COMMENTARY

Delivering High-Quality Primary Care Requires Work That Is Worthwhile for Medical Assistants

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Medical assistants are core members of the primary care team, but health care organizations struggle to hire and retain them amid the ongoing exodus of health care workers as part of the "Great Resignation." To sustain a stable and engaged workforce of medical assistants, we argue that efforts to hire and retain them should focus on making their work worthwhile. Work that is worthwhile includes adequate pay, benefits, and job security, but additionally enables employees to experience a sense of contribution, growth, social connectedness, and autonomy. We highlight opportunities during team huddles, the rooming of patients, and career development where the work of medical assistants can be made worthwhile. We also connect these components to the work design literature to show how clinic managers and supervising clinicians can promote worthwhile work through decision-making and organizational climate. Going beyond financial compensation, these components target the latent occupational needs of medical assistants and are likely to forge employee-employer relationships that are mutually valued and sustained over time. (J Am Board Fam Med 2023;36:193–199.)

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As primary care clinics have worked to improve service quality while operating within low profit margins, the employment of medical assistants (MAs), who provide both clinical and administrative support, has been seen as a cost-efficient solution.[1] Today, MAs continue to support the delivery of primary care, and they are considered core team members who are needed for high-quality care.[2] This is because MAs can rapidly flex their clinical or administrative skills to adapt to changing operational needs and, with training, are capable of specialized tasks like panel management or health coaching.[3,4] From 2011 to 2021, the number of MAs being employed in the United States grew steadily from 539,220 to 727,760 (see Figure 1), reflecting the importance of this occupation in primary care.[5]

Despite their importance, health care organizations are now facing challenges retaining and hiring MAs.[6] Before the COVID-19 pandemic, studies were already showing that more than half of MAs intended to leave their job within 5 years and that approximately 28% of people working as aides and assistants had left for another non–health care occupation between 2003 and 2013.[7,8] Then the pandemic hit, spurring a record number of workers in the United States to quit during the "Great Resignation," notably health care workers who were reporting higher levels of workloads, stress, burnout, and anxiety/depression than other industries.[9–11] More alarmingly, MAs reported feeling less valued during COVID-19,[9] and 29% intend to leave their jobs within the next 2 years.[10] When MAs leave, the organization incurs a turnover cost of 40% of their annual salary[12] as well as intangible

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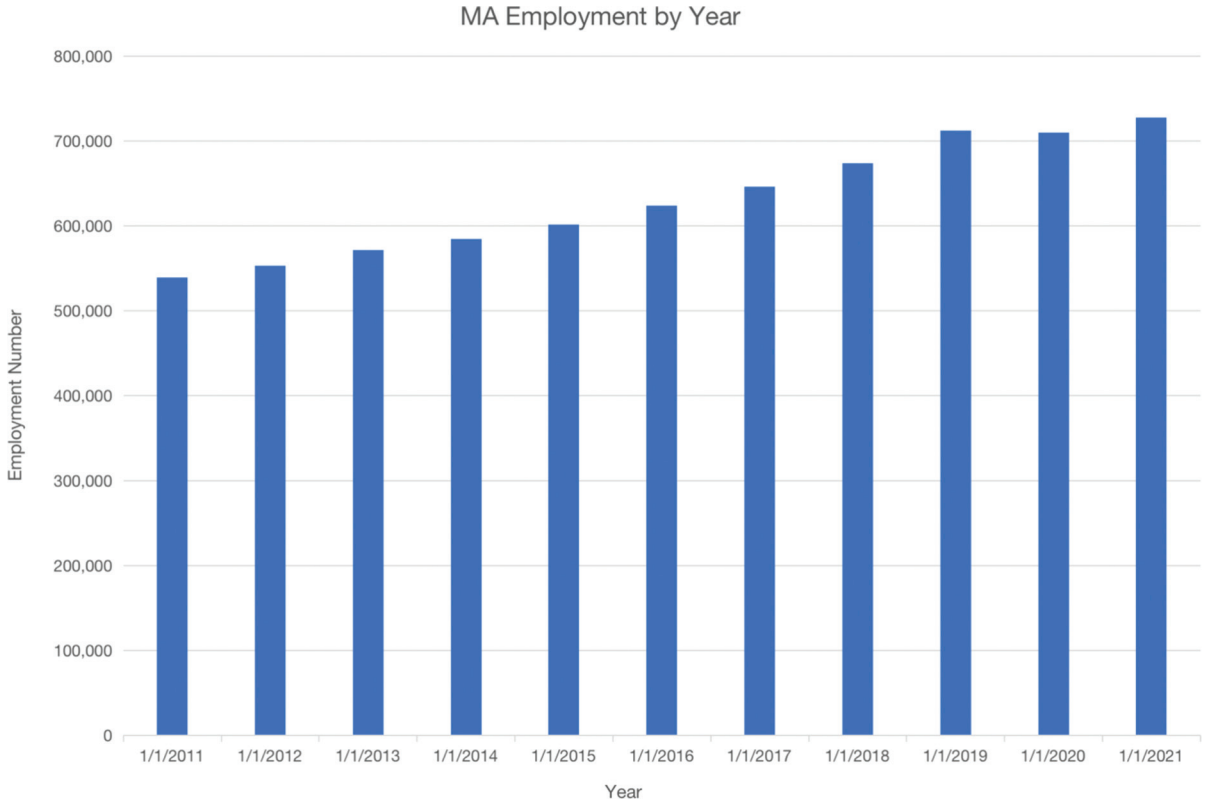
Figure 1. Number of medical assistants employed in the United States, 2011 to 2021. Source: US Bureau of Labor Statistics. Occupational Employment and Wage Statistics.



costs such as lower levels of productivity, staff morale, and patient satisfaction.[13,14] Robust strategies to sustain the employment of MAs in primary care are an organizational imperative.[15]

To better attract and retain MAs, they require work that is worthwhile to them. Worthwhile work goes beyond basic job components such as pay, benefits, and job security by enabling MAs to contribute to something valuable, grow professionally, build meaningful relationships, and have autonomy. This article highlights the limitations of using only pay incentives to retain and hire MAs and suggests the ways in which MAs can engage in work that is worthwhile to support high-quality primary care.

Higher Pay Is Not Enough

Because MAs are low-wage workers—their median annual hourly wage in 2020 was $17.23—conventional efforts to retain them may have centered on pay incentives.[16] Pay is important; consider what an MA shared as part of a qualitative study on what MAs value at work[4]:

> I had a coworker who is now working at a bar across the way here. She's a medical assistant and she's making more at a bar than she was in an office (primary care practice). So why come back? Unless it was a calling or career, and not just a job.

However, their pay only tells a part of the story. MAs also value using their clinical skills and building meaningful relationships with patients and coworkers.[4] In fact, subsequent research reveals that having meaningful relationships at work is a more important predictor of an MA's intention to stay than pay. (manuscript in preparation) Furthermore, while MAs are trained to support clinical and administrative tasks, it is the *clinical* component that makes their work particularly meaningful.[4]

What Makes Work Worthwhile?

To establish what makes work worthwhile to MAs, we draw on 3 frameworks from the capability approach (in studies on sustainable employability),[15,17] Good Jobs Institute,[18] and Great Jobs Study[19] to distill the following components:

Table 1. Mapped Components of Work That Is Worthwhile Based on Three Frameworks

Dimensions	Capability Framework	Good Jobs Institute	Great Jobs Study†
Pay and benefits	• Earning a good income	• Pay and benefits	• Level of pay • Employee benefits
Job security		• Schedules • Security and safety	• Stable and predictable pay • Stable and predictable hours • Job security
Contribution	• Using knowledge and skills • Contributing to something valuable	• Meaningfulness • Recognition	• Having a sense of purpose and dignity in your work
Growth	• Developing knowledge and skills	• Personal growth • Career path	• Career advancement opportunities
Social connectedness	• Building meaningful relationships	• Belonging	
Autonomy	• Being involved in decision-making • Setting own goals	• Achievement*	• Control over hours and/or location • Having the power to change things about your job that you are not satisfied with

*The Good Jobs Institute defined "achievement" as having "autonomy, tools, time and resources to do great work."[20]
†The Great Jobs Study used 10 workplace characteristics, although only 9 are shown here. The remaining characteristic was "enjoying your day-to-day work," which we regarded more as an evaluation of one's job instead of a dimension of work that is worthwhile.[19]

adequate pay, benefits, job security, as well as a sense of contribution, growth, social connectedness, and autonomy (see Table 1). These frameworks are grounded in theories used in psychological, occupational, and organization studies and are supported by empirical data. For example, the Good Jobs Institute uses extant theorizing on employee motivation, employee engagement, and work design,[20] and the Great Jobs Study was based on a sample of more than 6600 US workers.[19] Collectively, these frameworks reveal that a continuous focus on employee development and the social relationships employees have with others (ie, coworkers and patients) are important for keeping workers engaged.[21,22]

What Makes Work Worthwhile for MAs?

Competitive pay and benefits form the foundation of work that is worthwhile for MAs, and health care organizations need to calibrate their compensation packages both within and outside the health care industry. Within the health care industry, the American Association of Medical Assistants has released a national report on MA compensation trends based on region, setting, and specialty that can be used for benchmarking.[23] Because MAs are less "restricted" to working in health care than occupations with higher educational requirements, our research shows they use retail chains such as Target to benchmark their pay.[4] As non–health care companies change their compensation strategies—Target recently announced a raise in minimum wage to range from $15 to $24 per hour with additional health care benefits—so should health care organizations.[24] Failing to do so will likely result in MAs moving into other industries that are seen as viable alternatives.

Matching pay and benefits with non–health care companies is important but not sufficient. For health care organizations to outcompete alternative careers, they must further consider MA contribution, growth, social connectedness, and autonomy and pay attention to huddling, rooming, and career development, which we describe below.

Redesigning Huddles, Patient Rooming, and Career Development

Huddles allow members of the primary care team to discuss patients and anticipate their care needs for a given day and, consequently, lead primary care

team members to experience better teamwork and more supportive organizational climates.[25] Certain parts of the huddling process can be designed for MAs to play an active role to enable a sense of contribution. For example, MAs can be tasked to flag patients that are behind on screening or vaccination efforts ahead of appointments. MAs can also be invited to contribute meaningful information about patients because they can often connect with patients in a different capacity than other clinicians/staff and therefore uncover unique and relevant information, such as the specific needs of minority populations or housing and transport issues.[4,26,27]

The rooming of patients also enables a sense of contribution as MAs can use their clinical skills and knowledge (eg, answering patients' questions about blood pressure).[4] Moreover, rooming allows MAs to have direct patient interaction, which enables social connectedness. Pairing MAs with a clinician (ie, the "teamlet" model) and colocating them in the clinic will be beneficial, because it creates systemic opportunities for MAs to provide input while receiving appreciation for their contributions at work.[28,29] Furthermore, regular check-ins between clinicians and MA teamlets to exchange work-related resources such as information or advice to enable work, or interpersonal-related resources such as social support and friendship, will enhance social connectedness.[21]

A strategy to foster a sense of growth among MAs is to help them develop new clinical competencies, in line with evidence on how MAs value using their clinical skills at work.[4] Health care organizations can align additional clinical training with desired health outcomes for their patient population, such as training MAs as health coaches to facilitate hypertension or diabetes control among patients.[30] Over time, as health care organizations gain insight into additional MA competencies that they value, they can also proactively communicate with vocational schools and training programs to ensure that the graduates leave with the required skills.[4,31] For this strategy to succeed, however, a key consideration is whether the new clinical competencies being developed are in line with existing scope-of-practice regulations for MAs, which vary across states and organizations.[31,32]

To systematize the development of new competencies, health care organizations can also consider creating career-development programs for MAs to enhance their clinical, educational, and/or administrative skills.[33] MAs can grow in several areas, including panel management and care coordination, documentation support for electronic health record systems, clinical support for patient-centered care delivery, and/or supervision and training of other MAs (see Dill et al[33] for case study examples). While MA career-development programs are nascent, organizations are encouraging career growth by allowing MAs to attend conferences, enroll in university courses, or become a champion for infection control or employee engagement.[34] These career-development programs can result in pay increases ranging from $3,000 to $10,000, which are aligned with the competitive pay and benefits components of making work worthwhile.[33]

Emerging evidence suggests that MAs do not emphasize the importance of autonomy at work, plausibly because of the norm of seeing their work as primarily providing "assistance."[4] However, MAs should have some latitude to make certain decisions on how they approach their work, shape their working conditions to align with their needs and those of the clinic, or set their own work and career goals to make work more worthwhile.[35] Because rooming typically comprises the MA and patient only, MAs can be given latitude to decide on the sequence and timing of task performance (eg, taking vital signs, documenting main concerns for visit, reviewing preventive health activities, asking patients for changes in medication intake) as long as they do not interfere with the clinic's established workflow. Autonomy is experienced when, for example, MAs can articulate their preferred workflows for rooming and have them accepted as part of operational routines. Separately, career development is an area in which MAs can exercise autonomy—building on the examples above, MAs can choose which conference or course they want to attend or which clinic/quality improvement project team they want to join. Fostering autonomy in MA work can be achieved in various ways, but it remains crucial to balance what is beneficial for an individual MA as well as the clinic.

A Multiplier Effect among the Components That Make MAs' Work Worthwhile

There is a potential multiplier effect among contribution, growth, social connectedness, and autonomy as MAs experience these components. Over time, as MAs get to contribute more toward patient care or

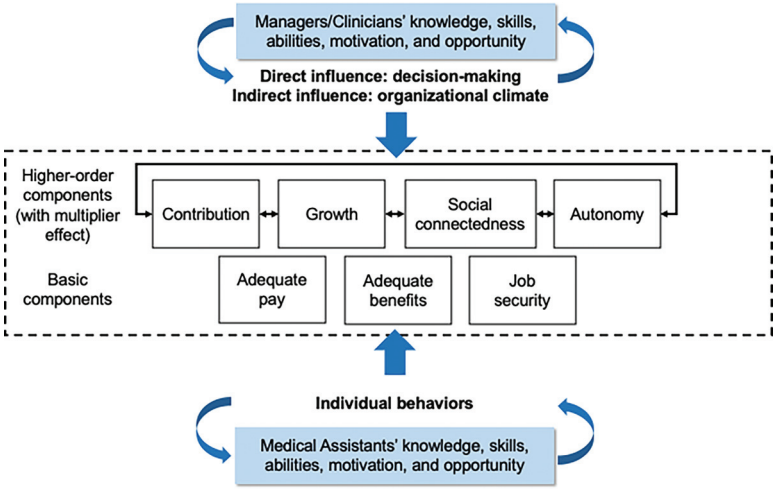
population health,[36] get to grow more in their career,[33] and/or get to connect more with coworkers and patients in the workplace,[21] they are likely to become better at recognizing the value of their roles in primary care and/or building self-efficacy.[37] In turn, MAs may become more autonomous in seeking out opportunities to contribute, grow, and connect. Alternatively, in growing their careers through courses, conferences, or new quality improvement projects, MAs may become more adept at connecting with others in the occupation or field of primary care and acquire new knowledge that can in turn contribute toward patient care or population health.

The Role of Clinic Managers and Supervising Clinicians

Clinic managers and supervising clinicians have an important role in providing and enabling the components that make work worthwhile for MAs. They do so in at least 2 ways: directly through their decision-making and indirectly through their influence on organizational climate. Clinic managers and supervising clinicians are often in positions to make decisions about MA work (eg, salaries, workflows, career-development opportunities), and they can therefore promote MA work to be worthwhile. Furthermore, they can advocate for any role expansion through huddling, rooming, or professional development to be commensurate with increases in salary. In addition, clinic managers and supervising clinicians can foster organization climates where MAs feel capable of voicing issues, appreciated as a member of the team, and recognized as a member of the MA occupation.[2,4] This is especially because MAs have historically been neglected as an occupational group, so strategies are needed to let MAs become more "visible" or feel safe when speaking up.[4,38] For example, studies have shown that high-performing primary care clinics engage in norms whereby team members who dominate discussions are asked to "step back," while those who have yet to contribute to "step up."[29]

Figure 2 encapsulates the discussion above while adapting from the work design literature.[39] Defined as "the content and organization of one's work tasks, activities, relationships, and responsibilities," work design is concerned with how work is achieved as well as the improvement of job quality and working environments of workers.[40] In this diagram, the components that make work worthwhile to MAs are in the center, with the multiplier effect highlighted among contribution, growth, social connectedness, and autonomy. The roles of clinic managers and supervising clinicians are reflected at the top—with a combination of their knowledge, skills, abilities, motivation, and opportunity, they can enable work components through decision-making or resource allocation and the creation of supportive organizational climates. A weaker path to enabling these components is through the individual behaviors of MAs themselves—the bottom of the diagram indicates how MAs may

Figure 2. Schematic diagram of components that make work worthwhile to medical assistants and their surrounding processes. Adapted from Parker SK, Van den Broeck A, Holman D. Work design influences: a synthesis of multilevel factors that affect the design of jobs. Academy of Management Annals 2017;11(1):267–308.



achieve the components, such as through negotiation, voicing needs, or volunteering. Although this diagram shows both top-down and bottom-up processes, research indicates that work design is more heavily influenced by managers.[39]

Conclusion

Implementing high-quality primary care depends on having a stable and engaged MA workforce in evolving care models that are focused on whole-person health, equity, sustained relationships, digitalization, and interprofessional teamwork.[2] MAs' needs have received disproportionately less attention compared with other health occupations, and systematic efforts to protect and promote this workforce are lacking. Efforts to hire, develop, and retain MAs need to create work that is worthwhile to them, and clinical managers and supervising clinicians can do so via direct and indirect ways. As the demand for MAs continues to increase, the components that make their work in primary care worthwhile will be crucial in fostering a work environment where MAs can enter the occupation, stay, and function in the long term.

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References

1. Hoff T. Embracing a diversified future for US primary care. Am J Managed Care 2013;19:e9–e13.
2. National Academies of Sciences, Engineering, and Medicine. Implementing high-quality primary care: rebuilding the foundation of health care. Washington (DC): National Academies Press; 2021.
3. Bodenheimer T, Willard-Grace R, Ghorob A. Expanding the roles of medical assistants: who does what in primary care? JAMA Intern Med 2014;174:1025–6.
4. Lai AY, Fleuren BPI, Larkin J, Gruenewald-Schmitz L, Yuan CT. Being "low on the totem pole": what makes work worthwhile for medical assistants in an era of primary care transformation. Health Care Manage Rev 2022;47:340–9.
5. U.S. Bureau of Labor Statistics [Internet]. Occupational employment and wages: 31-9092 medical assistants; 2022 [accessed 2022 Sept 15]. Available from: https://www.bls.gov/oes/current/oes319092.htm#ind.
6. Henry TA. Medicine's great resignation? 1 in 5 doctors plan exit in 2 years [Internet]. American Medical Association; 2022 [accessed 2022 Mar 13]. Available from: https://www.ama-assn.org/practice-management/physician-health/medicine-s-great-resignation-1-5-doctors-plan-exit-2-years.
7. Skillman SM, Dahal A, Frogner BK, Andrilla CHA. Frontline workers' career pathways: a detailed look at Washington state's medical assistant workforce. Med Care Res Rev 2020;77:285–93.
8. Snyder CR, Dahal A, Frogner BK. Occupational mobility among individuals in entry-level healthcare jobs in the USA. J Adv Nurs 2018;74:1628–38.
9. Prasad K, McLoughlin C, Stillman M, et al. Prevalence and correlates of stress and burnout among U.S. healthcare workers during the COVID-19 pandemic: a national cross-sectional survey study. EClinicalMedicine 2021;35:100879.
10. Sinsky C, Brown RL, Stillman MJ, Linzer M. COVID-related stress and work intentions in a sample of US health care workers. Mayo Clinic Proc 2021;5:1165–73.
11. Advisory Board [Internet]. The "Great Resignation": what health care leaders need to know now; 2022 [accessed 2022 Mar 13]. Available from: https://www.advisory.com/daily-briefing/2022/01/07/great-resignation.
12. Friedman JL, Neutze D. The financial cost of medical assistant turnover in an academic family medicine center. J Am Board Fam Med 2020;33:426–30.
13. Shanafelt T, Goh J, Sinsky C. The business case for investing in physician well-being. JAMA Intern Med 2017;177:1826–32.
14. Waldman JD, Kelly F, Arora S, Smith HL. The shocking cost of turnover in health care: health care management review. Health Care Manage Rev 2004;29:2–7.
15. Fleuren BPI, de Grip A, Jansen NWH, Kant I, Zijlstra FRH. Unshrouding the sphere from the clouds: towards a comprehensive conceptual framework for sustainable employability. Sustainability 2020;12:6366.
16. U.S. Bureau of Labor Statistics [Internet]. Occupational outlook handbook: medical Assistants; 2022 [accessed 2022 Mar 14]. Available from: https://www.bls.gov/ooh/healthcare/medical-assistants.htm.
17. Abma FI, Brouwer S, de Vries HJ, et al. The capability set for work: development and validation of a new questionnaire. Scand J Work Environ Health 2016;42:34–42.
18. Ton Z. The good jobs strategy: how the smartest companies invest in employees to lower costs and boost profits. Seattle (WA): Lake Union Publishing; 2014.
19. Gallup. Not just a job: new evidence on the quality of work in the United States. 2019.

20. Good Jobs Institute [Internet]. What is a "good" job?; 2017 [accessed 2022 Mar 13]. Available from: https://goodjobsinstitute.org/what-is-a-good-job/.
21. Yuan CT, Lai AY, Benishek LE, et al. A double-edged sword: the effects of social network ties on job satisfaction in primary care organizations. Health Care Manage Rev 2022;47:180–7.
22. Robertson KM, O'Reilly J, Hannah DR. Finding meaning in relationships: the impact of network ties and structure on the meaningfulness of work. AMR 2020;45:596–619.
23. American Association of Medical Assistants. 2021 CMA (AAMA) compensation and benefits report. 2021.
24. Target Corporation [Internet]. Target to set new starting wage range and expand access to health care benefits to more team members; 2022 [accessed 2022 Sept 19]. Available from: https://corporate.target.com/press/releases/2022/02/Target-to-Set-New-Starting-Wage-Range-and-Expand-A.
25. Rodriguez HP, Meredith LS, Hamilton AB, Yano EM, Rubenstein LV. Huddle up! The adoption and use of structured team communication for VA medical home implementation. Health Care Manage Rev 2015;40:286–99.
26. Lai AY. The incomplete, outdated, incorrect, and unknown: mitigating threats of knowledge errors in high-performance primary care. AMD 2021;7:581–602.
27. Chapman S, Marks A, Chan M. The increasing role of medical assistants in small primary care physican practice: key issues and policy implications. Center for the Health Professions at UCSF; 2010.
28. Bodenheimer T, Laing BY. The teamlet model of primary care. Ann Fam Med 2007;5:457–61.
29. Ghorob A, Bodenheimer T. Building teams in primary care: a practical guide. Fam Syst Health 2015; 33:182–92.
30. Nelson K, Pitaro M, Tzellas A, Lum A. Transforming the role of medical assistants in chronic disease management. Health Aff 2010;29:963–5.
31. Dill J, Craft Morgan J, Chuang E, Mingo C. Redesigning the role of medical assistants in primary care: challenges and strategies during implementation. Med Care Res Rev 2021;78:240–50.
32. Frogner BK, Fraher EP, Spetz J, et al. Modernizing scope-of-practice regulations—time to prioritize patients. N Engl J Med 2020;382:591–3.
33. Dill J, Craft Morgan J, Chuang E. Career ladders for medical assistants in primary care. J Gen Intern Med 2021;36:3423–30.
34. Vanderbilt University Medical Center. VUMC medical assistant clinical ladder. 2022.
35. Deci EL, Olafsen AH, Ryan RM [Internet]. Self-determination theory in work organizations: the state of a science; 2017. Available from: http://dxdoiorg/101146/annurev-orgpsych-032516-113108.
36. Fraher EP, Cummings A, Neutze D. The evolving role of medical assistants in primary care practice: divergent and concordant perspectives from MAs and family physicians. Med Care Res Rev 2021;78:7S–17S.
37. Figueroa Gray M, Coleman K, Walsh-Bailey C, Girard S, Lozano P. An expanded role for the medical assistant in primary care: evaluating a training pilot. TPJ 2021;25:1–9.
38. Edmondson AC, Lei ZK. Psychological safety: the history, renaissance, and future of an interpersonal construct. Annu Rev Organ Psychol Organ Behav 2014;1:23–43.
39. Parker SK, Van den Broeck A, Holman D. Work design influences: a synthesis of multilevel factors that affect the design of jobs. ANNALS 2017;11: 267–308.
40. Parker SK. Beyond motivation: job and work design for development, health, ambidexterity, and more. Annu Rev Psychol 2014;65:661–91.