THE PLANNED ADVANTAGE

Why Proactive Locum Tenens Staffing Outperforms the Alternative

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Introduction

Ask most hospital administrators what locum tenens staffing costs and they will tell you the bill rate. Ask them what a provider vacancy costs and many will pause. It is a hesitation worth noting, because the vacancy is often the more expensive problem and rarely the one appearing on a staffing report.

Locum tenens providers keep hospital service lines running, and when one of those positions goes uncovered, the financial damage does not come only from the absent provider's billings. It comes from everything that flows through their work, including the imaging ordered, the procedures scheduled, the referrals made, and the patients retained. Every day a position sits empty, those revenues stop generating, and the pressure on the permanent staff left to absorb the gap can accelerate the next vacancy.

The root issue is not the bill rate on a locum invoice. It is how hospitals are framing the cost conversation in the first place. When the comparison only includes a locum provider's bill rate, the cost of going without one, never enters the equation. The question you should be asking is not whether locum tenens staffing is expensive, it is whether the absence of providers costs more.

This paper presents the case for why an honest analysis of a planned locum tenens staffing strategy can help hospitals save money.

Costly Realities of a Provider Vacancy

The bill rate on a locum invoice is an obvious number, but the cost of a vacancy is not. It spreads across departments, time periods, and financial categories that rarely get aggregated into a single figure. Those invisible costs are a quiet drain on hospital margins. When a CRNA is unavailable, the OR may not open. When imaging is short-staffed, scans back up and procedures get deferred. When a specialist's chair sits empty, revenue from that specialty stops flowing entirely.

Physicians represent the most acute version of this dynamic because they make a hospital's service lines billable. Unlike nursing or allied shortages, where the operational disruption is real but the billing impact is indirect, a physician's absence removes the engine that drives revenue across the whole hospital. Imaging ordered, procedures performed, referrals made, patients admitted and retained: all of it flows through their responsibilities. Without a physician, there is no fuel for that downstream revenue. This is especially problematic since the Association for Advancing Physician and Provider Recruitment (AAPPR) reveals that the median time to fill a physician role was 118 days, with some specialties, like oncology, averaging over 300 days[1]. That is a long time to absorb vacancy costs, and leads to the real question: can your hospital afford to do so while the search runs its course?

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For rural and community hospitals, the damage extends further and compounds in a way that is difficult to recover from. When a specialty goes offline and you refer patients to a larger system, those patients often do not come back, not just for that specialty, but for primary care, imaging, and everything the individual–and their family–needs. The revenue loss from a single extended vacancy can quietly migrate an entire patient panel to a competitor. In markets where the hospital is already the primary provider of care for the surrounding community, that migration is not just a financial issue. It is a community health one, and it tends to be irreversible the longer it goes unaddressed.

Then there is the staff cost. When a position goes unfilled, permanent providers absorb the extra workload. The cycle becomes self-reinforcing: vacancy creates overload, overload creates burnout, burnout creates leaves and resignation, i.e. more vacancy. The American Medical Association (AMA) estimates that physician burnout alone costs the U.S. health care system approximately $4.6 billion annually, driven largely by turnover and reduced clinical hours[2]. Replacing the burned out physician then costs health systems between $500,000 and $1 million per doctor, when you factor in recruitment fees, sign-on bonuses, lost billings during the gap, and onboarding for the replacement[3]. And the impact does not stop there. An AMA-led study published by Mayo Clinic estimates that physician turnover adds about $979 million a year in extra health care spending across the U.S. population[4]. The impact is felt in the pockets of hospitals and their patients alike.

None of this appears on a locum invoice. But it is all part of the same financial equation.

Why Hospitals Wait and Why It Costs Them

Understanding the vacancy cost is only half the problem. The other half is that hospitals wait too long to engage. This behavior pattern is consistent across hospital systems of nearly every size and type. By the time locums staffing conversations happen, most of their leverage is gone. Two dynamics drive this: the internal pipeline problem and the credentialing challenge.

The credentialing challenge

There is also a credentialing reality that few hospital leaders have fully internalized. Getting a locum physician fully credentialed with all payers takes time. Hospitals that engage early can run that process alongside their permanent search, so coverage is available the moment it is needed. Hospitals that engage late often wait for credentialing to clear while vacancy costs accumulate. The same delay cycle that creates the urgent need also blocks the fastest path to resolving it.

The internal pipeline problem

Recruitment teams understandably do not want to signal that their internal pipeline is struggling. Instead, leadership thinks candidates are in progress. In reality, those candidates have fallen off due to credentialing delays, competing offers, or life circumstances, and the vacancy is now urgent. The call to an external staffing partner comes late, under pressure, with no time to negotiate rates and no room to absorb placements that fall off simply because credentialing took too long.

Hospitals also operate on a quiet assumption that locum providers will always be available when they eventually call. That assumption often comes with a hefty cost. Without an established staffing relationship, hospitals miss the window to verify provider availability, lock in favorable terms, or build a bench of qualified candidates. Locum tenens staffing covers an enormous range of physician specialties and advanced practice roles, and too often, a single vendor cannot deliver everything well. Not having active staffing contacts lands hospitals at the back of the candidate line for the hardest-to-fill roles, which are usually their most urgent vacancies.

> *The hospitals that engage first get the best candidates, the best rates, and more time to protect their budgets. The hospitals that engage when they are desperate often get whatever is left, at whatever price the urgency commands.*

The Blind Spot in Your Locum Tenens Strategy

Treating the bill rate as the only metric worth watching.

A locum bill rate is a line item. The vacancy cost is a diffuse number that spreads across revenue cycle, surgical volume, length of stay, payer contract negotiations, and staff retention. Hospitals that evaluate locum tenens by comparing its cost to nothing are making the wrong comparison. The honest comparison is locum cost versus total vacancy cost. When you make that comparison with real numbers, the math usually shifts.

Letting urgency become the only option.

By the time a hospital reaches out to a staffing partner under pressure, it has already absorbed weeks or months of vacancy cost. The conversation that might have taken three months and produced favorable terms now has to happen in days and on the agency's terms. The financial difference between those two scenarios, in bill rates, in candidate quality, and in time-to-fill, is not small.

Assuming the problem will eventually resolve itself.

Provider shortages are not temporary market fluctuations, and the data supports that. Physician turnover rates remain above pre-pandemic levels at a median of 7.3% in 2024, according to the AAPPR[1]. On top of this, burnout-driven departures from permanent roles are not slowing down, and a growing number of physicians are choosing locum work, not as a stepping stone, but as a long-term alternative. Younger providers entering the workforce are accelerating this dynamic further: Many want to test facilities and locations before committing permanently, which means the supply of clinicians willing to sign long-term agreements on the basis of an interview and a site visit is shrinking. Hospitals that build their workforce strategy around the assumption that permanent recruitment will get easier are likely to keep finding themselves in the same position: late, pressured, and paying for it.

Moving Beyond the Blind Spot

The principles that separate a proactive staffing strategy from a reactive one are not complicated, but they do require shifting how locum tenens is categorized internally

1

The first and most impactful shift to make is timing
Many hospitals may not realize that having a staffing agreement in place with one or two locum partners before a vacancy hits costs nothing and creates options. Not having any relationships when a provider leaves unexpectedly often means urgency premiums, a reduced candidate pool, and no leverage on contract terms. Hospitals that maintain active agency relationships are positioning themselves to outperform those that only pursue a partner when things have already gone wrong.

2

Next is running parallel search tracks
Most hospitals sequence their response: try internal recruitment first then call a staffing agency only if that fails. The time lost in that sequence is revenue lost. The more effective model runs both simultaneously, with locum coverage filling the immediate gap while permanent recruitment and fit assessment continue in the background. The two efforts are not in competition–they reinforce each other. And temp-to-hire remains an attractive possibility: A provider who has worked at a hospital on a locum basis already knows the clinical expectations, workplace culture, and patient population of that facility. The hire is lower-risk and makes retention chances higher. While conversion timelines can vary by specialty and role, this approach works across provider types and specialties.

> *A locum placement is not just gap coverage. Used intentionally, it is a working interview, one that eliminates most of the unknowns a traditional search cannot answer before the offer is made.*

3

Finally, it is important to know the tools available to you
Two major underutilized resources are the Interstate Medical Licensure Compact (IMLC) and Q6 modifier. The IMLC allows eligible physicians to obtain a state medical license in approximately 30 days, and most states participate. This compact dramatically reduces one of the biggest timeline barriers in locum placements, yet many hospital leaders are not aware it exists. Separately, hospitals can credential locum providers fully with all payers, just as they would permanent staff. For short-term physician placements, the Q6 modifier allows billing for services even before full credentialing is complete. Many facilities, particularly smaller and rural hospitals, are leaving real revenue on the table simply because they do not know these mechanisms are available to them.

None of this requires a wholesale change in how you operate. It requires treating locum staffing partnerships the way any strategic vendor relationship should be treated, with a standing agreement, an established process, and the expectation of yielding proactive results.

Time for an Honest Comparison

Provider vacancies are not a staffing inconvenience. They are a revenue issue, a workforce strain, and in many communities a barrier to accessing care. On top of that, the financial damage compounds every day a position stays open. The physician data makes this case more concretely, but the principle holds across the locum tenens spectrum. Whether the vacancy is a physician, a CRNA, or an advanced practice provider, the cost of waiting is almost always higher than the cost of a planned, proactive response.

The hospitals doing this well are not spending more. They focus on smarter spending, negotiating from a position of strength, filling positions faster, converting locum relationships into permanent placements, and avoiding the urgency premiums that come with crisis staffing.

Before turning staffing conversations to rates, ask what unplanned vacancies are quietly costing your organization, and what changes when those gaps are managed strategically.

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