2018 REVIEW

OF PHYSICIAN AND ADVANCED PRACTITIONER RECRUITING INCENTIVES

An Overview of the Salaries, Bonuses, and Other Incentives Customarily Used to Recruit Physicians, Physician Assistants and Nurse Practitioners

MERRITT HAWKINS
an AMN Healthcare company

2018 REVIEW

OF PHYSICIAN AND ADVANCED PRACTITIONER RECRUITING INCENTIVES

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Overview

Merritt Hawkins is a national healthcare search and consulting firm specializing in the recruitment of physicians in all medical specialties, physician leaders, and advanced practitioners. Now celebrating our 31st year of service to the healthcare industry, Merritt Hawkins is a company of AMN Healthcare (NYSE: AMN), the nation's largest healthcare staffing organization and the industry innovator of healthcare workforce solutions.

This report marks Merritt Hawkins' 25th annual *Review* of the search and consulting assignments the firm conducts on behalf of its clients. Merritt Hawkins' *Review* is the longest consecutively published and most comprehensive report on physician recruiting incentives in the industry.

Over the past 25 years the *Review* has become a standard benchmarking resource throughout the healthcare industry used by hospitals, medical groups and other healthcare facilities to determine which incentives are customary and competitive in physician recruitment. The *Review* also has become a resource widely utilized by healthcare journalists, analysts, policy makers and others who track trends in physician supply, demand and compensation.

The *Review* is part of Merritt Hawkins' ongoing thought leadership efforts, which include surveys and white papers conducted for Merritt Hawkins' proprietary use, and surveys, white papers and analyses Merritt Hawkins has completed on behalf of prominent third parties, including **The Physicians Foundation,** the **Indian Health Service,** the **American Academy of Physicians Assistants, Trinity University, Texas Hospital Trustees,** the **North Texas Regional Extension Center/Office of the National Coordinator of Health Information Technology,** the **Society for Vascular Surgery,** the **Maryland State Medical Society,** the **American Academy of Surgical Administrators,** the **Association of Managers of Gynecology and Obstetrics** and **Subcommittees of the Congress of the United States**.

The 2018 *Review* is based on a sample of 3,045 permanent physician and advanced practitioner search assignments that Merritt Hawkins and AMN Healthcare's sister physician staffing companies (Kendal & Davis and Staff Care) had ongoing or were engaged to conduct during the 12-month period from April 1, 2017, to March 31, 2018.

The intent of the *Review* is to quantify financial and other incentives offered by our clients to physician and advanced practitioner candidates during the course of recruitment. Incentives cited in the *Review* are based on formal contracts or incentive packages used by hospitals, medical groups and other facilities in real-world recruiting assignments. Unlike other physician compensation surveys, Merritt Hawkins' *Review* tracks ***physician starting salaries*** and other recruiting incentives, rather than total annual physician

compensation. It therefore reflects the incentives physicians are offered to attract them to new practice settings rather than what physicians in general may actually earn.

The range of incentives detailed in the *Review* may be used as benchmarks for evaluating which recruitment incentives are customary and competitive in today's physician recruiting market. In addition, the *Review* is based on a national sample of search assignments and provides an indication of which medical specialties are currently in the greatest demand as well as the types of medical settings into which physicians are being recruited.

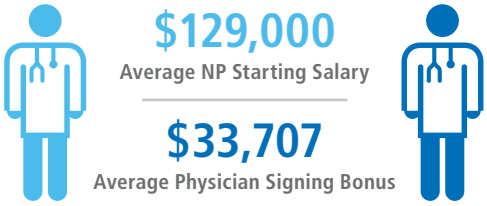
Following are several key findings of the *Review*.

Key Findings

Merritt Hawkins' 2018 Review of Physician and Advanced Practitioner Recruiting Incentives reveals a number of trends within the physician and advanced practitioner recruiting market, including:

- **For the 12th consecutive year, family physicians topped the list of Merritt Hawkins' 20 most requested recruiting assignments, underscoring the continued robust demand for primary care physicians at a growing number of settings, including hospitals, medical groups, urgent care centers, retail clinics, telemedicine providers and others.**
- Though primary care physicians are in strong demand, a growing volume of recruitment activity is shifting toward medical specialists. 74% of Merritt Hawkins' search assignments tracked in the 2018 *Review* were for medical specialists, up from 67% three years ago.

- **For third consecutive year, psychiatrists were second on the list of Merritt Hawkins' most requested recruiting assignments, reflecting a severe shortage of mental health professionals nationwide.**
- Demand for nurse practitioners (NPs) and physician assistants (PAs) is accelerating. Merritt Hawkins conducted more search assignments for NPs and PAs in the previous year than in any other 12-month period tracked by the *Review*.
- Invasive cardiologists have the highest average starting salaries of physicians tracked in the 2018 *Review* at $590,000, followed by orthopedic surgeons at $533,000.
- The average starting salary for family medicine physicians is $241,000, the highest amount ever recorded in the *Review*.



- **The average starting salary for NPs is $129,000, the highest amount ever recorded in the *Review*.**

- **The average signing bonus for physicians is $33,707, the highest amount recorded in the *Review.***

8% | **Of total physician compensation packages determined by quality/value-based compensation**

- **The use of quality/value-based physician compensation is rising. Nevertheless, quality on average determines only 8% of total physician compensation packages tracked in the *Review*.**

- Employment rather than independent practice remains the dominant physician recruiting model. Over 90% of Merritt Hawkins' search assignments feature employed practice settings, while less than 10% feature independent practice.

62% | **Recruiting Assignments Occurred in Commmunities of 100,000 or More**

- **62% of Merritt Hawkins' recruiting assignments tracked in the 2018 *Review* occurred in communities of 100,000 or more, a record high, further reflecting rising demand for medical specialists who tend to practice in larger communities.**

Following is a breakout of the characteristics and metrics of Merritt Hawkins' 2017/18 recruiting assignments.

Merritt Hawkins' 2018 Review of Physicians and Advanced Practitioner Recruiting Incentives: Recruiting Assignment Characteristics and Metrics

All of the following numbers are rounded to the nearest full digit.

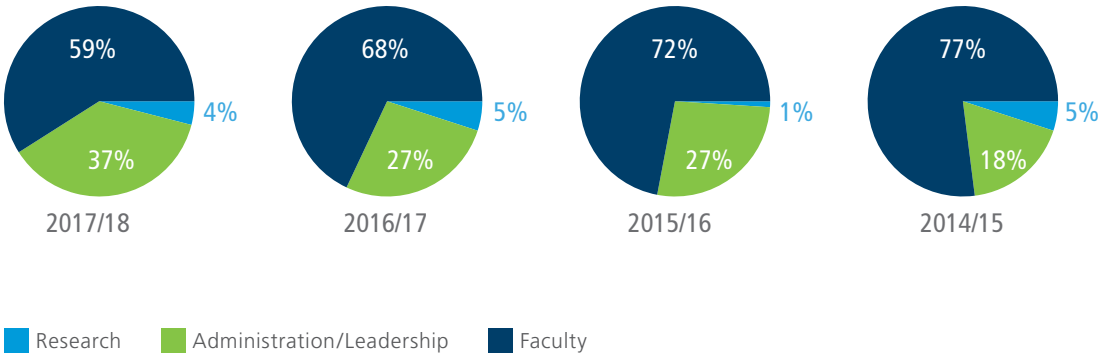
1 Total Number of Physician/Advanced Practitioner Search Assignments Represented

The 2018 *Review* is based on a sample of the 3,045 permanent physician and advanced practitioner search assignments Merritt Hawkins/AMN Healthcare's physician staffing companies had ongoing or were engaged to conduct during the 12 month period from April 1, 2017 to March 31, 2018. Data is extrapolated from the sample to derive the numbers below.

2 Settings of Physician Search Assignments

	2017/18	2016/17	2015/16	2014/15	2013/14
Hospital	1,230(40%)	1,415(43%)	1,639(49%)	1,596(51%)	2,006(64%)
Group	798(26%)	886(27%)	628(19%)	625(20%)	401(13%)
Solo/Direct Pay/Concierge	62(2%)	34(1%)	181(5%)	125(4%)	17(<1%)
CHC/FQHC/IHS	363(12%)	497(15%)	434(13%)	406(13%)	378(12%)
Academics	464(15%)	374(11%)	367(11%)	252(8%)	188(6%)
Urgent Care	91(3%)	66(2%)	80(2%)	33(1%)	N/A
Other	37(<2%)	15(<1%)	13(1%)	59(2%)	30(1%)

If Academics, what type of position? *(of 464 Academic positions)*



3 States Where Search Assignments Were Conducted

Searches also conducted in Washington, D.C. and Canada.

AK, AL, AR, AZ, CA, CO, CT, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MN, MS, MT, NC, ND, NE, NH, NJ, NM, NY, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY

4 Number of Searches by Community Size

	2017/18	2016/17	2015/16	2014/15	2013/14
0-25,000	612(20%)	755(23%)	870(26%)	1,184(38%)	1,044(33%)
25,001-100,000	545(18%)	742(22%)	766(23%)	689(22%)	819(26%)
100,001+	1,888(62%)	1,790(55%)	1,706(51%)	1,247(40%)	1,295(41%)

5 Top 20 Most Requested Searches by Medical Specialty

	2017/18	2016/17	2015/16	2014/15	2013/14
Family Medicine (includes FP/OB)	497	607	627	734	714
Psychiatry	243	256	250	230	206
Nurse Practitioner	220	137	150	143	128
Internal Medicine	150	193	233	237	235
Radiology	132	80	40	24	22
OB/GYN	118	109	112	112	70
Hospitalist	118	94	228	176	231
Gastroenterology	102	66	58	43	54
Urgent Care	91	74	80	33	16
Orthopedic Surgery	85	61	81	106	58
Emergency Medicine	74	90	70	80	89
Dermatology	66	83	71	44	30
Pediatrics	63	76	76	71	92
Cardiology	61	62	33	36	32
Neurology	57	61	101	60	61
Otolaryngology	52	42	44	52	32
Urology	41	37	51	40	29
Pulmonology	40	62	46	38	18
Anesthesiology	40	43	28	16	14
Physician Assistant	40	87	66	63	61

6 Other Specialty Recruitment Assignments

Adolescent Medicine
Advanced Cardiac Imaging
Advanced Practice Midwife
Allergy & Immunology
Anesthesiology
Bariatric Surgery
Breast Surgery
Burn Surgery
Cardiac Anesthesiology
Cardiothoracic Surgery
Certified Registered Nurse Anesthetist
Clinical Social Worker
Colon & Rectal Surgery
Cornea and Refractive Ophthalmology
Corneal and Contact Management
Counselor
Counselor of Mental Health
Critical Care-Intensivist Medicine
Critical Care-Intensivist Medicine
Developmental, Behavioral Pediatrics
Electrophysiology Cardiology
Endocrinology
Female Pelvic Medicine and Reconstructive Surgery
Gastroenterology - Hepatology
Geriatric Medicine
Glaucoma Ophthalmology
Gynecologic Oncology
Gynecology
Hematology
Hematology & Oncology
Hospice and Palliative Medicine
Infectious Disease
Interventional Pain Medicine
Laborist
Maternal & Fetal Medicine
Medical Genetics
Medical Oncology
Medical Toxicology
MOHS-Micrographic Surgery
Neonatal-Perinatal Medicine / Neonatology
Nephrology
Neurological Surgery
Neuromusculoskeletal Medicine & OMM
Nocturnist
Nurse Manager
Obstetrics
Occupational Medicine
Oculoplastic Ophthalmology
Ophthalmology
Optometrist
Oral & Maxillofacial Surgery
Oral and Maxillofacial Surgery
Pain Medicine
Pediatric Allergy/Immunology
Pediatric Anesthesiology
Pediatric Cardiac Anesthesiology
Pediatric Cardiology
Pediatric Cardiovascular Surgery
Pediatric Critical Care Medicine
Pediatric Dentistry
Pediatric Dermatology
Pediatric Emergency Medicine
Pediatric Emergency Medicine
Pediatric Endocrinology
Pediatric Gastroenterology
Pediatric Genetics
Pediatric Hematology-Oncology
Pediatric Hospitalist
Pediatric Intensivist
Pediatric Ophthalmology
Pediatric Pulmonology
Pediatric Rehabilitation Medicine
Pediatric Sleep Medicine
Pediatric Surgery
Pediatric Urology
Pharmacist
Physical Medicine & Rehabilitation
Plastic and Reconstructive Surgery
Plastic Surgery
Podiatrist
Psychologist
Pulmonary and Critical Care
Pulmonary Disease
Registered Nurse
Reproductive Endocrinology
Retina Surgery Ophthalmology
Rheumatology
RN Psych/Mental Health
Surgery
Surgical Critical Care (Trauma Surgery)
Surgical Oncology
Surgical Trauma Surgery (Critical Care)
Thoracic Surgery
Urgent Care
Urology
Vascular Surgery

7 Administrative, Academic and Executive Titles Include:

Administrative Director
Assistant Dean
Assistant Program Director
Assistant Professor
Associate Dean
Business Manager
Chair
Chair of Anesthesiology
Chair of Bioinformatics
Chair of Dermatology
Chair of Family Medicine
Chair of Internal Medicine
Chair of Obstetrics & Gynecology
Chair of Ophthalmology & Visual Sciences
Chair of Pathology
Chair of Pediatrics
Chair of Psychiatry
Chair of Rehabilitation Medicine
Chief Executive Officer
Chief Financial Officer
Chief Information Officer
Chief Medical Officer
Chief Nursing Officer
Chief of Adolescent Medicine
Chief of Cardiovascular Medicine
Chief of General Surgery
Chief of Geriatric Medicine
Chief of Hematology and Oncology
Chief of Infectious Diseases
Chief of Neonatal-Perinatal Medicine
Chief of Pediatric Cardiology
Chief of Pediatric Critical Care Medicine
Chief of Pediatric Endocrinology
Chief of Pediatric Gastroenterology
Chief of Pediatric Hematology/Oncology
Chief of Pediatric Hospital Medicine
Chief of Pediatric Nephrology
Chief of Pediatric Neurology
Chief of Pediatric Pulmonology
Chief of Pediatrics Genetics
Chief of Service Line
Clerkship Director of Dermatology
Clerkship Director of Internal Medicine
Clerkship Director of Radiology
Clinical Instructor
Dean
Director of Graduate Medical Education
Director of Nursing
Executive Vice President of Clinical Quality
Facilities Director
Medical Director
Office Manager
Practice Manager
Residency Program Director
RN Case Manager
Senior Medical Director
Service Line Director
Vice Chair
Vice President of Health Affairs
Vice President of Medical Affairs

8 Income Offered to Top 20 Recruited Specialties

(Base salary or guaranteed income only, does not include bonuses or benefits)

Family Medicine	Low	Average	High
2017/18	$165,000	$241,000	$400,000
2016/17	$110,000	$231,000	$400,000
2015/16	$135,000	$225,000	$340,000
2014/15	$112,000	$198,000	$330,000
2013/14	$140,000	$199,000	$293,000

Psychiatry	Low	Average	High
2017/18	$200,000	$261,000	$465,000
2016/17	$120,000	$263,000	$450,000
2015/16	$195,000	$250,000	$370,000
2014/15	$172,000	$226,000	$325,000
2013/14	$150,000	$217,000	$350,000

Nurse Practitioner	Low	Average	High
2017/18	$85,000	$129,000	$205,000
2016/17	$85,000	$123,000	$181,000
2015/16	$92,000	$117,000	$197,000
2014/15	$78,000	$107,000	$129,000
2013/14	$70,000	$106,000	$150,000

Internal Medicine	Low	Average	High
2017/18	$190,000	$261,000	$475,000
2016/17	$170,000	$257,000	$600,000
2015/16	$195,000	$237,000	$320,000
2014/15	$100,000	$207,000	$260,000
2013/14	$145,000	$198,000	$360,000

Radiology	Low	Average	High
2017/18	$309,000	$371,000	$650,000
2017/18 (Telerad)	$350,000	$375,000	$500,000
2016/17	$300,000	$436,000	$725,000
2016/17 (Telerad)	$400,000	$494,000	$600,000
2015/16	$275,000	$475,000	$750,000
2014/15	$150,000	$400,000	$500,000
2013/14	$225,000	$323,000	$500,000

OB/GYN	Low	Average	High
2017/18	$200,000	$324,000	$550,000
2016/17	$175,000	$335,000	$700,000
2015/16	$210,000	$321,000	$500,000
2014/15	$140,000	$276,000	$450,000
2013/14	$215,000	$288,000	$380,000

Hospitalist	Low	Average	High
2017/18	$215,000	$269,000	$365,000
2016/17	$200,000	$264,000	$400,000
2015/16	$180,000	$249,000	$390,000
2014/15	$170,000	$232,000	$300,000
2013/14	$145,000	$229,000	$350,000

Gastroenterology	Low	Average	High
2017/18	$355,000	$487,000	$725,000
2016/17	$300,000	$492,000	$800,000
2015/16	$300,000	$458,000	$600,000
2014/15	$275,000	$455,000	$600,000
2013/14	$240,000	$454,000	$560,000

Urgent Care	Low	Average	High
2017/18	$155,000	$234,000	$290,000
2016/17	$140,000	$219,000	$300,000
2015/16	$195,000	$221,000	$275,000
2014/15	$175,000	$210,000	$254,000
2013/14	$190,000	$204,000	$218,000

Orthopedic Surgery	Low	Average	High
2017/18	$340,000	$533,000	$985,000
2016/17	$192,000	$579,000	$1,000,000
2015/16	$350,000	$521,000	$800,000
2014/15	$350,000	$497,000	$800,000
2013/14	$350,000	$488,000	$700,000

Emergency Medicine (ABEM only)	Low	Average	High
2017/18	$250,000	$358,000	$568,000
2016/17	$250,000	$349,000	$450,000
2015/16	$250,000	$304,000	$425,000
2014/15	$300,000	$345,000	$434,000
2013/14	$220,000	$311,000	$400,000

Dermatology	Low	Average	High
2017/18	$280,000	$425,000	$650,000
2016/17	$250,000	$421,000	$1,000,000
2015/16	$250,000	$444,000	$650,000
2014/15	$265,000	$398,000	$550,000
2013/14	$300,000	$394,000	$500,000

Pediatrics	Low	Average	High
2017/18	$189,000	$230,000	$355,000
2016/17	$170,000	$240,000	$400,000
2015/16	$165,000	$224,000	$308,000
2014/15	$100,000	$195,000	$275,000
2013/14	$130,000	$188,000	$240,000

Cardiology (non-invasive)	Low	Average	High
2016/17	$300,000	$427,000	$580,000
2016/17	$300,000	$428,000	$580,000
2015/16	$250,000	$493,000	$700,000
2014/15	$200,000	$279,000	$400,000
2013/14	$400,000	$442,000	$500,000

Cardiology (invasive)	Low	Average	High
2017/18	$480,000	$590,000	$810,000
2016/17	$480,000	$563,000	$810,000
2015/16	$475,000	$545,000	$700,000
2014/15	$450,000	$525,000	$650,000
2013/14	$350,000	$454,000	$550,000

Neurology	Low	Average	High
2017/18	$255,000	$301,000	$395,000
2016/17	$220,000	$305,000	$400,000
2015/16	$220,000	$285,000	$500,000
2014/15	$180,000	$277,000	$350,000
2013/14	$180,000	$262,000	$400,000

Otolaryngology	Low	Average	High
2017/18	$325,000	$405,000	$600,000
2016/17	$200,000	$468,000	$1,000,000
2015/16	$305,000	$403,000	$700,000
2014/15	$150,000	$334,000	$450,000
2013/14	$250,000	$372,000	$500,000

Urology	Low	Average	High
2017/18	$290,000	$386,000	$700,000
2016/17	NA	$460,000	NA
2015/16	$325,000	$471,000	$625,000
2014/15	$260,000	$412,000	$550,000
2013/14	$430,000	$504,000	$625,000

Pulmonology	Low	Average	High
2017/18	$355,000	$418,000	$725,000
2016/17	$225,000	$390,000	$530,000
2015/16	$275,000	$380,000	$500,000
2014/15	$260,000	$331,000	$386,000
2013/14	$230,000	$358,000	$425,000

Anesthesiology	Low	Average	High
2017/18	$325,000	$371,000	$540,000
2016/17	$249,000	$376,000	$520,000
2015/16	$360,000	$397,000	$450,000
2014/15	$270,000	$361,000	$400,000
2013/14	$350,000	$383,000	$475,000

Physician Assistant	Low	Average	High
2017/18	$89,000	$109,000	$141,000
2016/17	$99,000	$115,000	$145,000
2015/16	$92,000	$114,000	$180,000
2014/15	$80,000	$107,000	$145,000
2013/14	$71,000	$105,000	$150,000

9 Average Salaries for Top Five Most Requested Specialties by Region

	Northeast	Midwest/ Great Plains	Southeast	Southwest	West
Family Practice	$226,000	$245,000	$231,000	$239,000	$242,000
Psychiatry	$252,000	$305,000	$300,000	$275,000	$265,000
Nurse Practitioner	$110,000	$125,000	$119,000	$129,000	$135,000
Internal Medicine	$230,000	$282,000	$239,000	$273,000	$246,000
Radiology	$375,000	$405,000	$400,000	$390,000	$388,000

10 Average Salaries for Top Five Most Recruited Specialties by Setting

	Academics	Community Health Center	Group	Hospital	Solo
Family Practice	$218,500	$225,000	$233,000	$248,000	$312,000
Psychiatry	$265,000	$282,500	$291,000	$235,000	$280,000
Nurse Practitioner	$121,000	$110,000	$129,000	$115,000	$128,000
Internal Medicine	$210,000	$237,000	$260,000	$275,000	$210,000
Radiology	$375,000	N/A	$450,000	$475,000	$400,000

11 Type of Incentive Offered

	Salary	Salary with Bonus	Income Guarantee	Other
2017/18	515(17%)	2,285(75%)	89(3%)	156(5%)
2016/17	723(22%)	2,359(72%)	121(4%)	84(2%)
2015/16	767(23%)	2,512(75%)	32(1%)	31(1%)
2014/15	715(23%)	2,219(71%)	124(4%)	62(2%)
2013/14	633(20%)	2,335(74%)	127(4%)	63(2%)

12 If Salary Plus Production Bonus, on Which Types of Metrics Was the Bonus Based? (of 2,285 searches offering salary plus bonus, multiple responses possible).

	RVU Based	Net Collections	Gross Billings	Patient Encounters	Quality	Other
2017/18	50%	10%	1%	4%	43%	4%
2016/17	52%	28%	6%	14%	39%	9%
2015/16	58%	22%	2%	8%	32%	8%
2014/15	57%	23%	2%	9%	23%	4%
2013/14	59%	21%	5%	11%	24%	9%

13 If quality factors were included in the production bonus, about what percent of physician's total compensation determined by quality?*

2017/18	2016/17	2015/16	2014/15	2013/14
8%**	4%**	6%**	5%**	3%**

**Question asked for the first time in 2017/18*

***Estimates based on extrapolating how the amount of production bonus based on quality metrics would determine total compensation (family medicine only).*

14 Searches Offering Relocation Allowance

	2017/18	2016/17	2015/16	2014/15	2013/14
Yes	2,999(98%)	3,132(95%)	3,173(95%)	2,623(84%)	2,845(90%)
No	46(2%)	155(5%)	169(5%)	497(16%)	313(10%)

15 Amount of Relocation Allowance *(Physicians only)*

	Low	Average	High
2017/18	$2,500	$9,441	$25,000
2016/17	$2,500	$10,072	$44,000
2015/16	$2,500	$10,226	$30,000
2014/15	$2,000	$10,292	$50,000
2013/14	$1,000	$9,849	$25,000

16 Amount of Relocation Allowance *(NPs and PAs only)*

	Low	Average	High
2017/18	$1,500	$6,250	$25,000
2016/17	$2,500	$8,063	$25,000
2015/16	$2,500	$8,649	$25,000
2014/15	$2,500	$9,436	$35,000
2013/14	$3,500	$6,904	$10,000

17 Searches Offering Signing Bonus

	2017/18	2016/17	2015/16	2014/15	2013/14
Yes	2,135(70%)	2,501(76%)	2,576(77%)	2,280(73%)	2,212(70%)
No	910(30%)	786 (24%)	766(23%)	840(27%)	946(30%)

18 Amount of Signing Bonus Offered
(Physicians only)

	Low	Average	High
2017/18	$2,500	$33,707	$180,000
2016/17	$2,500	$32,636	$275,000
2015/16	$1,000	$26,889	$350,000
2014/15	$2,500	$26,365	$275,000
2013/14	$1,000	$21,773	$150,000

19 Amount of Signing Bonus Offered
(NPs and PAs only)

	Low	Average	High
2017/18	$5,000	$11,944	$30,000
2016/17	$2,500	$8,576	$25,000
2015/16	$2,500	$10,340	$40,000
2014/15	$2,500	$8,791	$20,000

20 Searches Offering to Pay Continuing Medical Education (CME)

	2017/18	2016/17	2015/16	2014/15	2013/14
Yes	2,984(98%)	3,116(95%)	3,243(97%)	2,966(95%)	2,875(91%)
No	61(2%)	171(5%)	99(3%)	154(5%)	283(9%)

21 Amount of CME Allowance Pay Offered
(Physicians only)

	Low	Average	High
2017/18	$250	$3,888	$50,000
2016/17	$500	$3,613	$30,000
2015/16	$100	$3,633	$35,000
2014/15	$500	$3,649	$35,000
2013/14	$1,000	$3,515	$54,000

22 Amount of CME Allowance Pay Offered
(NPs and PAs only)

	Low	Average	High
2017/18	$650	$2,280	$5,000
2016/17	$400	$2,126	$5,000
2015/16	$400	$2,140	$3,950
2014/15	$1,000	$2,241	$5,000
2013/14	$1,000	$2,450	$5,000

23 Searches Offering to Pay Additional Benefits

	2016/17	2015/16	2014/15	2013/14	2012/13
Health Insurance	99%	98%	98%	99%	97%
Malpractice	99%	98%	99%	99%	99%
Retirement /401K	94%	95%	96%	96%	94%
Disability	98%	91%	97%	92%	86%
Educational Loan Repayment	18%	25%	26%	25%	26%
Other	N/A	<1%	<1%	<1%	<1%

24 If Educational Loan Forgiveness was Offered, What Was the Term?

(of 547 searches offering educational loan forgiveness)

	2017/18	2016/17	2015/16	2014/15	2013/14
One Year	18(3%)	40 (5%)	45(5%)	61(8%)	90(11%)
Two Years	104(19%)	191(23%)	155(18%)	104(13%)	173(21%)
Three Years	425(78%)	592(72%)	671(77%)	619(79%)	557(68%)

25 If Education Loan Forgiveness Was Offered, What Was the Amount?

(Physicians only)

	Low	Average	High
2018/18	10,000	$82,833	$300,000
2016/17	$10,000	$80,923	$260,000
2015/16	$10,000	$88,068	$300,000
2014/15	$2,500	$89,479	$250,000
2013/14	$4,000	$77,000	$336,000

26 If Education Loan Forgiveness Was Offered, What Was the Amount?

(NPs and PAs only)

	Low	Average	High
2017/18	$25,000	$59,860	$100,000
2016/17	$35,000	$56,442	$100,000
2015/16	$30,000	$61,667	$100,000
2014/15	$30,000	$54,286	$100,000
2013/14	$20,000	$40,000	$60,000

Trends and Observations

Merritt Hawkins' annual Review of Physician and Advanced Practitioner Recruiting Incentives, now in its 25th year, tracks three key physician recruiting trends, as well as various advanced practitioner recruiting trends.

1. Based on the physician recruiting assignments Merritt Hawkins is contracted to conduct, the *Review* indicates which types of physicians are in the greatest demand and which are the most challenging to recruit.

2. The *Review* also indicates the types of practice settings into which physicians are being recruited (hospitals, medical groups, solo practice etc.) and the types of communities that are recruiting physicians based on population size.

3. The *Review* further indicates the types of financial and other incentives that are being used to recruit physicians.

Each of these trends is discussed below, following an overview of the current healthcare market in which physician recruiting takes place.

MARKET CONTEXT

Merritt Hawkins' *2018 Review of Physician and Advanced Practitioner Recruiting Incentives* examines the permanent physician and advanced practitioner recruiting assignments Merritt Hawkins and AMN Healthcare's physician staffing divisions had ongoing or were engaged to conduct during the 12 month period from April 1, 2017 to March 31, 2018.

These search assignments reflect the types of physicians and advanced practitioners that hospitals, medical groups, Federally Qualified Health Centers (FQHCs), academic medical centers, government entities, and other organizations are seeking nationwide. They also reflect which types of physicians may be particularly difficult to recruit, necessitating the assistance and additional resources of a physician recruiting firm.

Physician and advanced practitioner recruiting takes place in the context of the nation's vast, complex and evolving healthcare system, on which Americans now spend more than the entire economies of all but six countries. Below is a brief look at some of the developments in healthcare that took place during the 12 months period covered by Merritt Hawkins' 2018 *Review*.

THE TIDE ROLLS ON

Since Merritt Hawkins completed its last *Review* in 2017, the healthcare system has weathered a major political debate during which Congress considered but did not pass the Republican-sponsored American Health Care Act (AHAC).

The Affordable Care Act (ACA) therefore remains the law of the land, though the individual insurance mandate was repealed by Congress and will be eliminated in 2019. Some 11.8 million people signed up for 2018 ACA coverage through the state-level exchanges, and close to 10 million others receive coverage through ACA-initiated Medicaid expansion or by staying on their parents' coverage through age 26.

However, uncertainty about the ultimate direction of the healthcare system remains, as the effects of insurance mandate repeal, the implementation of Medicaid work requirements at the state level, and the potential introduction of both short-term insurance plans and "hardship" exemptions remain to be seen.

Health insurance premiums are likely to rise in the coming year and the number of people covered by insurance exchanges is likely to decline. Rather than more uniform coverage and regulations across states, insurance costs, options and regulations can be expected to increasingly vary from state-to-state.

The future of Medicare's new physician reimbursement model, outlined in the Medicare Access and CHIP Reauthorization Act (MACRA), also remains in doubt, contributing to a climate of uncertainty and volatility throughout the healthcare industry. In addition, lawmakers continue to consider site-neutral payments that would pay hospital outpatient departments the same rate for evaluation/management and other services as the physician fee schedule (PFS) rate, further clouding the payment picture. As of publication of this *Review*, proposals are being put forth that would alter how pharmaceuticals are purchased, another factor contributing to industry uncertainty.

Despite this volatility, the vast tide that is healthcare delivery in the United States rolls on. Consider:

- U.S. healthcare spending is projected to rise 5.3% in 2018, up from 4.6% in 2017, and will reach over $3.5 trillion annually this year (*Reuters*. February 14, 2018).
- The Center for Medicare and Medicaid Services (CMS) projects healthcare spending will rise an average of 5.5% annually from 2017 to 2026. In 2026, healthcare spending will comprise 19.7% of GDP and will reach $5.7 trillion (*Reuters*. February 14, 2018).
- Last year, for the first time, healthcare became the economy's largest employment sector, exceeding retail and employing some 12.4 million healthcare professionals nationwide (*The Atlantic*. January 10, 2018).

- Of the ten jobs that the Bureau of Labor Statistics (BLS) projects will see the fastest growth in the next decade, five are in healthcare (*The Atlantic*. January 10, 2018).
- The healthcare sector now employs one in nine people in the U.S., up from one in 12 in 2000, and 35% of the nation's job growth since 2007 has come in healthcare (*New York Times,* April 22, 2017).
- The BLS projects 1.26 million job openings in healthcare per year from 2016 to 2026, including 624,000 clinical jobs.
- Over 10,000 baby boomers continue to turn 65 every day, according to the U.S. Census Bureau, using healthcare services at three times the rate of younger people.
- The Association of American Medical Colleges (AAMC) projects a shortage of up to 121,300 physicians by 2030.
- Consolidation continues. Hospital mergers jumped by 13% last year and the largest hospital systems now account for half of all hospitals (*Forbes*. January 29, 2018).
- Volume to value. The number of Medicare accountable care organizations (ACOs) increased from to 561 in 2018, up from 480 in 2017, a sign of continued industry-wide commitment to emerging models of value-based, team-driven care focused on population health management.

Though some uncertainties persist, what is clear is that the nation's 5,564 hospitals, 200,000 medical groups, 7,500 urgent care centers, 3,000 primary care retail clinics, 9000 Federally Qualified Health Center sites, 5,480 ambulatory surgery centers, 400 free standing emergency rooms and a variety of emerging technology-based healthcare services will continue to address the nation's escalating health needs while adapting to the winds of change. What also is clear is that they will need physicians to provide care and to lead the transformation from volume to value.

PHYSICIANS STILL DRIVE THE BUS

Throughout all the changes that have occurred during Merritt Hawkins' 31 year tenure, and throughout the 25 years we have published this *Review*, there remains one constant: physicians are at the center of the healthcare system, driving both quality and healthcare economics.

The healthcare delivery system has been engaged in a process of evolution for decades, from the "golden age" of fee-for-service in the Sixties, Seventies and Eighties, to the proliferation of managed care in the Nineties, to the increasingly corporatized and value-driven system in place today. Through each of these stages, little has been accomplished -- be it a hospital admission, prescription order, test, treatment plan, surgery or hospital discharge -- without the direction or supervision of a physician.

During the 1.3 billion annual office-based, hospital inpatient, and emergency room patient encounters they handle each year in the U.S., physicians determine the quality of care patients receive, through the treatment plans they develop, hospital admissions they order, prescriptions they write, tests they request, and procedures they perform. Increasingly, they do this as the directors of multi-disciplinary care teams that may include physician assistants, nurse practitioners, nurses, therapists, pharmacists, community outreach personnel, and others. The physician, however, remains the indispensable care giver on whose shoulders the totality of patient care continues to rest.

In addition to their key role as care givers, America's 800,000-plus practicing physicians can be considered engines that keep healthcare economics humming.

The extent of the economic contributions physicians make to healthcare is quantified by the January, 2018, AMA-sponsored study *The National Economic Impact of Physicians*. This study estimates the total economic impact of office-based physicians in active patient care in the U.S., using as barometers physician output, jobs, wages and benefits and state and local tax revenue. Highlights of physician economic contributions from the study include:

Total economic output: The combined economic output of office-based physicians in the United States is $2.3 trillion based on 2015 data, up from $1.6 trillion in 2012.

Per capita economic output: Each physician supports a per capita economic output of $3.1 million based on 2015 data, up from $2.2 million in 2012.

Jobs: On average, each physician supports about 17 jobs based on 2015 data, up from 14 jobs in 2012.

Wages and benefits: On average, each physician paid a total of $1.4 million based on 2015 data, up from $1.1 million in wages and benefits in 2012.

Tax revenues: On average, each physician supports $126,129 in local and state tax revenues, based on 2015 data, up from $90,449 based in 2012.

Source: American Medical Association. The National Economic Impact of Physicians. January, 2018

According to the Boston University School of Public Health, physicians control 87% of all personal spending on healthcare through hospital admissions, test orders, prescriptions, procedures, treatment plans and related activities.

Given their importance, it is essential that the supply of physicians be robust enough to meet the nation's growing healthcare needs. Any examination of current physician recruiting trends requires at least a brief look at the current state of physician supply and demand.

IS THE PHYSICIANS SHORTAGE A MYTH?

On February 16, 2018, the Association of American Medical Colleges (AAMC) issued the following alert:

"The United States is facing a serious shortage of physicians, largely due to the growth and aging of the population and the impending retirement of older physicians. There will be shortages in both primary and specialty care, and ***specialty shortages will be particularly large****. The shortages pose a real risk to patients. Because it takes up to 10 years to train a doctor, projected shortages in 2030 need to be addressed now so that patients will have access to the care they need."*

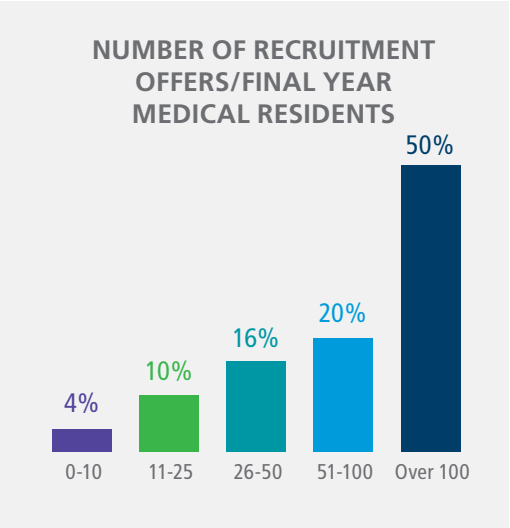
While alarming, the AAMC's projections of a physician shortage, which it has issued periodically since 2006, have not gained much traction in policy making circles, even though multiple bills have been introduced to Congress that would address the shortage by creating more residency training positions.

For example, The Resident Physician Shortage Reduction Act (S. 1301), and a similar bill introduced in the House in May, 2017, would create 15,000 Medicare –funded residency positions across the country that would be distributed on a needs-based hierarchy. These and similar bills introduced in Congress in previous years would remove the federal cap on graduate medical education (GME) spending that has limited the number of residency programs, even as U.S. medical school graduates have increased by close to 30% since 2006. However, these bills have repeatedly failed to garner support. The GME spending cap is still in place and is unlikely to be lifted in the foreseeable future.

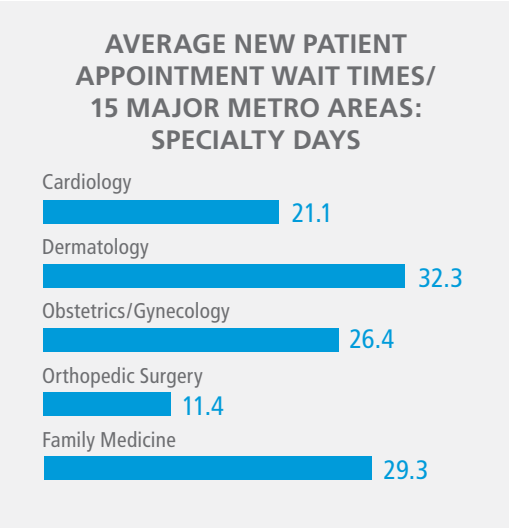
Various academics, particularly those affiliated with the *Dartmouth Atlas of Healthcare*, continue to argue there is no nationwide physician shortage, based on physician-to-population ratio projections and on the fact that PAs, NPs and other clinicians will absorb an increasing share of physician workload. Their arguments, and counter-arguments presented by the AAMC, can be reviewed in the March 20, 2017 edition of the *Journal of the American Medical Association (JAMA)*.

Merritt Hawkins' position on this subject is a matter of record. In 2004, Merritt Hawkins' executives authored the book *Will the Last Physician in America Please Turn Off the Lights: A Look at America's Looming Doctor Shortage* and we have subsequently written a variety of white papers and articles addressing the physician shortage.

We will therefore only include here two references to what may be termed our "street-level" perspective as physician recruiters whose task is to identify and recruit doctors on behalf of our clients.



Source: Merritt Hawkins 2017 Survey of Final-Year Medical Residents



Source: Merritt Hawkins 2017 Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates

One is the survey we periodically conduct of final-year medical residents in which we compile data about the job preferences and practice plans of physicians about to complete their training. The chart above quantifies the number of recruitment offers final-year medical residents report receiving.

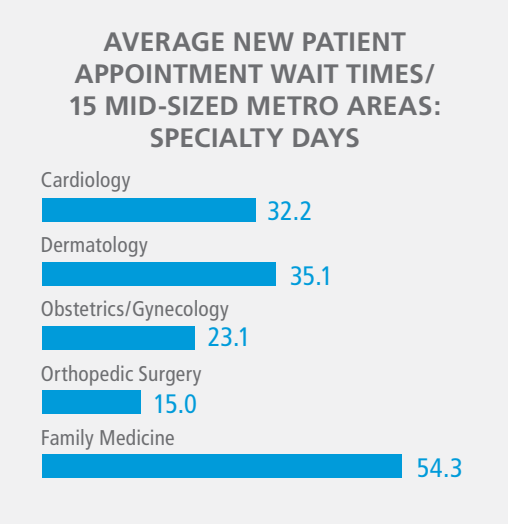
As the survey indicates, 70% of final-year medical residents report receiving 50 or more recruitment solicitations during their training, while one half receive over 100. Competition for the services of newly trained physicians is intense and newly trained doctors are in greater demand than virtually any other type of professional.

A second reference point is derived from Merritt Hawkins' *Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates*. This survey tracks the time it takes for patients to schedule a new patient appointment with physicians in various specialties in 15 large and 15 mid-sized cities. The 2017 version of this survey indicates that the average new patient physician appointment wait time has increased by 30% since 2014.

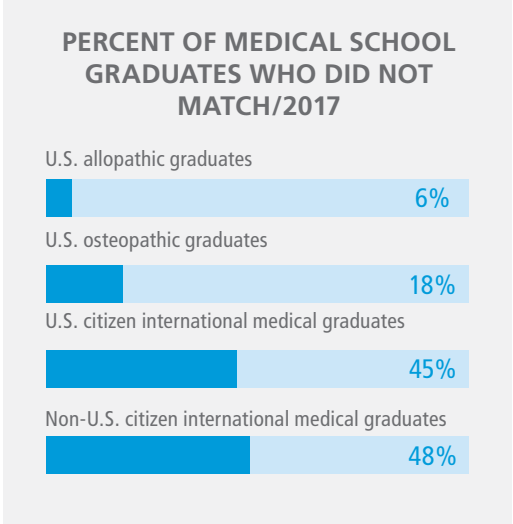
Average wait times in various specialties are indicated in the chart above.

It should be noted that physician appointment wait times are becoming more extended even in major metropolitan areas that have a higher than average ratio of physicians to population than other areas of the country. Average physician appointment wait times tracked in the survey are generally longer in mid-sized cities than large ones (see chart on page 22).

These numbers highlight the growing demand for physicians at a time when the supply of doctors remains constrained due to bottlenecks at the residency training level. Medical school graduates, whose numbers have grown significantly in recent years, are increasingly unable to match to a residency program, creating a pool of



Source: Merritt Hawkins 2017 Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates.



Source: National Resident Matching Program

physicians who cannot practice medicine (see chart above):

THE MISSOURI SOLUTION

In 2014, Missouri passed a law that created a new category of health professional – the "assistant physician." -- for graduates of medical schools who did not match to a residency program. Missouri's assistant physician license is open to all legal U.S. residents who graduated from medical school within the last three years and who passed the first two rounds of the U.S. Medical Licensing Exam (USMLE). It allows the holder to provide primary care in a designated medically underserved area with the supervision of another physician.

Since the Missouri law passed, legislators in Arkansas, Kansas and Utah have approved similar bills, a further sign of the severity of the physician shortage (*Associated Press*, March 14, 2017).

CHANGING PRACTICE PATTERNS

Physician supply also is being inhibited by changing physician practice patterns, particularly the employed physician model, which tends to reduce overall physician FTEs. According to the AAMC, physicians now 35 or younger, who are very likely to be employed, are projected to work 13% fewer hours than earlier cohorts (*JAMA*, March 20, 2017).

Physician aging and retirement are putting an additional constraint on physician supply. Over one-third of today's active physicians are projected to turn 65 within the next ten years (*USC Annenberg Center for Health Journalism blog*. February 15, 2018) and a wave of physician retirements can be expected.

THE FACTS ON THE GROUND

From the perspective of professionals whose daily task is to recruit physicians on behalf of our clients, Merritt Hawkins can state without equivocation that recruiting physicians is often a very time and labor intensive task around which an approximately $12 billion physician staffing industry has grown over the last 30 years. Whatever policy makers and others may conclude about the state of physician supply, those are the facts on the ground.

LOOMING HEALTHCARE CHALLENGES

As for the future, there is much to suggest that the risks of training too few physicians outweigh whatever downside can be associated with training too many. Consider:

- More than 70% of adults in the U.S. have at least one of the following unhealthy behaviors: Smoking, excessive drinking, insufficient sleep, physical inactivity and obesity. 12% of the country has three of these unhealthy behaviors. (*America's Health Rankings, United Health Foundation*).
- By 2030, the population 65+ will grow by 55% (*U.S. Census Bureau*).
- People 65 and older represent 14% of the population but account for 34% of inpatient procedures and 37.4% of diagnostic tests and treatments (*CDC*).
- U.S. life expectancy dropped for the second consecutive year in 2018 and now stands at 79 years. The average is 81 years for other Organization For Economic Cooperation and Development (OECD) nations (*CDC*).
- 57% of today's children will be obese by the time they reach 35 (*New England Journal of Medicine/USA Today*. November 11, 2017).
- 63,600 Americans died from drug overdoses in 2016, more than the 41,070 who died of breast cancer (*CDC*).
- The suicide rate in the U.S. increased by 24% from 1999 to 2014 and suicide is now the 10th leading cause of death (*CDC*)
- As of January, 2016, there were an estimated 15.5 million cancer survivors in the U.S. comprising 4.8% of the population (*National Cancer Institute*)
- This number is projected to increase by 31% to 20.3 million by 2026 (*National Cancer Institute*).
- Over the next decade, the number of cancer patients who have lived 5 years or more after their cancer diagnosis is expected to increase by 35% to 14 million (*National Cancer Institute*)
- 5.5 million people in U.S. have been diagnosed with Alzheimer's (*Alzheimer's Association*)

- This number is expected to increase to 16 million by 2050 (*Alzheimer's Association*)
- Each year, 5.4 million cases of non-melanoma skin cancer are detected (*Alzheimer's Association*).
- More new cases of skin cancer are detected every year than the combined cases of breast, prostate, lung and colon cancer (*Alzheimer's Association*).
- The number of total hip replacements among inpatients 45 and older increased from 138,700 in 2000 to 310,800 in 2010 and from a rate of 142.2 per 100,000 people to 257.0 per 100,000 people, while demand for knee arthroplasties will jump by 673% by 2030 (*Centers for Disease Control and Prevention/AAMC*)

THE AVAILABILITY OF INSURANCE

Though healthcare policy is subject to change, approximately 90% of American's now have some type of healthcare insurance, the highest percent ever, a further factor driving demand for physicians. Given these trends, it is a safe assumption that physician recruiting will take place in a market characterized by a high level of demand for doctors and an insufficient supply for decades to come.

Merritt Hawkins' 2081 *Review* offers insights into which types of physicians currently are in particularly high demand (see following):

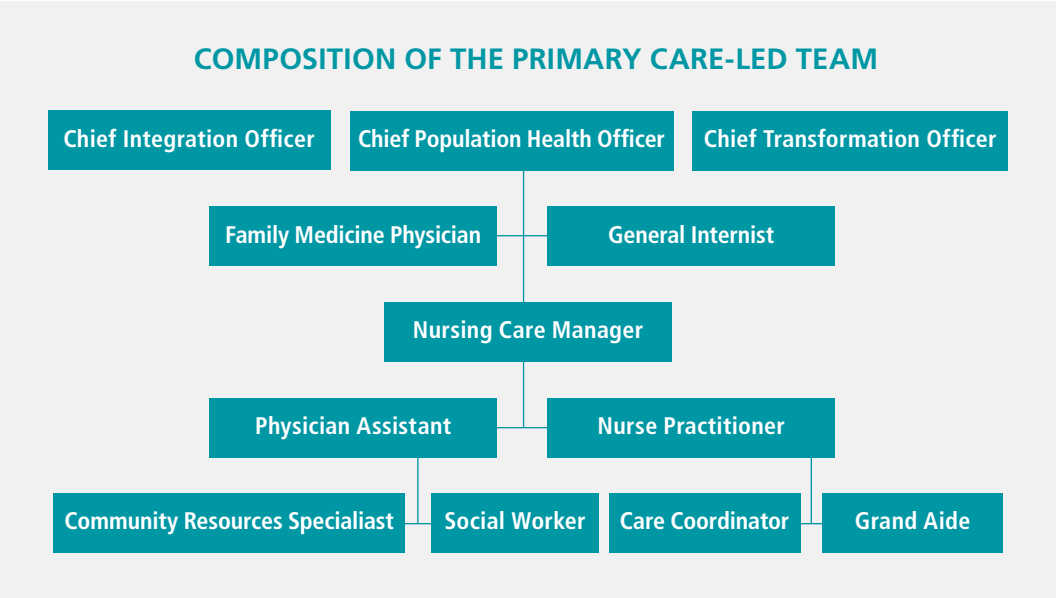
PHYSICIAN DEMAND: PRIMARY CARE, FAMILY MEDICINE, INTERNAL MEDICINE, PEDIATRICS

An Even Dozen for Family Physicians

For the twelfth consecutive year, family medicine was Merritt Hawkins' most requested search assignment, by far the longest period any one specialty has held this position.

Demand for primary care physicians, including family physicians, general internists and pediatricians, is driven in part by population growth. From 1987 to 2010, the U.S. population grew by 28%, going from 242 million to 310 million people in 23 short years, according to the U.S. Census Bureau.

Evolving healthcare delivery models are an additional demand driver for primary care physicians. In the population health management model, primary care-led teams coordinate care for defined population groups, such as blocks of Medicare patients, under a global payment model where the health system (and, increasingly, its physicians) assume risk.



Implementation of this model will likely be accomplished through inter-professional care teams, in which collaborative practice techniques will replace the current approach, where clinicians often train in silos.

Today the model is being implemented through a growing number of accountable care organizations (ACOs), large medical groups, hospital systems, major employers, insurance companies and other organizations. The primary care-led team in population health management typically consists of the providers pictured in the chart above.

Primary care physicians such as family physicians top the list of most in-demand doctors in part because of their key role as quarterbacks of the delivery team. Through the patient management and care coordination they provide, quality goals are achieved within an environment of defined financial resources. Primary care physicians then are rewarded for the savings they realize, the quality standards they achieve and for their managerial role.

CONSOLIDATION DRIVING DEMAND

Health system consolidation is a further driver of demand for family physicians and other primary care doctors. Whereas in the past, an individual acute care facility might recruit two or three primary physicians at a time, consolidated systems may recruit 20 or 30 in order to create the primary care networks needed to treat large population groups. Instead of recruiting *reactively* to fill a void or to respond to demand, health systems now are recruiting *proactively* to meet the needs of covered lives, and, in a growing number of cases, to manage their own health plans.

It also is primary care physicians who are the providers of choice for evolving, non-traditional practice settings and styles, including urgent care and retail centers, virtual patient care, concierge, quality review, and others.

DEMAND FOR PRIMARY CARE IS SHIFTING

Demand for various types of physicians ebbs and flows based on a variety of market conditions. In 2004, orthopedic surgery, radiology and cardiology were Merritt Hawkins' top three most requested search assignments during a time when hospitals and other facilities sought high-revenue generating specialists in a fee-for-service environment.

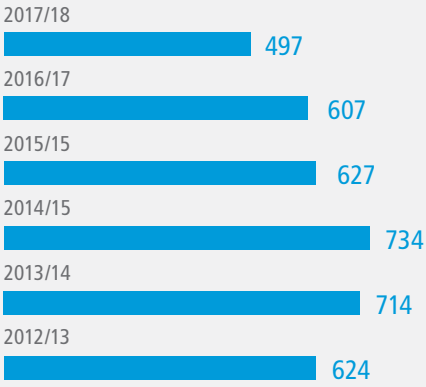
By contrast, for the last decade or more, primary care physicians have been at the top of most health facility administrators' wish lists for the reasons referenced above. There is evidence to suggest, however, that physician recruiting patterns may be shifting again.

Merritt Hawkins 2018 *Review* reflects a recent decline in the number of family medicine searches we conduct (see chart at right).

The 2018 *Review* shows the fewest number of family medicine searches that Merritt Hawkins has conducted since 2007, and an 18% year-over-year decline. Some of this may be accounted for by the shifting nature of primary care delivery, which is migrating from physician offices to urgent care centers, retail clinics and technology-based services offering telemedicine. Many searches for "urgent care" physicians are, in fact, searches for primary care physicians.

Though demand for family medicine physicians remains robust, a growing percent of Merritt Hawkins' search assignments are for specialty physicians.

MERRITT HAWKINS FAMILY MEDICINE SEARCH ASSIGNMENTS BY YEAR



In 2015, the year the number of primary care search assignments Merritt Hawkins conducted reached its peak, 33% of our search assignments were for primary care physicians. In the 2018 *Review*, that number declined to 26%.

Part of this decline may be cyclical, as many health systems have spent years building up their primary care networks and now are turning to bolstering their specialty care service lines. In addition, a growing volume of primary care services are being provided by inpatient physicians (hospitalists) and by nurse practitioners (NPs) and physician assistants (PAs).

A MATTER OF DEMOGRAPHIC DESTINY

What also is notable about this trend is that emerging integrated, value-driven delivery systems are designed to emphasize prevention and to address the social determinants of health, reducing the need for costly specialist interventions.

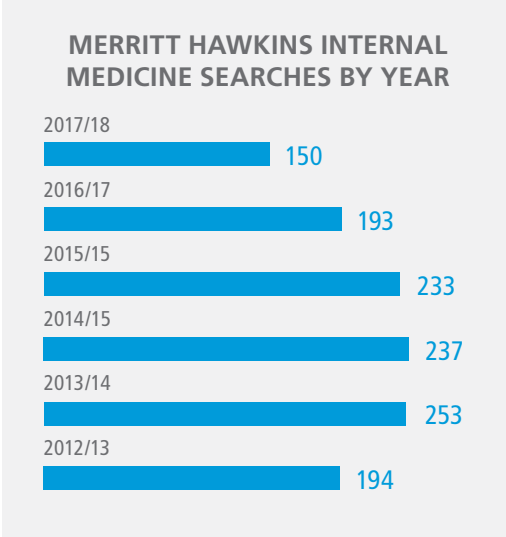
The accelerated recruitment of specialists indicates that demand for surgical and diagnostic specialists, driven largely by patient aging, is outpacing efforts to manage care and reduce specialty utilization.

It may be the case that the healthcare system cannot manage its way out of our collective demographic destiny, which will be characterized by a growing number of older patients with a growing number of healthcare needs. Organs, bones, skin and psyches eventually reach the point of obsolescence, and an increasing number of medical specialists are being recruited to address the physical and mental consequences of aging.

Primary care physicians have a key role to play in this scenario, managing the multiple chronic ailments of those who are aging in addition to younger patients subject to the interrelated pathologies created by lifestyle and social factors, such as obesity, diabetes, pulmonary disease, depression and others. However, the 2018 *Review* suggests that the momentum in terms of demand now appears to be on the side of medical specialists.

A SIMILAR PATTERN IN INTERNAL MEDICINE

The 2018 *Review* also shows that Merritt Hawkins is engaging in a still robust but diminishing number of internal medicine searches, with a 22% decline in internal medicine searches year-over-year (see chart below):



Though internal medicine trails only family medicine and psychiatry among Merritt Hawkins' top physician searches, the 2018 *Review* includes the fewest internal medicine search assignments Merritt Hawkins has conducted since 2004.

Despite the fact that demand for internal medicine physicians has somewhat diminished, the specialty remains difficult to recruit. Only about 20% to 25% of internal medicine residents go on to practice general internal medicine today, compared to 54 percent in 1998, according to the American College of Physicians (ACP). The great majority go on to specialize or practice inpatient medicine as hospitalists.

The supply of physicians willing to practice true inpatient/outpatient general internal medicine therefore is extremely constrained, and these types of positions remain a challenge to fill. The challenge has reached the point where services once provided by general internists are being delegated to pulmonologists, geriatricians and other specialists.

PEDIATRICS IN A HOLDING PATTERN

Pediatrics held its position from the previous year as Merritt Hawkins' 11th most requested physician search assignment (though number of searches declined 17% year-over-year) and is the third primary care specialty, along with family medicine and internal medicine, where demand, while robust, does not appear to be accelerating.

Demand for pediatricians is driven in part by birth rates, which have been in decline among U.S. women in the last several decades. In 1957, the U.S. averaged 123 births per 1,000 women of child bearing age. That average declined dramatically to 63 births by 2015 (*Wall Street Journal,* June 17, 2015).

Nevertheless, there are still about 4 million births in the U.S. annually, and immigration adds to the number of children in the population. Demand for pediatrics has held steady over the last five years in part for this reason and also due to shifting physician demographics. Approximately 73% of pediatric residents are women, who are coming to dominate the specialty. This trend is reducing overall pediatric FTEs, as female physicians are more likely to work part-time than are males, keeping demand for pediatricians reasonably strong.

OBSTETRICS/GYNECOLOGY IN THE TOP TEN

Demand for Obstetrics/Gynecology, sometimes included in primary care, also is driven by birth rates as well as by population growth among females. Nearly half the counties in the U.S. do not have a single Ob/Gyn, while 56 percent do not have a single nurse midwife, according to the American College of Nurse-Midwives.

The American Congress of Obstetricians and Gynecologists (ACOG) reports that the number of residents going into Ob/Gyn has remained virtually the same since 1980 at about 1,205. ACOG projects there will be 6,000 to 8,800 too few Ob/Gyns by 2020 as the number of women in the U.S. is expected to climb by 18% between 2010 and 2030 (*Columbus Dispatch,* August 28, 2016). The majority of Ob/Gyns who are 55 or older are men. However, about 4 in 5 first-year Ob/Gyns are women, which, as in pediatrics, reduces overall FTEs.

It should be noted that both male and female Ob/Gyns today express interest

in a "controllable lifestyle" and are less inclined to be on call, giving rise to the use of "laborists" whose sole function is to attend deliveries in the hospital. In addition, a growing number of Ob/Gyns are entering subspecialties such as gynecologic oncology, reproductive endocrinology and infertility, reducing the number available for routine care and deliveries. While seven percent of Ob/Gyn residents entered a subspecialty in 2000, 19.5% did so in by 2012 (*Columbus Dispatch,* August 28, 2016).

Based on these trends, Ob/Gyn remains among Merritt Hawkins' top ten most requested recruiting assignments with an eight percent increase in search assignments year-over-year, and the specialty is likely to be in strong demand for the foreseeable future.

A GROWING DEMAND FOR MEDICAL SPECIALISTS

In its April, 2018 report *The Complexities of Physician Supply and Demand*, the AAMC projected a shortage of up to 121,300 physicians by 2030. This includes a deficit of up to 49,300 primary care physicians, but also ***an even greater deficit of over 72,000 specialists***.

Merritt Hawkins' 2018 *Review* reflects the fact that demand for specialists may be increasing as approximately three out of four of the search assignments we conduct now are for specialists.

Below is an examination of several specialties that are in particular demand (for a more detailed analysis of the growing shortage of medical specialists see the Merritt Hawkins' white paper *Physician Supply Considerations: The Emerging Shortage of Specialists*).

PSYCHIATRY – THE CRISIS BUILDS

Merritt Hawkins examines supply and demand dynamics in psychiatry in its white paper, *The Silent Shortage*, but we will briefly address here what may be the most critically undersupplied specialty in medicine.

Psychiatry has been among Merritt Hawkins' top 20 most requested recruiting assignments for a number of years, gradually moving up from number 13 in 2001 to number three in our 2015 *Review*, and to number two in our 2016 *Review*. In the 2018 *Review*, it holds the second spot among our most requested physician search assignments for the third consecutive year, trailing only family medicine.

Merritt Hawkins' concern about the shortage of psychiatrists, first voiced over ten years ago, is now shared by a growing number of policy makers and healthcare experts.

In March, 2017, the National Council of Behavioral Health (NCBH) released a report compiled by a 27-member panel of experts drawn from providers, payers, government agencies and psychiatric associations. The

report indicates there is a national shortage of psychiatrists that is about to spiral out of control, with 77% of U.S. counties reporting a severe psychiatrist shortage. (*HealthLeaders, March 30, 2017*).

In June, 2016 it was reported that for the first time the largest share of healthcare spending in the U.S. is on mental health disorders. An estimated $201 billion dollars was spent on mental disorders in the U.S. in 2013, the most recent year data is available, followed by heart disease, trauma, cancer and pulmonary conditions (*HealthLeaders News, June 14, 2016*)

Approximately one in five adults in the U.S (43.8 million people, or 18.5% of the population) experience mental illness in a given year, with only 41% receiving mental health services. Among adults with a serious mental illnesses, just 62.9% received health services in the past year, according to the National Alliance on Mental Illness, while nearly one in 20 adults in America -- or 13.6 million people -- live with a serious mental illness. The mental health challenges facing the VA system have been widely noted as they struggle to cope with high incidences of post-traumatic stress syndrome and high suicide rates among veterans.

PSYCHIATRIC EMERGENCY ROOM VISITS AND DRUG-RELATED DEATHS

In a particularly telling statistic, emergency department visits for suicidal thoughts more than doubled during a recent seven year period according to a 2017 Agency for Health Research and Quality (AHRQ) statistical brief (*HealthLeaders*, March 3, 2017). As referenced above, suicide is now the 10th leading cause of death in the U.S. and over 63,000 Americans died of drug overdoses in 2016.

In some areas, primary care physicians attempt to address burgeoning demand for mental health services, but a report by the Commonwealth Fund indicates that more than 8 in 10 family doctors in the US say they are not adequately prepared to care for severely mentally ill patients. According to the report, just 16 percent of doctors said their offices had the capacity to care for those with serious mental illnesses, the lowest of any developed country besides Sweden (*The Hill, December 8, 2015*).

The supply of psychiatrists, already constrained, is soon going to diminish significantly as close to 60% of psychiatrists are 55 years old or older, with many set to retire.

As Merritt Hawkins has consistently observed in these *Reviews*, the shortage of psychiatrists is an escalating crisis of more severity than shortages faced in virtually any other specialty. With many psychiatrists aging out of the profession, and with a preference among psychiatrists for outpatient practice settings, it is becoming increasingly difficult to recruit to inpatient settings.

Because psychiatric disorders are so frequently misdiagnosed, patients often require extensive time with psychiatrists when their conditions eventually are diagnosed correctly, further increasing demand.

RADIOLOGY REACHES THE TOP FOUR

In 2003, radiology topped the list of Merritt Hawkins' most requested search assignments.

Demand for radiology diminished over subsequent years due to a robust supply of residents entering the specialty, payment cuts for imaging services, and utilization suppression linked to both the 2007 recession and to managed care, as well as the growing use of both domestic and offshore teleradiology services. In 2012, radiology dropped out of Merritt Hawkins' top 20 altogether.

It returned for the first time since then in the 2016 *Review* and built on its momentum in 2017, with a 100% increase in search assignments year-over-year. In the 2018 *Review*, radiology returns to our list of top four most requested physician search assignments, following only family medicine, psychiatry and internal medicine, with number of searches increasing 65% year-over-year.

Renewed demand for radiologists was inevitable because imaging remains central to diagnostic and procedural work in today's healthcare system, in which very little transpires without a picture. The importance of radiology is enhanced with each technological advance (including artificial intelligence) that makes imaging techniques more varied and effective.

Combine this with improvements in the economy allowing for more elective procedures and the effect of population aging on utilization, and demand for radiologists was going to rise at some point. In addition, close to 50% of radiologists are 55 or older and attrition is beginning to reduce the candidate pool.

Rising demand for radiology also is notable as it suggests that even with the widespread use of teleradiology, which allows for the distribution of imaging studies to radiologists nationally and even internationally, healthcare facilities are again seeking the assistance of recruiting firms such as Merritt Hawkins to help them find radiologists. Demand now is at the level where facilities are seeking both more traditional, on-site radiologists and those working as teleradiologists. Teleradiology has gained momentum recently due to technological advancements that improve quality and the ability of radiologists to work remotely.

GASTROENTEROLOGY MOVING UP

In the 12 month period covered by the 2018 *Review*, Merritt Hawkins conducted 102 search assignments for gastroenterologists, up 55% from the previous year and up 137% from three years ago. The emphasis on prevention typical of value-based, community health models is driving the need for gastroenterologists, as is the growing number of elderly patients.

According to the Health Resources and Services Administration (HRSA) report *National and Regional Projections of Supply and Demand for Internal Medicine Subspecialty Practitioners*, December 16, 2016, gastroenterologists are one of several internal medicine subspecialists projected to be in short supply in 2025.

The chart below indicates HRSA's shortage projections in these subspecialties.

As these numbers indicate, a variety of internal medicine subspecialists who treat conditions often associated with aging, such as heart disease, cancer, joint ailments, and others are projected to be in short supply by 2025.

ORTHOPEDICS CONTINUES STRONG

Demand also continues to be strong in some surgical specialties, including orthopedic surgery.

In 2003, orthopedic surgery was Merritt Hawkins' second most requested search assignment. While it never dropped out of the top 20, the number of orthopedic searches Merritt Hawkins conducted decreased from 193 in 2003 to 57 in 2013, a reduction of 70%. The number rose to 85 last year as indicated in the 2018 *Review*, a year-over-year increase of 39%.

NATIONAL ESTIMATES OF PHYSICIAN SUPPLY, DEMAND AND DEFICITS/INTERNAL MEDICINE SUBSPECIALTIES BY 2025

	Supply	Demand	Deficit/2025
ALLERGY AND IMMUNOLOGY	4,140	4,620	-480
CARDIOLOGY	28,560	35,460	-7,080
DERMATOLOGY	13,100	13,530	-430
GASTROENTEROLOGY	15,540	17,170	-1,630
HEMATOLOGY/ONCOLOGY	18,100	19.500	-1,400
PULMONOLOGY	14,110	15,510	-1,400
RHEUMATOLOGY	6,330	6,610	-280

Source: HRSA Regional Projections of Supply and Demand for Internal Medicine Subspecialty Practitioners. December, 2016.

Continued robust demand for orthopedic surgeons further illustrates how patient aging is driving the need for medical specialties. Between 2000 and 2014 the number of hip replacements in the U.S. more than doubled – from 160,282 to 371,605 annually, according to the Healthcare Cost and Utilization Project. The number of knee replacements saw even larger growth in the same period, from 274,467 to 680,886 (*Boston Globe,* April 6, 2018).

Aging baby boomers, committed to living an active lifestyle, ensure that demand for orthopedic surgeons will continue to remain strong.

Additional surgical specialties in robust demand include otolaryngology, dermatology, and urology

WHO LEADS IN "ABSOLUTE DEMAND?"

It is to be expected that specialties that have a comparatively high number of practicing physicians, such as family medicine and internal medicine, will generate a comparatively high number of searches. But how does the picture look if specialties are ranked by number of search assignments as a percent of all active physicians in a given specialty, or by what Merritt Hawkins calls "absolute demand?"

The chart on the following page ranks demand for particular types of physicians in this manner.

Considered this way, demand for specialties such as pulmonology, gastroenterology, dermatology, hematology/oncolology and radiology can be viewed as being particularly strong, while some specialties, such as family medicine and psychiatry, are in strong demand as ranked by both number of searches Merritt Hawkins conducts and by searches as a percent of all physicians in their respective specialties.

It should be noted that in the 2018 *Review* no primary care specialty (family medicine, internal medicine, pediatrics) is ranked in the top seven specialties that are in greatest "absolute demand."

HOSPITALIST STAFFING MODEL MAY BE CHANGING

"Hospitalist" medicine, which got its start in 1996, has grown from a few hundred physicians 20 years ago to more than 50,000 today. Nine out of 10 hospitals of more than 200 beds now have hospitalists who provide inpatient care to patients, many of whom have complex problems (*New England Journal of Medicine,* September, 15, 2016).

There are no hospitalist residency programs yet, though internal medicine residents can select hospitalist tracks in residency and have access to a variety of hospitalist fellowships. According to the Society of Hospital Medicine (SHM), hospitalist training breaks out as follows:

MERRITT HAWKINS TOP SEARCH ASSIGNMENTS AS A PERCENT OF ALL PHYSICIANS IN VARIOUS SPECIALTIES (PATIENT CARE ONLY)

	2017/18	2016/17	2015/16	2014/15
PULMONOLOGY	0.82%	1.32%	0.80%	0.66%
PSYCHIATRY	0.79%	0.82%	0.83%	0.78%
GASTROENTEROLOGY	0.78%	0.51%	0.47%	0.35%
DERMATOLOGY	0.60%	0.77%	0.67%	0.42%
RADIOLOGY (DIAGNOSTIC)	0.57%	0.38%	0.16%	N/A
HEMATOLOGY/ONCOLOGY	0.57%	0.47%	N/A	N/A
OTOLARYNGOLOGY	0.56%	0.48%	0.51%	0.61%
FAMILY MEDICINE	0.50%	0.69%	0.70%	0.82%
NEUROLOGY	0.50%	0.55%	0.92%	0.55%
ENDOCRINOLOGY	0.48%	N/A	N/A	N/A
ORTHOPEDIC SURGERY	0.47%	0.34%	0.46%	0.60%
UROLOGY	0.44%	N/A	0.55%	0.43%
OBSTETRICS/GYNECOLOGY	0.32%	0.38%	0.32%	0.32%
EMERGENCY MEDICINE	0.19%	0.25%	0.20%	0.23%
GENERAL SURGERY	0.19%	0.20%	0.27%	0.29%
CARDIOLOGY (NON-INV.)	0.17%	0.32%	0.17%	0.17%
INTERNAL MEDICINE	0.14%	0.20%	25%	0.25%
PEDIATRICS	0.11.%	0.15%	0.15%	0.14%
ANESTHESIOLOGY	0.11.%	0.11%	N/A	N/A
NURSE PRACTITIONER	0.08%	0.07%	0.08%	0.08%

HOSPITALISTS BY TRAINING

General internal medicine	**76.7%**
Family medicine	**9.2%**
Pediatrics	**6.3%**
Other specialties	**7.8%**

Source: SHM/Medscape, April 26, 2016

By developing inpatient expertise, hospitalists can reduce readmissions, reduce resource utilization and increase patient satisfaction, and therefore are one key to the transition to value-based care and global payments. Four in 10 hospitalists work in ACOs, underlining their role in emerging value-based, capitated delivery systems (*Medscape, April 26, 2016*). The hospitalist concept is extending to obstetrics/gynecology ("laborists") and also to surgery, neurology and other specialties.

The number of hospitalist search assignments Merritt Hawkins conducted declined year-over-year as tracked by the

2017 *Review*, but increased by 26% year-over-year as tracked by the 2018 *Review*. However, hospitalist searches remain down from recent previous years, which may signal that some hospitals have reached full hospitalist staffing. However, it is more likely a sign that staffing in the specialty is being more aggressively outsourced to a growing number contract management groups that are entering the temporary (locum tenens) physician staffing arena

For additional information on hospitalists see Merritt Hawkins' white paper *The Growing Use and Recruitment of Hospitalists*.

EMERGENCY MEDICINE REMAINS IN THE TOP TEN

Emergency medicine remains among Merritt Hawkins' top ten most requested physician search assignments, the 2018 *Review* indicates.

According to the Centers for Disease Control (CDC), annual U.S. hospital emergency department visits now stand at 136.3 million. Of these, 40.2 million are injury related and 16.2 million lead to hospital admissions (*Becker's Hospital Review,* October 7, 2016). Over half of hospital admissions now come through the ED (*New York Times, May 20, 2013*), illustrating that EDs can be an important loss leader for hospitals and a compelling reason to keep EDs staffed appropriately.

Though the ACA is intended to reduce ED admissions by allowing more patients with insurance coverage to see office-based physicians, there is evidence that higher rates of insurance do not necessarily reduce ED visits. ED visits went up in Massachusetts in 2006 when access to coverage in the state was expanded, and a similar trend was observed in Oregon when access to Medicaid was expanded. Eighty-four percent of ED visits are generated by patients with insurance (*Becker's Hospital Review, October 7, 2016*), and many ED patients, both insured and uninsured, fall back on the ED when they cannot obtain convenient access to office-based physicians.

Demand for physicians who work in the ED, particularly for physicians board-certified in emergency medicine, therefore remains robust. For additional information on emergency medicine see Merritt Hawkins' white paper *Emergency Medicine: Physicians Recruiting, Supply and Staffing Considerations in Today's Healthcare System*.

CONVENIENT CARE MOVEMENT STILL DRIVING SEARCH ASSIGNMENTS

Physicians who practice in urgent care settings represented Merritt Hawkins' 10th most requested recruiting assignment as tracked by the 2017 *Review* and remain in the top 10 in the 2018 *Review*, with number of searches up 23% year-over-year.

Increased recruitment of urgent care physicians underscores the rise of a movement seen throughout the economy in which convenience and ease of access are paramount. Uber, Netflix, Amazon, Spotify and other services illustrate this trend, which is accelerating rapidly in healthcare.

In order to capture consumer preferences for convenient care, hospitals, large medical groups, health corporations, insurance companies, and other organizations are developing outpatient sites of service, including urgent care centers, retail clinics, and free standing emergency rooms.

Providing urgent care services is no longer a secondary consideration filled by "moonlighting" primary care physicians – it is a distinct growth service line. There are over 7,500 urgent care centers in the U.S. today, according to the Urgent Care Association of America, generating over $15 billion in revenue (*Markets Insider*, April 5, 2017)

URGENT CARE LOCATIONS

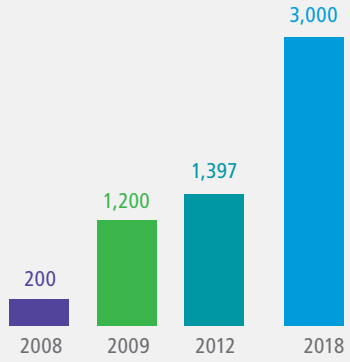
Shopping centers/strip mall	34.1%
Freestanding buildings	33.2%
Mixed-use buildings	13.6%
Medical offices	19.1%

Source: Urgent Care Association of America/Becker's Hospital Review, February 11, 2016

The rapid growth of urgent care centers represents an unusual intersection between the interests of consumers, physicians, healthcare systems and investors, all of whom are embracing this expanding model of delivery.

Retail clinics located in pharmacies, retail chains and supermarkets also are growing rapidly, as the chart below indicates:

NUMBER OF PRIMARY CARE RETAIL CLINICS IN THE U.S. 2008-2018



Source: Statista

Of the approximately 3,000 primary care retail clinics in the U.S. today, over 1,100 are MinuteClinics inside CVS and Target stores, with more to follow.

Increased access to medical services, or "being everywhere, all the time," is part of a wider trend in which healthcare facilities are evolving away from a transactional model of care and toward an "experiential" model characterized by customer service, price transparency, provider ratings, and ease of use. With the understanding that consumers punish complexity and reward simplicity, healthcare is shifting to a retail model with a wider menu of niche providers to suit varying customer preferences.

The trend extends to free-standing EDs, of which there are now some 400 in the U.S. though growth in this sector is uncertain

given certificate of need (CON) and other considerations (*Modern Healthcare,* October 4, 2016).

Convenient care settings can be staffed by primary physicians and emergency medicine physicians, and by advanced practice PAs and NPs, which will further drive demand for these types of clinicians (see below). These settings also are pushing into areas beyond primary care, including vision, hearing and even behavioral health. For further information on convenient care see the Merritt Hawkins' white paper *Convenient Care: Growth and Staffing Trends in Urgent Care, Retail Medicine and Free-Standing EDs*.

NURSE PRACTITIONER SEARCHES REACH ALL-TIME HIGH

The number of search assignments Merritt Hawkins conducts for nurse practitioners (NPs) reached a record high as tracked by the 2018 *Review*, and was up 61% year-over-year. Combined with physician assistant (PA) searches, searches for advanced practice professionals rank number two on our list of top search assignments for the first time. Ten years ago, Merritt Hawkins conducted only a handful of searches for NPs and PAs and neither was among our 20 twenty search assignments, either singly or combined.

There are approximately 248,000 NPs practicing in the U.S. today according to the American Association of Nurse Practitioners, 78% of them delivering primary care. There are over 120,000 PAs practicing in the U.S. today, about one-third of them in primary care and two-thirds in specialty areas, according to the American Academy of Physician Assistants (AAPA).

PAs and NPs are playing a growing role in team-based care (many were trained in this model), in some cases handling 80 percent or more of the duties physicians perform, allowing doctors to focus on the most complex patients and procedures. Their ability to educate patients, ensure patient compliance, reduce costs and enhance patient satisfaction makes them an ideal resource for value-based delivery systems operating in global payment structures.

Increasingly, NPs and PAs are viewed as appropriate leaders of the team-based care model, capable of coordinating the efforts of all members of the team, from physicians to community care coordinators. They also are being groomed for those leadership positions considered critical to the transition to quality-based care, including chief quality officer, director of population health management, and others.

PAs have prescriptive authority in all 50 states, while NPs now can practice independently of physicians in over 20 states and the District of Columbia, with scope of practice expected to expand. As referenced above, PAs and NPs provide the bulk of care at the growing number of urgent care and retail centers and also have been a fixture at Federally Qualified Health Centers (FQHCs) for years. Their

presence and role is likely to be determined on a state-by-state level, as each state has discretion to impose its own level of NP and PA management, oversight and autonomy.

Given these considerations and the continued physician shortage, demand for PAs and NPs can be expected to accelerate. A significant recruiting challenge is arising in this area as many PAs and NPs are choosing to specialize, making it more difficult to find PAs and NPs to fill primary care roles.

For more information on PAs and NPs, see Merritt Hawkins' white paper, *NPs and PAs: Supply, Distribution and Scope of Practice* and the survey of PA employers Merritt Hawkins conducted on behalf of the American Academy of Physician Assistants (*2016 Survey of PA Recruiting and Employment Trends*).

RECRUITMENT SETTINGS

Types of Healthcare Facilities Currently Recruiting Physicians

A growing variety of healthcare facilities and organizations recruit physicians today. When Merritt Hawkins was founded 31 years ago, hospitals funded the great majority of physician recruiting endeavors, often on behalf of the independent medical groups or solo physicians affiliated with them in which physicians were placed. Today, hospitals remain a major factor in physicians recruiting, but are much more likely to recruit physicians whom they employ directly or who are placed at hospital-owned medical groups.

Below is a review of the types of organizations recruiting physicians and the settings into which they are placed based on Merritt Hawkins' 2017/18 recruiting assignments.

HOSPITALS

According to the American Hospital Association (AHA), there are 5,564 hospitals in the United States., broken out as follows:

HOSPITALS/U.S.

Total all registered	5,564
Community (non-federal)	4,862
Urban community	3,033
Rural community	1,829
Non-government/not-for-profit	2,845
For-profit	1,034
State and local government	983
Federal government	212
Nonfederal psychiatric	401
Nonfederal long-term	79
Community hospitals in a system*	3,198
Community hospitals in a network**	1,677

**AHA defines "system" as either a multihospital organization or a diversified single hospital system*

***AHA defines "network" as a group of hospitals, physicians or other providers/insurers/community agencies that work together. Network participation does not preclude system affiliation.*

Source: Fast Facts on U.S. Hospitals, American Hospital Association, 2017

These facilities total 35,061,292 admissions annually and generate over $936 billion in spending.

Hospitals have been challenged in recent years to evolve from a transactional model based on maximizing individual patient encounters and services to alternative models focusing on population health management and resource utilization in which reimbursement is capitated and quality-driven. They also are embracing consumer driven demand for convenience by expanding outpatient services and sites, in some cases playing catch up with retail and other settings that have been quicker to embrace the convenient care model.

The need to reengineer their operations -- where by contrast new entrants to the market can simply introduce a new delivery model -- can put some hospitals at a strategic disadvantage. Addressing these challenges requires integration and consolidation, and as the numbers above indicate, the great majority of hospitals now are part of a system or a network.

For these reasons, hospital physician recruitment is transitioning from an ad hoc approach in which individual staff openings for physicians are addressed, often reactively, to a strategic, proactive approach in which entire "physician platforms" may be put in place to catapult a system into the new world of population care and global payments.

Rather than recruiting two or three physicians, hospital systems will recruit or acquire the practices of 20, 30 or more physicians, at the same time building inter-professional clinical teams around them and the management to support them.

For smaller, rural facilities the challenge today is to maintain a viable business model, often by affiliating with larger entities. Approximately 70 rural hospitals have closed in the last ten years, while about 700 are at high risk of closing (see the Merritt Hawkins' white paper *Rural Physician Recruiting Challenges and Solutions* for additional information on rural physician recruiting trends). These facilities are seeking alternative approaches to care delivery, including the expanded use of telemedicine and advanced practitioners such as NPs and PAs.

Forty percent of Merritt Hawkins' recruiting assignments were conducted for hospitals in the 2018 *Review*, down from previous years, due in part to the growth and proliferation of other sites of service, including large medical groups (see below):

PHYSICIAN-OWNED MEDICAL GROUPS

Physician-owned medical groups, which, like hospitals, are merging and consolidating to achieve economies of scale and to compete for contracts covering large patient populations, also are actively recruiting doctors.

The 2016 *Survey of America's Physicians*, which Merritt Hawkins conducted on behalf of The Physicians Foundation, indicates that 48% of physicians now are in practices of 11 physicians or more, compared to 34% in 2012, underscoring the proliferation of large medical groups.

The list below of the ten largest physician-owned medical groups in the U.S. illustrates the scope and potential resources of large scale groups.

LARGEST U.S. MEDICAL GROUPS

1.	Kaiser Permanente Medical Group – 7,948 physicians
2.	Cleveland Clinic – 2,138 physicians
3.	Mayo Clinic/Jacksonville – 1,776 physicians
4.	Mercy Clinic – 1,674 physicians
5.	North Shore-Long Island Jewish Medical Group – 1,380 physicians
6.	Aurora Medical Group – 1,308 physicians
7.	Palo Alto Medical Foundation Clinic – 1,158 physicians
8.	Duke University Affiliated Physicians – 1,090 physicians
9.	UW Physicians – 1,072 physicians
10.	IU Health Physicians – 1,053 physicians

Source: SK&A's 50 Largest U.S. Medical Groups, January 2016

Twenty-six percent of Merritt Hawkins' search assignments tracked in the 2018 *Review* were conducted for medical groups, up from 19% in 2016.

However, as can be seen from the list of large medical groups above, the difference between "hospitals" and "medical groups" can be one of semantics, as large medical groups often have the same structures and capabilities as hospitals. Large medical groups can be favorably positioned in today's market because they have been the first to employ extensive networks of physicians, embrace quality metrics and drive change through the development of physician executives.

FEDERALLY QUALIFIED HEALTH CENTERS/INDIAN HEALTH SERVICE FACILITIES

With over 50 years of service, Federally Qualified Health Centers (FQHCs) are one of America's healthcare success stories, supported with funding by both sides of the political aisle. FQHCs have expanded rapidly in recent years and now include approximately 1,400 centers providing services at over 9,000 sites nationwide.

Using a primary-care driven, preventive model now being adopted by other types of providers, FQHCs see over 24 million patients annually, while offering affordable, accessible care and seeing all patients regardless of their ability to pay. ***Merritt Hawkins is proud to be the sole provider of permanent physician search services for the National Association of Community Health Centers (NACHC) and to support the vital mission of FQHCs in addressing the needs of medically underserved populations***.

Due in part to their rapid growth, FQHCs are experiencing severe staffing challenges, highlighted by the following numbers:

FQHC WORKFORCE CHALLENGES

- 95% of FQHCs have at least one clinical vacancy
- The vacancy rate for family physicians is 25%
- 69% of FQHCs are recruiting for at least one family medicine physician
- Average time to recruit a family physician is 11.4 months
- Average time to recruit a psychiatrist is 12.7 months
- 50% of FQHCs have an opening for NPs
- 56% report at least one behavioral health staff vacancy
- FQHCs have a higher average vacancy rate than hospitals.

Source: National Association of Community Health Centers

Twelve percent of Merritt Hawkins' recruiting assignments in the 2018 *Review* were conducted for FQHCs or Indian Health Service (IHS) facilities, down from 15% in 2017, a decline which may in part be attributed to uncertainty about FQHC funding over the last year.

Merritt Hawkins was proud to have been selected by the IHS to conduct two national surveys; one of 380 IHS facility administrators and one of over 400 IHS facility physicians. Both surveys focused on IHS facility recruiting goals, incentives, methods and challenges with a view to expanding IHS physician and advanced practitioner recruiting capabilities.

Merritt Hawkins works with IHS facilities nationwide and anticipates these facilities will continue to expand their recruiting efforts to meet the needs of their constituents.

ACADEMIC MEDICAL CENTERS

Academic Medical Centers (AMCs) are hospitals and health systems with a close affiliation with a medical school. AMCs feature residency and often fellowship training programs and pursue clinical research in addition to direct patient care. They also often are considered tertiary care centers, because of their ability to treat a full range of complex conditions, in many cases by providing subspecialty care.

In 2013, the latest year for which data is available, approximately 400 U.S. hospitals were affiliated with a medical school. There were 144 allopathic medical schools accredited in 2017 by the Liaison Committee on Medical Education and 33 schools of osteopathic medicine accredited by the American Osteopathic Association (*U.S. News & World Report. March 19, 2018*).

Fifteen percent of Merritt Hawkins' search assignments tracked in 2018 *Review* were conducted for AMCs, up from 11% the previous year. This is the highest percentage of searches Merritt Hawkins has conducted for AMCs since we began tracking them as a separate category.

Recruitment of faculty, research and leadership positons at AMCs has increased in recent years due to the expansion of medical education in the U.S. and the continued vital role AMCs play as tertiary care centers. In 2006, the Association of American Medical Colleges (AAMC) announced the goal of increasing medical school enrollment by 30%, and that goal has been accomplished.

In addition, academic centers are typically major hubs of care in their communities, and often are contending with sharp increases in demand for services. They are seeking to significantly expand clinical capabilities and teaching capabilities simultaneously and can be overwhelmed for this reason.

AN EVOLVING KIND OF ACADEMIC LEADER

Over the past year, Merritt Hawkins observed several notable trends in AMC recruiting, including a significant increase in recruiting requests from osteopathic schools, which have been particularly dynamic in their expansion efforts.

Also notable is an evolution in the type of academic leaders being sought, with less emphasis placed on publication history and associated funding, and more emphasis placed on an understanding of profit/loss business dynamics, conflict resolution, interpersonal relationships and collaboration throughout the organization. The average tenure of AMC Deans placed by Merritt Hawkins is now approximately four years, as many centers are seeking a new breed of leader who can navigate the organization through transformative times.

Academic institutions also are making a concerted effort to diversify their leadership, seeking to identify and develop female and minority leaders.

AN ACADEMIC "TALENT DRAIN"

Academic recruiting is further driven by the physician shortage, which has seen many faculty members lured to private practice by comparatively high income offers. Leaders of academic medical centers, including Chairs, Department Chiefs and others, are being targeted for leadership positions by pharmaceutical companies, private health systems, and other organizations, contributing to a "talent drain" that has challenged some academic facilities. This challenge has become more acute as expectations for greater clinical throughput grows at AMCs while protected research time is reduced.

Combined with the need to replace an aging academic workforce, these trends have accelerated the pace of academic medical center recruitment (see the Merritt Hawkins' white paper *The Changing Landscape in Academic Recruiting* for more information on AMC recruitment trends).

In response, Merritt Hawkins' Department of Academics has expanded its resources, forming an Academic Advisory Council of nationally prominent academic medicine leaders to help set strategic goals and to source top candidates for academic leadership positions. **The Advisory Council is composed of Tom Lawley, MD, former Dean of Emory Medical School; Phillip Pizzo, MD, former Dean of Stanford Medical School; and Arthur Rubenstein, MD, former Dean of the University of Pennsylvania School of Medicine.**

VETERANS AFFAIRS (VA) HOSPITALS

There are currently 157 hospitals in the U.S. operated by the Department of Veterans Affairs (VA) serving approximately 5.7 million patients.

VA hospitals are included in the "hospital and hospital owned group" category in the *Review*, but require a separate mention as they have significantly expanded their physician recruiting activities in the last several years.

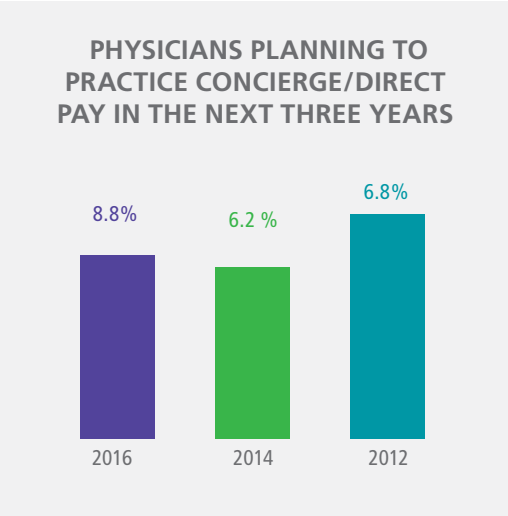
Accelerated recruitment efforts have come as a response to highly publicized reports of long patient wait times at VA facilities and particular challenges in mental health, with approximately 45,000 job openings for physicians, nurses and other healthcare professionals system-wide (*Government Executive,* September 27, 2017).

Based on the work we have done with a number of VA facilities nationwide, Merritt Hawkins is proud have been selected twice to submit a **Statement of Record to the House Subcommittee Health Oversight Hearing on the Ability of Department of Veterans Affairs to Effectively Recruit, Onboard, and Retain Qualified Medical Professionals**. The two Statements outlined the challenges Merritt Hawkins has encountered when recruiting for VA facilities and included suggestions for how VA facilities can streamline and enhance their physician recruiting processes.

SOLO PRACTICE/DIRECT CARE

In 2001, 22% of Merritt Hawkins' search assignments were for solo practice settings. Since then, market forces, regulatory compliance issues, and physician practice preferences have eroded the viability of the solo physician model. Only 2% of the searches Merritt Hawkins conducted in the 2018 *Review* period were for solo settings.

The future of solo practice may lie with the direct pay or concierge practice model in which physicians bypass third party payers and contract directly with patients. A growing number of physicians plan to adopt this model in the next several years (see chart on next page):



Source: 2016 Survey of America's Physicians. The Physicians Foundation/Merritt Hawkins

Most of the solo physician practice searches Merritt Hawkins conducted in the 2018 *Review* period were for direct pay/ concierge settings.

THE EMPLOYED PHYSICIAN MODEL DOMINATES

The majority of the organizations recruiting physicians today – hospitals, medical groups, urgent care centers, FQHCs, academic centers, and others -- typically employ physicians rather than establishing them in private practices.

While it is hard to be precise given the hybrid nature of some physician contacts, the 2018 *Review* suggests that the great majority of physicians accepting new positions today – over 90% -- will practice as employees and not as independent practice owners/partners. By contrast, in 2001, this number was approximately 40%.

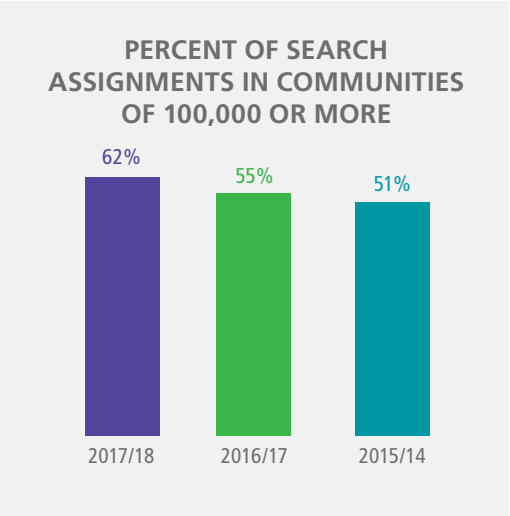
Physician employment may be required to implement the integration, evidence-based treatment protocols, IT standardization, global payments and other hallmarks of value-based care. In order to establish a value-based organizational culture and a uniform compensation plan for hundreds and even thousands of physicians, employment is the model of necessity if not preference. Employing physicians also can help hospitals comply with Stark and federal fraud and abuse statutes.

In addition, employment is the preferred practice model of many physicians today who do not want the attendant responsibilities, time constraints and stress of "running a business." The challenges of physician recruiting become more daunting for those facilities unable or unwilling to offer physicians employment.

PHYSICIAN RECRUITING BY COMMUNITY SIZE – FLIPPING THE SCRIPT

Physician shortages, and, by extension, physician recruiting efforts, are often thought to be concentrated in smaller communities and rural areas. Merritt Hawkins' 2018 *Review* underscores how this dynamic is changing.

For the first 22 years Merritt Hawkins completed this *Review*, the number of search assignments we conducted in communities of 100,000 or more never exceeded 50%. That has not been the case over the last three years (see chart on next page):



Source: 2016 Survey of America's Physicians. The Physicians Foundation/Merritt Hawkins

As these numbers indicate, over six in ten search assignments Merritt Hawkins conducts now are for communities of 100,000 or more.

This trend further underscores how demand for medical specialists, who typically practice in larger communities, is driving a growing number of recruiting efforts. Physician shortages have by no means diminished in rural areas, but recruiting challenges and efforts have expanded into larger communities as well, particularly those seeking specialists.

Merritt Hawkins worked for clients in all 50 states and the District of Columbia and Canada during the 2018 *Review* period, underlying the national presence of physician recruiting needs and challenges.

SALARIES AND CONTRACT STRUCTURES

Merritt Hawkins' annual *Review of Physician and Advanced Practitioner Recruiting Incentives* tracks the starting salaries being offered to recruit physicians, as well as other recruiting incentives typically offered to doctors and advanced practitioners.

Average starting salaries represent the base only and are not inclusive of bonuses or other incentives. This is in contrast to physician compensation numbers compiled by the Medical Group Management Association (MGMA), the American Medical Group Association (AMGA) and other organizations, which track overall average physician incomes, not just salaries.

Merritt Hawkins' salary ranges are therefore indicators of the financial incentives needed to attract physicians already established in a practice or those coming out of residency to a practice opportunity, rather than indicators of physician average incomes. If Merritt Hawkins' compensation numbers are equal to or exceed numbers of other surveys that track total physician earnings, that is a strong indicator that demand in those specialties is particularly high. It therefore can be useful to use Merritt Hawkins' surveys in tandem with surveys tracking total physician earnings when developing physician compensation packages.

It also should be noted that in today's market the salary amount is just one metric to consider – it also is important to consider how salaries are structured.

SALARIES IN PRIMARY CARE PLATEAUING?

Salaries for primary care physicians as tracked by Merritt Hawkins' *Review* have been on an upward trajectory for years. Average salary offers to family medicine physicians grew from $185,000 in the 2013 to $231,000 in 2017, an increase of 25%. Similarly, average salaries for internal medicine physicians grew from $208,000 to $257,000 in the same period, an increase of 24%. Average salaries for pediatricians also grew, from $179,000 in 2013 to $240,000 in 2017, an increase of 34%.

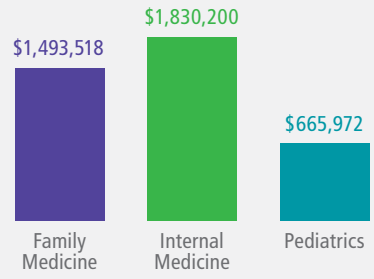
The 2018 *Review* indicates that average starting salaries for both family physicians and internists increased year-over-year, by 4% and 2% respectively, while average starting salaries for pediatricians declined by 4% year-over-year.

As is referenced above, competition for primary care physicians remains robust but is not at the same level of two or three years ago as tracked by Merritt Hawkins' *Review*. Whether average starting salaries for primary physicians can continue to climb at the rate seen in the last several years is open to question.

Through their role as gatekeepers and as managers of both quality and cost, primary care physicians continue to play a central role in healthcare economics. Though hospitals and other healthcare facilities may lose money directly on primary care physician contracts, they often more than make up for it through the "downstream" revenue primary care physicians generate.

The economic contribution of primary care physicians to hospitals is quantified by Merritt Hawkins' 2016 *Survey of Physician Inpatient/Outpatient Revenue* (see chart below).

AVERAGE ANNUAL NET INPATIENT/OUTPATIENT REVENUE GENERATED BY PRIMARY CARE PHYSICIANS ON BEHALF OF THEIR AFFILIATED HOSPITALS



In addition, salary increases for family physicians can be tied to the increased demand created by the growing number of urgent care centers, retail clinics, and technology-based providers, which are competing with other traditional providers for the services of family doctors.

However, despite the critical role they play in healthcare economics, primary care physicians generally do not perform the high-dollar procedures on which many healthcare facilities still depend. There is not as much latitude to increase their salaries as there is in the case of some specialists, as procedures continue to be economically rewarded above consultation in today's healthcare system. That average salaries for family physicians and internists nevertheless increased (though moderately) year-over-year underscores the fact that primary care doctors continue to be in strong demand.

At some point, starting salaries for primary care physicians will plateau. With the exception of pediatrics, this was not observed by the 2018 *Review*, but Merritt Hawkins projects slower growth in primary care starting salaries over the next several years than has been seen previously.

SALARIES FOR SPECIALISTS MIXED

As referenced previously, demand for specialists is being driven upward by population aging and other factors. Average

SPECIALTIES SEEING YEAR OVER YEAR AVERAGE STARTING SALARY INCREASE/DECREASE

	2017	2018	Increase/Decrease
Psychiatry	$263,000	$261,220	-1%
Ob/Gyn	$335,000	$324,000	-3%
Hospitalist	$264,000	$269,000	2%
Emergency Med	$349,000	$358,000	3%
Dermatology	$421,000	$425,000	1%
Radiology	$436,000	$371,000	-15%
Urgent Care	$219,000	$234,000	7%
Gastroenterology	$492,000	$487,000	-1%
Pulmonology	$390,000	$418,000	7%
Cardiology (non-inv)	$428,000	$427,000	-2%
Cardiology (inv.)	$563,000	$590,000	5%
Orthopedic Surgery	$579,000	$533,000	-8%
Neurology	$305,000	$301,000	-1%
Anesthesiology	$376,000	$371,000	-1%
Otolaryngology	$468,000	$405,000	-13%
Urology	$460,000	$386,000	-16%

salaries, however, do not always correspond to increases in demand, at least not initially, as the market needs time to adjust to changing supply and demand dynamics.

The chart on page 47 indicates that not all specialists saw year-over-year gains in average salaries:

Some specialties listed in the chart, including psychiatry, ob/gyn, hospitalist, emergency medicine, dermatology, gastroenterology, non-invasive cardiology, and neurology saw starting salaries remain essentially flat, with increases or decreases of no more than three per cent year-over-year. In some of these specialties, flat starting salaries were proceeded by significant increases in previous years.

Psychiatry, for example, saw an increase in starting salary from $218,000 in 2013 to $263,000 in 2017, a growth rate of 21%. Emergency medicine saw an increase from $288,000 in 2013 to $349,000 in 2017, a growth rate of 21%. Salaries have leveled off in these specialties, at least for the short-term, after robust growth, but can be expected to climb again.

Urgent care (+7%), pulmonology (+7%), and invasive cardiology (+5%) saw more significant year-over-year increases in starting salaries. Urgent care has yet to hit a ceiling as demand in this sector continues to be fueled by explosive growth. As referenced above, pulmonology is the most sought after specialty in terms of "absolute demand" which accounts for significant salary increases seen in this specialty. Invasive cardiology is a procedure-oriented specialty where demand is driven by population aging and lifestyle factors also referenced above.

Several specialties, including orthopedic surgery (-8%), otolaryngology (-13%), radiology (-15%) and urology (-16%) saw more significant year-over-year declines in starting salary. These declines may be one-year aberrations as they were preceded by increases in recent years. The market dynamics referenced above suggest that average salaries in these specialties are likely to increase in subsequent years.

SALARIES FOR PAs AND NPs

Average salaries for NPs increased year-over-year, from $123,000 in the 2017 *Review* to $129,000 in 2018, an increase of 5%. The number of searches Merritt Hawkins conducted for NPs has increased dramatically over the last several years reaching a record high in 2017/18. It is anticipated that demand for NPs will continue given their role in team-based health and given the continued physician shortage.

Average salaries for PAs decreased from $120,000 as tracked in the 2017 *Review* to $109,000 in 2018, a decline of 5%. While still in demand, PAs do not command as much recruiting attention as NPs in today's market given the relatively broader level of clinical autonomy NPs possess and their

ability to provide stand-alone services in rural areas.

As referenced previously, many sites of service, including urgent care centers, retail clinics and FQHCs, all of which are expanding aggressively, are recruiting PAs and NPs, boosting average salaries past the six-figure mark.

SALARIES BY REGION AND TYPE OF SETTING

The 2018 *Review* breaks out for the third year average starting salaries by region for Merritt Hawkins' top five most requested specialties, including family practice, psychiatry, internal medicine, nurse practitioner, and radiology. The 2018 *Review* indicates that physician salaries tend to be lowest in the Northeast and highest in the Midwest/Great Plains.

The Midwest/Great Plains is generally considered to have comparatively high third party reimbursement and a comparatively large number of productive, independent physicians, factors contributing to higher salaries. Some areas of the Midwest/Great Plains are isolated and so must be highly competitive in their salary offers to attract candidates. This concept applies to other regions with a comparatively high number of isolated communities.

A high ratio of physicians per capita in the Northeast creates competition, suppressing salaries, as does a relatively high prevalence of managed care/capitated compensation plans, while a higher ratio of fee-for-service and a lower ratio of physicians per capita create higher salaries in the Midwest and other regions.

The 2018 *Review* also tracks for the third year starting physician salaries in Merritt Hawkins' top five most recruited specialties by search setting, including hospital, medical group, academic, community health center and solo settings. Academic institutions and community health centers typically offer less than hospitals and medical groups based on budget and policy restrictions that limit what they may be able to offer.

IS THE MARKET MOVING TOWARD QUALITY-BASED PHYSICIAN PAYMENTS?

In order to evolve away from the fee-for-volume model, ACOs, hospitals, medical groups, and other organizations are striving to create physician payment structures that reward doctors for providing value, which is measured by various metrics, including:

Quality/Value-Based Physician Compensation Metrics

- Patient satisfaction scores
- Adherence to treatment/quality protocols,
- Reduction of hospital readmissions/errors
- Quality measure tracking

- Group governance participation
- Cost reduction/containment
- Appropriate coding
- Implementation/use of electronic health records.

At the same time, facilities that employ physicians want to ensure that they stay productive, and "productivity" still is measured in part by what are essentially fee-for-service metrics, including relative value units (RVUs), net collections and number of patients seen.

The goal is to find the "Goldilock's zone" – physician payment models that encourage physicians to see the patients and generate the revenue that healthcare facilities still need, but that also reward doctors for adopting the behaviors and practices that will drive reimbursement in emerging value-based payment models.

MORE PRODUCTION BONUSES TIED TO QUALITY

Merritt Hawkins' 2018 *Review* provides an indication of the extent to which physicians currently are compensated based on quality metrics. Seventy-five percent of searches tracked in the 2018 *Review* feature a salary with a production bonus, up from 72% the previous year. The remaining 25% feature a straight salary, an income guarantee or other arrangement. The great majority of hospitals and medical groups offer physicians the salary plus production bonus formula, while FQHCs, urgent care settings and academic centers are more likely to offer straight salaries.

Of the 75% of searches offering a production bonus, 43% featured a bonus based in whole or in part on quality metrics such as patient satisfaction, adherence to treatment protocols, etc. This is up from 39% in 2017 and is the highest percent of contracts offering a quality-based production bonus that Merritt Hawkins has tracked in its *Reviews*.

QUALITY AS A PERCENT OF TOTAL COMPENSATION

While the 2018 *Review* indicates that quality is becoming a more common determinant of physician production bonus amounts, a question arises as to the amount of total physician compensation that is tied to quality.

The 2018 *Review* tracks this amount directly for the first time (previous *Reviews* tracked the percent of production bonuses determined by quality metrics, rather than total compensation). In instances where the production bonus includes quality metrics, the 2018 *Review* indicates that, on average, 8% of the physician's total compensation will be determined by quality. Whether this amount is enough to influence physician behaviors is an open question.

Many healthcare systems are struggling with quality/value-based reimbursement models. Geisinger Health System, known as a pioneer in quality payments, recently abandoned tying compensation directly to quality and moved their physicians to the straight salary model. In addition, the future of MACRA, Medicare's quality-driven physician reimbursement model, now is in doubt and the direction of physician payments remains transitionary.

Relative value units (RVUs), which are a volume-based metric measuring physician work levels, were used in 50% of production formulas tracked in the 2018 *Review*, down from 52% in 2017 and down from 58% in 2016. Other volume based metrics, such as net collections and number of patients seen, also declined as a percent of production formula metrics, indicating that physician production bonuses are becoming more equally balanced between volume and quality metrics.

SIGNING BONUSES AND CME

Signing bonuses were offered in 70% of the recruiting assignments Merritt Hawkins tracked in the 2018 *Review*, down from 76% percent the previous year. Signing bonuses remain a standard recruiting incentive among hospitals and medical groups, though they typically are not part of incentive packages offered by academic medical centers (AMCs), direct pay/concierge, urgent care centers, Indian Health and other settings. Growth in the number these types of searches conducted by Merritt Hawkins year-over-year was the primary reason for the decline in percent of searches offering signing bonuses as tracked by the 2018 *Review*.

Signing bonuses offered to physicians in 2017/18 averaged $33,707, the highest amount ever tracked in the *Review*, up from $32,636 the previous year and up from $26,889 in 2016. These increases underscore the continued competitive environment in physician recruiting in which signing bonuses, for the facilities that offer them, can be used to persuade physicians with multiple offers to make a decisive commitment.

Signing bonuses offered to NPs and PAs averaged $11,944, up $8,576 in 2017 and up from $10,340 in 2016, and are at the highest level since Merritt Hawkins began tracking them in this *Review.* Signing bonus increases suggest that NPs and PAs have a growing number of opportunities from which to choose and that employers are bringing more to the table in order to set themselves apart.

Certain other incentives, such as paid relocation, paid CME, health insurance and malpractice insurance are standard in the majority of Merritt Hawkins' physician search assignments. The average relocation allowance offered to physicians as tracked by the 2018 *Review* was $ 9,441, a modest decrease from $10,072 in 2017 and $10,226 in 2016.

The average relocation allowance offered to NPs and PAs was $6,250, down from $8,063 in 2017 and down from $8,649 in 2016. This decrease is difficult to account for but may be a result of a greater number of local NP and PA searches, in which candidates were recruited from within the state or region.

Virtually all of the incentive packages tracked by the 2018 *Review* (98%) offered a continuing medical education (CME) allowance. The average CME allowance for physicians tracked in the 2018 *Review* was $3,888, compared to $3,613 in 2017 and $3,633 in 2016 . The average CME allowance for NPs and PAs in 2018 was $2,280, up from $2,126 in 2017 and up from $2,140 in 2016.

MEDICAL EDUCATION LOAN REPAYMENT

Eighteen percent of Merritt Hawkins' 2017/18 search assignments featured medical education loan repayment, compared to 25% in 2017 and 26% in 2016. Educational loan repayment entails payment by the recruiting hospital or other facility of the physician's medical school loans in exchange for a commitment to stay in the community for a given period of time.

The term of educational loan repayment in 78% of searches in the 2018 *Review* was three years. Nineteen percent of searches offered a two-year term, and three percent offered a one-year term. The average amount of loan forgiveness offered to physicians was $82,833, up from $80,923 in 2017 and down from $88,068 in 2016. The average amount of loan forgiveness offered to NPs and PAs was $59,860, up from $56,442 in 2017 and down from $61,667 in 2016.

Conclusion

Merritt Hawkins' *2018 Review of Physician and Advanced Practitioner Recruiting Incentives* indicates that while demand for primary care physicians remains strong, a growing level of recruitment activity is being directed toward medical specialists. This trend is being driven by both population aging and by the growing prevalence of lifestyle and socially derived medical conditions commonly treated by specialists, such as obesity, diabetes, drug addiction, mental health and others.

The crisis in mental health is underscored by the fact that for the third consecutive year, psychiatry ranked second among Merritt Hawkins' most requested searches, the first time it has held this ranking for such an extended period of time in the 25 years we have completed this *Review*.

Signaling the emergence of team-based care and a pervasive physician shortage, the 2018 *Review* indicates that demand remains strong for non-physician clinicians such as NPs and PAs, who combined represented Merritt Hawkins' second most requested search. In a clear indication that the "convenient care" movement is accelerating, physicians practicing in urgent care settings represented Merritt Hawkins' ninth most requested search in the 2018 *Review*.

The 2018 *Review* indicates that employment rather than independent practice is the standard recruiting model. Over 90% of the search assignments Merritt Hawkins conducted as tracked by the 2018 *Review* featured an employed setting, while less than 10% featured an independent practice setting.

While a growing percentage of physician recruiting contracts feature quality-based payments, the 2018 *Review* indicates that quality comprises less than 10% of total physician compensation.

The 2018 *Review* further indicates that physician recruiting activity is increasingly prevalent in larger communities and is not confined to rural areas. Sixty-two percent of Merritt Hawkins' recruiting assignments as tracked by the 2018 *Review* took place communities of 100,000 or more, the highest percent in our 31-year history.

While hospitals remain a key driver of physician recruitment, other settings, such as physician-owned medical groups, FQHCs, academic medical centers, and urgent care centers have increased their recruiting activities, creating a more diverse market for physicians.

As noted above, while the general direction of the healthcare system remains uncertain, the rising $3.2 trillion tide that is healthcare rolls on, carrying a continued demand for physicians and advanced practitioners with it.

For additional information about Merritt Hawkins' thought leadership resources contact:

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