

RESEARCH BRIEF

The Increasing Role of Medical Assistants in Small Primary Care Physician Practice: Key Issues and Policy Implications

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Introduction

Solo and small group practices provide much of the primary care in underserved communities across the state. Previous studies in California have highlighted the increasing role that nonlicensed personnel play in delivering services to patients in solo and small group primary care practices.^{1,2} The quality of work of staff members and problems with recruitment and retention were also identified as key challenges for these practices. Medical assistants (MA) are the most common nonphysician staff found in medical office practices.³ Despite the significant role they play in the delivery of patient care, they have received little attention in efforts to improve health care quality.

The purpose of this project was to understand the role of medical assistants in solo and small primary care practices. We described the background, training, and certification for MAs, assessed the gaps in their training and discuss the impact those gaps may have on the quality of patient care. This research brief presents a profile of the medical assistant workforce in California and summarizes our key findings.

Methods

Publicly available workforce and educational data were analyzed and a review of medical assistant educational programs and employment listings was performed. Key informant interviews were conducted with 19 experts representing medical assistant training programs, certification agencies, educational accrediting bodies, various large employers, and regulatory

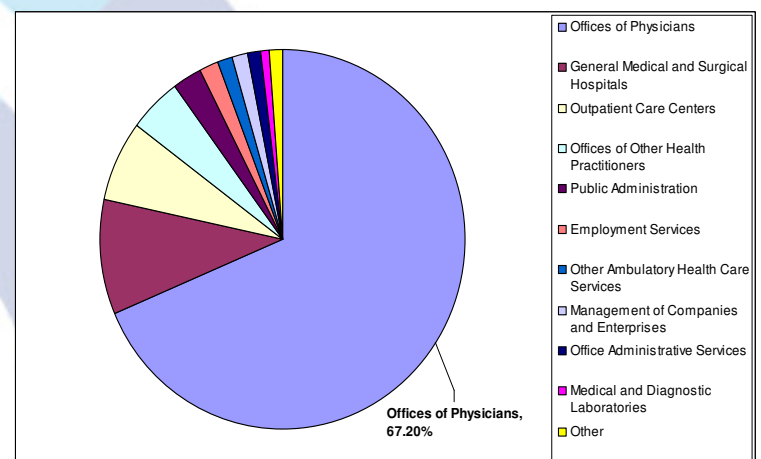
agencies. Focus groups were conducted in three regions of California; focus group participants included 25 physicians and 24 medical assistants from solo and small primary care physician practices.

Profile of Medical Assisting

Size of the Workforce and Employment Setting

In 2007 there were an estimated 64,600 medical assistants in California.⁴ Figure 1 displays information about the employment setting of MAs. About 67.2% of MAs were employed by physician office practices. The medical assistant workforce in California is projected to have a 30.8% increase between the years 2006-2016, which is the third largest growth rate among allied health professions in the state.⁵

Figure 1: Places of Employment for Medical Assistants in California



Source: Occupational Employment Statistics (EDD-OES).

Demographic Characteristics

Table 1 presents data on the race/ethnicity and sex of employed MAs and recent graduates of MA programs. Latinos represent the greatest proportion of the current medical assistant workforce in California (43.8%), and the vast majority are female (88%). Demographic data for recent graduates of medical assistant educational programs is comparable.

Table 1: Race/Ethnicity and Sex of Medical Assistants in California

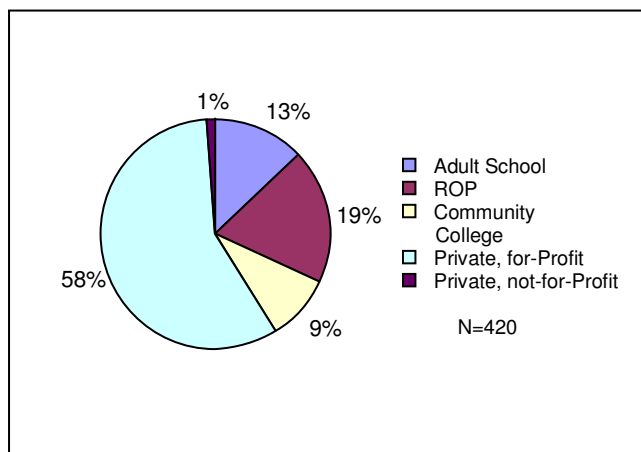
Race/Ethnicity	Recent Graduates (2006)	Employed MAs (2005/2006)	CA Labor Force (2005/2006)
Latino	46.9%	43.8%	33.8%
White	19.7%	34.1%	44.5%
Asian	8.2%	13.9%	13.2%
African American	12.2%	5.61%	5.8%
Multirace	-	1.9%	-
Other	1.0%	0.7%*	2.7%
Unknown	12.0%	-	-
Sex			
Female	90%	88%	49.9%
Male	10%	12%	50.1%

Sources: Integrated Postsecondary Education Data System (IPEDS), 2006; American Community Survey Public Use Microdata Sample (PUMS), 2005/2006.

Educational Programs

Private, for-profit vocational schools are the predominant source of formal medical assistant training programs. Figure 2 displays information on MA programs in California. Approximately 60% of all programs are in the private, for-profit sector.

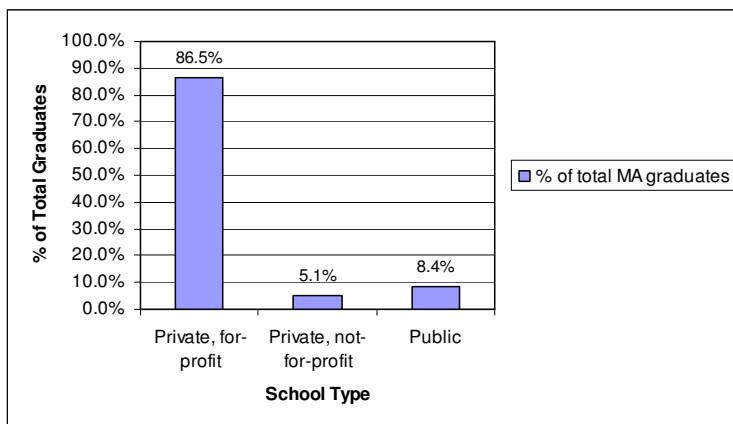
Figure 2: Types of Schools Offering Medical Assistant Programs in California



Source: Center for the Health Professions website review

Figure 3 displays data on the proportion of MA graduates by program type. Over 86% of all medical assisting program graduates are from private, for-profit schools. Over 75% of medical assistant program graduates complete non-degree programs that are less than one year long.

Figure 3: Type of School – Percentage of Graduates



Source: Integrated Postsecondary Education Data System (IPEDS), 2006

Summary of Key Findings

Key findings and policy recommendations were developed from information received from the focus groups and key informant interviews. Medical assisting is a rapidly growing profession and the demand for medical assistants is expected to continue to rise. Despite the significant role that medical assistants play in patient care, there is little regulation of their practice or standardization of education or certification.

The medical assistant is a critical component of small office practices. Yet, the high rate of medical assistant turnover experienced by these practices has many implications for the practices' success. In spite of the high value placed on the role of the medical assistant, little investment is made in the recruitment and retention of these staff.

Medical assistants have little opportunity for a career ladder. While the medical assistant role continues to expand, particularly in primary care settings, career advancement for medical assistants remains limited. Medical assisting represents one of the most ethnic and racially diverse health care workforces in California, yet little is done to encourage their upward movement to other types of health care careers.

There are many ongoing discussions about opportunities to utilize medical assistants in innovative ways that could help improve solo and small group practice. However, there is little preparation or additional training for those expanded roles. Greater investment in MA training, development of new skills, and retention is needed to effectively integrate MAs into a team model of care.

Policy Recommendations

Eight strategies are recommended that address the key issues with the medical assistant workforce in solo and small primary practices.

1. Improve the quality of and access to affordable medical assistant educational programs.

There should be improvements in the overall quality of medical assistant educational programs, particularly in the private sector, and better promotion of existing publicly funded medical assistant programs. There also needs to be an increase in the public sector's overall training capacity in response to regional demands for medical assistants.

2. Improve the health care career ladder for medical assistants while also helping to improve diversity in other health professions.

There is an opportunity to improve the diversity of the broader health care workforce by encouraging and facilitating the advancement of medical assistants into expanded career options or other health care careers. Doing this would require partnerships between educators and employers.

3. Develop and encourage on-the-job training opportunities.

More emphasis should be placed on training for "soft skills" (e.g., effective communication and customer service), in medical assistant educational program curricula, on-the-job training programs, and continuing education. These trainings should be accessible and affordable to the office practice and medical assistant participants.

4. Provide more information to solo and small practices about the role and scope of practice for medical assistants.

Both physicians and medical assistants in solo and small practices should be better informed

about the various medical assistant education and certification options and the specifics of the legal scope of practice. This will help assure compliance and provide a framework for the expansion of roles and responsibility.

5. Educate physicians and medical assistants on the breadth of culturally competent care.

There is an opportunity to improve culturally competent care by providing education to solo and small practices, particularly regarding the necessary qualifications for medical interpretation as well as how to find and use existing language resources.

6. Establish a regional mechanism for solo and small practice physicians to access and share information about the best ways for reducing medical assistant turnover.

A regional mechanism for solo and small practice physicians to access, share, and explore the best methods for hiring, training, utilizing, and retaining office staff should be established. This could also serve as a resource to better orient medical assistants to the structure of solo and small practices and help improve inter-office communication and work relationships, all of which could impact medical assistant retention.

7. Enhance the medical assistant's role to improve practice performance.

There is an opportunity to integrate medical assistants into chronic disease care, pay-for-performance activities, and medical home initiatives. A formal "expanded role" could utilize the medical assistant in more comprehensive care of patients with chronic illnesses while providing medical assistants with more opportunities for career growth.

8. Engage medical assistants as partners in pay-for-performance activities in solo and small practices.

This would involve utilizing medical assistants in more creative ways to help achieve performance goals. It could help broaden the skill set of the medical assistants while also directly benefiting the medical practice. Allowing the medical assistant to be a beneficiary of a portion of the compensation for positive performance would be an incentive for improved performance and help with employee retention.

Limitations

The publicly available workforce and educational data used in this report represent the best available sources of data to describe the medical assistant and related professions. The medical assistant workforce data is limited in that the Bureau of Labor Statistics – Occupational Employment Statistics survey is primarily collected from larger employers and does not include the self-employed. Therefore, estimates of the number of employed medical assistants may be artificially low. In addition, the qualitative data were collected from a small sample of key stakeholders and focus group participants. However, the themes were consistent across respondents.

Conclusion

Medical assisting is a rapidly growing profession, and the demand for medical assistants is expected to continue to rise. The medical assistant is a critical component of small-office practices, yet medical assistants are often underprepared for the role most valued by those practices, providing a satisfactory and high-quality experience for the patient and maximizing the efficiency and effectiveness of the medical care. Training for medical assistants that is accessible, affordable, easily delivered, and responsive to the concerns of solo and small primary care practices is needed. Quality improvement initiatives targeted at these practices should have a substantial component dedicated to the medical assistant role and their relationship with the practice.

Notes

- ¹ Maas, E, Blash, L, & Lee C. (2008, September). Quality Improvement in Solo and Small Group Practice: Strengthening the Private Practice Safety-Net. CMA Foundation.
- ² National Committee for Quality Assurance. (2006). Innovative Practices in Multicultural Health Care. Retrieved April 9, 2008 from http://www.ncqa.org/Portals/0/HEDISQM/CLAS/CLAS_InnovativePrac06.pdf.
- ³ Taché, S & Chapman, S. (2004). Medical Assistants in California. San Francisco: Center for the Health Professions, University of California San Francisco.
- ⁴ State of California Employment Development Department (2007). Occupational employment statistics survey. Employment Development Department. Retrieved July 16, 2008, from <http://www.labormarketinfo.edd.ca.gov>.
- ⁵ Bureau of Labor Statistics. (2008). Occupational Outlook Handbook, Medical Assistants. Retrieved July 16, 2008, from <http://www.bls.gov/oco/ocos164.htm>.

Acknowledgements



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