelerates attrition**
- **Credentialing delays prevent proper payer enrollment**
- **Service lines go understaffed—or offline entirely**

The 2024 HRSA State of the Primary Care Workforce report projects a shortfall of more than 87,000 primary care physicians by 2037,³ driven by an aging workforce and a pipeline unable to keep pace. The financial impact of that shortage isn't hypothetical. They are already visible in rising vacancies, deferred appointments, and mounting financial risk.

Knowing this, *the real question isn't whether to invest in locum tenens.* It's what happens when you don't.

Yet hesitations persist. Not because the data is unclear, but because legacy processes reinforce outdated beliefs. When locums are introduced too late, credentialed slowly, and excluded from **payer enrollment** (the process of registering physicians with Medicare, Medicaid, and commercial plans so their services can be billed), it becomes easy to mistake improper deployment for inherent limitations.

To move forward, systems must examine the assumptions holding them back. The following five myths keep strategic workforce planning at a standstill—and carry measurable costs.



75%
of organizations cite **"allowing continual treatment of patients"** as the top benefit of locum tenens.⁴

The most persistent myths—about cost, timing, and performance—lead to stalled strategies, lost productivity, and avoidable gaps in care. Let's take a closer look:

Myth 1: "We can't afford locums."

This myth is the most common—and the costliest. Systems tend to focus on the hourly rate of locums instead of the value. When appropriately enrolled with payers from the beginning, locums billing yields a return well beyond the contract rate.

On average, CHG Healthcare data shows that health system clients generate four times their locums spend in gross billables, with top performers achieving as high as eight times. The difference comes down to smooth payer enrollment and the ability to start billing sooner, which prevents months of billable potential and millions of dollars systemwide from being lost.

Myth 2: "We only need locums when someone leaves."

Coverage is needed before vacancies occur—before burnout, before leakage, and before momentum is lost.

Strategic organizations use locums to provide relief long before a departure to fill and prevent gaps. They absorb patient load, safeguard continuity of patient care, and signal to stretched-thin teams that support is on the way. This proactive approach reduces burnout-driven turnover and extends the lifespan of core clinical teams, especially in hard-to-fill specialties like otorhinolaryngology (228 days), obstetrics and gynecology (226 days), and hospice and palliative care (218 days).

Myth 3: "Locum tenens don't deliver the same quality of care as FTEs."

Many leaders hesitate to deploy locums due to concerns about clinical quality. But the evidence tells a different story. Across nearly 2 million Medicare hospitalizations—and specialty-specific research in neurosurgery and emergency medicine—studies show no difference in patient outcomes between locum tenens and full-time staff.⁵

Mortality, complication rates, readmissions, and care costs remain equivalent. In a care environment moving towards value-based care, that matters. Quality measures tied to reimbursement—like safety, effectiveness, and patient experience—don't depend on a physician's employment status. They depend on system access and integration.

Myth 4: "It's not worth enrolling locums in the short term."

Many organizations avoid enrolling short-term locums, viewing payer paperwork as unnecessary overhead for brief assignments. But that logic is backwards. Most locums generate enough net patient revenue to cover their contract within a single day of coverage.

Even short-term physicians can often extend, return, and even transition to full-time roles. Avoiding enrollment only prevents patient encounters from translating into billable charges. Each week a physician works without enrollment is a week of forfeited billing, lost reimbursement, and missed ROI.

Myth 5: “If we rely on locums, it means we’re falling behind.”

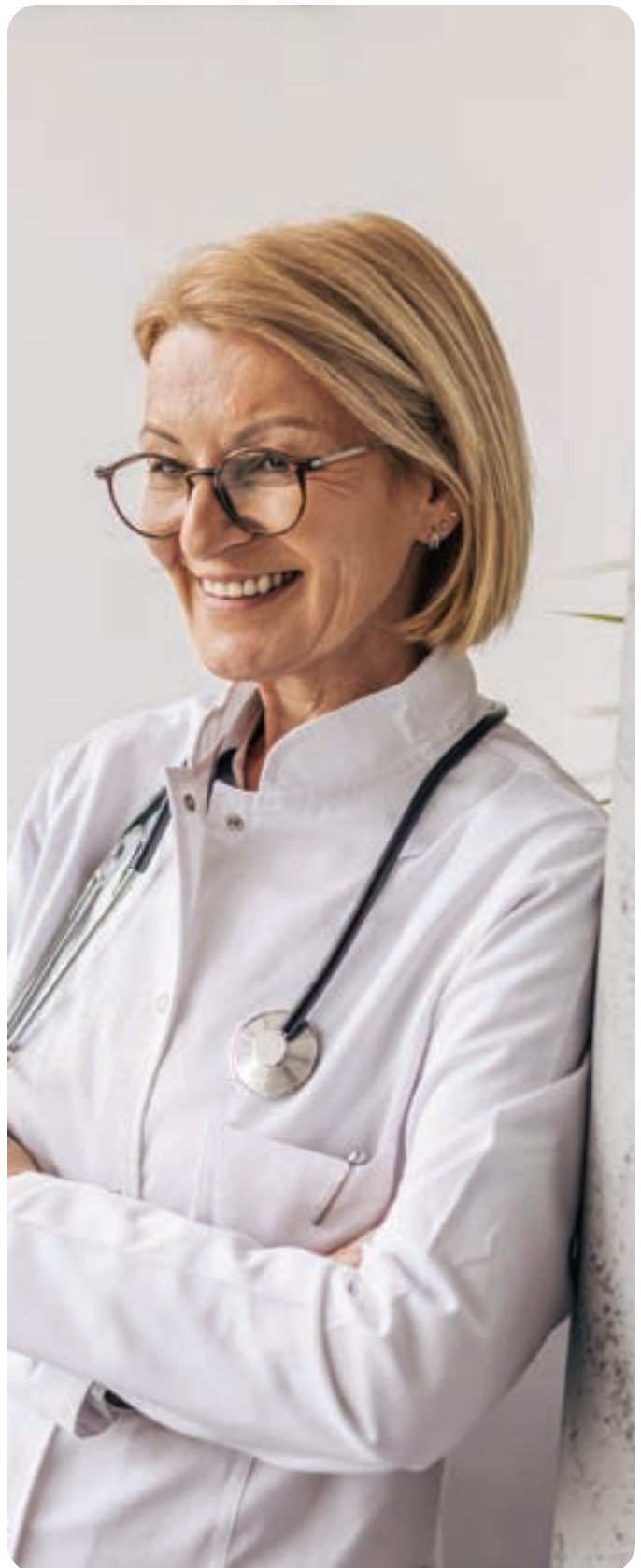
This mindset assumes that using locums equates to a failure of some kind: of retention, of staffing, or of predicting patient volume. Instead, reframe it to mean adaptation.

With time-to-fill stretching past 200 days in many specialties, even top systems use locums to protect margins, reduce team strain, and expand access. And they’re not alone in a time of unprecedented volatility in the industry.

According to a January 2025 CHG Healthcare client survey, 80% of healthcare leaders said they planned to maintain or increase their locums utilization in 2025.⁶

Top-performing systems aren’t retreating from using locums with some alternative strategy for these issues. Instead, they’re getting better at using them.

At a time when every margin point matters, leadership must challenge long-standing assumptions. Intentional use of locums protects organizational resources instead of draining them. That difference is measured in dollars and impact.



At a glance: What leaders get wrong about locum tenens

Myth	Truth	Cost
<i>“We can’t afford locums.”</i>	The cost of not staffing is higher. Strategic locums billing returns 4 - 8x gross billables to spend ratio.	Gross patient revenue lost in contract-to-bill gap. One uncovered week in high acuity roles is a six-figure miss.
<i>“We only need locums when someone leaves.”</i>	Locums prevent gaps, especially when you fill early.	Oncology roles take 197 days to fill. ⁷ That’s 6+ months of delays and patient leakage, plus \$7.4M in lost billings.
<i>“Locum tenens don’t deliver the same quality of care as FTEs.”</i>	Care quality isn’t contract-dependent. Locums sustain clinical outcomes when integrated.	Studies show locums deliver equivalent care to full-time physicians across specialties, including neurosurgery and emergency medicine. ⁸
<i>“It’s not worth enrolling them in the short term.”</i>	Short term ≠ limited value. Enrolling early protects revenue from day one.	One missed week due to delayed enrollment can forfeit \$50K+ in billable charges, per specialty.
<i>“If we rely on locums, it means we’re falling behind.”</i>	Locums aren’t a fallback—they’re a competitive advantage. Most systems plan to use them more, not less.	Letting optics delay staffing = lost ground to more agile competitors.

Section 2

The road to 8x ROI with physician locums

The value of locums isn't determined by cost, but by how well they're deployed. Lack of clear locums ownership, ineffective billing, inadequate onboarding, and increased time to fill are common pit falls. By implementing a locums process, you can streamline operations and unlock value through strategic locums utilization.

Many health systems use locum tenens—64% of them, in fact—yet few are maximizing their potential. Across CHG's client base, top-performing systems generate gross billables up to 6 - 8 times their locums spend, well beyond the norm.⁴

What sets these companies apart?

- Assigning clear locums ownership
- Proactive payer enrollment
- Strong clinical integration
- Standardized billing

These systems treat locums as a mechanism to protect care access, preserve revenue, and power growth, even when they're called during an unexpected gap.

Before we explore the shifts these systems make, a diagnostic framework can help executives assess where their organization stands—and what's holding it back.

The following three moves build on that foundation and turn self-assessment into action.

From scrambling to scaling: The locums maturity model

Level	Definition	Common Pitfalls
Scrambling	Reactive, last-minute locums deployment for unexpected gaps or backfill vacancies. Often triggered by crisis or team burnout.	Missed billing due to delayed payer enrollment, minimal onboarding, no defined owner of the locums process.
Structuring	Locums used in a more planned, cyclical way—often tied to gaps like sabbaticals, leave coverage, or recruiting lag.	Locums treated like “others” instead of team members, enrollment workflows still fragmented, cost-benefit analysis not regularly performed.
Scaling	Locums integrated into the workforce as a strategic lever. Used proactively to stabilize service lines, support growth, and extend reach.	ROI not consistently tracked or communicated, strategic use unlinked to broader system goals like recruitment and retention, learnings siloed between departments.

Move 1

Activate revenue from day one

In a margin-squeezed environment, delayed billing is more than a minor inconvenience. It's a structural liability. In many systems, billing is treated like a downstream function, only addressed after the physician is already on site. The result? Avoidable revenue gaps and physicians who deliver care without capturing the full value.

Every locum tenens physician can be billed— whether they're covering as replacement physician services (<60-day gap) or serving as supplemental staffing. But billing—and achieving 8x ROI—requires proactive planning.

Here's how strategic systems approach it:

- Classify the physician early (replacement vs. supplemental) to trigger the appropriate billing process
- Start payer enrollment in parallel with credentialing
- Prioritize your 3 - 6 highest-volume payers to ensure claims submissions can start flowing early
- Align vendor and internal timelines to prevent process gaps
- Leverage Q6 modifiers and Form CMS-855I for streamlined day-one reimbursement across Medicare, Medicaid, and commercial plans

Payer enrollment toolkit

A quick guide to the forms and codes that unlock day-one billing for locums:

Q6 Modifier

Signals that services were provided by a locum tenens physician rather than a regular physician. Allows billing under the absent physician's NPI for up to 60 days.

Form CMS-855I

Enrolls an individual provider in Medicare and reassigns billing rights to your organization—required for claims to be reimbursed under existing contracts.

Provider group code

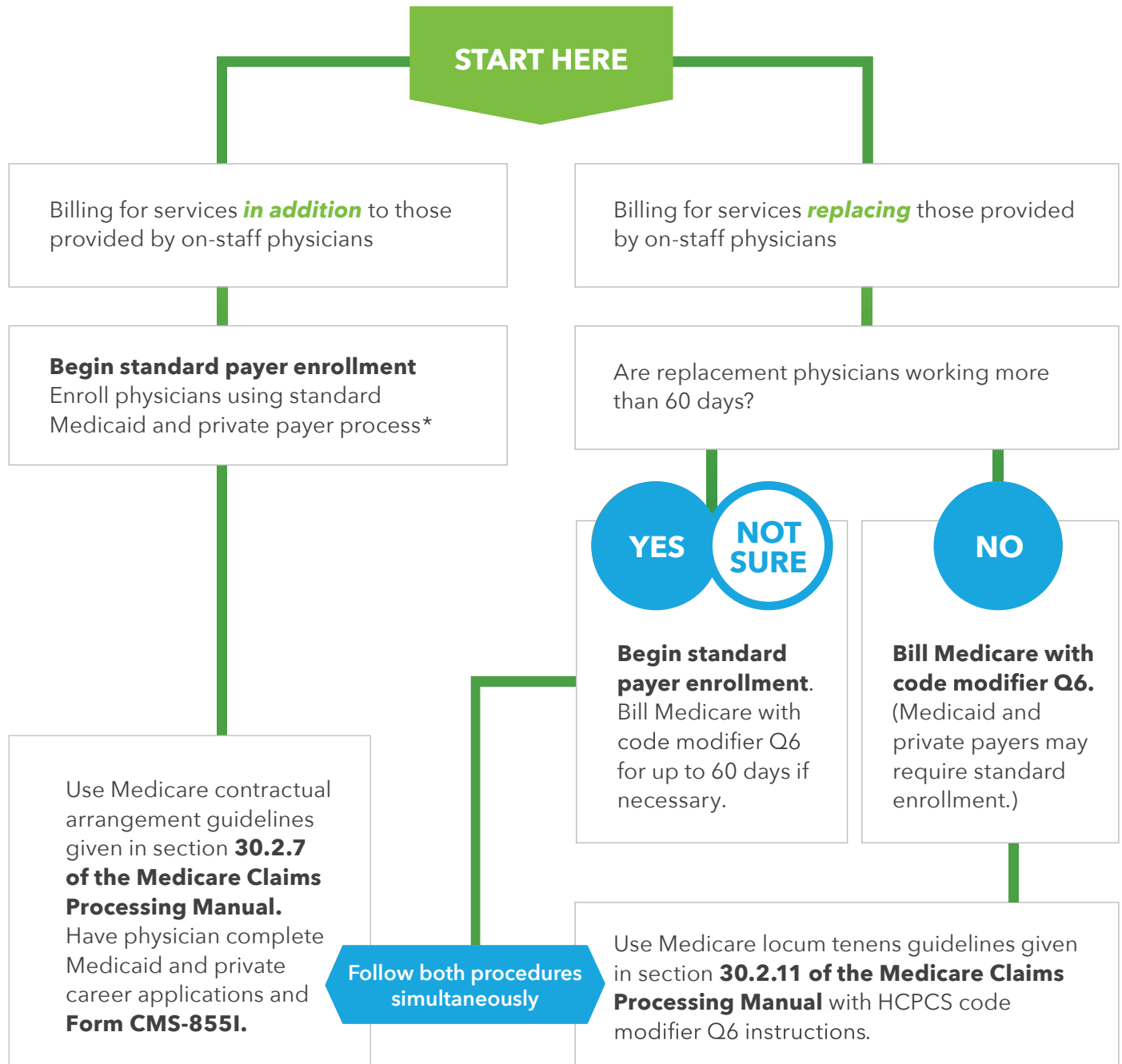
Links the locum to your billing group so payers can process and accept claims accurately.

Key Insight

Health systems with defined payer enrollment workflows are 400% more likely to capture full billing potential.⁶

Without that foresight, the revenue drag adds up fast. A 120-day enrollment delay—common in fragmented systems—can cost over \$122,000 in missed income per physician.⁹

How to bill for locums and temporary physician services



*Billing for Medicaid and private payers varies from state to state and carrier to carrier

The most future-ready systems ensure every patient encounter is billable from the start. When enrollment is built into the deployment plan, locums aren't placeholders. They're contributing to gross patient revenue from the moment they walk through the door.

Move 2

Start before the vacancy

Vacancies put a strain on the entire department. Burnout, rising patient loads, and the lack of relief on the horizon can build silent resentment and result in further resignations. Planning for vacancies can mitigate their impact.

One departure, two outcomes

Proactive vs. reactive staffing in practice

REACTIVE: The panic path

- **Day 0**
A surprise resignation leaves you scrambling. The psychiatrist is gone in 60 days.
- **Days 30 - 60**
You start sourcing a locum, but credentialing can't begin until a doctor is confirmed. Payer enrollment isn't even on the radar.
- **Days 60 - 180**
You finally get a locum on-site—but the Q6-modifier rule no longer applies, and standard payer enrollment steps were bypassed. Meanwhile, the patient care provided by the locums psychiatrist goes unbilled to commercial and public payers.

Total gap: 120 - 150+ days. Services rendered go unbilled.

Cost: Psychiatry vacancy → \$768K in lost revenue, \$384K turnover cost.¹⁰

PROACTIVE: The prepared path

- **Day 0**
Your psychiatrist gives notice. It's a blow, but not a crisis. You engage your physician staffing partner to begin candidate outreach the same day.
- **Days 1 - 15**
Credentialing and payer enrollment kick off in parallel. You're not scrambling; you're tracking.
- **Days 45 - 60**
Locum is credentialed and enrolled, patients are seen, claims submitted, and gross patient revenue begins to outpace costs—often 1.7 - 3.5x their professional fees within days.

Total gap: <60 days. No service line closure. No lost referrals. No chaos.

Most health systems still initiate recruitment and credentialing after a departure is announced. By then, the window to preserve team stability and protect revenue has already narrowed. One inescapable truth underpins high-performing organizations: Time-to-fill is a known risk. The question is whether it's planned for or ignored.

Credentialing delays remain one of the most underestimated and impactful bottlenecks in healthcare staffing. A typical facility juggles 115 physician searches annually: That's roughly two per week. Priority is often given to credentialing and payer enrollment for these permanent hires, while the same steps for locum physicians are often overlooked.

High-performing systems plan for the vacancy and the interim.

Each gap has a price tag. Consider oncology: one of the most recruitment-challenged specialties in both urban and rural markets. For every oncologist vacancy, hospitals lose an average of \$10.35 million in missed revenue while recruitment drags on. When factoring in onboarding, recruitment, and incentive expenses, the total cost to replace a single oncologist can exceed \$598,000.

Pre-credentialed locums enable seamless transitions, ensuring both continuity of care and protection of margins. When vacancies aren't filled promptly, the delay can jeopardize immediate patient access and lead to patients seeking care elsewhere—resulting in lost revenue and diminished market share. High-performing health systems prioritize patient experience, and proactively plan for both the vacancy and the interim coverage.



Move 3

From coverage to catalyst

Most health systems bring in locums to keep the lights on, but the strategic ones use them to brighten up new rooms.

In future-ready organizations, a proactive locum tenens utilization is baked into workforce strategy. They use locums to launch service lines, test market demand, extend high-margin throughput, and strengthen long-term recruitment pipelines. What was once a coverage tool is now a catalyst for growth.

For example, in high-throughput areas like orthopedics, the upside is apparent. With an average net patient charge of \$33,563 per day, even modest locum coverage in the OR can bring in \$3 - 6 million annually. That's only achievable, though, when locums are treated like clinical equals: integrated into schedules, enabled with full systems access, and aligned to maximize coverage and productivity.

Scenario

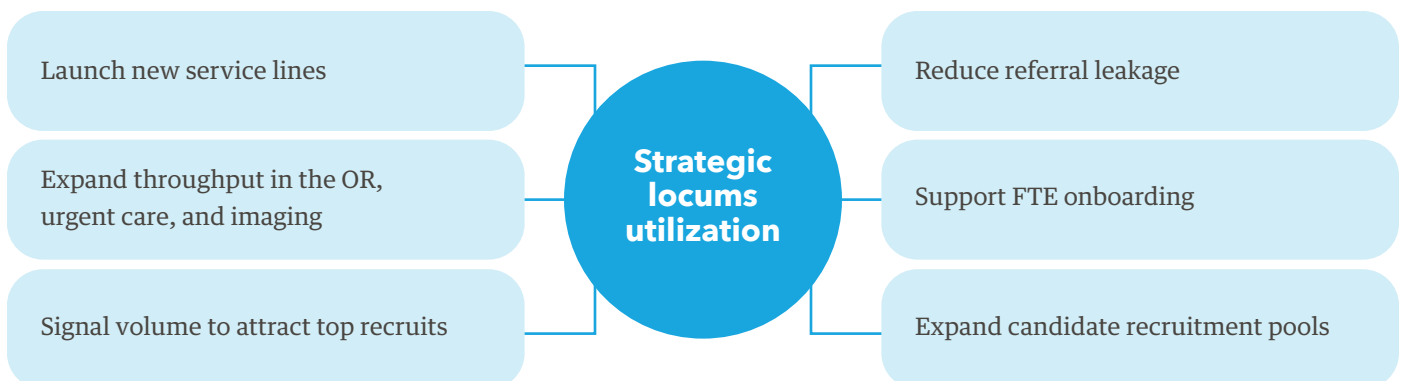
Locum tenens as a catalyst for high-margin services

Challenge: A hospital in New Mexico faced sudden, complete turnover of its three-member neurosurgery team, putting an entire high-acuity program at risk.

Action: Over two years, the systems relied on locums neurosurgeons to maintain 95% program capacity while focusing on permanent recruitment. Locums ensured continuity of care and helped demonstrate potential patient volume to protective hires.

Outcome: The hospital retained gross patient revenue streams, avoided patient care gaps, and created an onboarding bridge for new surgeons. One locums physician ultimately transitioned into a permanent leadership role as a program director.

Unlocking value through strategic locums utilization



When locums are deployed with this lens, they become a lever for agility—preserving care standards, loyalty, and team well-being, even as systems scale. It's the difference between a necessary expense and untapped potential.

Section 3

What strategic physician locums makes possible

Sometimes hiring a physician locum can make the difference between a patient receiving care or not—especially in rural areas. Strategic locums coverage allows healthcare systems to sustain and extend their reach. From keeping service lines open to sustaining continuity of patient care, and they can preserve health system revenue.

In large health systems, locum tenens can enhance performance. In rural and underserved regions, it sustains it. These communities face higher stakes and stronger headwinds: physician shortages, recruitment deserts, and aging populations that stretch already limited clinical capacity. Without the economies of scale or recruitment infrastructure larger systems rely on, rural hospitals face a far more precarious calculus: Deliver care with what you have—or not at all. **Strategic locum tenens coverage changes that.**

When deployed with foresight, locums do more than plug temporary gaps. They help rural hospitals keep care close to home and uninterrupted. According to CHG data, 71% of locum tenens utilization occurs in underserved areas.¹¹ That’s a signal of how vital strategic coverage is to maintain rural care infrastructure.

The needs are only growing. Psychiatry, orthopedic surgery, and general surgery top the list of hardest-to-fill rural roles and are also among the specialties most likely to extend beyond 10 days of coverage. That alignment creates opportunity: Longer assignments in high-need specialties can deliver care continuity, preserve access, and prevent costly service disruption.

“If I lose a physician, it could take six months to a year before I find somebody to replace them... I’ve had openings in my ER now for years that we fill in with part-time providers and with locums.”

— Susan Miklavcic, senior director of medical staff services at Samuel Simmonds Memorial Hospital in Utqiagvik, Alaska

Across high-need geographies, locum tenens enables hospitals to say “yes” when they’d otherwise have to say “not anymore.” They keep OB units open when retirement looms. They extend access to psychiatry in counties without physicians. And they give hospital leaders room to test market demand before investing in permanent recruitment.

Locums create space for strategic growth, smarter staffing, and long-term care delivery models that reflect the realities rural systems face daily. In communities with limited specialist access, a single unfilled OB-GYN role, can mean months of missed appointment opportunities and delayed care. Take North Dakota, for example. By 2022, 73% of hospitals had closed their obstetric units.

Section 3 | What strategic physician locums makes possible

Recruiting full-time OB-GYNs takes time—165 days for the average facility and up to 263 days for facilities in below average location desirability, according to AAPPR.¹² Every day without coverage means revenue loss, delayed care, and increased travel burdens on expecting patients.

But when rural hospitals deploy locums proactively, the calculus shifts. Just one locum OB-GYN on assignment means a rural hospital averaging one delivery per day could preserve more than \$2 million in gross billable hours over that vacancy period. And just as important, physician locums help keep maternal health local, protect service lines, support continuity of care, and signal stability to the communities they serve.

When rural systems plan for locums with foresight, they cover shifts and protect futures.

Scenario

Turning short-term coverage into long-term value

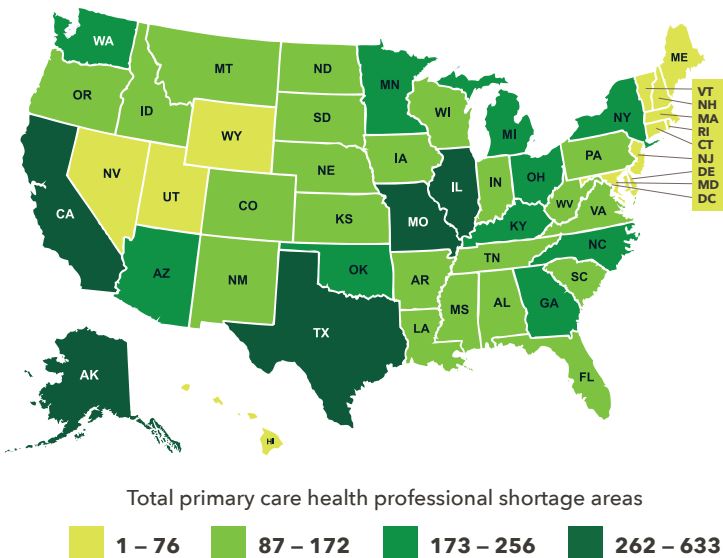
A rural hospital's proactive use of locums kept care local, preserved revenue, and seeded long-term recruitment success.

Challenge: A rural health physician retires unexpectedly, risking disruption to local care continuity and high-acuity procedures.

Action: The hospital activates a pre-credentialed locum to cover services without delay, keeping patients and revenue in-house.

Outcome: In just two months, the system retains six figures in professional and facility fees that would have otherwise gone out-of-network. Demand holds steady and the assignment is extended into a scalable, near-term solution that lays the groundwork for permanent recruitment.

The scale of shortages: Why locums matter



1 in 4 searches

for family medicine, internal medicine, or hospital medicine physicians¹²

180 days

average time to fill a primary care role

\$1.77M

PCPs average annual billing potential

-\$873,155

Estimated gross patient revenue lost during 6-month vacancy

\$950K+

Potential gross patient revenue preserved with proactive locums utilization

Section 4

Build a better physician locums strategy

The difference between backfill and workforce strategy is structure. CHG Healthcare’s 7 steps to building a strategic physician locum workflow, creates a locums strategy with a thoughtful and intentional approach, from implementing new workflows to evaluating performance.

A strong locums strategy doesn’t happen all at once. When managed strategically, they become a powerful catalyst for organizational growth. The following seven steps show how a locums strategy evolves—from reactive coverage to repeatable structure that deliver consistency and ROI.

7 steps to building a standardized, locums workflow



Step 1: Establish clean ownership of locum physicians

Ownership of locum physicians often lag due to an unclear understanding of the value of locums. Without defined ownership, key steps get lost in the departmental shuffle.

Key actions

- Align locum onboarding protocols with existing FTE processes
- Assign a dedicated lead for locum tenens payer enrollment

Step 2: Identify and prioritize by stressors

Getting ahead of your open roles includes assessing your current staff structure and deployment strategies. Gauging future demand based on today’s internal stressors will help you to plan.

Key actions

- Conduct an audit of turnover by department to identify teams that need the most support
- Review patient volume trends to forecast future staffing needs

Step 3: Assess organizational baseline

You can't improve what you can't see. A baseline assessment helps identify gaps and breakdowns, especially around enrollment and billing.

Key actions

- Calculate the percentage of locum physicians actively enrolled and billing
- Audit enrollment gaps by specialty and payer
- Map the current process to highlight workflow friction or ambiguity

Step 4: Quantify the opportunity

CHG's locum tenens revenue estimator tool helps you visualize the positive impact of locums on your bottom line. Plug in your numbers and see how strategic locum tenens coverage pays for itself.

[Try it here](#)

Step 5: Build a locums ROI tracker

Locum-specific ROI is often invisible, especially when reimbursement lags service delivery for weeks or months. A tracking system closes that gap and brings locums into the larger conversation around performance and efficiency.

Key actions

- Create dashboards to monitor enrollment status, physician productivity, and gross billables
- Build in regular checkpoints to assess performance and adjust accordingly



Step 6: Standardize billing from the start

Inconsistent billing creates unnecessary delays. A clear, standardized process ensures each locum's assignment starts on solid ground.

Key actions

- Develop a standardized billing packet to be used for each locum physician
- Ensure consistent use of Q6 modifiers, Form CMS-855I, and group codes
- Include billing steps as early as possible in the credentialing process, not as an afterthought

In an environment where every FTE hire is a six-figure investment and time-to-fill can exceed six months, systems need more than backfill. They need an ongoing, fully enabled integrated provider pool. Locums can be the strategic lever to get them there.

Step 7: Evaluate, refine, repeat

Strategic locums use isn't a set-it-and-forget-it process. High-performing systems treat workforce management like any other operational strategy: measurable, trackable, and continually optimized.

Once your locum tenens deployment is up and running, build in regular checkpoints to assess both financial and clinical performance.

Key actions

- Track billing success rates, enrollment timelines, and gross billable gaps
- Audit payer enrollment workflows for process delays and missed payers
- Assess clinical integration to identify underused locums physicians and missed volume
- Regularly update your locums ROI tracker to reflect revenue contribution



Section 5

Closing the gap

Across the industry, health systems are contending with a new kind of scarcity that goes beyond physician shortages. It includes time, flexibility, and operational bandwidth. Between changing patient demographics, rising clinical complexity, and persistent turnover, every unfilled shift stretches burned-out teams and erodes margins. This is the new operating environment, and systems that don't adapt will be left behind.

For years, the standard response has been to wait: for the right candidate, for volume to stabilize, and for recruitment to solve a structural challenge that needs a new solution. As time-to-fill extends across specialties and patient access dwindles, one thing has become clear—waiting for the perfect full-time hire is no longer a viable strategy.

That's where locum tenens enters as a strategic lever for addressing a myriad of labor challenges. When fully enabled, locums help systems close the gap between need and access. They stabilize coverage before it widens, protect revenue while FTEs are hired, and ensure the continuity of quality healthcare patients need.

The organizations leading this strategic shift are designing differently. They stopped viewing continuity of care as a luxury and started treating it like a function of future-ready capacity planning. These organizations embed locums early, with clear ownership, defined metrics, and an eye toward the healthcare landscape of tomorrow.

This is how the gap gets closed:

1 By building in coverage instead of scrambling for it

2 By operationalizing agility instead of waiting for alignment

3 By using locums to stabilize operations and build organizational strength

Coverage is just the surface. Strategic locums can enable growth, speed up system recovery, and support bold moves that otherwise wouldn't be possible.

The health systems that act on this won't just be ready for what's next. They'll be shaping it.

CHG Healthcare partners with leading health systems to:

- Refine their benchmarks and future-proof physician workforce strategies
- Assess and help customize hybrid staffing models that balance agility with efficiency to help solve immediate challenges and mitigate future gaps
- Implement physician-centered engagement and governance models
- Leverage proprietary technology platforms to improve physician experience and labor visibility
- Maximize revenue from locum tenens labor by supporting your physician workforce strategy



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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 locums utilization, capture unrealized care opportunities, and provide insights on how to better manage your provider pool.

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