Tailoring Career Ladders for Medical Assistants in Primary Care: A Qualitative Assessment

Stacie Vilendrer (✉ staciev@stanford.edu)

Stanford University School of Medicine

Alexis Amano

Stanford University School of Medicine

Cati Brown Johnson

Stanford University School of Medicine

Timothy Morrison

Stanford Health Care

Steve Asch

Veteran Affairs Center for Innovation to Implementation

Research Article

Keywords: medical assistants, career ladders, team-based care, population health measures, behavior change

Posted Date: August 30th, 2021

DOI: <https://doi.org/10.21203/rs.3.rs-778712/v1>

License: © ⓘ This work is licensed under a Creative Commons Attribution 4.0 International License. [Read Full License](#)

Abstract

Background: Growing demand for medical assistants (MAs) in team-based primary care has led health systems to explore career ladders as one solution to improve MA recruitment and retention. The practical implementation of career ladders remains a challenge for many health systems, and an improved understanding of MA perspectives on career ladders is needed.

Methods: Semi-structured focus groups were conducted August to December 2019 in primary care clinics based in three health systems in California and Utah. MA perspectives of existing career ladders, including acceptability, appropriateness and impact on career intentions were discussed, recorded, and qualitatively analyzed.

Results: Ten focus groups conducted with 59 participants showed the MA employment decisions were influenced by a number of factors, with opportunities for economic and professional growth predominating. MA career aspirations varied, with “stepping stone” MAs using their role to advance into other health professions and “contented career” MAs hoping to grow within their MA career. Career ladders were acceptable in theory but MAs felt current implementations could benefit from clear and transparent expectations for advancement, consistent recognition of training, experience and work responsibilities, the ability to advance in place, and career counseling.

Conclusion: MAs held positive perceptions of career ladders, yet recommended a number of improvements to their practical implementation across three institutions. The emergence of two distinct clusters of MA professional needs and desires suggests an opportunity to further optimize career ladders to provide tailored support to MAs in order to strengthen the healthcare workforce and talent pipeline.

Background

Primary care practices have increasingly turned to team-based primary care models in their efforts to efficiently provide high quality care.^{1,2} As work processes shift in these multi-disciplinary teams to allow each member to perform “at the top of their license”^{3,4}, medical assistants (MAs) have seen their responsibilities expand to include panel management, health coaching, scribing, translating, phlebotomy, and other multi-functional roles, which vary by site and state licensing.^{5–7} Demand is skyrocketing for MAs; growth projections exceed the average for all occupations by over four-fold.⁸ Factors contributing to demand include the relative value of MAs in health systems (2019 median salary \$34,800⁸), short training periods, scope of work flexibility, and contribution to positive patient outcomes.^{5,9}

Efforts to employ and retain such a valuable workforce are of considerable interest to healthcare organizations, given the shortage of available MAs, annual turnover rates of 20-30%, and replacement costs that reach 40% of MA yearly salary.^{10,11} Research around these challenges is limited; lack of career advancement opportunity^{10,12} and negative perceptions of organizational culture may contribute to MA turnover.¹³

Given these challenges, many organizations are exploring novel solutions to recruit and retain the MA workforce with the goal of ultimately improving patient outcomes and workforce efficiency. One such solution is the implementation of career ladders—paths of professional advancement that provide employees with greater compensation as they cultivate and demonstrate additional skills and increase job responsibilities.¹⁴ Formal MA career advancement opportunities have been associated with improved quality of care, teamwork, employee satisfaction and intent to stay with current employer.^{5,9,15,16} An evaluation of 15 case studies in which new MA roles and opportunities for advancement were implemented alongside primary care model redesigns found associated improvements in patient and employee satisfaction, cost reduction, and quality.⁵

Despite these benefits, health organizations face challenges expanding the MA role and structuring meaningful advancement opportunities.^{7,17} Lags in implementation of a career ladder following MA role expansion can lead to MA frustration, particularly as these workers may see their responsibilities, but not pay, increase.⁷ Career ladders often require institutional-level support, given that adjustments to compensation often occur at a system-wide level.^{7,18} Variation in state certification and licensure requirements present further obstacles.⁷

As healthcare organizations continue to establish and refine career ladders, MA perspectives of how career ladders impact their professional intentions are lacking. This assessment aims to fill this gap with qualitative analysis of MA focus groups discussing career ladders implemented at three institutions.

Methods

MA perspectives of existing career ladders within their institutions were assessed through a series of semi-structured focus groups. Implementation outcomes were drawn from the Implementation Outcomes Framework, including acceptability, appropriateness, and perceived effectiveness at improving recruitment and retention.²

Settings

Sites included primary care clinics in three health systems across urban, suburban and partially rural U.S. geographies (University Healthcare Alliance, Newark, CA; Stanford Health Care, Stanford, CA; Intermountain Healthcare, Salt Lake City, UT). Within each institution, a subset of sites were chosen to represent urban (including suburban) and partial rural settings where available.

MA career ladders were in place for at least one year across organizations, though two organizations were in the process of revising career ladder details. The study was reviewed by the Stanford School of Medicine and Intermountain Healthcare Institutional Review Boards and, as quality improvement, did not meet the definition of human subjects research (Protocols #51945, #1051215, respectively). All participants gave verbal informed consent.

Data Collection

From August to December 2019, all MAs within each selected clinic were emailed an invitation to participate in an hour-long focus group by managers who were not present during the conversation. Participants did not receive financial compensation, though lunch was provided. No author practiced within these clinics. Focus groups consisted of a qualitative semi-structured discussion around MA perceptions of career ladders and financial incentives, the latter of which is the focus of other work.¹⁹ (See protocol in Appendix A.)

Data Analysis

Conversations were recorded with permission from all participants and transcribed (Rev, Austin, TX). Data collection continued until thematic saturation was achieved. Authors created an initial codebook based on emergent themes from early transcripts and used a constant comparative method²⁰ to categorize remaining data using software (NVivo 12, Burlington, MA). Authors collectively reviewed a subset of transcripts to reach consensus on a coding structure before recoding all remaining transcripts in sequence to ensure consistency. Codes were further analyzed to identify any potential differences in MA perceptions across clinic organizations and geographies. Early findings were reported back to operational leaders at each institution to inform ongoing improvement.²¹

Results

Across the three institutions, ten focus groups were conducted with 4 to 9 participants each for a total of 59 participants. Most MA participants (78.0%) worked in urban/suburban settings, 44% were 30–39 years of age, 92% were female, 37% were white, and 54% were non-Hispanic. Nearly half had worked as an MA for 10+ years (Appendix B). Findings were consistent across institutions as well as urban versus partial rural areas and are therefore described uniformly.

Qualitative analysis led to the following five findings:

- 1) MAs' decisions to join and remain in a given role are influenced by a number of factors, with opportunities for economic and professional growth predominating.
- 2) Career ladders are acceptable in theory but current implementations are felt to be sub-optimal.
- 3) MA career aspirations vary with some using their role as a stepping stone to advance into other health professions and others hoping to grow within their MA career.
- 4) "Stepping stone" MAs face several obstacles in obtaining additional education to transition into other health and non-health professions.
- 5) "Contented career" MAs desire additional economic and professional opportunities within their existing role, which are often felt to be lacking.

Factors influencing recruitment and retention

Medical assistants described a range of factors considered in their decisions to join and remain within their organization, including economic growth opportunity, professional growth opportunity, compensation reflecting job responsibilities, job security, fair compensation relative to internal and external peers, lasting interest in healthcare, appropriate workload, and social attachments to peers (Table 1). Several MAs focused on the frustration that MAs have recently been asked to take on more administrative responsibilities without commensurate

increases in pay: "Two [years ago the work increased]...My workload's way different ...a lot more computer stuff, reports, calling patients" (MA4, FG7). MAs expressed that this felt unfair: "It's just discouraging if we're doing all this work, and we're not being recognized on our title and on our paycheck" (MA8, FG6). Some expressed a desire for a return to their prior responsibilities, or reported the variety of responsibilities and sheer workload created time pressures that reduced job satisfaction.

Table 1
Medical assistant considerations related to recruitment and retention

Consideration	Definition	Example Quotations
Economic growth opportunity	Degree to which MAs are able to increase their compensation	Retention Context "I tapped out [left organization]. There was no more growth at all in regards to getting pay increases." (MA7, FG6) "[People leave because they are] probably burnt out or promised something that doesn't get followed through...I already know that I'm topped out based off of the last raise that we were supposed to get...." (MA1, FG5)
Professional growth opportunity	Degree to which MAs are able to increase their professional skills by learning new tasks and/or gaining new responsibilities	Retention Context I feel like it's more I've been in this position now for 17 years, almost 18 years as a medical assistant in different facilities, different companies. And I just learned a lot through the years, so I have a lot of knowledge and stuff. And I feel like as the older I get, if I was a nurse, I could go on and be like a manager, or a lead, or a teacher. But I don't feel like I can do that as an MA. (MA1, FG 4) "So, a lot of my friends have moved over to [competitor health system] because of the advancement in leadership where it can lead to private management. They pay less, but they promote higher. For example, I think the starting rate is [lower than nat'l average] over there, which is discouraging, but the possibilities are more endless there than here." (MA7, FG6)
Compensation that reflects job responsibilities	Degree to which pay increases as responsibilities increase	Recruitment context "One of my friends almost got hired, but she denied it. She worked at urgent care, and then she found out the things we have to do because she thought she was going to get more pay because more responsibility. [When she learned this wasn't the case], she declined it...She said that her life was already hectic. She didn't need to make it more hectic for same pay. If it was more, then it would be worth it." (MA6,FG6) Retention context "MA1: I think the responsibilities and the pay, there's a huge difference because, just an example, what I get paid here now to do the amount of work that I do...At [competitor institution], I get the same amount of pay, and I do way less work. MA3: Yeah. MA5: They're not even doing Injections or blood draws.... MA1: So I think that really attracts a lot of people to move elsewhere." (MA1, MA3, MA5, FG4)
Job security	Degree to which a worker feels the organization is looking out for their best interests and protects their job	Retention context "MA1: ...a lot of people say that they don't feel like they're protected here. Like you could literally get fired for the smallest things. MA3: ...I was always afraid that I was getting fired because of things that were said...And just constantly getting talked to, or at, about certain things and never having that representative for myself in there. It was always my word against the manager's word... MA2: You feel like management is against you and trying to get rid of you kind of thing. And then when you try to reach out to HR, they kind of give you that whole, 'It's your manager. I'm going to have his or her's back, not your back, because you're replaceable and management's not replaceable.'" (MA1, MA2, MA3, FG4) "I almost feel a bit villainized. If I say anything, if I complain or say, 'Hey, maybe this'. It's almost like you're afraid of stepping on toes or walking on eggshells... Because you can get written up and then that's the risk of being fired. They want to hear our opinions. But when we do [share opinions]...it's just shut down." (MA5, FG8)

Consideration	Definition	Example Quotations
Fair compensation relative to internal and external peers	Degree to which compensation is felt to reflect level of training and experience, relative between employees within an organization and relative to regional market	<p>Recruitment context</p> <p>“So, right now supposedly, I'm the lead MA. So I have the title...I'm the lead MA but...my badge doesn't say it. I don't know if my pay also says it. I did [get a raise upon receiving this title]. But, it wasn't...when I looked online [at competitor organizations]...it would have been way different than what I'm getting here...More.” (MA4, FG2)</p> <p>Retention context</p> <p>“MA2: It took me 10 months full time [to complete MA certification], which is frustrating because I paid \$10,000 for my education, which is way more now. And then they're hiring people off the street that we are training.</p> <p>MA3: That are making the same as you.</p> <p>MA1: Or more.</p> <p>MA2: Some left because they found out that the people they were training were making more money than them.</p> <p>MA3: That have been here for five years...</p> <p>MA1: But they don't realize that what they [administration] are doing is making the MAs that are actually certified frustrated and that's what's making them leave.” (MA1, MA2, MA3, FG8)</p>
Lasting interest in the healthcare field	Degree to which the content of their work in healthcare remains interesting	<p>Retention context</p> <p>“MA2:...I've thought about it over the years. I don't want to be an RN now...I won't go back to school for that...Because I'm going to leave healthcare...It's 14 years [working as an MA] in January and I'm done....</p> <p>MA3: So I wanted to become an RN, but I kind of got sick of healthcare and I [also] want to do something different.” (MA2, MA3, FG10)</p>
Appropriate workload	Perception that the amount of work is manageable given the allotted time to complete it	<p>Retention context</p> <p>“MA2: [It is] hard to get off on time and when you have like a babysitter and a baby, like you have to pick them up.</p> <p>MA3: And you can't leave until the doctors are done.</p> <p>MA4: Yep....I'll sit down at the end of the day cause we don't have any time and there's 50 messages I have to answer.</p> <p>MA3: We can't have overtime, but we can't do our job. We can't do everything we need to do in the amount of the time we have.” (MA2, MA3, MA4, FG8)</p>
Social attachments to coworkers	Degree to which social relations with coworkers contributes to job satisfaction	<p>Retention context</p> <p>“I've been here with [health system]... for 14 years now...and last year I felt...I couldn't take it anymore with everything they piled on us...I left last year, but the minute I walked into my new job I thought, hell, have I done? Because I've worked here so long. And even though the [original] job is stressful and hard and you go home tired... And the raise is a slap in the face each year... I love everybody here [original job]... That makes a difference in staying as well...this is my family.” (MA4, FG8)</p>

At the same time, MAs shared frustration at the limitations of what their licenses or job responsibilities allowed them to do. This sentiment clustered around the lack of upward growth opportunities available (see Finding 5 below) as well as limitations in day-to-day activities. One MA expressed dissatisfaction at the loss of her ability to place intravenous lines (IVs) due to changes in institutional protocols. Activities that were valued included patient-facing interaction, minor procedures (e.g. IV placement); less valued were computer work and scheduling. Overall, MAs' desire for increased patient-facing and procedural responsibilities was uniform and appeared conditional on having enough time during the day to complete such tasks and the recognition of this added value in their paychecks.

Finally, job security was another factor that some MAs described as driving their desire to leave a given organization. Even while MAs were reportedly in short supply, they reported hearing the message from administration that they were dispensable. Some MAs described their human resource contact as being largely unhelpful, particularly related to questions of work performance, promotion, or career ladders.

Career ladders acceptable but current implementations are sub-optimal

MAAs overall welcomed the existence of a career ladder that would help them understand steps to gaining skills and increasing professional and economic growth. One MA shared, “I think it's [career ladder] a positive thing. Also, if they're going to pay you more, then it's a really, really good positive thing” (MA 1, FG 2). However, most MAAs described a lack of clarity regarding career ladder details:

“Facilitator: So if you wanted to move up,... what would you have to do?”

MA2: I have no idea.

MA4: We have no idea.” (FG3)

This challenge was attributed to a lack of communication from administration, both about the overall system and where individuals fit within that system: “We don't know what level we're in.” (MA1, FG 5). Other challenges included inconsistent recognition of responsibilities, inability to advance without re-applying for an open position or specializing, lack of individual career counseling, education funds that were challenging to use in practice, and desire for greater appreciation from local physicians and the health system overall. These sub-themes have been converted to direct and implied recommendations for career ladder improvement (Table 2).

Table 2
Direct and implied MA recommendations for improving career ladders

Recommendation	Example Quotation
Clear and transparent expectations for advancement, regularly communicated	“[We need] a better understanding of the tiers of how you become an MA 2? How you become MA 3? What are they basing that on? What skill set? You know, because a lot of us have been doing this for like 10 years plus. So what experience skills is necessary for...And it would have to be consistent from every [health system] clinic... cause it's not [currently].” (MA 4, FG 3)
Consistent recognition of training, experience and work responsibilities, despite variation across backgrounds and clinic location	“So, I don't think it's fair to be categorized under the whole [health system] because we really do more than other MAAs do at other locations. I think that for our location, we should be categorized separately because we do a lot more than they do at regular [clinics].” (MA9, FG6)
Ability to advance without waiting for a role opening	“MA 1: Yeah, I would have to leave this clinic in order to just to become an M.A. 2, one level up... MA2: Yeah, cause I started at Menlo medical clinic as an M.A. 2, and I came here cause it was like less of a commute for me, and the only available spot they had was an M.A. 1, and now I'm doing so much more than I was doing over there but it's still M.A. 1. And I have the experience, well, we all have the experience of like an M.A. 3.” (MA1, MA2, FG 3)
Ability to advance while specializing in certain tasks	“Yeah, I just know of other medical companies, very close to us, that have MAAs who function as MAAs, and room the patients and take care of the patients, and they have other people in their buildings who do the referrals, and do the faxes, and do the paperwork. That's what I came from. ... So it's separate, and it's not merged into one position. So having it separate, and not putting all the pressure and responsibility on one person, seems to be a better...Instead of so much responsibility on one person, and then we all have burnout and don't want to come to our job... ” (MA7, FG10)
Individual career counseling	“MA1: I think they should individually sit down with you and talk to you where each of you are at, individually, that way we know where to grow, and where to become a better MA. We have our ‘yearlys’ [annual review], but it has nothing to do with this [career ladder]. MA4: I don't have a yearly. (MA1, MA4, FG5)
Direct payment for educational opportunities out of educational funds	“I want to do my certificate, but the money is a barrier. We have the \$2000 [in education credit] that we all have, but instead of [the health system] paying the money towards that, they want us to pay it directly and then they'll refund it. I think if they can pay them directly, it will make it a little bit easier for us to do the certification for MA. Or go back to school, get the online courses, go in to become and RN or whatever someone would like to be.” (MA1, FG5)
Demonstration of appreciation from health system and local physicians	“But there's no promotion, even if you do a perfect job, you don't have a promotion with that. Okay. No we don't have anything, we don't have an employee of the month, or anything like that as this office.” (MA 1, FG 2) “You know, it's really not just about the money, but we do so much more than a lot of our other clinics...I feel that it would be awesome to have that [increased compensation] though, and title change just to show the appreciation for the medical assistants and for how much they do.” (MA 4, FG 3)

Where career ladder knowledge existed, MAAs faced other obstacles to advancement, like the need for self-funded education: “You can become MA3, ...but you have to have specific certification and you have to do CME [continuing medical education]. You have to pay for that yourself.” (MA 3, FG 7) In addition, many MAAs who wanted to advance up the career ladder reported having to wait until a position of that particular level opened.

Further, MAs felt the career ladder did not acknowledge responsibility differences across clinic sites within the same institution, or differences in individual years of experience and training. Several MAs reported that job responsibilities varied between clinics. For example, some standard MAs are asked to do front desk, back office, phlebotomy work, and patient phone calls while others simply obtain vitals and room patients; MAs reported these differences were not reflected in the career ladder.

Underscoring these concerns was a sense that MAs were not appreciated for their work. MAs highlighted the need to build this recognition into career ladder and compensation structure: “I think being more appreciated is a huge thing... knowing that I'm making a difference.” (MA5, FG9) These collective challenges made it difficult for MAs to advance within their existing role and clinic.

MA career aspirations vary

MA career aspirations varied considerably and fell in two clusters: “stepping stone” MAs who are pursuing their current role as one step along a path to obtain a higher level license in healthcare, and “contented career” MAs who are not interested in obtaining a higher license in healthcare but rather are largely interested in growing within their careers as MAs (Table 3). Whether a given MA fell into one category or another was reported to depend on their backgrounds: “...personality-wise, we're not all the same person. We have huge diversity groups in how you were raised or what your projection is on what you want out of life..” (MA 2, FG 7)

Table 3

Medical assistant desired career trajectories and recommended path for advancement by cluster

Cluster	Definition	Example of cluster	Direct and implied recommended paths for advancement
"Stepping stone" medical assistants	These individuals pursue an MA role as one step along a path to obtain a higher level license in healthcare	<p>"I'm going to be going into nursing school, so I'm using medical assisting as a stepping stone, to get where I want to be, and also have a good resume. So, I really like it.</p> <p>Facilitator: Because it's hard to get into nursing school?</p> <p>MA: Right. And also saving up money. (MA 4, FG 10)</p> <p>"I know some people want to be nurses. They're not quite sure that they want to be an RN and be that committed. So, they try to be a medical assistant, and if that goes well, they go to the next step." (MA 7, FG 6)</p> <p>"I actually want to become a primary school teacher, so this is just to save money for school. And then I'm going to go back to school... So I wanted to become an RN, but I kind of got sick of healthcare and I want to do something different." (MA 5, FG 10)</p>	<p>Offer generous post-training work agreements for loan-forgiveness</p> <p><i>Reported loan-forgiveness at one institution in evaluation</i></p> <p>"MA9: There's an agreement, where you have to stay with [health system], for a certain amount after, or you would have to pay them back...I would say three years... It's like 1%.</p> <p>Interviewer: Okay, so it's 1% of tuition cost, but in order to not pay that back, you have to work for them for three years?</p> <p>MA9: Right." (MA9, FG10)</p> <p>Work with local training programs to build work-study program</p> <p>"...like even any leadership position or training position you have to have a BA or a BS or something like that to move up for those, so that's where the struggle is for that, especially with the hours that we work it's hard to do schooling to completely finish a program without leaving your job position." (MA 2, FG 1)</p>
"Contented career" medical assistants	These individuals are not interested in receiving additional training to move out of the MA role; some are interested in growing within their careers as MAs.	<p>"MA2: I know I don't want to be a nurse, so I'm not going to go to school for that. Would I love to make more money? Sure. Do I love my schedule here? Yes. I work four 10s, Fridays off, don't work holidays, don't work weekends. I don't want to go to graveyard. I don't want to go to weekends. I don't want to be on call...I mean I know it's not the best thing to do but right now I'm happy and comfortable. My bills are paid....</p> <p>MA4: If you love the provider you work with, you have the perfect schedule and you're not totally getting crappy pay then that's a comfortable spot to be in." (MA2, MA4, FG7)</p> <p>"I actually literally got into a discussion with an RN who told me that us MAs are nurse wannabes that couldn't cut it. I was like 'How insulting'. First off, we do this for a reason...we love the clinic setting. I said 'you couldn't step into my clinic and do what I did no more than I could step in and run your machines...You just couldn't, I don't care what your degrees.' It's different but the pay differences is ridiculous but what we do is equally as important as what they do. We're not nurse wannabes. I wouldn't be a nurse over an MA." (MA3, FG9)</p>	<p>Hire medical assistants into internal administrative roles</p> <p>"I don't know it was this year or last year, but I had heard that there was some clinic, somewhere, that [INSTITUTION] had actually hired a medical assistant as an assistant manager, and I think for a little while that was kind of motivating. Because you're like, 'Oh, we can actually do that?'... there's a lot of people that are medical assistants that are actually striving to be management." (MA3, FG4)</p> <p>Offer medical assistants designated time to specialize in new responsibilities</p> <p>"MA3: At my other clinic [prior to switching to current clinic] I very well would have been the managing MA that writes the schedule, covers the docs.</p> <p>Interviewer: So that would have been motivating for you?</p> <p>MA3: Oh, absolutely...Because with that came a pay raises as well." (MA3, FG9)</p>

"Stepping stone" MAs reported a desire to gain experience and save money in order to return to school primarily to become a nurse, though individuals also shared plans to become a physician or health administrator. Understanding their personal interest in healthcare before committing to additional training was felt to be a key reason for choosing the MA role: "Nursing... it's expensive, and then it's hard to get into. So, you don't want to be that committed [before knowing you are ready]... I have friends that went into the medical field, and then after [they] were done or close to being done, they found out that they hate blood" (MA6, FG 6). The cost of making a mistake in investing in one's career was thought to be high.

Alternately, "contented career" MAs did not nurture plans to return to school or switch professions. Instead, they expressed general contentment in their field and even described the benefits of being an MA over other healthcare careers:

"MA3:...I wouldn't even want to go to school as an RN... You just don't get that interaction with the patient...they [nurses] have time to go in, start the IV, run the machine, change bags, and then they're gone....I don't want to be that, I want to do patient interactions.

MA4: Our patients know our names.” (MA3, MA4, FG9)

A majority hope to grow within their existing career and share a desire to move into administration, teaching, or other leadership opportunities. Rare individuals expressed no desire to move up the career ladder. One attributed this to being late in her career:

“Maybe at age 60, I might want to retire...So, why stress myself out even further along...my mental health is something to consider too. So then, I said, ‘I’d rather leave it for somebody that’s younger.” (MA 3, FG 2)

“Stepping stone” MAs face several obstacles to achieving their goals

MAs who hope to return to school face challenges obtaining financial resources to pursue this education, often while balancing family responsibilities: “[Returning to school requires] debt, time. Hard especially if you have family.” (MA8, FG6) While MAs in several settings described receiving funds for continuing education for their employer, these were a small portion of what was required for additional training. One MA described a loan-forgiveness program where the health system paid a fraction of her loans in exchange for an agreement to work at the institution following training. This program did not seem to entice the MA to shift her plans.

“Contented career” MAs desire additional growth opportunities within their profession

Some of the MAs who expressed a desire to stay within their given roles and clinics still hoped for increased growth opportunity within this role. Many felt this was lacking: “I’m in that mode where I’m struggling...I want to be more but I have to do X, Y, and Z, and leave where I’m currently happy at in order to do that.” (MA1, FG1) Other MAs gave clues as to what might constitute these growth opportunities within their given roles. In particular, an MA at an outside clinic was reportedly hired into an administrative role; the MAs in the focus group found this to be motivating. Another participant identified that taking on a new specialized responsibility might increase her job satisfaction.

Discussion

Well-designed career ladders have the potential to improve job satisfaction, thereby improving recruitment and retention of health workers with downstream benefits on patient care and operational efficiency. We found positive MA perceptions of career ladders in principle, though elements of their practical implementation were reported to need improvement across three institutions. Reported and implied recommendations for career ladder improvement included the need for clear and transparent expectations for advancement; consistent recognition of training, experience, and work responsibilities across the organization; the ability to advance in place or with increased specialization; career counseling; and streamlined opportunities to use educational funds. The need for transparency and consistency in career ladder implementation is consistent with prior work⁷, though this evaluation further contributes to discussions around structuring opportunities for advancement including continuing education and recognition that MAs may cluster into distinct segments based on their needs and career aspirations.

Employee segmentation based on wants and needs may be warranted

MAs varied in terms of their professional ambitions, including the degree to which they hoped to grow within their existing role and whether they planned to pursue additional training to move into another profession. Designing career experiences around employee career aspirations, including “grouping employees into clusters based on their wants and needs” has been briefly explored in business literature,²² yet such programs have yet to be formally explored in healthcare. Diverse MA needs discovered here suggest opportunities to optimize career ladders from the perspective of two distinct groups: “stepping stone” MAs and “contented career” MAs.

Build the bridge to other health professions

For “stepping stone MAs”, these results suggest health systems may benefit from anticipating—and moreover supporting—transitions from MA to other health professions, particularly for individuals who hope to remain within a given medical system. MAs frequently reported considering nursing as the next step in their career, a profession with well-documented worker shortages and high turnover cost.^{23–26} Supporting these “stepping stone” MAs in their desire to become fully-trained nurses or other types of healthcare professionals may be a savvy way for health systems to create talent pipelines. We heard a single example in which one health system paid a small amount of tuition for additional education in exchange for an agreement to work after training for a minimum number of years. Such agreements exist

in other industries and are increasingly used with physician trainees²⁷; extending an adapted program to other health professions, including MAs, deserves further exploration.

MAs' varied levels of ambition suggest that at least some turnover should be anticipated. Further study is needed to quantify the impact MA career intentions have on turnover, including the portion of MAs who may be retained or positively directed towards other roles within a given health system. We also note that supporting such MA advancement opportunities may benefit institutional goals towards diversifying workforce and leadership, as MAs typically come from diverse backgrounds that often closely align with the patient population they serve.^{5,28}

Create advancement-in-place opportunities

For the "contented career" MAs, we heard that opportunities that allow for advancement within their current MA profession may increase job satisfaction and thereby retention with its downstream financial and organizational benefits.^{10,11} Literature outside healthcare also suggests that organizations can benefit when promoting from within, given that employees retain institution-specific knowledge that increases productivity.^{29,30} We note major barriers to facilitating MA advancement within their current roles include licensing restrictions and common staffing structures in primary care—MA role expansion may mean MAs have taken over the historical positions they might have once stepped up into. Some primary care settings, including those in this analysis, are actively exploring further specializing MA roles based on additional training in mental health, population health management, or value-based care.^{5,31} These opportunities may facilitate higher level advancement-in-place opportunities for MAs without requiring years of additional training.

We recognize another tension in that local clinic needs can vary significantly, and each may require different competencies from their MAs (e.g. phlebotomy, population health measures). This goes against MAs' voiced desire that a career ladder consistently reflect competencies across an organization. Based on our overall findings, it seems that allowing for some local clinic-level flexibility to facilitate advancement-in-place opportunities may outweigh MA desire for career ladder consistency across the organization. Administrators must recognize and balance this tension in their efforts to optimize career ladder design.

MA role expansion often not reflected in career ladders

Underlying these conversations was the dominant theme of MA role expansion in the last several years. While prior work has largely emphasized the benefits of this transition^{5,32,33}, we were struck by the unfavorable perspectives many MAs held when role expansion was discussed in the context of their career progression and, indirectly, compensation. In particular, MAs seemed to recognize they were providing more value to the health system than before, generally without increased compensation. Fortunately, despite these sentiments, early literature based on a subset of the population represented here suggests MAs do not experience significantly elevated rates of burnout¹³, though additional study is needed. Future efforts to optimize career ladders may benefit from participation from both administrative and MA representation to address aspects of compensation.

Limitations

Focus groups within three institutions across two geographies cannot encompass the full range of MA perspectives across the U.S., particularly as licensing laws vary from state to state. This evaluation reflects learnings to inform institutional practices, and extrapolation to outside settings is therefore limited. Furthermore, we acknowledge two institutions at the time of interviews were working on career ladder improvements; this period of ongoing change may have reduced overall MA knowledge and satisfaction with the pre-existing programs. Our use of focus groups may also have limited certain individuals' disclosures, though we felt the benefits from a synergistic discussion with multiple voices outweighed that risk.

Conclusions

MA roles have undergone significant expansion in recent years, and identifying the right balance between organizational and employee needs is ongoing. Career ladders are perceived favorably by MAs in principle but their practical implementation merits further attention. Segmenting MAs into distinct clusters based on their career aspirations may serve as a useful model to further tailor career ladders to employee needs, though additional evaluation is still needed. Such efforts have the potential to strengthen the healthcare workforce and talent pipeline, with downstream benefits to patient care and operational efficiency.

Abbreviations

MA = medical assistant; FG = focus group; CME = continuing medical educator

Declarations

Ethics approval and consent to participate:

The study was reviewed by the Stanford School of Medicine and Intermountain Healthcare Institutional Review Boards and, as quality improvement, did not meet the definition of human subjects research (Protocols #51945, #1051215, respectively). All participants gave verbal informed consent, and all methods were performed in accordance with the relevant guidelines and regulations.

Consent for publication:

Not applicable

Availability of data and materials:

Original qualitative interview recordings and transcripts will not be shared given possible risk to individual privacy.

Competing interests:

No competing interests are reported.

Funding:

This work received indirect support through the Stanford-Intermountain Fellowship in Population Health, Primary Care and Delivery Science.

Authors contributions:

Author SV conceived of the concept; SV, SA and CB-J designed the evaluation and focus group protocol. Author SV collected focus group data with support from author TM. Authors SV, AA, CB-J analyzed the qualitative transcripts while author SV led the drafting of the manuscript. All authors contributed to the manuscript content and edits.

Acknowledgments:

The authors would like to acknowledge Dr. Raj Srivastava of Intermountain Healthcare, Catherine Krna of the University Healthcare Alliance and Dr. Bryan Bohman of Stanford School of Medicine for their support in facilitating this evaluation.

References

1. Findlay S. Implementing MACRA. Health Policy Briefing. Published March 27, 2017.
<https://www.rwjf.org/en/library/research/2017/03/implementing-the-medicare-and-chip-reauth-act.html>
2. Reiss-Brennan B, Brunisholz KD, Dredge C, et al. Association of Integrated Team-Based Care With Health Care Quality, Utilization, and Cost. *JAMA*. 2016;316(8):826–834. doi:10.1001/jama.2016.11232
3. Bodenheimer T, Laing BY. The Teamlet Model of Primary Care. *The Annals of Family Medicine*. 2007;5(5):457–461. doi:10.1370/afm.731
4. Anderson P, Halley MD. A new approach to making your doctor-nurse team more productive. *Fam Pract Manag*. 2008;15(7):35–40.
5. Chapman SA, Blash LK. New Roles for Medical Assistants in Innovative Primary Care Practices. *Health Services Research*. 2017;52(S1):383–406. doi:10.1111/1475-6773.12602
6. Ferrante JM, Shaw EK, Bayly JE, et al. Barriers and Facilitators to Expanding Roles of Medical Assistants in Patient-Centered Medical Homes (PCMHs). *J Am Board Fam Med*. 2018;31(2):226–235. doi:10.3122/jabfm.2018.02.170341

7. Dill J, Morgan JC, Chuang E, Mingo C. Redesigning the Role of Medical Assistants in Primary Care: Challenges and Strategies During Implementation. *Medical Care Research and Review*. Published online August 14, 2019:107755871986914. doi:10.1177/1077558719869143
8. Bureau of Labor Statistics, US Department of Labor. *Medical Assistants*; 2020. Accessed August 14, 2020. <https://www.bls.gov/ooh/healthcare/medical-assistants.htm>
9. Nelson K, Pitaro M, Tzellas A, Lum A. Transforming The Role Of Medical Assistants In Chronic Disease Management. *Health Affairs*. 2010;29(5):963–965. doi:10.1377/hlthaff.2010.0129
10. Taché S, Chapman SA. *Medical Assistants in California*. University of California, San Francisco; 2004. Accessed August 14, 2020. https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/7.%202004-05_Medical_Assistants_in_California.pdf
11. Friedman JL, Neutze D. The Financial Cost of Medical Assistant Turnover in an Academic Family Medicine Center. *J Am Board Fam Med*. 2020;33(3):426–430. doi:10.3122/jabfm.2020.03.190119
12. Taché S, Hill-Sakurai L. Medical assistants: the invisible “glue” of primary health care practices in the United States? *Journal of Health Organization and Management*. 2010;24(3):288–305. doi:10.1108/14777261011054626
13. Seay-Morrison TP, Hirabayshi K, Malloy CL, Brown-Johnson C. Factors Affecting Burnout Among Medical Assistants. *J Healthc Manag*. 2021;66(2):111–121. doi:10.1097/JHM-D-19-00265
14. Bodenheimer T, Willard-Grace R, Ghorob A. Expanding the Roles of Medical Assistants: Who Does What in Primary Care? *JAMA Internal Medicine*. 2014;174(7):1025–1026. doi:10.1001/jamainternmed.2014.1319
15. Willard-Grace R, Najmabadi A, Araujo C, et al. “I Don’t See Myself as a Medical Assistant Anymore”: Learning to Become a Health Coach, in our Own Voices. *i.e inquiry in education*. 4(2).
16. Dill JS, Morgan JC, Weiner B. Frontline health care workers and perceived career mobility: do high-performance work practices make a difference? *Health Care Manage Rev*. 2014;39(4):318–328. doi:10.1097/HMR.0b013e31829fcbfd
17. Gray CP, Harrison MI, Hung D. Medical Assistants as Flow Managers in Primary Care: Challenges and Recommendations. *J Healthc Manag*. 2016;61(3):181–191.
18. Dill JS, Chuang E, Morgan JC. Healthcare organization–education partnerships and career ladder programs for health care workers. *Social Science & Medicine*. 2014;122:63–71. doi:10.1016/j.socscimed.2014.10.021
19. Vilendrer S, Brown-Johnson C, Kling S, et al. Financial Incentives for Medical Assistants: A Mixed-Methods Exploration of Bonus Structures, Motivation, and Population Health Quality Measures. *Academic Medicine (forthcoming)*.
20. Miles MB, Huberman AM, Saldana J. 2019. *Qualitative Data Analysis*, 4th ed. Los Angeles: Sage.
21. Brown-Johnson C, Safaenili N, Zionts D, et al. The Stanford Lightning Report Method: A comparison of rapid qualitative synthesis results across four implementation evaluations. *Learning Health Systems*. Published online December 21, 2019. doi:10.1002/lrh2.10210
22. Yohn DL. Design Your Employee Experience as Thoughtfully as You Design Your Customer Experience. *Harvard Business Review*. Published online December 8, 2016. <https://hbr.org/2016/12/design-your-employee-experience-as-thoughtfully-as-you-design-your-customer-experience>
23. Duffield CM, Roche MA, Homer C, Buchan J, Dimitrelis S. A comparative review of nurse turnover rates and costs across countries. *J Adv Nurs*. 2014;70(12):2703–2712. doi:10.1111/jan.12483
24. Zhang X, Tai D, Pforsich H, Lin VW. United States Registered Nurse Workforce Report Card and Shortage Forecast: A Revisit. *Am J Med Qual*. 2018;33(3):229–236. doi:10.1177/1062860617738328
25. Hayes LJ, O’Brien-Pallas L, Duffield C, et al. Nurse turnover: A literature review – An update. *International Journal of Nursing Studies*. 2012;49(7):887–905. doi:10.1016/j.ijnurstu.2011.10.001
26. Waldman JD, Kelly F, Aurora S, Smith HL. The Shocking Cost of Turnover in Health Care: *Health Care Management Review*. 2004;29(1):2–7. doi:10.1097/00004010-200401000-00002
27. Scheinman SJ, Ryu J. Why a Teaching Hospital Offers an Employment-Based Tuition Waiver Program. *NEJM Catalyst*. Published online June 26, 2019. https://catalyst.nejm.org/doi/full/10.1056/CAT.19.0646?casa_token=_ugA89cfTkGAAAAA:JcOwSI1AYL9wez4fMx0X8J0h_Fk9KEmNol7VLV3WGnREa9e8upBd8HPW20_HBWszDU0lv_jWDYElVj8
28. Bates T, Hailer L, Chapman SA. *Diversity in California’s Health Professions: Current Status and Emerging Trends*. The Public Health Institute and the UC Berkeley School of Public Health; 2008. Accessed January 28, 2021. <https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/10.%20Diversity-in-Californias-Health-Professions-Current-Status-and-Emerging-Trends.pdf>
29. Benson A, Rissing BA. Strength from Within: Internal Mobility and the Retention of High Performers. *Organization Science*. 2020;31(6):1475–1496. doi:10.1287/orsc.2020.1362

30. Prendergast C. The Role of Promotion in Inducing Specific Human Capital Acquisition. *The Quarterly Journal of Economics*. 1993;108(2):523–534. doi:10.2307/2118343
31. Djuric Z, Segar M, Orizondo C, et al. Delivery of Health Coaching by Medical Assistants in Primary Care. *J Am Board Fam Med*. 2017;30(3):362. doi:10.3122/jabfm.2017.03.160321
32. Bodenheimer T, Willard-Grace R, Ghorob A. Expanding the Roles of Medical Assistants: Who Does What in Primary Care? *JAMA Internal Medicine*. 2014;174(7):1025. doi:10.1001/jamainternmed.2014.1319
33. Chapman SA, Marks A, Dower C. Positioning Medical Assistants for a Greater Role in the Era of Health Reform: *Academic Medicine*. 2015;90(10):1347–1352. doi:10.1097/ACM.0000000000000775
34. United States Census Bureau: Urban and Rural. Published February 24, 2020. Accessed January 15, 2020. <https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural.html>

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- [APPENDIX.docx](#)