ON THE MARK
HEALTHCARE WORKFORCE INTELLIGENCE

EXECUTIVE BRIEF NO. 003 · NOVEMBER 2026

WORKFORCE PLANNING / SERVICE DEMAND / READINESS

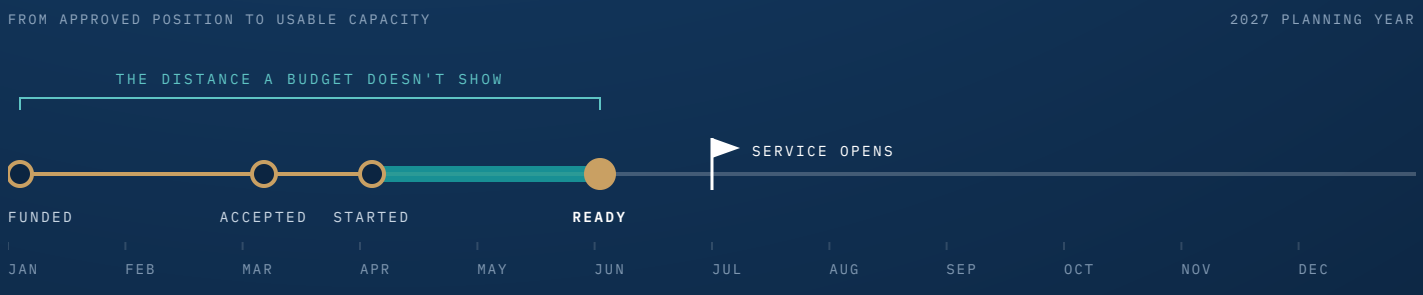
The 2027 Healthcare *Workforce Plan*

Are We Planning for Demand or Just Budgeting for Vacancies?

THE QUESTION BEFORE YOU APPROVE 2027

What workforce capacity will our priority services need, and when will it be ready?

2027



PREPARED FOR
Health System Executive Leadership

READING TIME
12 Minutes

FOCUS
Demand · Capacity · Readiness

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EXECUTIVE SUMMARY

The Decision Behind the 2027 Budget

Before approving 2027 plans, leadership needs to answer one practical question: *what workforce capacity will our priority services need, and when will it be ready?*

A budget can authorize positions months before a service has the qualified staff and coverage it needs. The position count looks complete in January. The service may still open short in July because a transfer is waiting on specialty training, an external hire is still in credentialing, or a vacancy the plan never counted has reopened.

On The Mark's previous brief made the case for treating recruitment, retention and development as connected workforce decisions. This brief carries that case into the budget. For every priority service, leaders should be able to say how much care they need to deliver, what skills and coverage that requires, and when the team will be ready to deliver it.

The pages that follow set out the current data, walk through one illustrative outpatient expansion, apply the five-question Workforce Planning Alignment Test and close with four actions to take into the first 2027 operating review.

> ON THE MARK PERSPECTIVE
>
> ***An outpatient expansion can have its FTEs approved and still miss its opening date. The plan should be judged by when capacity is ready, not by how many positions it funds.***

SECTION 02

What the Data Tells Us

Hiring is still moving, recruiting resources are tighter, and employers are looking inside for hard-to-fill roles.

42,000

Net change in U.S. healthcare payrolls, October 2026

U.S. healthcare payrolls rose by 42,000 in October, above the prior 12-month average of 31,000. Hospitals added 16,000, home health care services 11,000, and outpatient care centers 5,000.[1]

PERIOD
October 2026 · preliminary estimate

POPULATION
U.S. health care payroll employment, seasonally adjusted; excludes social assistance

SOURCE
U.S. Bureau of Labor Statistics, The Employment Situation

FOR YOUR PLAN
Use the national data as context and test hiring assumptions against your own geography, specialty and shift.

7.4%

Lower median budget for internal physician recruitment departments

AAPPR reported a decline from $553,376 in 2024 to $512,500 in 2025. Median searches per recruiter were roughly steady: 35.6 in 2024 and 36.5 in 2025.[2]

PERIOD
2025 compared with 2024

POPULATION
Internal physician recruitment departments reporting to AAPPR

SOURCE
AAPPR, 2026 Physician and Provider Recruitment Benchmarking Report

FOR YOUR PLAN
Before committing to more searches, check whether the team has the resources to deliver them.

41%

Of HR professionals report training existing employees for hard-to-fill roles

SUPPORTING CONTEXT · FROM BRIEF 002

SHRM's cross-industry survey provides a reason to test internal pathways alongside external sourcing.[3]

PERIOD
2026 Talent Trends, published April 20, 2026

POPULATION
More than 2,000 HR professionals across industries; not healthcare-specific

SOURCE
SHRM, 2026 Talent Trends

FOR YOUR PLAN
In healthcare, account for training seats, preceptor time and the date staff can practice independently.

READ SEPARATELY These are three different measures of three different populations: national net payroll change, the budgets of internal physician recruitment departments, and a cross-industry survey of HR professionals. They describe the environment for a 2027 plan. They should not be combined or read as a single trend.

Where the operating plan and the workforce plan meet

Becker's October coverage puts access, throughput, utilization and retention on the COO agenda.[4] The American Hospital Association's 2026 Workforce Scan describes how health systems are using team-based care, redesigned workflows and education pathways to respond to staffing pressure.[5]

Together, these perspectives support a planning discussion that starts with the service outcome and weighs retention, development, redesign and recruiting against the same readiness date.

ON THE MARK PERSPECTIVE

A month of strong national payroll growth does not tell you whether your service will have ready staff on its opening date. Your own lead times, recruiting capacity and training seats will.

SECTION 03

Start With the Care You Need to Deliver

Workforce requirements should come from the service plan. The opening date sets the clock for everything behind it.

Most workforce budgets begin with positions: last year's complement, plus the FTEs a new service has been approved to add. A demand-led plan begins one step earlier, with the care the service has to deliver. Volume, coverage and skill mix determine how many people are needed, which credentials they need, and the date each one has to be ready.

ILLUSTRATIVE EXAMPLE · ALL DATES AND FIGURES BELOW ARE ON THE MARK ASSUMPTIONS, NOT RESEARCH FINDINGS

A new outpatient specialty clinic

PLANNED OPENING	EXPECTED VOLUME	COVERAGE	SKILL MIX
July 1, 2027	**90 visits / day**	**Mon–Sat, 7–7**	**20 positions**
Fixed by the operating plan and facility schedule.	At opening, rising to 110 by month six.	Two overlapping shifts with licensed staff on site.	5 RN · 3 LPN · 8 MA · 4 patient access.

Volume sets the headcount

Expected visits determine how many rooms and shifts must be staffed at opening, and the month-six figure determines what has to be added later.

Coverage sets the schedule

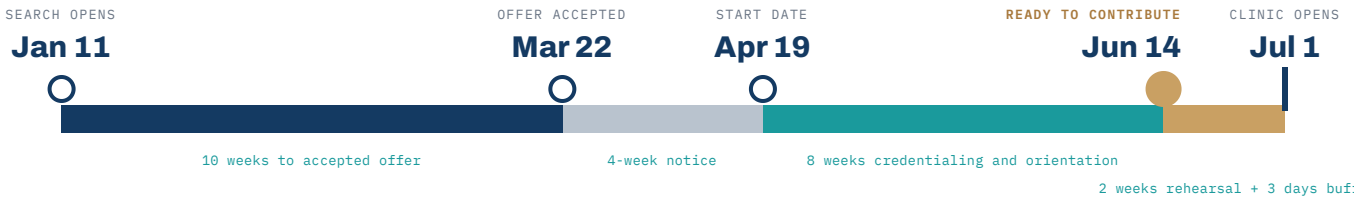
Twelve-hour days across six days require overlapping shifts, so the plan needs relief coverage before anyone takes leave.

Skill mix sets the lead time

Each role carries its own licensure, credentialing, orientation or specialty training. That determines how early each search has to start.

Working backward from opening: one external RN hire

Assumed lead times appear in teal beneath each segment.



Repeat the chain for every position in the plan, using each role's own lead times. The earliest search-open date across the clinic sets the latest date the 2027 workforce plan can be approved without putting the opening at risk.

WHO DECIDES IF A CRITICAL RN IS LATE

If any role the clinic needs to open is projected to be ready after June 14, the COO and CNO, with the clinic's service leader, decide whether to open July 1 at reduced volume or defer the launch. They make that call against the minimum coverage the clinic needs to open safely, agreed before the first search opens.

EXECUTIVE QUESTION

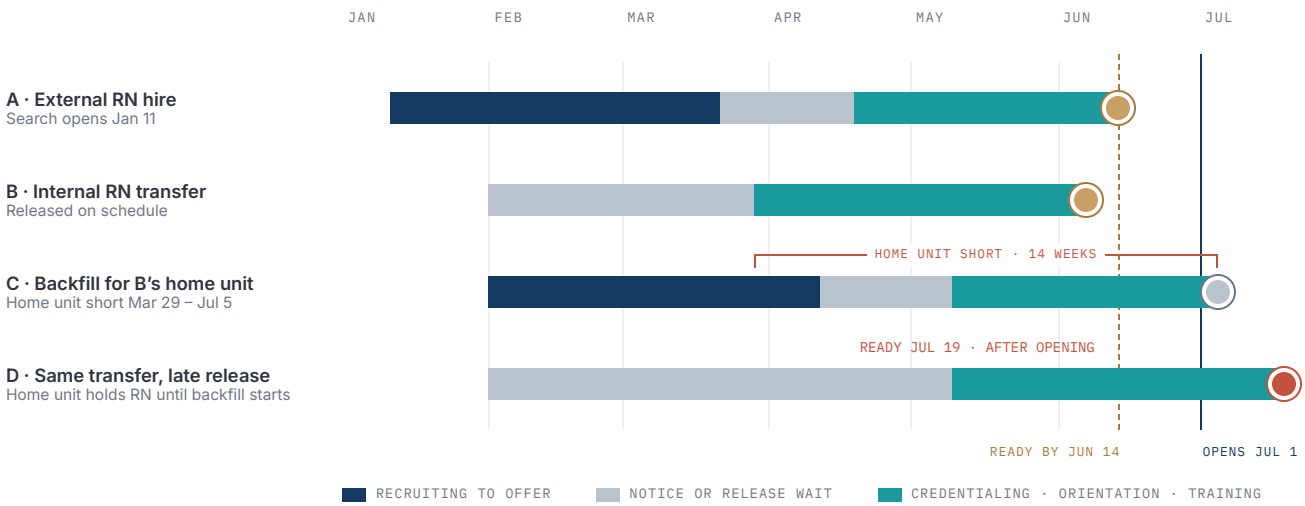
For our highest-priority services, what capacity will be available when patients need it, and which workforce assumption is most likely to put that date at risk?

SECTION 04

Plan for Losses, Hiring and Readiness

Every approved position turns into usable capacity on its own clock, and a move in one department can reset another department's clock.

ILLUSTRATIVE EXAMPLE CONTINUED · SAME CLINIC, SAME ASSUMED LEAD TIMES · NOT RESEARCH FINDINGS



Releasing the transfer opens a 14-week gap

Releasing the RN on March 29 gets the clinic's transfer ready by June 7 and leaves the home unit with a 14-week coverage gap before its backfill is ready. Holding the transfer until the backfill starts moves clinic readiness to July 19. Before approving the transfer, both service leaders should agree on interim coverage and the minimum staffing required to open July 1.

Expected losses run on the same clock

Turnover does not pause for a launch. If one of the clinic's 20 positions comes open on May 3, the same assumed lead times put a ready replacement in early October. A plan that funds 20 positions but budgets no replacement demand is planning to open short.

MILESTONE 1	MILESTONE 2	MILESTONE 3	MILESTONE 4
Funded position	**Accepted offer**	**Start date**	**Ready to contribute**
The budget authorizes the FTE. No one is on the schedule yet.	A person is committed, but is still working a notice period or a release wait.	On payroll and in orientation. Uses preceptor time before adding coverage.	Credentialed, oriented and trained. Counts toward the service's coverage.

ON THE MARK PERSPECTIVE

The hiring plan can be on schedule while the service is not. Count capacity on the date people can contribute.

SECTION 05

The Workforce Planning Alignment Test

Five questions every healthcare executive should ask before finalizing a 2027 workforce plan.

01 | DEMAND ALIGNMENT

Are our workforce requirements tied to projected operational demand?

Look beyond historical staffing levels and authorized positions. Consider service growth, patient volumes, clinical requirements, skill mix and evolving care delivery models.

BRING TO THE REVIEW

Service-volume forecast

Expected volume by priority service, with a higher-demand scenario, translated into coverage and skill mix.

02 | RETENTION EXPOSURE

Does our plan account for the workforce we may lose?

Evaluate turnover patterns, recurring vacancies, retirement exposure, early-tenure attrition and departments experiencing persistent staffing instability.

BRING TO THE REVIEW

Turnover projection

Expected losses and recurring vacancies by department, including backfill created by internal moves.

03 | INTERNAL TALENT CAPACITY

Are we developing the talent we already have?

Identify opportunities for internal mobility, clinical advancement, cross-training, succession planning and career development before relying exclusively on external recruitment.

BRING TO THE REVIEW

Internal training plan

Training seats, preceptor time and the date each participant can practice independently.

04 | RECRUITMENT EXECUTION

Can our Talent Acquisition infrastructure deliver the hiring plan?

Assess requisition demand against recruiter capacity, sourcing resources, hiring-manager responsiveness, assessment processes and onboarding readiness.

BRING TO THE REVIEW

Recruiting workload forecast

Projected searches by volume and complexity against recruiter capacity, sourcing support and hiring-manager availability.

05 | OPERATIONAL READINESS

Are we measuring when workforce capacity becomes available?

Evaluate the full timeline from identifying a workforce need through recruitment, onboarding, credentialing, training and readiness to contribute.

BRING TO THE REVIEW

Readiness schedule

Offer, start and ready-to-contribute dates for each critical position, measured against the service launch date.

EXECUTIVE TAKEAWAY

A funded position is not the same as available workforce capacity.

A stronger 2027 workforce plan connects the people an organization can hire with the skills, resources and operational readiness it actually needs.

An original On The Mark executive planning framework.

SECTION 06

Four Executive Actions

Who should lead each action, what decision to bring to the next operating review, and the evidence that supports it.

01 Set a capacity target for each priority service.

Have Operations and Finance agree on the expected patient volume, coverage, skill mix and readiness date. Test a higher-demand scenario before signing off.

LEAD	DECISION TO BRING	SUPPORTING EVIDENCE
COO and CFO, with service-line leaders	Approve one capacity target per priority service: volume, coverage, skill mix and the date staff must be ready.	Service-volume forecast, staffing model and the higher-demand scenario showing what changes if volume runs ahead.

02 Budget for expected losses and internal development.

Use turnover and recurring vacancies to estimate replacement demand. Fund internal training and backfill where those pathways can put qualified staff in place by the required date.

LEAD	DECISION TO BRING	SUPPORTING EVIDENCE
CHRO and CFO, with the CNO for nursing roles	Fund replacement demand and the internal pathways, including backfill, that can meet each readiness date.	Turnover and recurring-vacancy history by department, training-seat and preceptor capacity, and projected completion dates.

03 Commit to a hiring plan TA can deliver.

Compare projected search volume and complexity with recruiter capacity, sourcing support and hiring-manager availability. Sequence searches by impact on patient access and service delivery.

LEAD	DECISION TO BRING	SUPPORTING EVIDENCE
CHRO with the Talent Acquisition leader	Approve a sequenced hiring plan that fits current TA capacity, or approve the added capacity the plan requires.	Recruiting workload forecast, current searches per recruiter, sourcing resources and hiring-manager response times.

04 Track the date staff can contribute.

Review offer acceptance, starts and readiness separately. Give credentialing, orientation and training milestones clear owners, and agree on when to escalate a projected delay.

LEAD	DECISION TO BRING	SUPPORTING EVIDENCE
COO and CNO, with service leaders and TA	Agree on milestone owners and the threshold at which a projected delay is escalated.	Readiness schedule tracking offers, starts and ready dates, with credentialing, orientation and training status.

FOR THE FIRST 2027 OPERATING REVIEW

Ask each service leader to bring the capacity target, the readiness date, and the specific trigger that would change the operating plan.

EXECUTIVE EVIDENCE

Sources & Further Reading

Each statistic was checked against its original source on November 6, 2026. Qualifications that affect how a figure should be read appear with it.

01 **U.S. Bureau of Labor Statistics** — The Employment Situation, October 2026

Released Nov. 6, 2026. National, seasonally adjusted payroll estimates. Health care excludes social assistance.

QUALIFICATION October estimates are preliminary national net payroll estimates and subject to revision. Payroll gains measure net employment change, not total hires.

bls.gov/news.release/archives/empsit_11062026.htm

02 **Association for Advancing Physician and Provider Recruitment (AAPPR)** — 2026 Physician and Provider Recruitment Benchmarking Report findings

Released Sept. 16, 2026.

QUALIFICATION The 7.4% budget figure applies to internal physician recruitment departments. It is not a measure of total recruitment spending.

aappr.org/2026/09/16/physician-hiring-challenges-persist-as-recruitment-budgets-decline-aappr-report-finds

03 **SHRM** — 2026 Talent Trends

Published April 20, 2026. Survey of more than 2,000 HR professionals. Also cited in Executive Brief No. 002.

QUALIFICATION Cross-industry survey. The 41% finding is not specific to healthcare employers.

shrm.org/topics-tools/research/2026-talent-trends

04 **Becker's Hospital Review** — October 2026 issue

Oct. 26, 2026. Coverage of the operational metrics drawing COO attention, including access, throughput, utilization and retention.

beckershospitalreview.com/print-issues/october-2026-issue-of-beckers-hospital-review

05 **American Hospital Association** — 2026 AHA Health Care Workforce Scan

Team-based care, redesigned workflows and education pathways as responses to staffing pressure.

aha.org/aha-workforce-scan

ABOUT THE ILLUSTRATIVE EXAMPLE

The outpatient clinic on pages 04–05, including its opening date, volume, coverage, skill mix and every lead time, is a set of On The Mark planning assumptions built to show the method. It is not drawn from any organization or benchmark. Substitute your own service plan and measured lead times.