The Velocity Gap: Why Retrospective Staffing is Failing Modern Medicine

Three Insights to Improve Access with Strategic Clinical Workforce Planning

February 2026

Executive Summary

Health systems are facing mounting clinical workforce pressures as recruitment timelines lengthen, labor costs rise, and patient access becomes increasingly constrained. In response to immediate staffing gaps, more than 80% of leaders continue to rely on familiar, short-term levers—such as hiring, contract labor, and shift incentives—while fewer than half turn to technology-enabled automation, which is widely viewed as a longer-term solution rather than a near-term fix. Physician leaders see substantial opportunity to advance workforce planning using large datasets (including provider practice data) powered through AI to increase recruiting speed, reduce onboarding friction, and enable smarter workforce planning. And early adopters are using AI-powered solutions to surface hiring inefficiencies, support frontline clinical leaders with staffing and scheduling decisions, and reduce administrative burden across clinical roles.

This report synthesizes findings from a survey of 40 senior health system physician executives. To examine how leading health systems are making strategic decisions about the clinical workforce and where the use of large datasets, data models, and AI can more efficiently support clinical workforce planning efforts. Survey results were augmented with focused, in-depth interviews with physician executives and CFOs. Three key findings emerged:

1. Clinical workforce planning fails in silos—it requires **tight partnership between finance and physician leaders**.
2. With 80% of health systems underusing AI and automation, slow hiring is no longer a surprise—it's a call to **modernize workforce planning now**.
3. Rapid changes in clinician expectations are outpacing available data, highlighting the **need for more real-time workforce intelligence**.

These perspectives highlight a clear inflection point: workforce challenges can no longer be addressed through short-term fixes alone. Health systems that invest in AI-enabled workforce planning and management will be better positioned to improve access, control costs, and sustain clinical capacity in an increasingly constrained market.

Key Takeaway #1

Clinical workforce planning fails in silos—it requires **tight partnership between finance and physician leaders**.

Clinical workforce planning is highly heterogeneous within and across health systems and service lines, shaped by local market dynamics and patient access needs. While physician executives initiate clinical workforce and growth decisions at most health systems (83%), the financial impact of hiring decisions has become more pronounced. Health systems are increasingly formalizing governance structures that tightly integrate physician leadership with finance department-based analytics—linking workforce decisions to enterprise strategy, multi-year forecasts, and standardized assessments of demand, productivity, and financial risk.

Approaches to Clinical Workforce Planning are Highly Variable

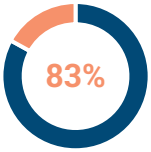
Health systems do not follow a single, standardized approach to workforce planning, even within the same organization. Planning models often vary by service line, specialty, geography, and market dynamics, with the employed medical group serving as the primary engine for decision-making. As one Chief Physician Executive noted, “If you see how we make decisions at one of our locations, you’ve only seen how we make decisions at just one of our locations.” This variation reflects the reality that workforce needs, financial viability, and access requirements differ substantially across settings.

Finance–Physician Partnership is Becoming Central to Workforce Decisions

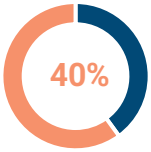
Clinical workforce planning and growth decisions are overwhelmingly initiated by physician executives at 83% of health systems. But finance leaders are now far more integrated into workforce planning than in the past, given the significant budgetary impact of clinical workforce decisions. Historically, some organizations made hiring decisions largely within clinical leadership teams. Today, many health systems are formalizing the process, embedding finance expertise into planning frameworks and tying workforce decisions more closely to enterprise-level strategic planning.

As one Chief Finance Officer described, structured templates and hiring committees—including finance representation—have replaced ad hoc decision-making. Finance teams contribute analytics on market demand, ramp-up losses, productivity expectations, and first-year financial impact, enabling more disciplined prioritization across roles. As the CFO emphasized, “We have to be disciplined on hiring, because the effects show up a year and a half later—even if you make the decision today.” Strong partnership between finance and physician leaders is increasingly seen as essential to balancing access, sustainability, and long-term workforce outcomes.

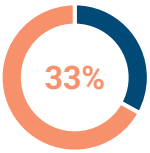
Who typically initiates the decision for physician and APP workforce planning and growth decisions in your organization? *N = 40*



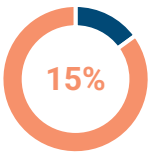
Chief Medical Officer, Chief Physician Executive, or Chief Clinical Officer



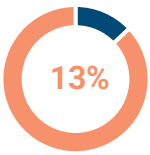
Chief Executive Officer



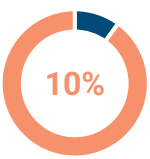
Chief Operating Officer



Medical Group President



Chief Strategy Officer



Chief Financial Officer

Distinct Models for High-Margin and Access-Oriented Markets

In higher-volume, urban markets, (particularly for high-margin specialties and subspecialties), health systems tend to rely on traditional, financially-driven workforce planning models. Leaders assess current and potential volumes, forecast demand assuming full market capture, and determine the number of providers needed based on expected productivity and national benchmarks. These decisions are often grounded in ROI calculations and payer mix assumptions and are more easily supported by existing datasets.

By contrast, workforce planning in rural or poor-access markets follow a fundamentally different logic. In these settings, volumes are often insufficient to financially support multiple specialists, yet maintaining access remains strategically critical. As a result, provider satisfaction, sustainability, and community need frequently outweigh traditional financial metrics. Leaders begin with loss-leading questions, such as what is the minimum financial loss the system can absorb to ensure patient access. Then they incorporate patient behavior data, e.g., willingness to travel, distance thresholds, and types of care patients will travel for, to make decisions about the region's workforce needs.

Proactive Planning Requires Integrating Large Datasets into Decision-Making

Decision-making cadence for when to hire new clinicians varies widely. Some health systems remain reactive, initiating recruitment only after backlogs emerge and staffing shortages are confirmed as the root cause. Others adopt a more proactive approach, embedding workforce planning into annual and multi-year strategic planning processes across service lines.

Proactive approaches leverage a broad set of data sources—such as compensation and benefits information (78%), procedure and encounter data (63%), provider financials (55%), labor market statistics (50%), and candidate availability (50%)—to inform and execute hiring decisions. Despite these efforts, leaders acknowledge that even well-defined models still struggle to keep pace with rapidly shifting recruitment dynamics and evolving clinician expectations.

To the best of your knowledge, which five of the following sources of data does your health system use to plan for/manage the provider supply chain? *(Percentage of respondents) N = 40*

Data Source	% of Respondents Ranked Among Top 5
Compensation and Benefits (e.g., salary, insurance, retirement)	78%
Procedure and Encounter Data (e.g., volume data by physician, site of care, etc., and service utilization)	63%
Provider Financials (e.g., revenue per employee, cost per hire)	55%
Labor Market Statistics (e.g., geographical distribution, employment projections)	50%
Candidate Supply/Availability (e.g., candidates per job opening, attrition-to-risk ratio, tenure, experience)	50%
Recruiting (e.g., job requisitions, candidates, assessments)	43%
Revenue Capture (e.g., time-to-revenue, revenue capture percentage, referral capture percentage)	33%
Talent and Career Planning (e.g., skills, mentorship, development plans)	30%
Provider Credentials (e.g., licensure, certifications, privilege affiliations, malpractice)	28%
Performance Management (e.g., performance review data, goal setting)	28%
Practitioner Adverse Events (e.g., malpractice claims, adverse licensure, certification, and clinical privileges)	15%
Employee Engagement and Satisfaction (e.g., engagement driver	13%
Candidate Social Media history, community involvement, etc.	5%

One health system described a structured process in which workforce planning flows through the medical group leadership, with annual planning, ongoing audits, and multi-year forecasting for service lines. Importantly, all workforce decisions originate from—and must be approved within—the medical group budget. For net-new roles or positions expected to be loss leaders, decisions are elevated to system-level executives, reflecting the strategic and financial implications of these hires.

Implications for Health System Leaders

IMPLICATION	SUMMARY
Tailor workforce planning to market context and dynamics	One-size-fits-all approaches are ineffective. Urban, high-volume specialties require ROI-driven models, while rural or low-volume markets demand strategies focused on access, provider satisfaction, and community need. Leaders must explicitly define planning objectives based on local market dynamics.
Move from reactive to proactive planning	Waiting for backlogs to trigger hiring decisions risks delayed access and lost revenue. Integrating multi-year workforce forecasting into strategic planning allows organizations to anticipate needs, optimize recruitment timing, and align staffing with demand trends.
Strengthen finance-physician leader collaboration	Embedding finance leaders in workforce planning enhances the rigor and sustainability of hiring decisions. Analytics on market demand, productivity, and financial impact help prioritize roles, balance costs, and align staffing decisions with broader system strategy.
Formalize process and decision frameworks	Ad hoc hiring leads to inefficiencies and misalignment. Structured committees, templates, and annual audits provide accountability, standardize decision-making, and ensure all workforce decisions are tied to strategic priorities and the medical group budget.
Plan for strategic, loss-leading roles	Certain positions may not be financially profitable in the short term but are critical for access, quality, or market presence. Leaders must explicitly account for these roles in system-level planning and resource allocation decisions.

Key Takeaway #2

With 80% of health systems underusing AI and automation, slow hiring is no longer a surprise—it's a call to **modernize workforce planning now**.

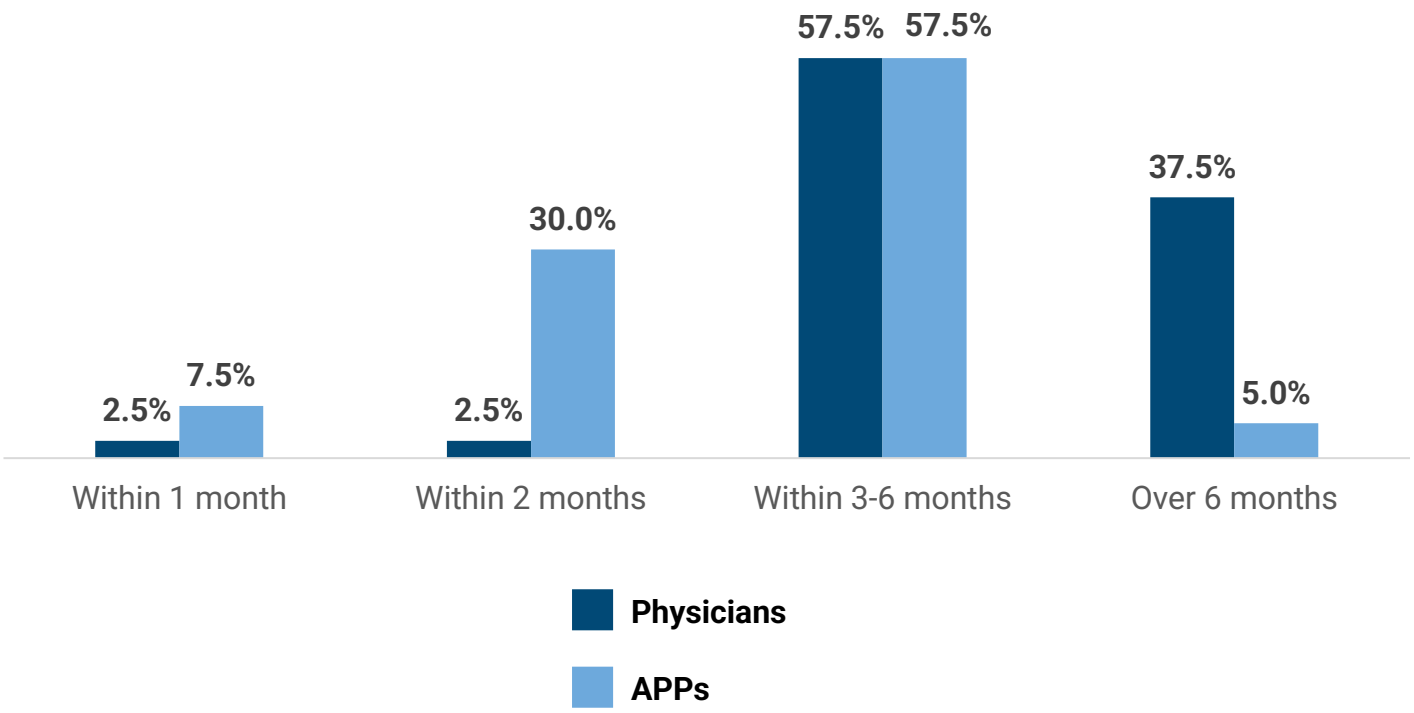
Physician recruitment timelines have nearly doubled since COVID-19, with prolonged time-to-fill rates now challenging patient access, margin performance, and provider satisfaction across health systems. Although leaders recognize reducing time-to-fill rates as a top operational priority and see AI-enabled workforce intelligence as a lever to improve planning and recruiting, slow adoption is forcing organizations into reactive, higher-cost staffing models and longer-range hiring decisions that reduce strategic agility.

Rising Recruitment Timelines Threaten Health System Capacity and Access

Physician leaders report that primary care recruitment typically took four to five months prior to COVID-19. Now, it often exceeds nine months to a year. Specialty recruitment has also slowed, with hiring timelines extending from six months pre-pandemic to over a year in some cases. As health systems experience these sharply increasing time-to-fill periods for physician roles, it's creating operational challenges and risking patient access. According to our survey, 57.5% of health system leaders report it takes 3-6 months to recruit and onboard physicians, while an additional 37.5% say it takes more than 6 months. In contrast, only 5% report similar delays for advanced practice providers (APPs). Several physician executives and CFOs confirm these extended timelines, noting that hiring processes once lasting six months now often stretch up to 18 months.

> *"I don't know if there can even be a long-term plan anymore for physician hiring. You almost have to be looking at that constantly at this point."*
>
> –Chief Financial Officer,
> Leading Health System

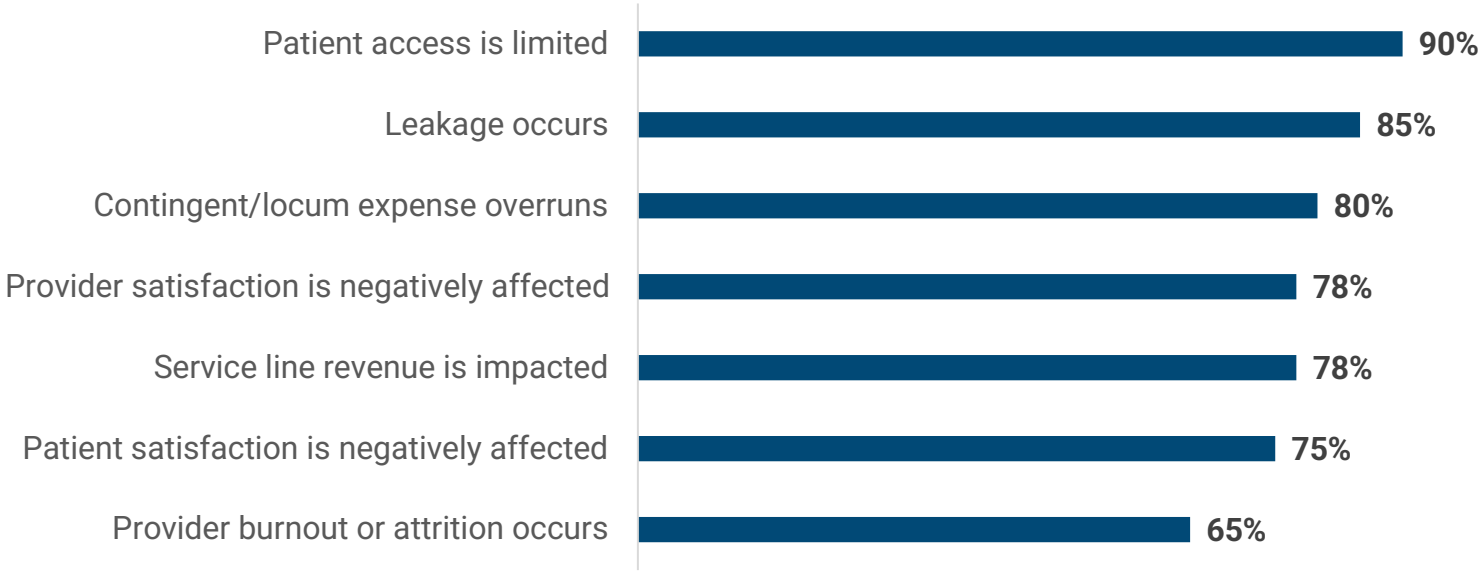
On average, approximately how long does it take your organization to find and hire physicians vs. APPs? *N = 40*



Time-to-Fill Is a Critical Operational Metric with Wide-Ranging Impact

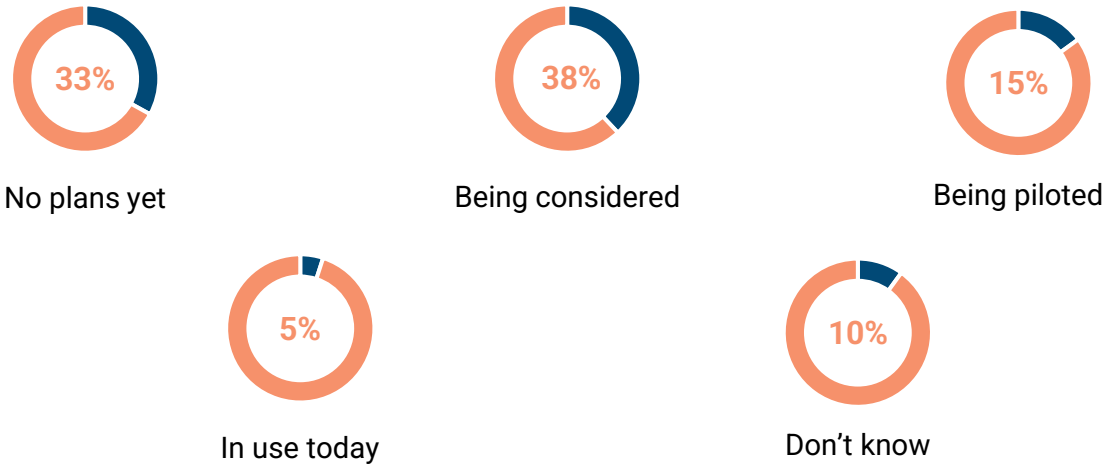
Survey respondents consistently rank reducing time-to-fill for priority clinical roles among their top three metrics for measuring organizational effectiveness in provider recruitment. Extended hiring delays contribute to decreased patient access, increased leakage, reduced service line revenue, and negatively impact both provider and patient satisfaction.

What is the felt impact on your health system when provider shortages or delays in recruiting/onboarding occur? *N = 40*



Despite these challenges, word-of-mouth referrals remain the most effective recruitment tool, with 60% of respondents rating it as highly or most effective. Physicians cultivate their existing relationships is what makes word-of-mouth referrals a highly effective strategy for bringing quality new hires into a health system, but it does not scale. Some health systems are leveraging automation to better enable this process. However, one in three health systems have no plans to use AI or large data analytics to enhance recruitment—a missed opportunity to streamline hiring.

To what extent does your organization use AI for precision sourcing and recruiting? *N = 40*



Innovative Workforce Strategies Can Offset Recruitment Challenges

To mitigate hiring delays, health systems have implemented several alternative workforce models, including:

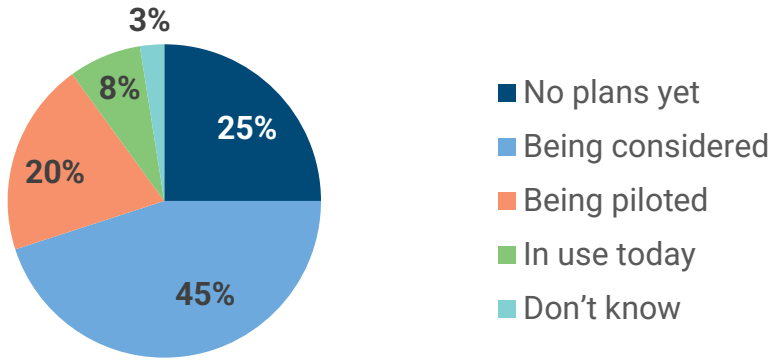
- **Telehealth Expansion:** Investing in 24/7 virtual urgent care and other telehealth services to meet demand and reduce reliance on physical sites.
- **Specialty Float Pools:** Deploying flexible specialty staffing to address short-term gaps, despite concerns about provider satisfaction.
- **Future Workforce Development:** Partnering with local high schools to create pathways for nursing and support staff certification to 1) improve retention, 2) familiarize future support staff with scaling technologies that help combat shortages early, and 3) reduce administrative burden across roles.
- **Internal Locum Pools:** Utilizing retired primary care physicians in non-panel roles to maintain internal capacity.
- **Prioritized Use of Locum Tenens as Transitional Clinical Resources:** Employing locum clinicians more aggressively, particularly for specialists, to maintain capacity despite higher costs.

Advancing Planning Operations with Workforce Intelligence Possible, but Adoption Lags

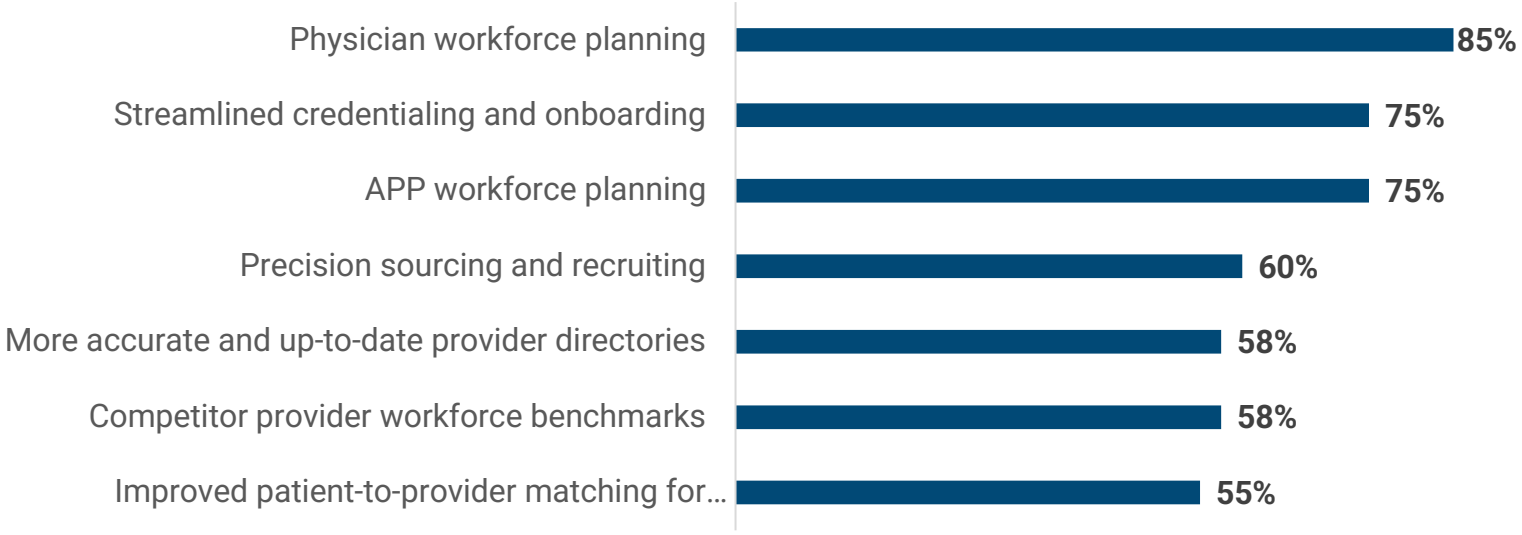
THMA's annual Finance and Budgeting CFO survey found that the limited dollars in health system budgets are tilting to AI and permanent staff and away from temp labor and corporate overhead. 96% of leaders plan to increase AI spending, with nearly one in four anticipating significant boosts (up 12% from 2024). Budgets also favor APPs and permanent clinicians, while cuts target travel/contract labor and corporate offices (65% expect reductions). And physician executives broadly agree that data-driven insights could improve physician and APP workforce planning (at 85% and 75% respectively), streamline credentialing and onboarding (75%), advance precision sourcing and recruiting (60%), and ensure more accurate provider directories and better competitor benchmarks (58%).

Despite widespread agreement that AI-driven insights can improve these operations, only 8% of health systems report using AI for provider workforce planning today and another 20% are piloting it for some functions. This technology adoption lag exacerbates the need for many systems to plan recruitment up to two years in advance, overspend on contingent labor and external recruiters to fill gaps, and limits agility and responsiveness to constantly changing market dynamics.

To what extent does your organization use AI for provider workforce planning? *N = 40*



Which areas could AI-driven insights about providers inside and outside your organization improve operations? *N = 40*



Implications for Health System Leaders

IMPLICATION	SUMMARY
Leverage advanced analytics and AI	Adopting AI, large datasets, and automation can help optimize recruitment, reduce time-to-fill, and improve candidate targeting. Further, large datasets that help with monitoring of labor market trends and specialty demands allows health systems to create contingency strategies for hospital-based specialties vulnerable to recruitment and salary pressures.
Anticipate the impact of time-lag in decisions	Workforce decisions take months—or even years—to fully materialize. Leaders must account for long lead times in hiring, onboarding, and ramp-up productivity when setting workforce strategies.
Invest in agile and modular staffing models	Expanding telehealth, specialty float pools, internal locum resources, and locum tenens strategically can help temporarily mitigate patient access challenges during hiring delays.
Move further upstream to develop future workforce pipelines	Partner with local educational institutions to train, familiarize with scaling technologies, and certify support staff, stabilizing clinical teams and enhancing retention.

Key Takeaway #3

Rapid changes in clinician expectations are outpacing available data, highlighting the **need for more real-time workforce intelligence**.

Health system executives cite data timeliness—not data quality—among the primary barriers to effective clinical workforce planning, as market dynamics and clinician expectations evolve faster than traditional planning cycles can respond. While organizations are striving to shift from reactive to proactive hiring, fragmented data and slow adoption of AI-enabled workforce intelligence continues to limit precision in workforce decisions. Ultimately, these dynamics increase the risk of either having underutilized capacity or access-constraining shortages across a health system.

Data Challenges and Evolving Workforce Planning in Health Systems

Health system leaders report that while data is critical to clinical workforce planning, **timeliness—not accuracy—is the primary challenge**. Trends in clinician expectations, labor markets, and patient demand are evolving faster than even the best datasets can capture. The COVID-19 pandemic accelerated this challenge, shifting health systems from reactive hiring toward more proactive planning, but many processes remain in transition.

Historically, many health systems waited until clinics or service lines reached high volumes before hiring additional physicians or APPs. Today, leaders aim to anticipate demand and hire proactively, but finding the "sweet spot" remains difficult. Hiring too early risks underutilized clinicians, while waiting too long exacerbates capacity constraints, patient wait times, and specialist backlogs.

> *"We need to be more thoughtful about how we anticipate what we need and hit the sweet spot. Obviously, we don't want to be too early, because then they won't be busy. But we also don't want to wait too long, because then our wait time and capacity issues get worse, both in the clinic, but especially for our specialists, and more importantly, in the hospital or the cath lab."*
>
> —Chief Physician Executive,
> Leading Health System

Key Data Sources for Workforce Planning

Workforce planning should be powered by workforce intelligence—using data to improve, design, and align health system workforce practices. But leaders report that while some datasets are readily accessible, others are siloed across disparate departments and standalone tools, difficult to pull, or incomplete, leaving health systems with a less-than-optimal mix of data for decision-making. For example, many are actively exploring what constitutes the optimal care team, ideal ratios of clinicians to support staff, and the internal processes to determine those ratios, but they stress the need for better information to do so effectively. As one physician executive stated, *"We're trying to be more fact-based today, than data-driven. Our process is as data-driven as we can get, but it feels like there's not a lot of data out there. In fact, we actually don't have a lot of data to help us here, so we're trying to strategically think about this and what we need."*

Self-Reported Datasets & Sample Metrics Used in Workforce Intelligence[1]

Productivity & Volume	Financial Information	Quality & Safety	Patient & Experience	Referral & Network Insights
• wRVUs/RVUs, visits, encounters, procedures, cases • Appointment utilization, open slots, template optimization	• Revenue per encounter, payer mix, cost per member • Claims data, MGMA benchmarking	• Readmissions • SSI rates • Mortality • Length of stay • CPOE adherence	• Patient satisfaction • Net promoter score • Consumer experience scores	• Referral patterns • Network integrity • Referring physician data • Surgery conversion rates

Frequently — **Consistency of Use across Health Systems** — *Rarely*

1) Based on an analysis of 30 physician executive responses to the open-ended question, "Once providers are onboarded, what information regarding their practice trends, patient population, and workloads is applied?" and five interviews with financial and physician executives.

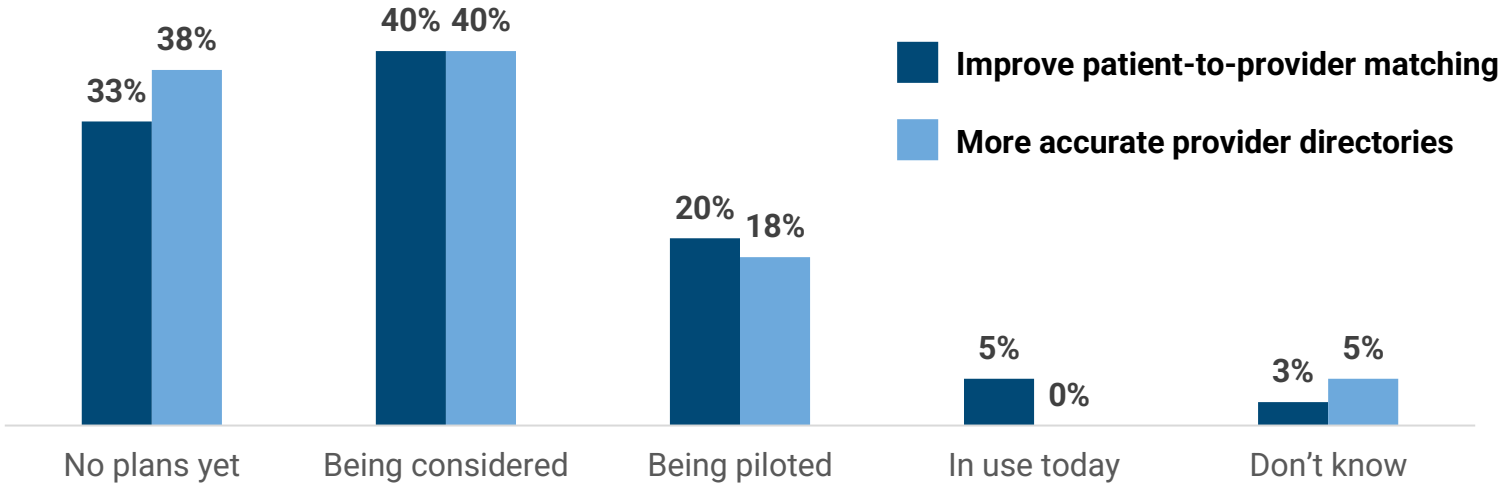
As health systems aim to move beyond reactive hiring, they need access to datasets that integrate access, quality, experience, and population health insights to identify trends, anticipate shortages, and make proactive, strategic staffing decisions. Some commonly referenced measures include:

- **Recruitment datasets and predictive models** managed by centralized recruitment offices, though visibility to CPEs is often limited.
- **Productivity metrics**, such as time to third next available appointment (TNAA), to gauge clinician capacity.
- **Physician tenure** to anticipate potential attrition or retirement.
- **External projections of service line shortages**, that consider closer to real-time changing labor market dynamics.
- **Internal volume and workforce data** to align supply with demand across locations.

AI can automate the timely updating and matching of information across these large datasets, integrating information that is internal and external to the health system. While the plurality of surveyed health systems are still considering using AI-enabled support systems, many physician leaders report feeling behind on taking advantage of the possibilities AI can offer clinical workforce management.

> *"AI can automate credentials evaluation, ongoing practice performance, and payer credentialing. AI can also automate physician practice profiles, locations, directories, HR, and some finance/accounting functions […] Such a tool does not yet seem to be present in the marketplace, but a tool will come and will underpin the functioning of every hospital/health system, radically improving efficiency and accuracy."*
>
> —Medical Group President, Leading Health System

To what extent does your organization use AI to improve patient-to-provider matching for referrals and appointments vs. more accurate and up-to-date provider directories? *N = 40*



Implications for Health System Leaders

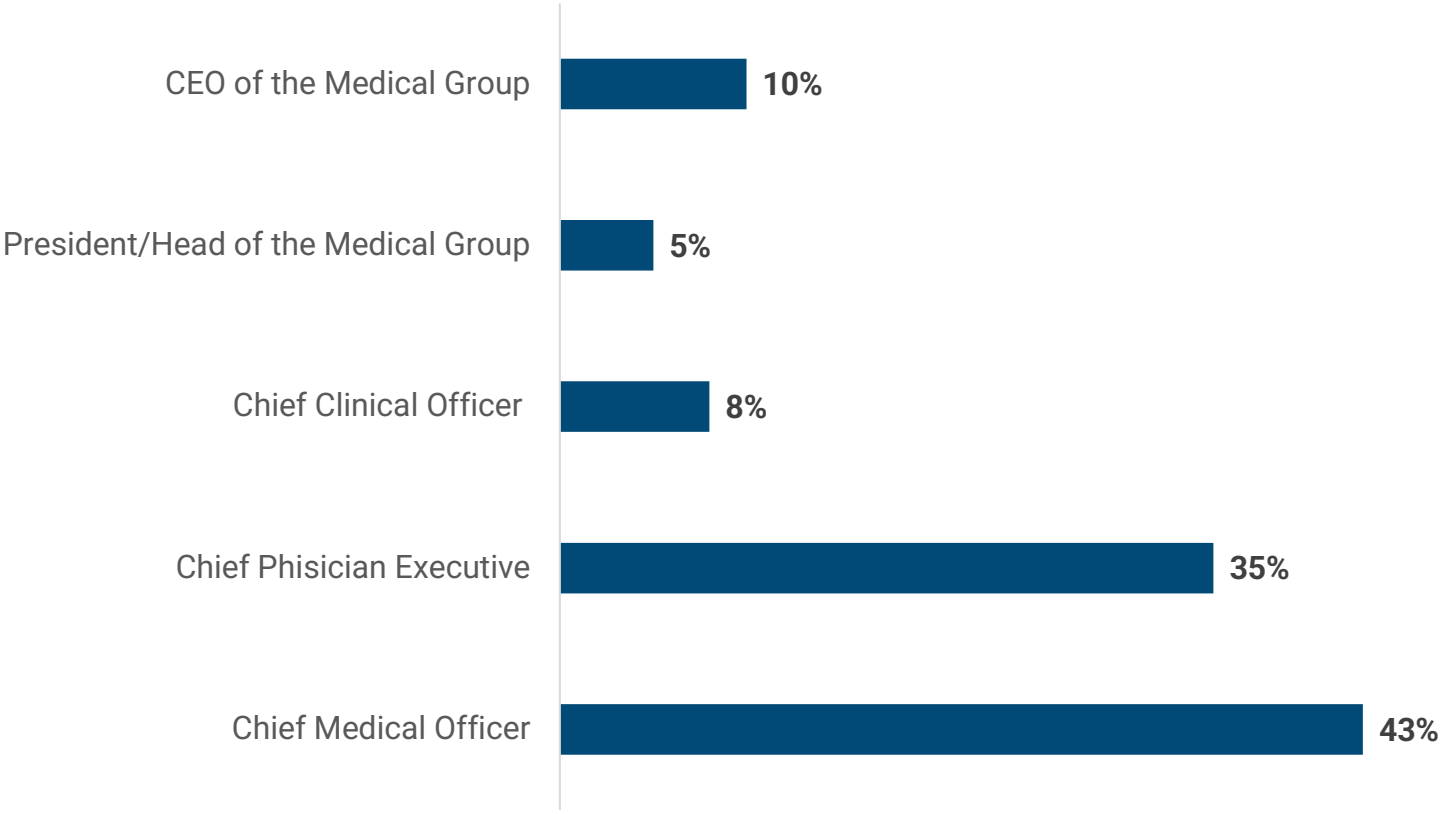
IMPLICATION	SUMMARY
Invest in timely, regularly updated, integrated data	Current post-onboarding physician analytics that fuel workforce intelligence are productivity-centric and fragmented, creating opportunities to adopt more standardized, holistic approaches that integrate access, quality, experience, and population health insights.
Leverage predictive analytics to evolve from workforce planning to ongoing workforce intelligence	Apply predictive models to identify future shortages, optimal care team ratios, and retention risks, enabling timely recruitment and capacity planning that is aligned with health system workforce practices.

Appendix

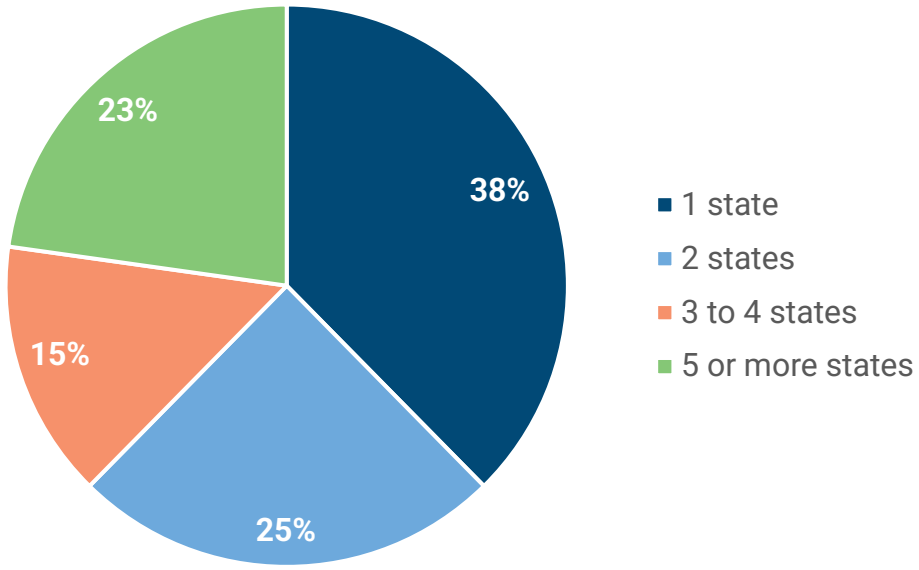
This section provides a detailed breakdown of the survey dataset (N=40 health system executives) on executives' perspectives on the signals and downstream impact of provider supply and demand on health systems, including respondent demographics.

Sample Descriptives

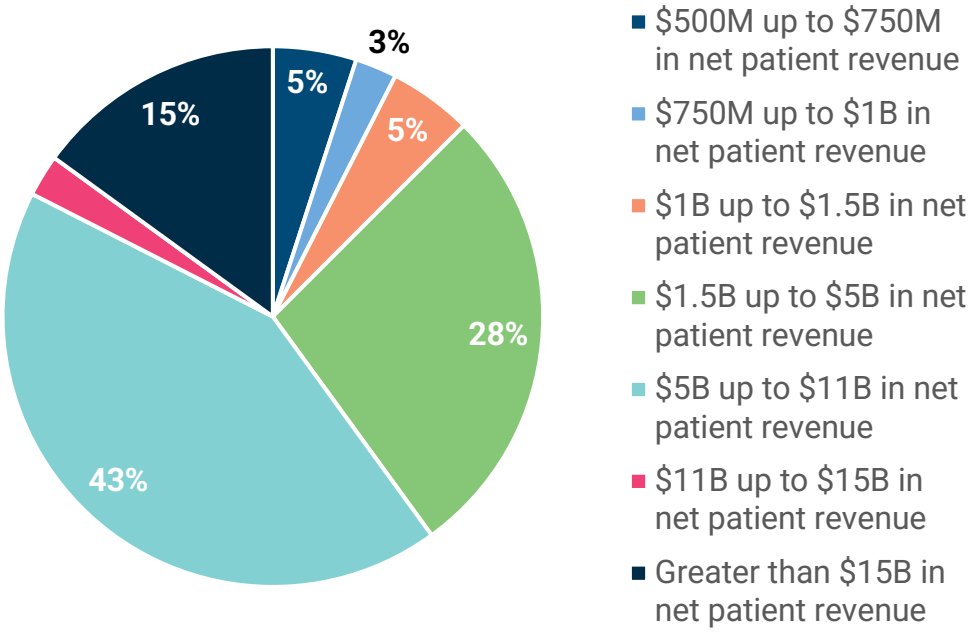
1. What is your current role title? *N = 40*



2. What is the geographic footprint of your health system? *N = 40*

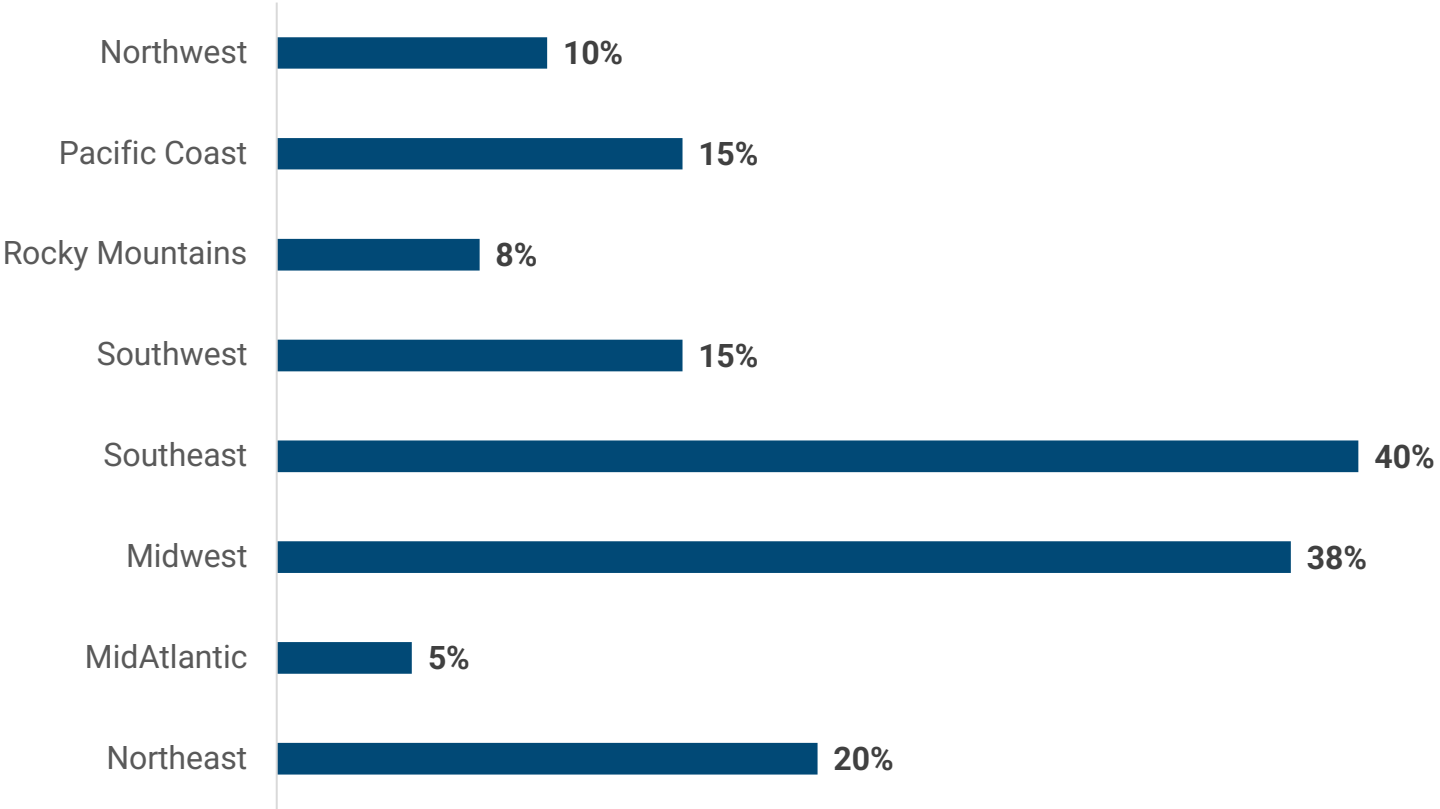


3. What is the size of your health system (annual net patient revenue)? *N = 40*

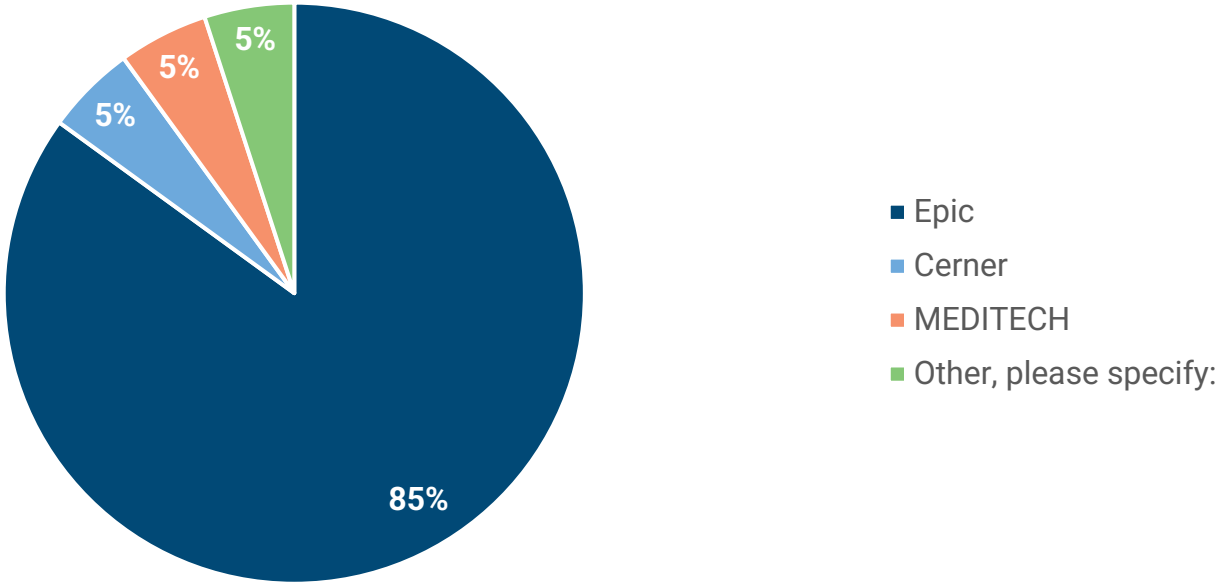


4. In what regions is your health system located? *N = 40*

Note: Counts sum up to a number greater than 40 because some health systems exist across multiple states. Percentages are still calculated based on 40 respondents. For example, 20% of respondents are in a health system that operates in the Northeast.



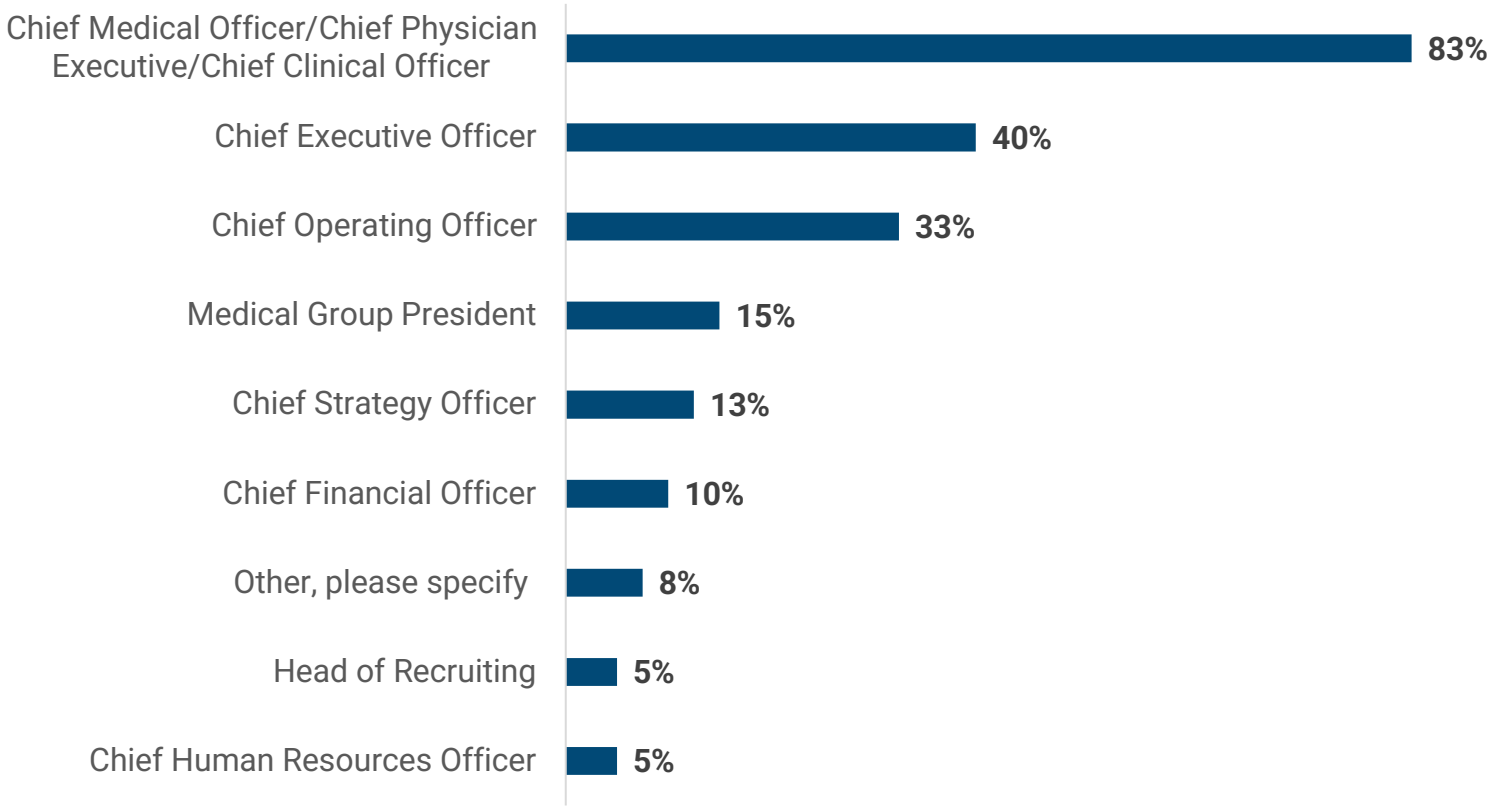
5. What is your primary EHR (Electronic Health Record) platform? *N = 40*



Other responses:

- All three at the present time
- Multiple EMRs

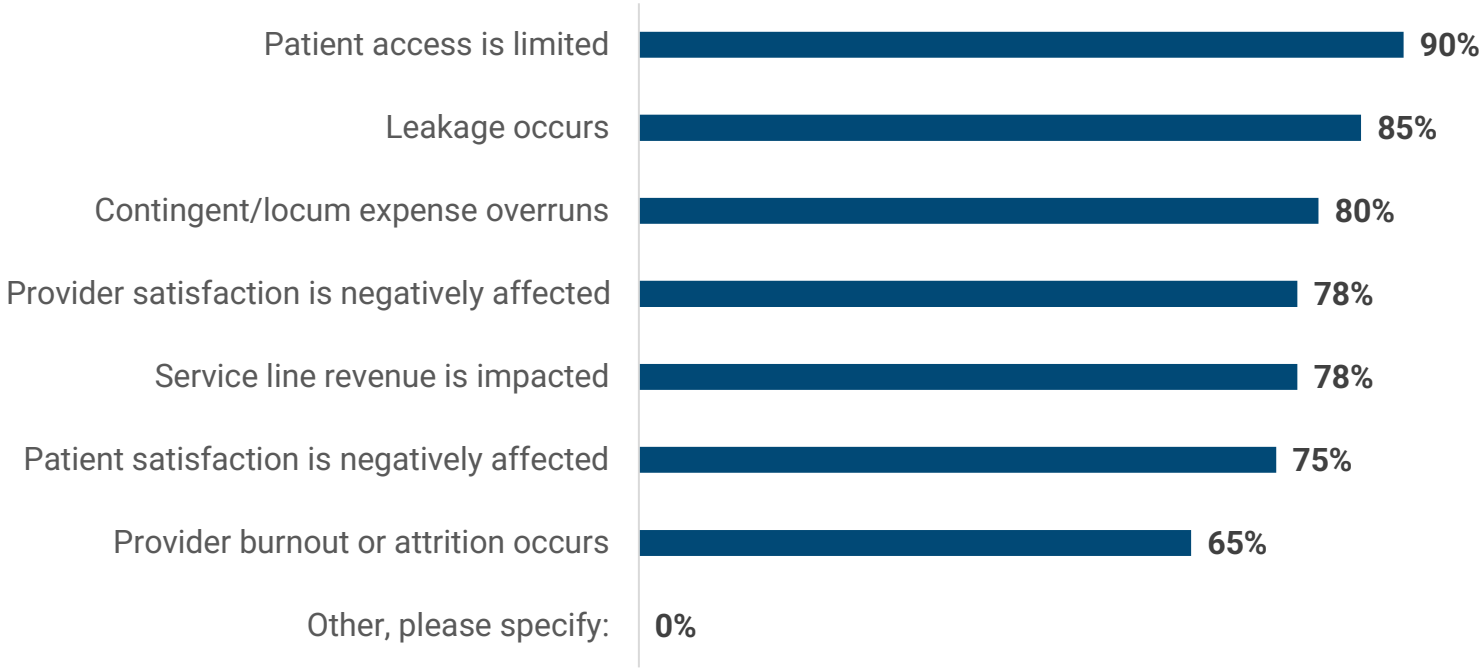
6. Who typically initiates the decision for physician and APP workforce planning and growth decisions in your organization? *N = 40*



Other responses:

- Dean, Institute Chiefs, and Department Chairs

7. What is the felt impact on your health system when provider shortages or delays in recruiting/onboarding occur? *N = 40*



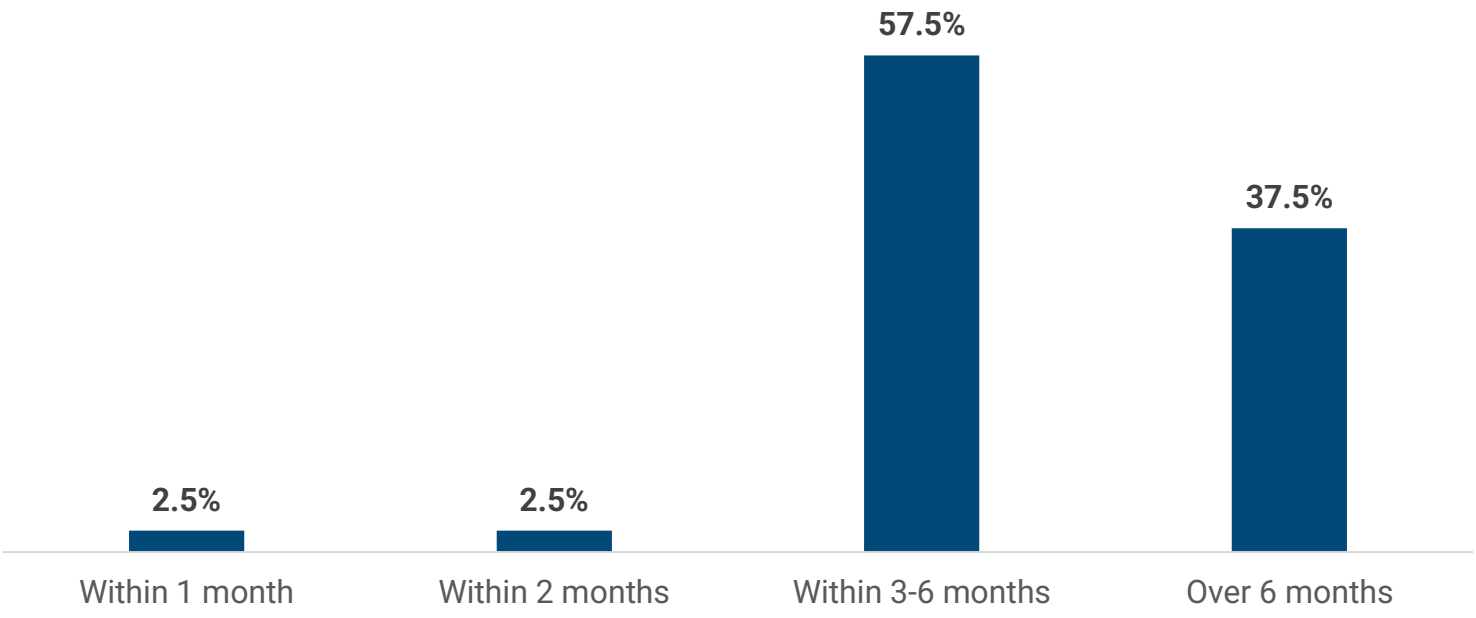
8. Of the following metrics, which three are the most important for determining the effectiveness of an organization's functions when planning to bring on new clinical talent? *(Percentage of respondents) N = 40*

	% Rank #1	% Rank #2	% Rank #3	% Ranked in Top 3
Average annual net patient revenue per provider	2.5%	10.0%	2.5%	15.0%
Provider engagement and satisfaction (e.g., NPS)	15.0%	5.0%	10.0%	**30.0%**
% reduction in application turnaround time	7.5%	0.0%	5.0%	12.5%
% reduction in time to clinician activation	2.5%	2.5%	10.0%	15.0%
% reduction in overall onboarding time	0.0%	7.5%	5.0%	12.5%
% reduction in missed start dates	0.0%	7.5%	2.5%	10.0%
% reduction in time-to-fill for priority roles	12.5%	12.5%	7.5%	**32.5%**
% reduction in time to source candidates	2.5%	5.0%	5.0%	12.5%
Expansion into new markets	12.5%	5.0%	7.5%	**25.0%**
Change in workforce FTE	2.5%	10.0%	0.0%	12.5%
Physician vs. APP Mix	0.0%	0.0%	10.0%	10.0%
Specialty revenue baselines	7.5%	5.0%	5.0%	17.5%
Specialty contribution margin baselines	5.0%	7.5%	10.0%	22.5%
Sourcing time baselines by role	2.5%	0.0%	0.0%	2.5%
Locum tenens cost by role	7.5%	10.0%	10.0%	**27.5%**
External recruiting fees	0.0%	2.5%	0.0%	2.5%
Claims denial rate	2.5%	0.0%	5.0%	7.5%
Provider turnover rate	12.5%	10.0%	2.5%	10.0%
Other, please specify (see write-in responses)	--	--	--	--

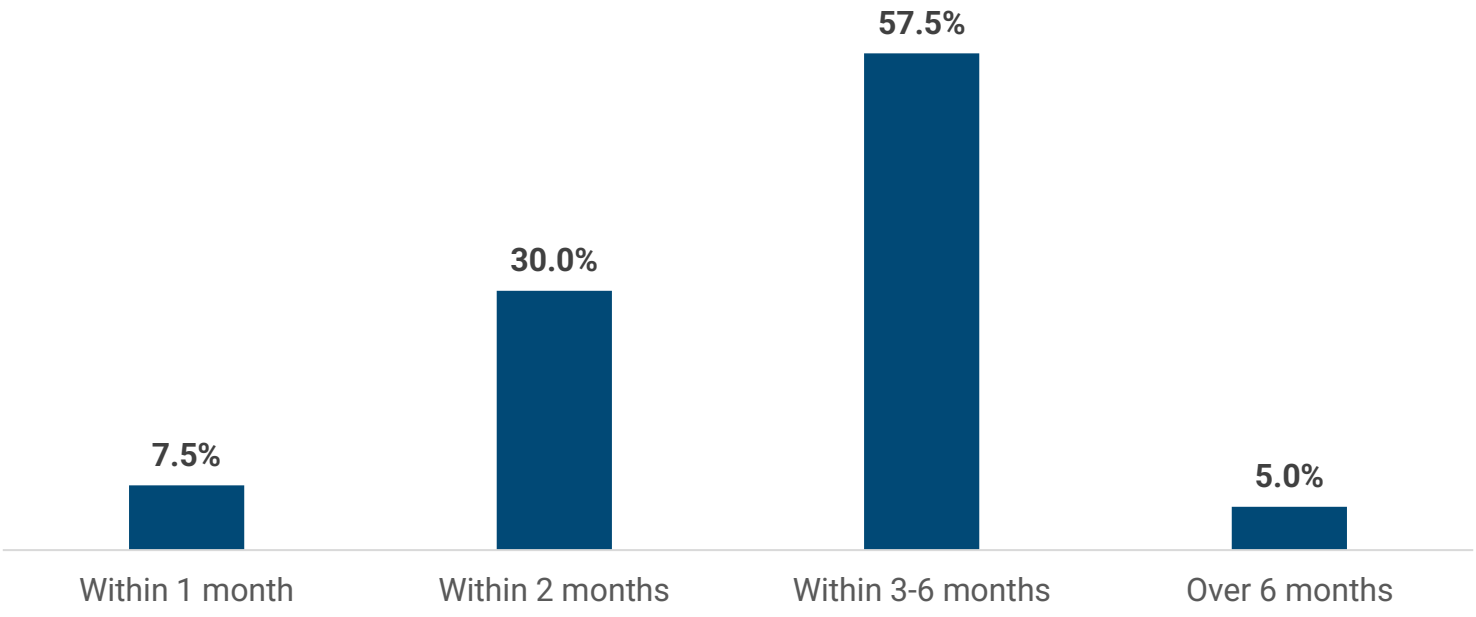
Other responses:

- Rank #1 Most Important: Access to high demand specialties; Patient access
- Rank #2 Most Important: N/A
- Rank #3 Most Important: Capacity to see new patients

9. On average, approximately how long does it take your organization to find and hire physicians? *N = 40*



10. On average, approximately how long does it take your health system to find and hire APPs? *N = 40*



11. Please rate the effectiveness of the following resources during the physician recruitment process on a scale of 1-5, with 1 = least effective and 5 = most effective. *(Percentage of respondents) N = 40*

	1 (Least effective)	2	3	4	5 (Most effective)
Use outside recruiting firms to find physician candidates	5%	30%	35%	20%	10%
Use contingent/locums labor to fill gaps	20%	15%	35%	25%	5%
Word of mouth (or referrals)	3%	10%	28%	30%	30%
Job postings on job boards	8%	15%	48%	25%	5%
Internal-only hiring	10%	13%	38%	30%	10%
Use temp agencies to shortlist candidates	25%	33%	33%	5%	5%

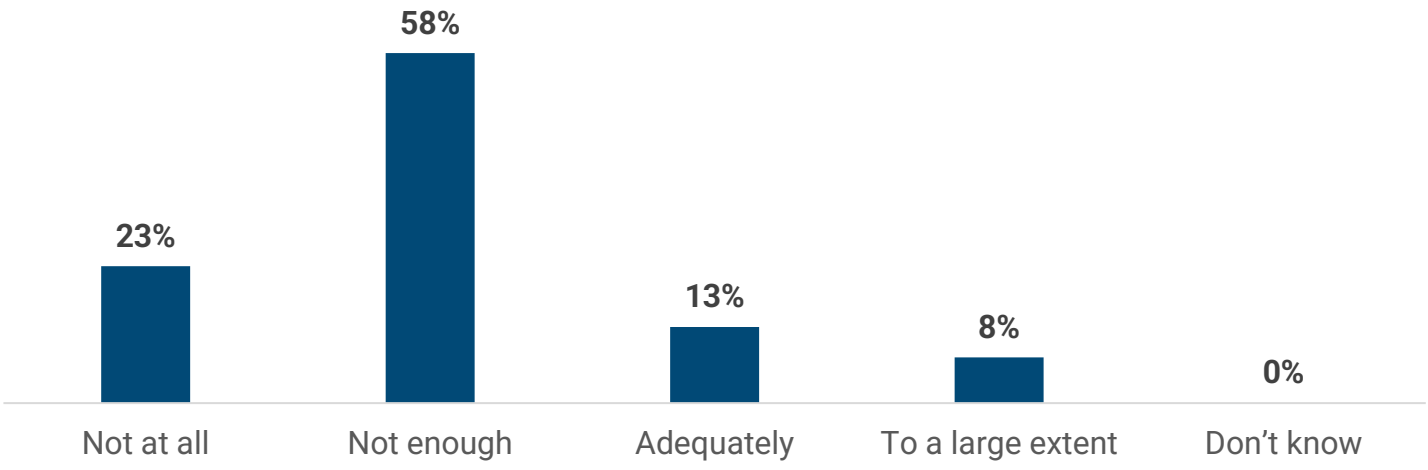
Other responses:

- Rank #1 Most Important: Access to high demand specialties; Patient access
- Rank #2 Most Important: N/A
- Rank #3 Most Important: Capacity to see new patients

12. To the best of your knowledge, which five of the following sources of data does your health system use to plan for/manage the provider supply chain? *(Percentage of respondents) N = 40*

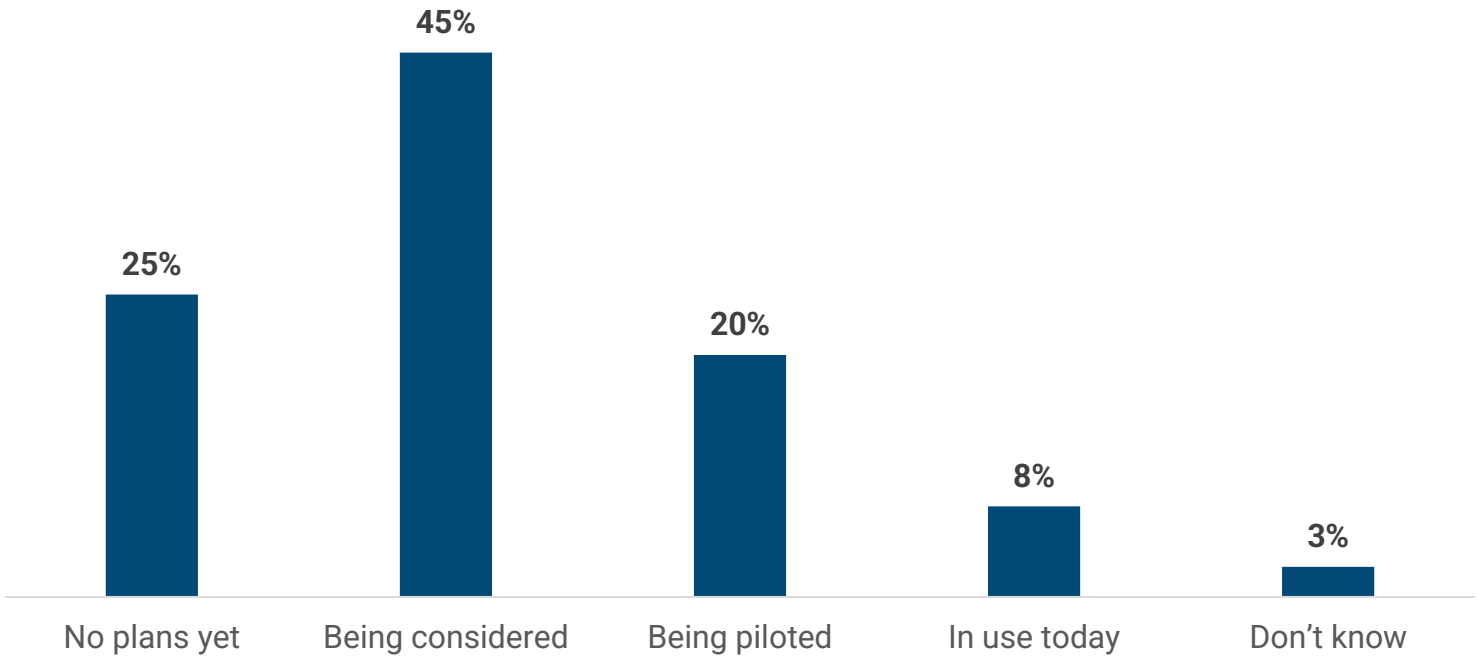
Data Source	Rank 1	Rank 2	Rank 3	Rank 4	Rank 5	% of Respondents Ranked Among Top 5
Compensation and Benefits (e.g., salary, insurance, retirement)	8%	13%	35%	15%	8%	78%
Procedure and Encounter Data (e.g., volume data by physician, site of care, etc., and service utilization)	35%	10%	8%	8%	3%	63%
Provider Financials (e.g., revenue per employee, cost per hire)	15%	18%	8%	3%	13%	55%
Labor Market Statistics (e.g., geographical distribution, employment projections)	8%	18%	15%	8%	3%	50%
Candidate Supply/Availability (e.g., candidates per job opening, attrition-to-risk ratio, tenure, experience)	8%	5%	10%	13%	15%	50%
Recruiting (e.g., job requisitions, candidates, assessments)	8%	5%	5%	20%	5%	43%
Revenue Capture (e.g., time-to-revenue, revenue capture percentage, referral capture percentage)	8%	10%	0%	13%	3%	33%
Talent and Career Planning (e.g., skills, mentorship, development plans)	3%	0%	8%	13%	8%	30%
Provider Credentials (e.g., licensure, certifications, privilege affiliations, malpractice)	3%	8%	3%	3%	13%	28%
Performance Management (e.g., performance review data, goal setting)	0%	3%	5%	8%	13%	28%
Practitioner Adverse Events (e.g., malpractice claims, adverse licensure, certification, and clinical privileges)	0%	3%	3%	0%	10%	15%
Employee Engagement and Satisfaction (e.g., engagement driver	0%	3%	3%	0%	8%	13%
Candidate Social Media history, community involvement, etc.	3%	3%	0%	0%	0%	5%

13. To what extent do you believe your organization is leveraging advanced technologies, such as large data models, AI, and automation, to optimize provider recruitment? *N = 40*

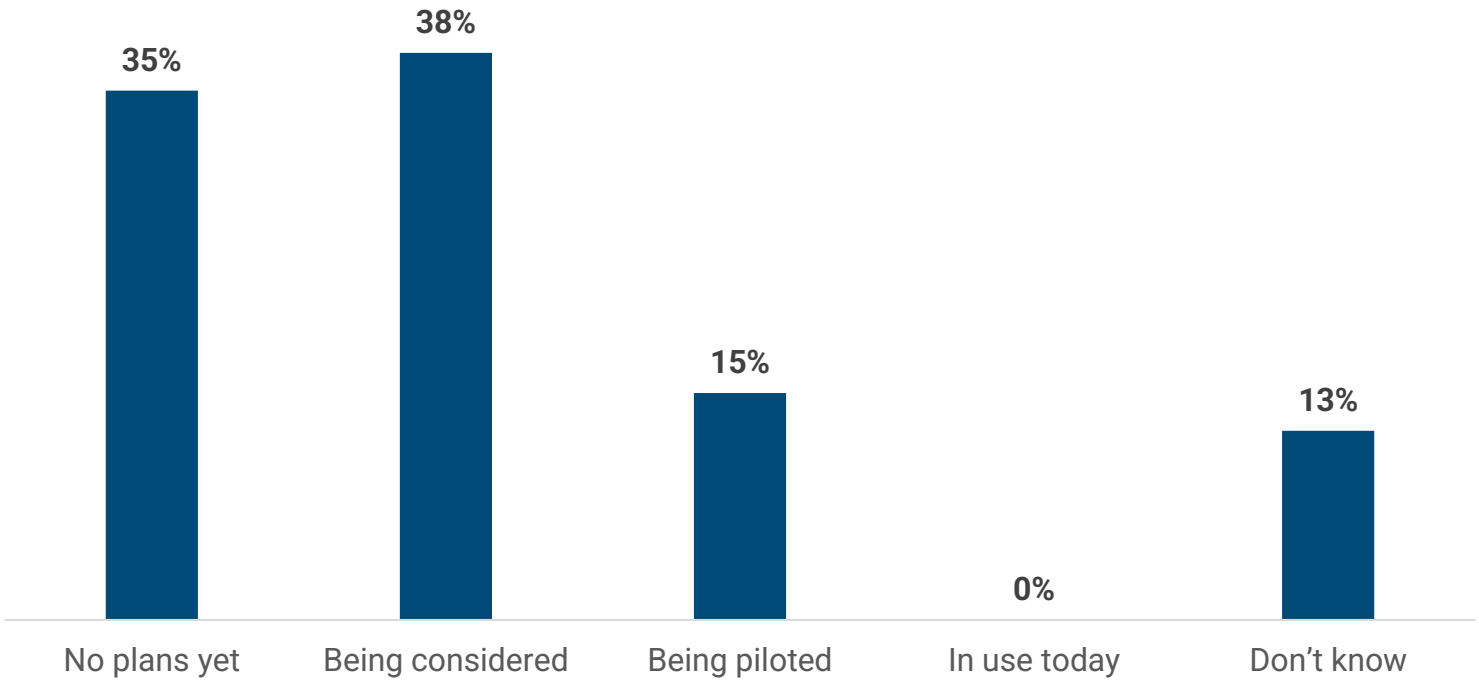


14. Which areas could AI-driven insights about providers inside and outside your organization improve operations? *N = 40*

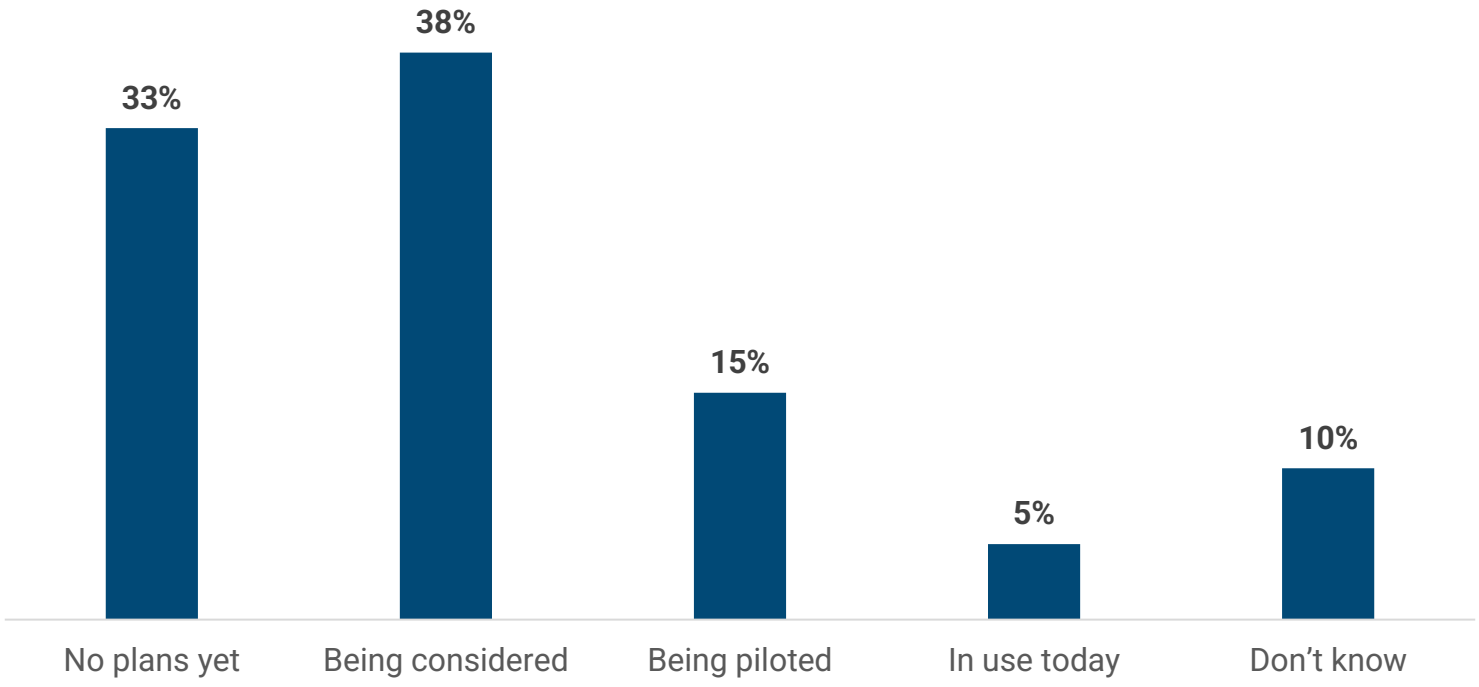
15: To what extent does your organization use AI for provider workforce planning? *N = 40*



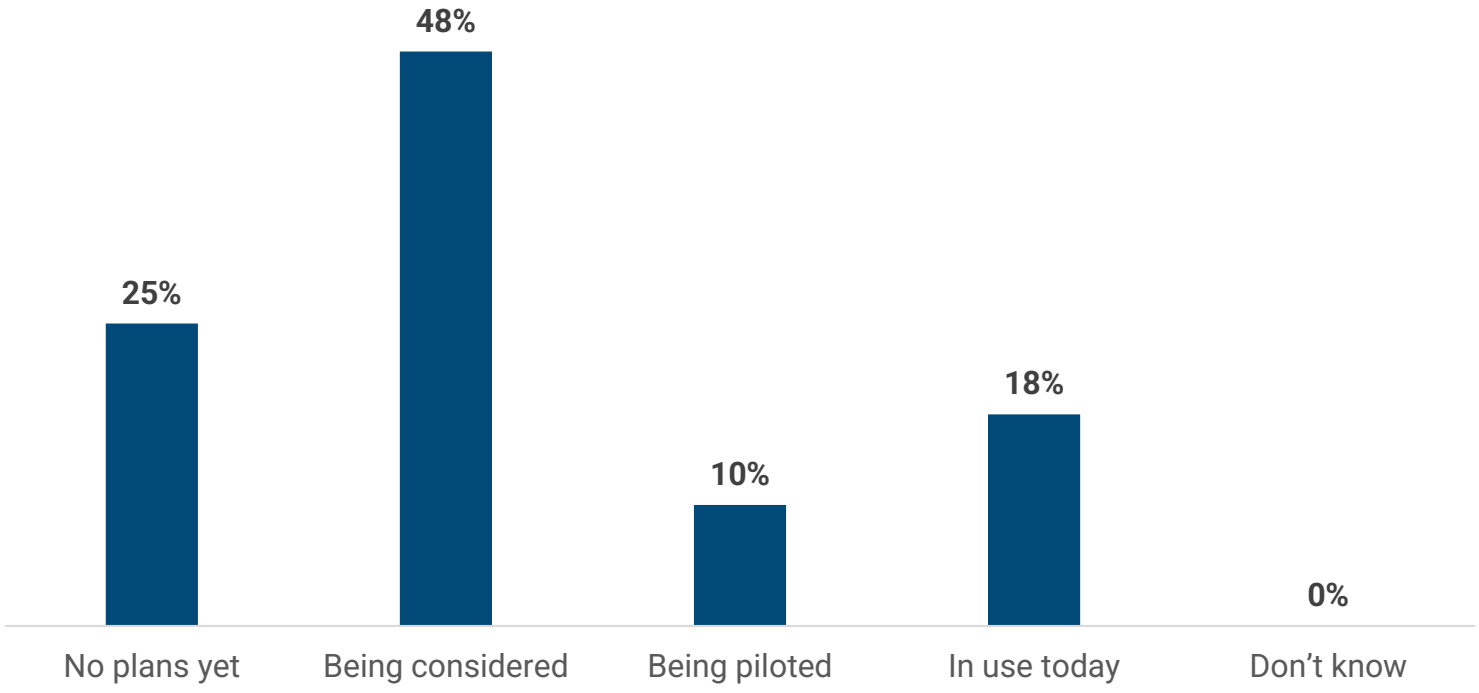
16: To what extent does your organization use AI to access competitor provider workforce benchmarks? *N = 40*



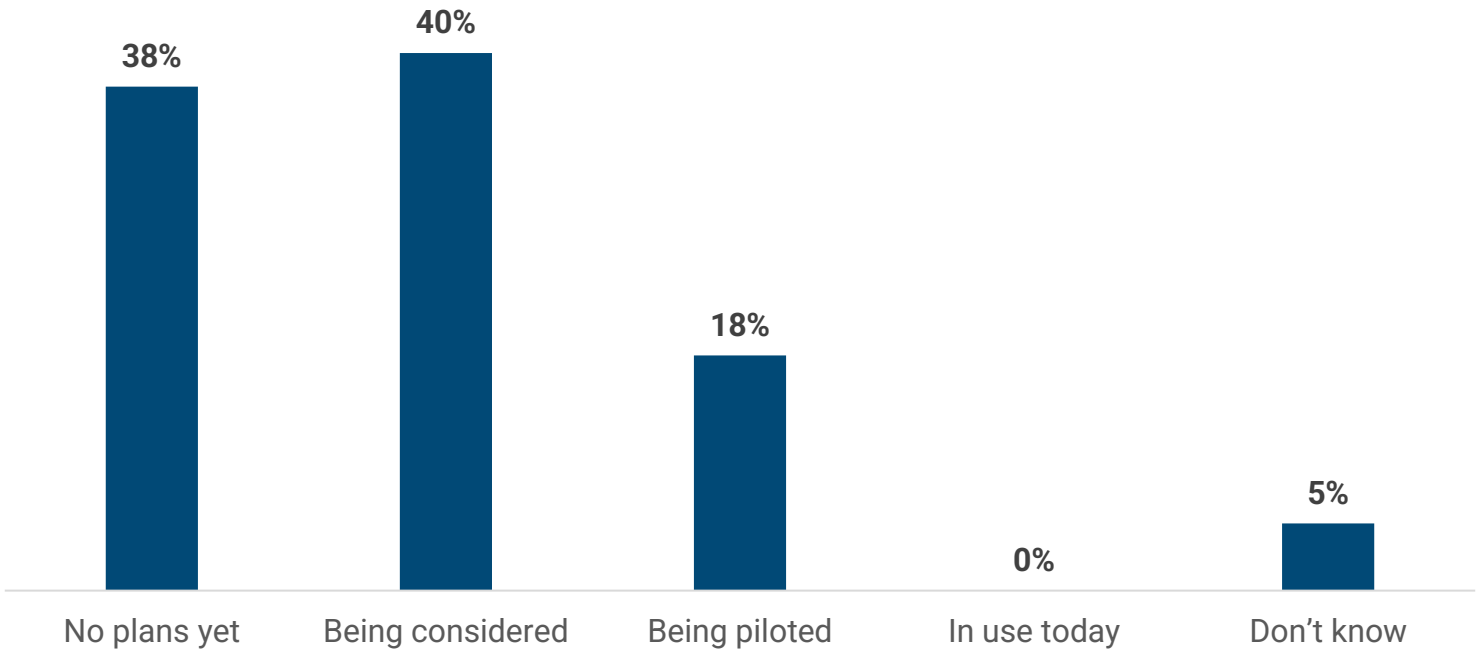
17: To what extent does your organization use AI for precision sourcing and recruiting? *N = 40*



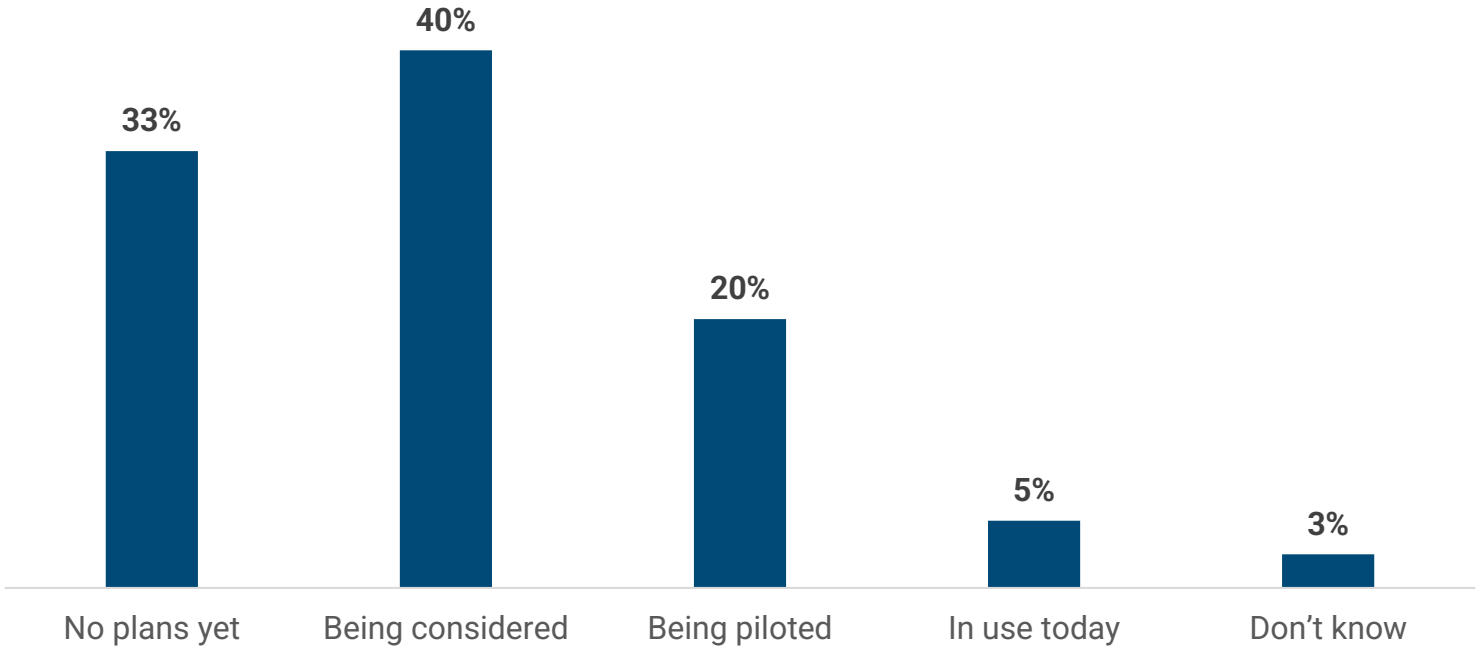
18: To what extent does your organization use AI for streamlined credentialing and onboarding? *N = 40*



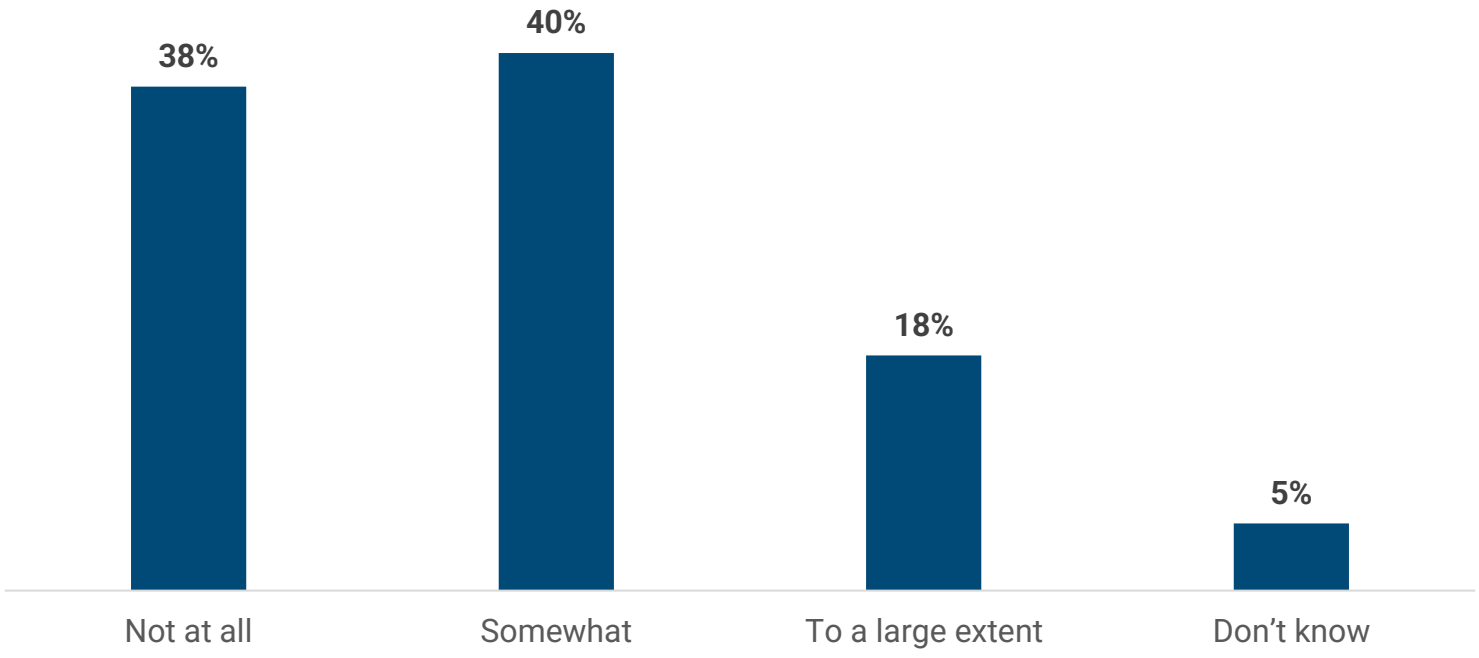
19: To what extent does your organization use AI for more accurate and up-to-date provider directories? *N = 40*



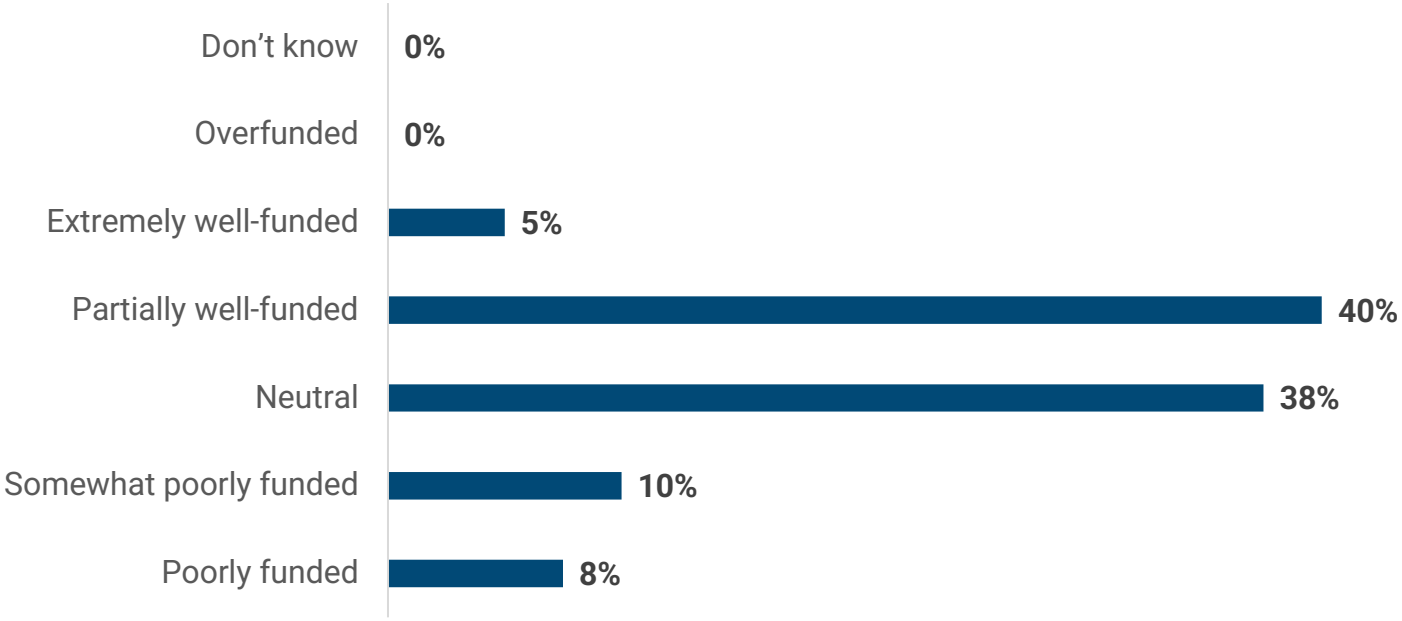
20: To what extent does your organization use AI to improve patient-to-provider matching for referrals and appointments? *N = 40*



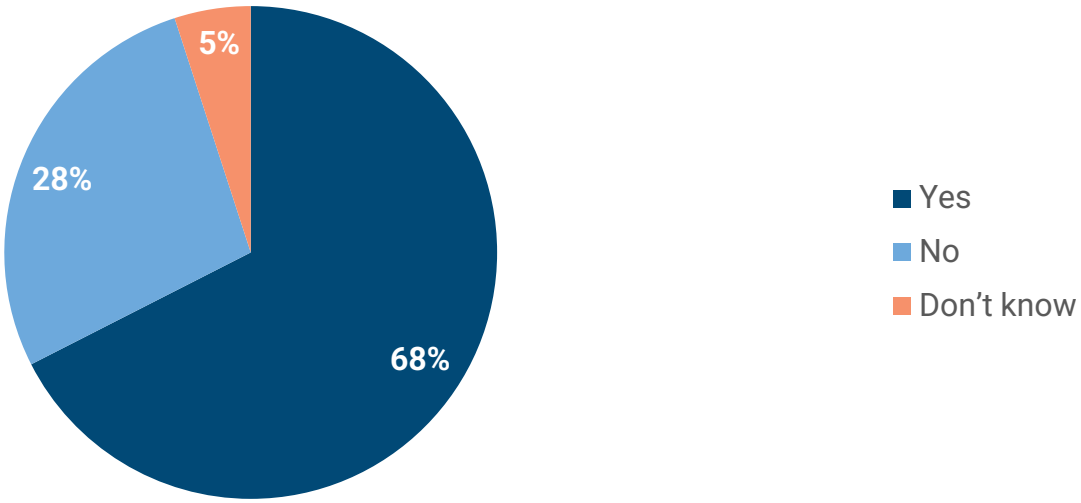
21: To what degree do you think competitors using AI for recruiting/onboarding threaten your ability to compete for talent? *N = 40*



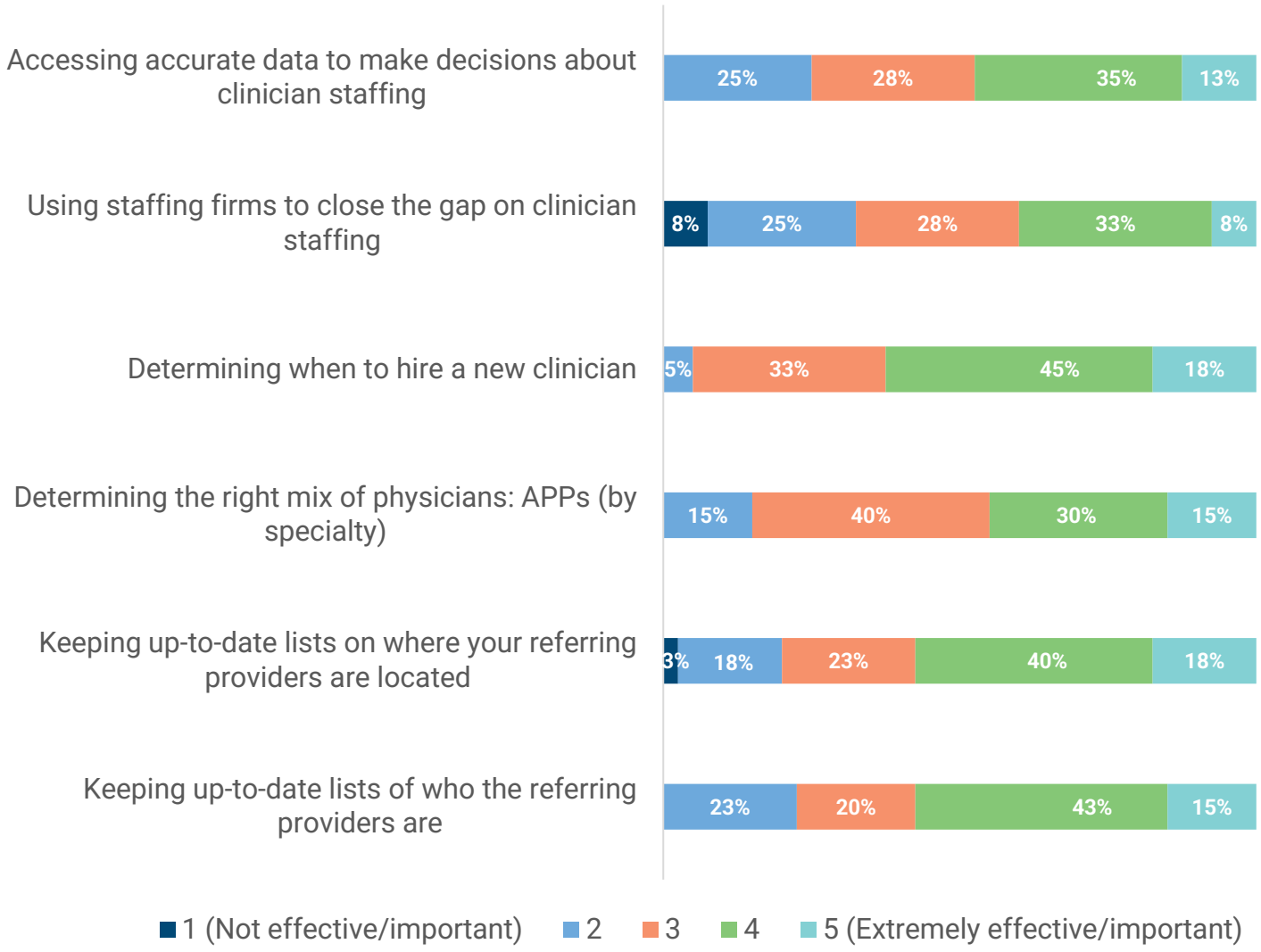
22. When considering your health system's budget to support recruitment needs, how well-funded do you consider your recruiting functions to be? *N = 40*



23. Does your organization measure provider satisfaction (e.g., Net Promoter Scores) for providers who go through the onboarding process? *N = 40*



24. Rate your perception of how your organization performs these functions today, and their level of importance, with 1 = not effective at all/not important at all and 5 = extremely effective/extremely important. *N = 40*



25. What have you found to be the best methods to measure capacity and adapt to patient demand? *N = 30*

1. Surveys, data analysis, community access
2. Timeliness of patient access to appointments. Workload of physicians (patient numbers and RVUs). ...when there are no available appointments and the specialists are working very hard then new doctors/APPs must be hired
3. Surveys
4. Strong analytic team with analysis of current productiviy and demand to determine FTE need
5. Use of AI tools to better meet the demands of patients that align with the service line and patient outcomes
6. Slot utilization. Days wait. OR block fill. Contribution Margins. Surgery conversion rate
7. Using real time understanding with market dynamics
8. Manual assessment of addressable market using Epic
9. EMR tools
10. We continue to analyze these factors manually and create our own conclusions based on learnings from in-house data
11. Access delay
12. Open patient slots, days to next available appointment, percent of new patients
13. Patient access metrics: time from referral to visit, new pcp visits, referral options in area, referral volumes per provider
14. Patient volume trends, market share, and population growth.
15. We look at the length of time to get an appointment primarily. If our patients can't be seen in a timely fashion, then we look at bringing on more providers.
16. I believe one should hire in advance to anticipate more patients.
17. Volume, population growth, TNAA, payer mix, distance to clinic under 15 min drive
18. Using epic data - measure next available and next third available appointments Use historical data
19. Good use of APPs. Open access scheduling. High quality
20. Time to next third available appointment.
21. We are constantly over capacity, unable to adapt to patient demand rapidly
22. Leakage, patient volume, payor mix
23. Provider utilization, visits slots available, provider productivity, and referral volume with time between referral to first visit
24. New patient appointment slot availability
25. Clinic activity, time to next appointment
26. Referral data and OR availability, physician templates
27. Market studies. Leakage maps. Net patient service revenue comparisons.
28. Reduction in patient access to care
29. Leverage virtual tech to tap into remote specialists
30. We don't unfortunately.

26. Once providers are onboarded, what information regarding their practice trends, patient population, and workloads is applied? *N = 30*

1. Patient volume and RVUs are monitored. Case volumes, procedure volumes are monitored.
2. Primarily wRVU productivity.
3. Fcots, readmissions, mortality, ssi rate.
4. Essentially only wRVU productivity %ile with a counterbalancing access metric.
5. Primarily use RVUs and also use quality and financial data such as care plans cost per member metrics.
6. Dashboard about quality matrices, outcomes and patient satisfaction along with financial matrices.
7. Slot utilization. Payer mix. Surgery conversion rate.
8. RVU, performance.
9. Depends on if they are part of the medical group or private practice.
10. Quarterly updates on this information.
11. Clinician dashboards.
12. Rvu volumes. Patient satisfaction. Claims data. Template optimization.
13. Not much.
14. We track efficiency data primarily. This is done in the form of RVU analysis.
15. Readmission rates, SSI rates, CPOE adherence, Length of Stay.
16. Visits, NPS, appointment utilization.
17. Each specialty has a different metric.
18. Panel size, new patient percentage, open slots, patient revenue, RVUs, network integrity, procedures performed.
19. We monitor patient panels, encounters per day, revenue per encounter, and for pcps we monitor their referral trends.
20. Not much currently. We need to do better in the space.
21. Total visits, procedures/cases, wRVUs, use of EMR outside of office hours, quality/safety.
22. Their RVU production, number of pts seen.
23. None.
24. I think all those aspects are important for the success of the patient.
25. Data analysis, population analytics, quality data tools.
26. TNAA, patients per hour, MGMA modeling.
27. Demographic and referring md.
28. Monitor clinical productivity and location of referrals.
29. RVU, RVU/encounter, revenue, scheduling anomalies and optimization.
30. Appts per unit time, quality score, NPS for consumer experience, impressions from colleagues.

27. What else do you want to share about the use of provider practice data and AI to improve planning, recruiting, onboarding, or optimization of your provider network? *N = 30*

1. AI can automate credentials evaluation, ongoing practice performance, and payer credentialing. AI can automate physician practice profiles, locations, directories, HR, and some finance/accounting functions as there are linkages between all these activities, surrounding physicians profiles/credentials/enrollment/visiblitiy/productivity/scheduling/payment. Such a tool does not yet seem to be present in the marketplace but a tool will come and will underpin the functioning of every hospital/health system, radically improving efficiency and accuracy.
2. Need to invest more in this technology.
3. Recruitment is way too slow and AI could help us. Interested in presentation. We miss way too many opportunities not have the right provider in place at the right time for the right subgroup of patients. Lost patients!
4. This is a gap that more technology could be beneficial.
5. Need better dashboards.
6. Not much.
7. I don't have any additional feedback.
8. It will help and not hurt
9. We don't use AI at this point, and unclear what role it would play when we rely on word of mouth and interviews.
10. AI is likely to help but not in the LLM sense. I think machine learning to enhance referrals will be helpful but I haven't yet seen anything particularly meaningful.
11. We are excited about the possibilities but are a little behind in this area.
12. I think it will become more widely used relatively quickly to help improve efficiencies.
13. Well having the AI scribe has been very helpful.
14. Systems need to be more proactive for credentialing to reduce delays and waste.
15. None. *(Note: Write-in response that was stated by 2 respondents.)*
16. We need to start looking deeper into AI for assist.
17. It's still very early in the development of such tools.
18. I would love to be more data driven in optimizing planning, recruitment, onboarding, and retention of our medical staff.
19. Ability to integrate multiple data sources.
20. For it to work optimally- indirect patient care time that includes all non-direct patient care required tasks must be considered- and a measure of complexity of decision making that is not billing related.
21. I think this would be nice for targeting recruitment.
22. Huge opportunity, much tuning to do to get it right.
23. It feels like we are behind on workforce planning and site of service planning that AI could assist with.
24. Physician satisfaction, FCOTs, Provider turnover rate.
25. N/A *(Note: Write-in response that was stated by 2 respondents.)*
26. Need to find time to teach clinicians how to use AI to monitor and grow their own practices.
27. We lack at it and need cheap AI to help.
28. Nothing.

Partnership Overview

The Health Management Academy (THMA) and Axuall Partnership

Axuall and THMA have partnered on this research brief to examine how leading health systems make strategic decisions about the clinical workforce and where the use of large datasets, data models, and AI can more efficiently support clinical workforce planning efforts. The collaboration combines THMA's proprietary research and executive network with Axuall's expertise in workforce intelligence. Through original research including surveys of health system executives and in-depth interviews, this partnership generates key takeaways on the evolving approaches to clinical workforce planning, management, and execution.

About The Health Management Academy

Since 1998, The Health Management Academy has cultivated the premier community of influential changemakers in healthcare. Our members are aligned around a common goal of improving health for all, and a core belief that partnership will accelerate progress. Our member community includes Leading Health Systems – the approximately 150 innovative integrated delivery systems with over $2B in total operating revenue – and innovative Industry Partners that are working alongside health systems to drive health forward. We power our members by building our community and fostering connections through executive peer learning. We support professional growth through talent and development. We accelerate understanding by delivering timely and actionable data and insights on key challenges. And we catalyze transformation by building alliances in areas where the power of the collective is greater than the power of one. Learn more about The Health Management Academy at hmacademy.com.

About Axuall

Built with leading healthcare systems, Axuall is a workforce intelligence company powered by a national, near real-time practitioner data network. The technology enables healthcare systems, staffing firms, telehealth, and health plans to dramatically reduce onboarding and enrollment time while also providing unique, powerful data insights for network planning, analytics, and reporting. To learn more, visit www.axuall.com.

Methodology Overview and Demographics

This data reflects insights from **40 senior health system executives** who participated in a survey conducted by The Health Management Academy. The survey was administered across September and October 2025, and responses were collected to capture executive perspectives on the signals and downstream impact of provider supply and demand on health systems. Participants represent a broad cross-section of U.S. health systems, varying in size, geography, and leadership focus offering a comprehensive view of how large providers are navigating decision-making about the clinical workforce.

Roles Represented

Respondents held a range of executive titles spanning both clinical and operational leadership. Chief Medical Officers comprised the largest share (43%), followed by Chief Physician Executives (35%) and CEO/Head of the Medical Group (15%).

Health System Size

Participants represented systems of varying scale. The largest segment (43%) reported annual net patient revenue between $5B and $11B, while 28% represented systems generating $1.5B to $5B annually. Another 15% reported revenues greater than $15B annually.

Geographic Footprint

Most respondents reported health systems with broad regional reach. Over one-third (38%) operate in a single state, while an equal share (38%) span operations across three or more states. Another 25% operate in two states, underscoring a balance between localized and multi-state systems.

EHR Landscape

Epic remains the dominant electronic health record (EHR) platform among participating systems, used by 85% of respondents. MEDITECH, Cerner, and multiple EMR platforms compromise the remaining share.