MERRITT HAWKINS
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White Paper Series

Examining topics affecting the recruitment and retention of physicians and advanced practice professionals

Family Medicine Recruiting Trends and Recommendations

A resource provided by Merritt Hawkins, the nation's leading physician search and consulting firm and a company of AMN Healthcare (NYSE: AHS), the largest healthcare workforce solutions company in the United States.

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Introduction

Merritt Hawkins is the nation's leading physician search and consulting firm and is a company of AMN Healthcare (NYSE: AMN) the largest healthcare staffing organization in the country and the innovator of healthcare workforce solutions.

As the thought leader in its field, Merritt Hawkins produces a series of surveys, white papers, speaking presentations and other resources intended to provide insight into physician supply and demand, physician compensation, practice patterns, recruiting strategies and related trends.

This white paper examines trends in the recruitment of family medicine physicians, including current supply and demand projections, compensation in the specialty, the expanding role of family physicians and recommendations for recruiting these highly sought-after health professionals.

Role of Family Physicians, Education and Training

According to the American Academy of Family Physicians (AAFP), "family physicians are personal doctors for all people of all ages and health conditions. They are a reliable first contact for health concerns and directly address most health care needs."

Ideally, family physicians create enduring partnerships with their patients, helping them to prevent, understand, and manage illness, navigate the health system and set health goals. "Family physicians and their staff adapt their care to the unique needs of their patients and communities. They use data to monitor and manage their patient population, and use best science to prioritize services most likely to benefit health," the AAFP notes.

Increasingly, family physicians are responsible for implementing emerging healthcare delivery models emphasizing population health management, prevention, and cost efficiency, a topic explored in more detail below.

Path to Becoming a Family Physician

Training for family physicians is a process that begins with medical school, continues through residency, and lasts throughout a physician's career. Family physicians, like other doctors, are expected to acquire new knowledge and skills during the course of their careers and to maintain knowledge and skill levels.

According to the AAFP, "all family physicians begin their training by graduating from an accredited school of medicine. During medical school, students take two "step" exams, called the **United States Medical Licensing Examination (USMLE)**(www.usmle.org), and must take core clerkships, or periods of clinical instruction. Passing both exams and the clerkships grants students the "Doctor of Medicine" (MD) degree, which entitles them to start full clinical training in a residency program."

Residency

After completing medical school, medical graduates must complete a residency in family medicine. Medical students apply to and interview for residency program placement during the last year of medical school. Most residency programs in the United States utilize the nationwide **Match process** to process applications and select residents.

Students who graduate from a medical school outside of the United States are considered International Medical Graduates (IMGs) and must meet certain criteria in order to apply to a US-based residency program (for more information on this topic see the Merritt Hawkins' white paper International Medical Graduates: Qualifications to Practice in the U.S. and Related Considerations).

According to the AAFP, "Family medicine residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) require three years of training. As with other specialties, family medicine residency programs have specific requirements with certain numbers of hours that must be completed for board certification. They are designed to provide integrated experiences in ambulatory, community, and inpatient environments during three years of concentrated study and hands-on training."

The first year of residency, called the internship year, is when the final "step" of the USMLE (Step 3 exam) is taken. This step includes rotations in the major medical disciplines with time allotted each week to the family medicine continuity clinic to provide ongoing care to a panel of patients. In the second and

third years of residency, additional exposure is given to the major specialty and subspecialty areas, with increased time spent in the family medicine continuity clinic.

Requirements During Residency

The AAFP states that "during their three years of training, residents must meet the program requirements for both residency education in family medicine and certification by the **American Board of Family Medicine (ABFM)**(www.theabfm.org). Specific requirements for family medicine residency training vary by program, although several months are spent in required rotations in each of the following areas: obstetrics, pediatrics, general surgery, and inpatient hospital care in CCUs or ICUs. Each resident spends a few nights per month "on call" and on rotation throughout the hospital."

"After three "program years" of training are completed and all requirements are met, residents are eligible to take the certification exam by the ABFM. Toward the end of residency, physicians also apply for licensure from their state, which determines where they can practice as a board-certified family physician. Although each state has different requirements for initial medical licensure, all physicians must pass Step 3 of the USMLE."

Additional Training

Family physicians can acquire additional residency training through dual-degree residency programs. There are three types of these programs which require additional training, typically five years, including:

FM-Emergency Medicine
FM-Internal Medicine
FM-Psychiatry

Dual degree programs are designed to provide residents who complete them with certifications from both boards; they also must recertify with each board.

Fellowships

After residency, additional opportunities are available to residents who seek advanced training in areas of family medicine, according to the AAFP. Some residents choose a fellowship as a post-residency option because it offers more concentrated training in fields such as:

Faculty development Research

Geriatrics	Rural medicine
Obstetrics	Sports medicine
Preventive medicine	

According to the AAFP,"fellowships last an additional 12 months after residency training (although they vary by program) and are run through existing residency programs. Some are strictly for educational purposes, while others lead to Certificates of Added Qualifications (CAQs), which are offered in conjunction with other medical specialty boards."

Composition of the Family Medicine Workforce

Family medicine is one of the largest medical specialties in the U.S. and includes more than 110,000 physicians. Of these, 93,231 are in active patient care. The chart below provides data on the current composition of the family medicine workforce.

Family Medicine Specialty Demographics:

Total family physicians	110,319
In Active Patient Care	93,231
International Medical School Graduates	21,767
Board Certified	80,670
Research	193
Administrative/Teaching	2,990
Last Year Residents	3,149
Female	38,050
Male	55,181
45 and over	69,019
55 and over	41,300

Source: AMA Physician Master File

SUPPLY AND DEMAND TRENDS

The Association of American Medical Colleges periodically releases a report projecting nationwide physician supply and demand trends. In its February, 2018 report, entitled *The Complexities of Physician Supply and Demand: Projections from 2016-2030,* the AAMC estimates a shortage of up to 121,300 physicians by the year 2030. This includes a deficit of 49,000 primary care physicians and a deficit of 72,000 specialists.

In a press release announcing the report's findings, AAMC President and CEO Darrell G. Kirch, MD said, "This year's analysis reinforces the serious threat posed by a real and significant doctor shortage. With the additional demand from a population that will not only continue to grow but also age considerably over the next 12 years, we must start training more doctors now to meet the needs of our patients in the future."

As the AAMC press release notes, "As in prior projections, much of the increased demand comes from a growing, aging population. The U.S. population is estimated to grow by nearly 11%, with those over age 65 increasing by 50% by 2030. Additionally, the aging population will affect physician supply, since one-third of all currently active doctors will be older than 65 in the next decade. When these physicians decide to retire could have the greatest impact on supply".

The AAMC supports lifting the cap on funding for graduate medical education that Congress put into effect in 1997, limiting the number of physicians entering the workforce each year.

The shortage of family physicians has been a concern for decades and others have noted it.

*The Health Resources and Services Administration (HRSA) projects a shortage of 65,560 primary care physicians by 2020.

*The Robert Graham Center projects a deficit of 52,000 primary care physicians by 2025.

In addition to an emerging shortage of physicians nationwide, the U.S. has long experienced a maldistribution of physicians. As of July, 2018 there were 6,739 Health Care Professional Shortage Areas (HPSAs) for primary care in the United States, about double the number identified by HRSA 15 years ago. These are areas with fewer than one primary care physician per 3,500 people (3000 to one in designated "high need" areas). Over 65 million people live in a primary care HPSA and 67 percent of HPSAs are in rural areas. HRSA projects it would take over 17,000 additional primary care clinicians to achieve this ratio in the nation's 6,700-plus HPSAs.

Disparities in the supply of primary care physicians can be pronounced on a state-by-state basis, as the numbers below indicate:

Primary Care Physicians Per 100,000 Population

All U.S.		**92**
1.	**Massachusetts**	**134**
2.	**Vermont**	**132**
3.	**Maine**	**130**
4.	**Rhode Island**	**116**
5.	**Hawaii**	**116**
45.	**Oklahoma**	**75**
46.	**Idaho**	**73**
47.	**Texas**	**72**
48.	**Nevada**	**70**
50.	**Mississippi**	**50**

Even states like California, which ranks 22nd nationally with 87 primary care physicians per 100,000 population, have primary care supply challenges. A study by the Robert Graham Center found that the state will need an additional 8,243 primary care physicians by 2030 (*Bloomberg Law. July 17, 2018*)

Family Medicine Number One for 12th Consecutive Year

Each year, Merritt Hawkins releases our *Review of Physician and Advanced Practitioner Recruiting Incentives,* which tracks metrics from the more than 3,000 recruiting assignments we conduct during the 12 month period from April 1 of one year to March 31 of the next. These metrics include the types of physicians requested by our clients, average salaries being offered, and other data. Two thousand eighteen marks the 25th year we have released the *Review.* **For the twelfth consecutive year, family medicine was Merritt Hawkins' most requested search assignment as ranked by the *Review***, by far the longest period any one specialty has held this position and a strong indicator that demand for family physicians remains very robust.

Population Growth a Demand Driver

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. According to demographic experts at the University of Virginia, the U.S. population will reach 383 million by 2040, adding an additional 73 million people over three decades.

The Role of Emerging Delivery Models

Evolving healthcare delivery models are an additional demand driver for primary care physicians such a family physicians. In the emerging 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 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) that may include 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 following:

Composition of the Primary Care-Led Team

Chief Population Health Officer/Chief Integration Officer/Chief Transformation officer

Family medicine physician or general internist

Nurse Case Manager

Physician assistant and/or nurse practitioner

Social Worker/Community Resources Specialist/Care Coordinator/Grand Aide

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. They are the lynchpins of integrated models of care and are in demand in part for this reason.

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.

The Impact of "Convenient Care"

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, Federally Qualified Health Centers (FQHCs) and others. These emerging practice settings place an emphasis on patient access to outpatient care, and they are proliferating in communities around the country. As healthcare moves to the "convenient care" model, additional family physicians will be needed to ensure patients have the ready access to care that the market now is demanding. For more information on this topic see the Merritt Hawkins' white paper *Convenient Care: Growth and Staffing Trends in Urgent Care, Retail Medicine and Free-Standing Emergency Centers*.

Lengthening Family Medicine Appointment Wait Times

Given the current imbalance between supply and demand for family physicians, it could be expected that access to family physicians is becoming more difficult, and that appears to be the case. Through our *Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates*, Merritt Hawkins tracks the time it takes to schedule a new patient appointment with physicians in various specialties in fifteen major metropolitan areas. The chart below shows how wait times for appointments with family medicine physicians vary by city, as well as the rates at which family medicine physicians accept Medicare and Medicaid patients.

FAMILY MEDICINE APPOINTMENT WAIT TIMES/LARGE METRO AREAS

City	Total Responses	Shortest Time to Appt.	Longest Time to Appt.	Average Time to Appt.	Accept Medicaid ? YES (%)	Accept Medicare ? YES (%)
Boston, 2017	18	3 days	365 days	109 days	78	100
Boston, 2013	20	12 days	152 days	66 days	65	95
Boston, 2009	17	6 days	365 days	63 days	53	NA
Los Angeles, 2017	20	1 day	365 days	42 days	45	85
Los Angeles, 2013	19	1 day	126 days	20 days	53	79
Los Angeles, 2009	20	1 day	365 days	59 days	30	NA
Portland, 2017	20	1 day	240 days	39 days	55	60
Portland, 2013	20	3 days	45 days	13 days	60	85
Portland, 2009	19	3 days	16 days	8 days	79	NA
Miami, 2017	20	3 days	180 days	28 days	40	80
Miami, 2013	16	1 day	56 days	12 days	56	81
Miami, 2009	15	1 day	25 days	7 days	40	NA
Atlanta, 2017	20	1 day	169 days	27 days	35	80
Atlanta, 2013	20	1 day	112 days	24 days	40	80
Atlanta, 2009	18	3 days	21 days	9 days	67	NA

Denver, 2017	20	4 days	180 days	27 days	20	40
Denver, 2013	20	1 day	62 days	16 days	20	55
Denver, 2009	16	1 day	45 days	14 days	94	NA
Detroit, 2017	17	1 day	112 days	27 days	71	88
Detroit, 2013	20	1 day	74 days	16 days	50	90
Detroit, 2009	17	3 days	31 days	14 days	59	NA
New York, 2017	20	1 day	365 days	26 days	80	85
New York, 2013	19	14 days	38 days	26 days	32	42
New York, 2009	19	6 days	61 days	24 days	79	NA
Seattle, 2017	17	1 day	180 days	26 days	71	47
Seattle, 2013	20	3 days	129 days	23 days	55	100
Seattle, 2009	20	2 days	14 days	8 days	80	NA
Houston, 2017	20	1 day	180 days	21 days	30	65
Houston, 2013	20	1 day	178 days	19 days	55	70
Houston, 2009	20	1 day	29 days	17 days	50	NA
Philadelphia, 2017	16	1 day	47 days	17 days	88	100
Philadelphia, 2013	18	1 day	98 days	21 days	67	89
Philadelphia, 2009	18	3 days	15 days	9 days	72	NA
Wash., D.C., 2017	15	1 day	62 days	17 days	53	80

Wash., D.C., 2013	14	1 day	62 days	14 days	71	93
Wash., D.C., 2009	19	3 days	365 days	30 days	63	NA
San Diego, 2017	12	4 days	41 days	13 days	33	75
San Diego, 2013	14	1 day	17 days	7 days	86	100
San Diego, 2009	20	1 day	92 days	24 days	80	NA
Dallas, 2017	20	1 day	111 days	12 days	25	50
Dallas, 2013	20	1 day	10 days	5 days	30	55
Dallas, 2009	20	1 day	27 days	8 days	50	NA
Minneapolis, 2017	18	1 day	39 days	8 days	100	100
Minneapolis, 2013	17	1 day	30 days	10 days	35	53
Minneapolis, 2009	20	2 days	23 days	10 days	85	NA
Total, 2017	**273**	**1.7 days**	**175.7 days**	**29.3 days**	**55**	**76**
Total, 2013	**277**	**2.9 days**	**79.3 days**	**19.5 days**	**51**	**77**
Total, 2009	**278**	**2.5 days**	**99.6 days**	**20.3 days**	**65**	**NA**

As these numbers indicate, the average wait time to schedule a new patient appointment with a family physician in the 15 metro areas examined in the survey is 29.3 days, up from 19.5 days in 2013, **an increase of 50%.**

Merritt Hawkins' *Survey of Physician Appointment Wait Times* also tracks time needed to schedule a new patient appointment in 15 moderately sized communities with populations of approximately 100,000. As the chart below indicates, wait times to see a family physician in these communities usually are considerably longer than in larger communities.

FAMILY MEDICINE APPOINTMENT WAIT TIMES/MID-SIZED METRO AREAS

City	Total Responses	Shortest Time t Appt.	Longest Time t Appt.	Average Time t Appt.	Accept Medicaid? YES (%)	Accept Medicare? YES (%)
Yakima, 2017	5	90 days	220 days	153 days	80	80
Albany, 2017	10	7 days	365 days	122 days	90	100
Evansville, 2017	6	5 days	180 days	76 days	50	100
Cedar Rapids, 2017	6	2 days	180 days	75 days	33	50
Manchester, 2017	10	5 days	180 days	72 days	90	100
Savannah, 2017	10	3 days	365 days	61 days	50	90
Hartford, 2017	10	1 day	180 days	60 days	60	80
Dayton, 2017	7	1 day	180 days	40 days	100	100
Fort Smith, 2017	9	2 days	180 days	37 days	56	67
Hampton, 2017	10	1 day	120 days	35 days	40	80
Odessa, 2017	6	5 days	89 days	24 days	50	50
Temecula, 2017	10	1 day	50 days	22 days	40	90
Fargo, 2017	5	12 days	33 days	20 days	100	100
Lafayette, 2017	5	1 day	19 days	10 days	20	60
Billings, 2017	6	2 days	11 days	7 days	100	100
Total, 2017	**115**	**9.2 days**	**156.8 days**	**56.3 days**	**64**	**83**

As the numbers above indicate, the average wait time for a new patient appointment with a family physician in the 15 moderate sized communities included in the survey is 56.3 days, almost twice as long as the average of 29 days in larger communities.

These extended wait times underscore the continued widespread shortage of family medicine physicians.

FAMILY MEDICINE SALARY/INCENTIVES

In our annual *Review of Physician and Advanced Practitioner Recruiting Incentives* Merritt Hawkins tracks the starting salaries our clients offer to recruit family physicians and other types of physicians. The chart below indicates low, average and high starting salary numbers for family physicians over the last several years.

Family Practice	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

As these numbers indicate, average starting salaries for family medicine physicians have increased by approximately 30% since 2014, a further indicator of rising demand for family doctors.

Starting salaries for family physicians and other doctors typically vary by region, as the numbers below indicate:

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

Starting salaries for family physicians and other types of doctors also vary by the type of medical facility recruiting physicians, as the numbers below suggest:

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

It is important to note that Merritt Hawkins' physician compensation numbers reflect average salaries offered to recruit physicians, not average total physician compensation, which, in addition to salaries, may include production bonuses or other sources of income. There are various surveys that track average physician total compensation in family medicine, and these are indicated below:

Average Family Physician Compensation As Tracked by Various Sources

Sullivan Cotter	$266,562
Integrated Health Strategies	$262,683
ECG Consulting	$249,087
American Medical Group Assn.	$244,799
Merritt Hawkins	$241,000
Hospital & Healthcare Compensation Service	$240,466
Compdata	$235,100

These total average compensation numbers can be used in tandem with Merritt Hawkins' average salary numbers when developing incentive programs for family physicians and other types of doctors.

A Source of Revenue

Family physicians, like other types of physicians, represent a source of revenue for hospitals that balance out the costs to recruit and employ them. Merritt Hawkins' *Physician Inpatient/Outpatient Revenue Survey* tracks the net revenue that physicians in various specialties generate for their affiliated hospitals annually. The chart below indicates these numbers for family medicine and several other specialties:

Annual Net Revenue Generated by Physicians for Hospitals By Selected Specialties

Family Medicine	$1,493,518
Internal Medicine	$1,830,200
Pediatrics	$655,972

Source: Merritt Hawkins 2016 Survey of Physician Inpatient/Outpatient Revenue

For more information about compensation trends and contracts in family medicine see *Employment Contracts for Family Physicians in an Evolving Market*, an article written by Merritt Hawkins executives and published in the American Academy of Family Practice (AAFP) magazine *Family Practice Management.*

FAMILY MEDICINE PHYSICIANS: PRACTICE PATTERNS AND PERSPECTIVES

Every other year, Merritt Hawkins conducts a national survey of physicians on behalf of The Physicians Foundation. The survey tracks the practice patterns, morale levels and career plans of doctors nationwide and is one of the largest and most comprehensive physician surveys undertaken in the United States.

Below are responses to several (though not all) questions from the 2018 version of the survey that were provided by 1,013 family physicians.

What is Your Current Professional Status?

Practice owner/partner/associate	25.1%
Employed by a hospital	15.4%
Employed by a hospital-owned medical group	22.6%
Employed by a physician-owned medical group	11.7%
Other	25.2%

2. Which best describes your professional morale and your feelings about the current state of the medical profession?

Very positive	5.5%
Somewhat positive	36.4%
Somewhat negative	40.5%
Very negative	17.6%

3. What is your position on concierge/direct pay medicine?

I now practice some form of concierge/direct pay medicine	7.4%
I am planning to transition fully to this model	4.6%
I am planning to transition in part to this model	13.7%
I have no plans to transition to this model	74.3%

. **4. On average, how many hours do you work per week (include all clinical and non-clinical duties)?**

0-20	5.2%
21-30	5.1%
31-40	13.8%
41-50	28.1%
51-60	25.1%

61-70	13.6%
71-80	5.9%
81 or more	3.3%
OVERALL AVERAGE	**49.5 hours**

5. Of these, how many hours do you work each week on NON-CLINICAL (paperwork) duties only?

0-5	20.4%
6-10	28.1%
11-15	19.6%
16-20	14.5%
21-25	7.5%
26 or more	9.9%
OVERALL AVERAGE	**12.2 hours**

6. On average, how many patients do you see per day (include both office and hospital encounters)?

0-10	10.8%
11-20	44.5%
21-30	33.9%
31-40	7.3%
41-50	2.2%
51-60	0.7%
61 or more	0.5%
OVERALL AVERAGE	**20.4**

7. Which of the following best describes your current practice?

I am overextended and overworked	26.8%
I am at full capacity	56.2%
I have time to see more patients and assume more duties	17.1%

8. Is any of your compensation tied to quality metrics such as patient satisfaction, following treatment guidelines, compliance, "citizenship", error rates, etc.?

Yes	**56.9%**
No	**34.3%**
Unsure	**8.7%**

9. What percent of your TOTAL compensation is tied to such metrics?

0-10	41.2%
11-20	22.1%
21-30	9.3%
31-40	3.7%
41-50	2.1%
51 or more	3.2%
OVERALL AVERAGE	14.4%

10. How many of your patients are affected by a social situation that poses a serious impediment to their health?

All	7.3%
Many	50.9%
Some	31.2%
Few	9.5%
None	1.1%

11. On the whole, how would you describe the current state of relations between physicians and hospitals, many of which now would employ physicians?

	All
Mostly positive and cooperative	7.9%
Somewhat positive and cooperative	25.9%
Neither positive nor negative	23.5%
Somewhat negative and adversarial	33.2%
Mostly negative and adversarial	9.5%

At Capacity or Overextended

Notable among these responses is that 83% of family physicians indicted they are either at capacity or are overextended, while only 17% indicated they have the time to see new patients or take on more duties. In addition, 75% of family physicians indicated they are either employed by a hospital or medical group or are in some other practice status, while only 25% indicated they are in independent, private practice. This compares to 33% of all physicians responding to the survey who indicated they are in independent, private practice. These numbers underline the fact that the employed physician model is particularly prevalent in primary care.

While the majority of family physicians (57%) indicated that some of their compensation is tied to quality-based metrics such as patient satisfaction, a still substantial one-third indicated that none of their compensation is tied to quality. Of those who do have compensation tied to quality, quality metrics determine an average 14.4% of their total compensation.

It is troubling to note that 58% of family medicine physicians described their morale as somewhat or very negative. There are a number of reasons why many physicians, including family physicians, are experiencing poor professional morale, and these are explored in more detail in the analysis section of the *2018 Survey of America's Physicians: Practice Plans and Perspectives* that Merritt Hawkins conducted on behalf of The Physicians Foundation. Low levels of morale, and the increased employment of physicians by hospitals, medical groups and other facilities, speaks to the need for enhanced physician retention programs to minimize physician burnout and turnover. These topics are addressed in more detail in Merritt Hawkins' white paper *Addressing Physician Burnout and Turnover.*

It also is troubling to note that 88% of family physicians indicated that some, many, or all of their patients are subject to a social condition such as poverty that poses a serious impediment to their health. The majority of family physicians (58%) indicated that many or all of their patients are subject to such a condition. These stark numbers underscore the challenges physicians face treating patients with few resources or those who suffer from drug addiction, lack of education and other social conditions that can be tied to poor health outcomes. The population health management model referenced above is an emerging method for dealing with these challenges.

Recruiting Recommendations

The recruiting market in family medicine today is one in which there are many more practice openings for physicians than there are doctors to fill them. The mission for facilities recruiting family physicians, therefore, is finding ways to differentiate the practice opportunity from others physicians may be considering.

In previous years, variety among family medicine practice opportunities generally was more prevalent than it is today. Practice styles varied from the "Marcus Welby" type on one end of the spectrum, in which family physicians had a "Swiss Army knife" tool kit and practiced not only family medicine, but some level of surgery, pediatrics, cardiology, psychiatry and inpatient work as independent practice owners, often in solo practice. On the other end of the spectrum was the employed, outpatient model.

Today, family medicine practices usually have a more standardized look and fall on the employed, outpatient end of the spectrum. Physicians generally work nine to five, with no inpatient work, and are offered a salary with a production bonus if their employer is a hospital or medical group, or typically a straight salary if their employer is an urgent care center of a Federally Qualified Health Center (FQHC).

There is virtually one of these types of practice settings on every corner, and family physicians today can take their pick. If the practice is located in a coastal location, a mountain resort, or a highly desirable

city or suburban area, it may well be the pick of one or more family physicians (though even desirable areas have their recruiting challenges given the high cost of living in these areas and other potential drawbacks).

If the practice is not located in an area perceived to be a popular destination, the need to stand out in some way increases.

This may be by offering an "old school" independent practice. There are still physicians who want to be their own boss and who want a traditional practice with the chance to do inpatient work, minor procedures and even obstetrics. While these physicians are in the distinct minority, they still exist and finding them, while difficult, remains possible.

In general, however, the recruiting facility will need to be flexible about the practice structure and characteristics to attract candidates, most of whom will not be looking for a traditional, independent style of practice. This may include offering candidates an opportunity to practice a subspecialty, attracting family physicians who always wanted to focus women's health, sports medicine, geriatrics or some other area.

Flexibility also could include refining the types of patients the family physician will see. Some family physicians prefer to see all adult patients, as they are less inclined to see children who may have trouble communicating to them what their medical condition is.

Practice schedule, however, is the area where maximum flexibility is required, with the more options the better. Part-time schedules are attractive to many physicians who have family obligations, and flexibility regarding time-off for family and related personal matters when needed also is highly desired by today's candidates. The more schedule options the practice can offer the better its chances of standing out in today's market.

A competitive salary also is important (see compensation data above) but salaries for family physicians do not tend to vary widely in today's market, so a good salary on its own may not be enough to attract candidates.

Ideally, the practice will be able to offer a variety of attractions, including good financials, a flexible schedule and perhaps the opportunity to do specialty work. For younger physicians, educational loan forgiveness can be a compelling attraction.

The key is to make the practice environment – the physician's "workshop" – as appealing as possible. Hospitals, medical groups and other facilities seeking physicians cannot control their location or the number of professional sports teams or other attractions in their area. However, they can take steps to ensure that the practice conditions under which the physician will work will be as positive as possible.

This may include staffing the practice with physician assistants or nurse practitioners, allowing family physicians to play a leadership role and assist in the implementation of emerging delivery models such as population health management that are built around the team-based approach to care (for more information on this topic see Merritt Hawkins' white paper *Population Health Management and Physician*

Staffing). It also could include the use of locum tenens physicians to provide physicians with more schedule flexibility or help during peak usage periods, thereby reducing stress and burnout. The use of scribes to assist with quality tracking and data entry is appealing to many family physicians, as is access to specialists.

In today's market, it is important to remain objective on candidate parameters. A newly minted resident may not be the most appropriate candidate. The right candidate may be an older physician with a proven track record who wants to be in your community or a candidate who requires the employer's assistance in obtaining a work visa or green card. It is important to focus on practical qualities such as training, commitment, work ethic and bedside manner rather than seeking an idealized candidate from Central Casting.

The challenges inherent to recruiting family physicians are unlikely to ease, but with maximum effort and a willingness to tailor the practice to the wants and needs of today's doctors, recruiting success still is attainable.

About Merritt Hawkins

Established in 1987, Merritt Hawkins is the leading physician search and consulting firm in the United States and is a company of AMN Healthcare (NYSE: AMN), the largest healthcare workforce solutions organization in the nation. Merritt Hawkins' provides physician and advanced practitioner recruiting services to hospitals, medical groups, community health centers, telehealth providers and many other types of entities nationwide.

The thought leader in our industry, Merritt Hawkins produces a series of surveys, white papers, books, and speaking presentations internally and also produces research and thought leadership for third parties. Organizations for which Merritt Hawkins has completed research and analysis projects include **The Physicians Foundation, the Indian Health Service, Trinity University, the American Academy of Physician Assistants, the Association of Academic Surgical Administrators, The Maryland Medical Society, and the North Texas Regional Extension Center.**

This is one in a series of Merritt Hawkins' white papers examining a variety of topics directly or indirectly affecting the recruitment and retention of physicians and advanced practice professionals, including physician assistants (PAs) and nurse practitioner (NPs).

Additional Merritt Hawkins' white papers include:

- The Growing Use and Recruitment of Hospitalists
- Ten Keys to Enhancing Physician/Hospital Relations: A Guide for Hospital Leaders
- Rural Physician Recruiting Challenges and Solutions
- Psychiatry: "The Silent Shortage"
- Nurse Practitioners and Physician Assistants: Supply, Distribution, and Scope of Practice

Considerations
- The Physician Shortage: Data Points and State Rankings
- Physician Supply Considerations: The Emerging Shortage of Medical Specialists
- RVU FAQ: Understanding RVU Compensation in Physician Employment Agreements
- The Economic Impact of Physicians
- Ten Keys to Physician Retention
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