COMMENTARY

Applying Organizational Behavior Theory to Primary Care

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ABSTRACT

Addressing the mounting primary care shortage in the United States has been a focus of educators and policy makers, especially with the passage of the Affordable Care Act in 2010 and the Medicare Access and CHIP Reauthorization Act in 2015, placing increased pressure on the system. The Association of American Medical Colleges recently projected a shortage of as many as 65,000 primary care physicians by 2025, in part because fewer than 20% of medical students are picking primary care for a career.

We examined the issue of attracting medical students to primary care through the lens of organizational behavior theory. Assuming there are reasons other than lower income potential for why students are inclined against primary care, we applied various principles of the Herzberg 2-factor theory to reimagine the operational flow and design of primary care. We conclude by proposing several solutions to enrich the job, such as decreasing documentation requirements, reducing the emphasis on specialty consultations, and elevating physicians to a supervisory role.

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From the outside, the view of a life in medicine usually involves meaningful patient contact, rewarding longitudinal relationships, and collaborative practice with nurses and specialists—in short, a vision that resembles the work of a primary care physician (PCP). At the outset of their training, almost half of all medical students indicate an interest in primary care.[1] However, as students approach the beginning of their fourth year and begin to make defining choices for their future, that number drops to about 15%. With the Association of American Medical Colleges projecting a shortage of as many as 65,000 PCPs by 2025, the primary care workforce is in a deficit crisis.[1]

With the passage of the Affordable Care Act in 2010 and the Medicare Access and CHIP Reauthorization Act in 2015, there is now even more stress on the system; these acts envision a healthcare system with the PCP squarely in the center, serving as both the linchpin and gatekeeper to complex medical coordination. Despite the election of a new administration that favors market-based solutions over mandates, the emphasis on care coordination and "value" is not likely to go away. The changing policy landscape provides opportunity: as reimbursement structures change and health systems compensatorily alter their workflow, we can consider solutions that require us to revisit these blueprints. In this paper, we consider how such operational improvements can motivate more talented medical learners to pursue primary care.

When considering how to motivate and retain talent in medicine, all too frequently we reach into our bag of financial rewards—increased base salary, loan forgiveness, or fringe benefits—for the answer. Nevertheless, although research does show that financial incentives tend to lead to increased output and productivity in the short term, such gains are usually modest and not sustained.[2] Additionally, such financial rewards come with hidden costs, such as their propensity to mitigate the attractiveness of the task at hand and distract from the process of task activity to the product of getting the reward.

Behavioral Theory

Behavioral theory, first proposed approximately 5 decades ago by Frederick Herzberg alters this traditional management approach by dichotomizing the sources of employee satisfaction. Herzberg distinguished between the factors that make people satisfied and motivated on the job (motivators) from those that make them dissatisfied (hygiene factors) as separate entities altogether (**Table**).[3]

TAKEAWAY POINTS

Although there is a heavy reliance on increasing financial remuneration to primary care physicians as a way of recruiting members to the field, we can look to other modalities—informed by organizational behavior theory—to enrich the field and make it a more attractive option for trainees. The added benefit of such an approach is significant cost savings, which can then be invested back into the primary care practice. These modalities include:

- Decreasing documentation requirements.
- Increasing the supervisory role of physicians in a multidisciplinary practice.
- Reducing the reliance on specialists to manage the care of patients with chronic diseases.

Herzberg demonstrated, through an examination of the work lives of engineers and accountants, that factors providing positive satisfaction arise from the intrinsic nature of the work itself, such as challenging goals, increasing responsibilities, and opportunities for personal growth. These intrinsic factors contain the stimuli necessary to address individuals' deep-seated needs for growth and achievement. Hygiene factors tend to be environmentally situated and peripheral to the job itself, such as one's relationships with peers and supervisors, salary, work conditions, and company policy; by themselves, these factors tend not to motivate an employee to enter a particular field and excel.

Application to Primary Care

In considering how to make the field of primary care more attractive to students, we must avoid falling into the trap of optimizing solely for hygiene factors despite these often tending to be the lowest hanging fruit and easiest to execute. Students privately fret over the lack of prestige in primary care, believe the notion that one can be "too smart" for such a generalist career, or become concerned about the administrative workload and hassle of such a coordination-heavy role. In light of this information, it becomes clear that the charges laid against primary care are more fundamental than simply the financial piece.[4] Improving hygiene factors alone, therefore, will likely not be as successful as considering how to make the job itself more compelling.

The push toward demonstrating value in healthcare is a fine starting point, with most of the population-based value metrics falling to primary care for both their delivery and documentation.[5] This added burden comes with little substantive support for those most responsible for the activity, however. Moreover, the existing documentation and clerical burdens of primary care—requirements that grow ever more detailed and billing-centric—represent quintessential horizontal job enlargement. Instead of providing opportunity for an employee's psychological growth, such overloading merely makes a job structurally bigger.

Understanding how to modify the job to make it more enriching leads to solutions for organizing work and expanding access to the physician, and it suggests a potential funding mechanism. Per Herzberg's recommendations to enable employees to become experts at specialized tasks, we can configure systems that would allow physicians to practice at the top of their license by reassigning routine and clerical tasks to midlevel providers.[3] This argument has been repeatedly used in an attempt to show commitment to deemphasizing the administrative burden on primary care, but, to date, has seldom been met with actual resources. A related principle calls for removing some controls while retaining accountability. We interpret this to mean elevating physicians to the more supervisory role of midlevel providers who handle the bulk of follow-up visits and maintenance care.

Herzberg also calls for introducing new and more difficult tasks not previously handled. This could translate to expanding the scope of problems that primary care offices can manage. Currently, more than half of specialist visits are for routine follow-up of chronic disease management—a real perversion of this expensive resource and a further weakening of the role and capacity of PCPs.[6] Systems that allow for management of the vast majority of health problems to fall under the purview of PCPs for most diagnoses and care, with specialists only intermittently consulted when diagnosis or management dilemmas require special expertise, would automatically reap savings, a proportion of which would naturally need to flow toward PCPs. That they would also serve to enhance the intellectual challenge and satisfaction of primary care is a bonus.

Herzberg's theory is sometimes criticized for generalizing employee behaviors without considering individual personality traits that respond differently to incentives and for conflating job satisfaction with increased productivity. Although the theory is imperfect, it draws its enduring value from being one of the most replicated studies in various corporate settings and across different populations.[7]

TABLE. Sample Motivator and Hygiene Factors, According to the Herzberg Theory[3]

Examples of Motivators	Examples of Hygiene factors
Achievement	Company policy and administration
Recognition	Relationship with supervisor
Challenging work	Work conditions
Responsibility	Salary
Advancement and growth	Relationship with peers

Evidence of Applicability

Organizations that have begun implementing these principles have already reaped dividends. Two years after moving to an enhanced staffing model with a greater reliance on midlevel providers, the Seattle-based Group Health Cooperative noted a halving of reported rates of physician burnout, a 29% reduction in the use of specialty consultations, and overall cost savings of $14 per member per month.[8] The SouthCentral Foundation, based in Anchorage, Alaska, designed its practice around a medical home that distributes work so that each team member operates at the highest level of their credentials: nurses focus on care coordination, medication refills, chronic disease monitoring, and test notifications; medical assistants handle point-of-care testing; and behavioral health consultants address mental health complaints, parenting and family dysfunction, and communication challenges.[9] This gives physicians greater bandwidth to offer up to 50% to 80% of appointments to same-day visits for acute complaints. Over a 5-year period, from 2000 to 2005, the system saw a 60% drop in visits to specialists and a 40% decrease in hospital days and admissions.

Conclusions

If we are to address the challenges of cost, access, and sustainability, then the inevitable future of primary care will involve utilizing physicians in a supervisory capacity at the head of large, multidisciplinary teams, the members of which are trained and competent to be able to see patients on their own while still reporting back to the physician. These changes will not only foster greater cost savings, but will likely also benefit the issue of talent management. As a form of job enrichment, changing the very nature of the work will serve as an important recruiting and retention tool for PCPs. ■

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REFERENCES

1. Novak S. Luring students into family medicine. *The New York Times* website. http://www.nytimes.com/2012/09/10/us/10iht-educlede10.html. Published September 9, 2012. Accessed Aug 1, 2016.
2. Benabou R, Tirole J. Intrinsic and extrinsic motivation. *Rev Econ Stud.* 2003;70(3):489-520.
3. Herzberg F. One more time: how do you motivate employees? *1968. Harv Bus Rev*. 2003;81(1):87-96.
4. Warm EJ, Goetz C. Too smart for primary care? *Ann Intern Med.* 2013;159(10):709-710. doi: 10.7326/0003-4819-159-10-201311190-00009.
5. Porter ME, Pabo EA, Lee TH. Redesigning primary care: a strategic vision to improve value by organizing around patients' needs. *Health Aff (Millwood).* 2013;32(3):516-525. doi: 10.1377/hlthaff.2012.0961.
6. Starfield B. The future of primary care: refocusing the system. *N Engl J Med.* 2008;359(20):2087-2091. doi: 10.1056/NEJMp0805763.
7. Bassett-Jones N, Lloyd GC. Does Herzberg's motivation theory have staying power? *J Manag Dev.* 2005;24(10):929-943.
8. Reid RJ, Coleman K, Johnson EA, et al. The Group Health medical home at year two: cost savings, higher patient satisfaction, and less burnout for providers. *Health Aff (Millwood).* 2010;29(5):835-843. doi: 10.1377/hlthaff.2010.0158.
9. Klein S, McCarthy D. CareOregon: transforming the role of a Medicaid health plan from payer to partner. The Commonwealth Fund website. http://www.commonwealthfund.org/publications/case-studies/2010/jul/careoregon. Published July 22, 2010. Accessed August 1, 2016.

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