An Expanded Role for the Medical Assistant in Primary Care: Evaluating a Training Pilot

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ABSTRACT

Introduction: The patient-centered medical home model stresses the importance of team-based care as a foundation to improving care, costs, and patient experience. Medical assistants (MAs) are being used as key care team members even as traditional educational programs may not equip them for this new way of working.

Methods: This paper describes an on-the-job, predominantly virtual training program aimed at building care teams by redefining the role of the MA and fostering team-based functioning. Participating MAs, clinic managers, and clinicians in 11 primary care clinics completed 18-item pre- and post-training surveys to assess confidence in MA skills and performance. In-depth 1-hour qualitative interviews were conducted with selected participating MAs, managers, and clinicians to assess MA self-efficacy and to understand their use of new skills.

Results: MAs, clinicians, and managers agreed that MAs improved skills in planned care and population management, self-management support and health coaching, and interdisciplinary communication and collaboration. MAs reported a positive training experience, that they shared their knowledge with other MAs in their clinic, and that their job satisfaction increased.

Discussion: A predominantly virtual 12-week program built the skills and confidence of MAs in proactive population management, health coaching, and collaboration and communication. This program shows the promise of a virtual approach to training that identifies, trains, and recognizes high-potential MAs.

INTRODUCTION

Importance of Team-Based Care

The patient-centered medical home model stresses the importance of team-based care as a foundation to improving care, costs, and patient experience. High-performing care teams and expanded roles for care team members improve health outcomes for the chronically ill1-6 and have the potential to improve the satisfaction of clinicians and patients.5,7-14 Emerging evidence indicates that teams can bolster access to care15,16 and more effective engagement of practice members in continuous quality improvement (QI).17

However, bringing these promising outcomes to fruition requires substantive work for practices that are not organized in this way.18 Historically, primary care practices relied on clinicians to provide the totality of preventive, chronic, and acute care for patients. Recent literature has highlighted the logistic challenges associated with this model.19,20 Medical assistants (MAs) and other professionals are increasingly being called upon to perform key roles on the care team21-25 even as traditional educational programs may not equip them for this new way of working. This paper describes the development, curriculum, and outcomes of an on-the-job training program aimed at building care teams by redefining the role of the MA and fostering a new team-based way of functioning.

Importance of MA Role in Team-Based Care

MAs play a crucial role on the health care team and are one of the fastest growing health professions.26 Traditionally, MAs have worked closely with clinicians facilitating in-person visits and office flow.27 As primary care works to better meet the increasing chronic and preventive care needs of patients, the role of the MA is being reimagined. MAs can take on expanded roles and responsibilities including panel management and patient outreach, health coaching, and scribing.2 MAs are also being trained to take on specialized roles, such as conducting behavioral risk factor screening28 and delivering culturally congruent health coaching interventions to patients.29 Some practices have tried a teamlet model of care where MAs serve as co-caregivers with clinicians and conduct pre-visit, post-visit, and between-visit care.23

Expanding MA responsibilities to take on roles such as health coaching may improve patient-clinician communication and contribute to improved trust and patient satisfaction with clinicians.30

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Abbreviations: KPWA = Kaiser Permanente Washington; MA = medical assistant; QI = quality improvement
Workflow redesigns that support these new roles and responsibilities—such as co-location of clinician/MA dyads, daily huddles, and MAs as flow managers responsible for triaging patient care needs (e.g., test results, referrals, patient communication)—can improve communication, sense of teamwork, and involvement in care decisions.31,32

Challenges to Expanded MA Role
Despite the growing evidence to support a team-based approach to primary care and the importance and potential to grow the MA role in care teams, widespread adoption of these changes has not taken place.33 Challenges to expanding the MA role include quality and safety assurance, confusion about scope of work, and clinician comfort with expanded MA responsibilities.24,34 Additionally, MAs are among the lowest paid members of the healthcare workforce,35 and a high rate of staff turnover is a challenge for small and large systems alike.36 There is a lack of career ladders to provide advancement opportunities for MAs who embrace a larger role on the team.

These challenges point to a significant need for training and other implementation support to broaden MA roles. The educational pathway to becoming a MA is varied, and traditional MA programs focus on teaching administrative tasks, customer service, and patient flow.37 Despite some novel MA training programs,38 the lack of a nationally recognized or widely implemented curriculum results in MAs being underprepared to take on new and expanded roles.37 For now, individual organizations interested in bolstering team-based primary care must take the initiative to identify the MA roles and skills needed and develop and implement training programs and corresponding career ladders internally. This paper describes the structure, content, and lessons learned from one such effort in hopes of building the field with examples others can use.

METHODS
Program Design
The Kaiser Permanente Washington (KPWA) Learning Health System program, an initiative that works to bring research capabilities to strategic priorities of the enterprise,29 convened researchers and care delivery leaders to design an MA training program, which was funded by the Group Health Foundation Partnership for Innovation. The MA training program built upon learnings from the Robert Wood Johnson–supported Learning from Effective Ambulatory Practices initiative, which identified the roles and functions required for high-performing team-based primary care (see Appendix A).22,25,37 The program curriculum drew on Silverman and Blust’s Care Coordination Fundamentals,40 as well as peer-reviewed literature on panel management, opportunistic care, QI, and population health principles.

An advisory group provided input on the content and implementation of the MA training program and included clinician managers, primary care clinicians, MAs, a nurse educator, and health services researchers with expertise in qualitative methods, QI, and practice transformation.

Recruitment and Training
Clinic managers and primary care clinicians nominated MAs to participate in this voluntary training program based on their capability for leadership and potential to contribute to the primary care teams. MAs were supported during their training by a designated clinic manager, to whom they reported, and a clinician. The project team reviewed nomination forms, selected MAs who had the pledged support of a manager and clinician, and notified managers and MAs of acceptance via email. While no incentives were provided to participate in the training, to be nominated was considered to be an honor by the MAs because it recognized them as emerging leaders. MAs were also self-motivated to expand their role in primary care and improve patient care.

The training leveraged tablet technology to engage MAs in 4-hour weekly virtual interactions: enabling remote peer-to-peer learning. The course was delivered for 12 weeks from January to March 2017. During that time, KPWA backfilled the clinic staffing so that primary care teams could be fully operational during the 4 hours per week of training time. The content of this course is shown in Appendix A. The nurse educator (SG) made bi-weekly rounds to observe workflow, assess for application of new learning, and to offer chairside instruction with each MA every other week for a total of eleven 4-hour sessions. Managers and clinicians participated in group email and phone conversations facilitated by the nursing educator to review the cohort’s progress. The MA, clinician, and manager for each clinic formed a team that designed and implemented a clinic-focused population-based QI project in their clinic led by the MA. All participating MAs presented data-driven QI projects at a KPWA nursing best practice forum.

Evaluation
This descriptive study demonstrates the range of experiences of a sample of MAs, providers, and managers who participated in an MA training program. All participating MAs, managers, and clinicians were asked to complete 18-item pre- and post-training surveys to assess knowledge, confidence, and skills in three MA skill areas: planned care and population management (8 items), self-management support/health coaching (6 items), and interdisciplinary
communication and collaboration (4 items), with a 4-point response scale (strongly agree to strongly disagree) and optional open-ended free text response. All three participant groups were administered the same questions; the referent was modified based on respondent role (eg, “I am” vs. “the MA is”). Surveys were administered online prior to the training in January 2017 and again upon training completion in April 2017. See Appendix B for complete list of survey items. Percent agree or strongly agree for each item was averaged across the items in each area to create overall scores.

In-depth semi-structured 1-hour qualitative interviews were conducted with selected participating MAs, managers, and clinicians in the same clinic to assess MA self-efficacy and to understand how their new skills were being utilized in the clinic. Informants were purposely selected to represent a range of clinic size and geography, with a goal of interviewing about half of the participants. A health services researcher (KC) and a PhD medical anthropologist (MFG) conducted the interviews and a master’s level research specialist (CW-B) took notes during interviews. The research team held post-interview debrief meetings to discuss findings.

Interviews were audio-recorded with participant consent. Audio recordings were transcribed by a professional transcriptionist. Transcripts were analyzed with Atlas.ti qualitative data analysis software using an ethnographic framework and applied thematic analysis to elicit the lived experience and perceptions of the training for each participant. All transcripts were coded by the medical anthropologist. The research team met weekly during data analysis to develop the codebook and review emergent themes. Research team members who conducted the interviews discussed codes and themes to reach consensus on code meanings and domains co-creating the structure of the analysis and establishing trustworthiness. The finalized codebook was then used to code all transcripts. The evaluation team reviewed the themes that emerged from the analysis process and those data are represented in the Results section. Quotations have been edited for clarity.

This QI program evaluation was classified as “not research” by the KPWA Institutional Review Board administrator.

RESULTS
Program Participation
Fifteen MAs from 10 KPWA primary care clinics representing geographically diverse regions were nominated, accepted, and enrolled into the MA training program. All who were nominated were accepted, and all who were accepted enrolled. Four of these MAs dropped out early in the training and the survey responses of these MAs, their managers, and clinicians are not included. Eleven MAs from 9 clinics completed the training program and survey.

All 11 MAs who completed training responded to both pre- and post-training surveys. Nine managers and 7 clinicians completed pre-training surveys; 11 managers and 9 clinicians completed post-training surveys. The same managers and clinicians completed pre-post surveys; with extra outreach 2 providers and 2 managers who had not completed the pre survey completed the post. The percentages reported in the tables below reflect the proportion of “moderately agree” and “strongly agree” responses.

Six participating MAs representing 5 clinics, chosen to represent different geographic regions and patient populations, were invited to participate in evaluation interviews as were their clinic managers (n = 5) and clinician dyad partners (n = 5). All invited participants completed interviews. No incentives were provided.

Training Outcomes
At baseline, self-reported MA skill ranged widely across the three domains: planned care and population management, self-management support and health coaching, and interdisciplinary communication and collaboration. Average agreement increased post-training in all three domains and as reported by all three respondent types. Managers and clinicians were also more likely to endorse MA skills and performance across these domains, compared to baseline (Figure 1). Survey item data and illustrative quotations from qualitative interviews are presented separately for each domain.

Planned Care and Population Management
Post-training, MA, manager, and clinician mean endorsement was 79% across the 8 skill and performance items related to planned care and population management. Managers and clinicians most changed in their assessment of the MAs’ ability to lead or participate in huddles (Table 1). The greatest increase MAs reported was for patient outreach.

After the training, 100% (9 of 9) of clinicians agreed or strongly agreed that MAs worked with clinic staff as part of a team to provide care—the only item in this domain with universal agreement and a 43-point increase from baseline.

All clinicians interviewed described an increase in MA confidence and leadership in planned care and population management following training. The MAs proactively anticipated care needs, brought ideas to the clinician rather than waiting to be told what to do next, and spent more time directly engaging with patients about care.

“I loved that she would try to lead [our morning huddle] and start thinking about what people need. MA’s can totally anticipate most things if they’re thinking
about clinical care, and that way, better care is delivered, and flow is better. I have noticed that she’s able [to talk] about each individual patient and saying what healthcare need is due and what the patient is following up for and if any particular labs or something are needed.” (Clinician 1)

“This I’ve noticed recently that he’s anticipating more. As I’m seeing a patient for whatever issue, he’ll think well, maybe this is what she needs, and he’ll order and pen things for me. He’ll do research and then come and present whatever needs to be done.” (Clinician 2)

“[Our MA] definitely became more confident finding resources for patients and explaining things she may not have done before and doing a little bit of that motivation to help get them an immunization or a mammogram done or just understand something better, their blood pressure or something to that effect. She learned a lot from [the training].” (Clinician 4)

“She is definitely more of a partner, not at all hesitant to approach me and say hey, I’ve got this situation, or this idea, or I’d like to get moving on outreach—do you have some thoughts about how we should do that? I think initially [with] some of the outreach, she felt like she was bothering people, she seemed a little more hesitant. She seems absolutely not at all hesitant anymore, and I love it—yesterday we had someone who came in for a chronic condition review, and she said, ‘I’ve been working on getting her in here for so long, I’m so glad she’s finally here.’ And that really underscored her perseverance, and I think that’s because she seems the value and the real importance of the work she does.” (Clinician 3)

MAs shared specific examples of how participating in the training gave them confidence to do more patient engagement via proactive outreach. Their understanding of the importance of patient outreach increased.

“Are patients ready to make a change in their life? If they are, then we want to be here. [I learned] it’s not

![Figure 1. Overall changes in three skill categories.](https://doi.org/10.7812/TPP/20.091)
really about the numbers, it’s about engaging the patients in their healthcare. And I found with that dedicated outreach time that I could spend an extra 1 or 3 or 5 minutes talking with a patient, do they have any concerns about taking [their meds] or what are their barriers to getting in, instead of just calling them and saying it’s time for your Pap smear.” (MA 2)

“Patients understand that our main job is to get them in, take their vitals, get their chief complaint and have a little bit of conversation with them, ease their mind a bit. But with these additional skills and attributes, we’re in there an extra 30, 45 seconds, a minute, having to more of an in-depth conversation with them, and it seems to establish more of a rapport and trust with the medical assistant. (MA 6)

“Before I would have [the clinician] generate his list of patients that I would need to call for cervical cancers, but now I’m actually using the report in Epic and that’s generating for all the clinicians. And then we’re looking at HEDIS (Healthcare Effectiveness Data and Information Set) measures, at where we need to focus on more and what clinicians we need to help a bit more, to get our number to meet goal.” (MA 4)

Self-management Support and Health Coaching This domain started with the fewest participants across roles endorsing MA skills and performance, and in fact, for two items in this domain, none of the MAs or managers endorsed the skill at baseline (Table 2). The greatest improvement was seen in the skill with the lowest baseline score—the MA’s ability to support chronic disease management (46 point difference in both the MA and managers’ endorsement, 30 point difference for clinicians).

After the training, there was variation in how participants across roles perceived MA skills and performance. For example, most managers believed the MAs were documenting self-management support care plans in the electronic health record (82% managers vs 27% of MAs and 56% of clinicians).

MAs, along with their managers and clinicians, described an increase in MA skills and comfort engaging patients in health coaching, an area of focus in the training program.

“I’m more open with talking with patients about blood pressure issues, weight issues, things like that, whereas before I didn’t know the information that I had and the resources I could use to actually help a patient out.” (MA 5)

“Sometimes it’s right to help patients meet their health maintenance needs. I wasn’t as comfortable with that before, but now I feel like I’m more a part of the patient’s care.” (MA 4)

“Health coaching was the thing that I was really, really scared to do. I’m afraid I might say something wrong to a patient—I don’t know. But my Clinician—her help too, pushing me, telling me you know what, you gotta stay positive, you just need to relax. I learned a lot [about health coaching] from this training.” (MA 3)

“The big improvement was coaching. I know that [our MA] at the beginning of that part of the pilot was very uncomfortable with providing that kind of discussion or education with patients. I think she was concerned that it was outside of the MA scope, wasn’t sure that she had enough knowledge to really be able to do that well. And I know she was fearful of providing incorrect information to patients. [Now] she feels like she’s been able to start incorporating that into her daily practice with her patients and so she’s definitely comfortable with it after the training, but not something that she felt she ever would have been able to do or been comfortable without that added piece of training.” (Manager 3)

“I know [our MA] really felt she learned a lot from the teaching, that didactic teaching on how to do more

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<tr>
<th>Table 2. Endorsement of self-management support and health coaching skills and performance by role (percent agree or strongly agree).</th>
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<tbody>
<tr>
<td><strong>MA</strong></td>
</tr>
<tr>
<td><strong>Pre (n = 11)</strong></td>
</tr>
<tr>
<td>Describe/demonstrate chronic disease management</td>
</tr>
<tr>
<td>Provide health coaching to patients</td>
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<tr>
<td>Employ patient activation strategies</td>
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<tr>
<td>Document self-management support care plan in EHR</td>
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<tr>
<td>Discuss relevant community resources</td>
</tr>
<tr>
<td>Ensure patients understand self-management plan</td>
</tr>
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Diff = difference; EHR = electronic health record.
from the get-go this expanding MA project, if it’s done nothing else for our team, it has given the MAs a voice. They feel more comfortable speaking out and talking about improvements and their impact on those improvements.” (Manager 4)

“The most significant expectation for the MA that we chose was to establish a voice, because we knew she was a really strong clinician, kind of on the quiet shy side, but the goal for me, her ability to have the voice, to really become a leader with a voice. And increase her confidence and her knowledge, all of which happened.” (Manager 2)

“And rather than the clinician sending the list of patients to the MA, which is what happened before the pilot, they would just send the list to the MA to contact this patient and tell them that they need to—now the MAs and the clinicians are really sitting together most of the time and going through the dashboard together and having conversation about it instead of just a directive. That culture seems to have spread, because most of our dyads are now doing that here.” (Manager 1)

**MA Training Experience** MAs who participated in post-training interviews expressed their enthusiasm for the opportunity to increase their knowledge and skills. They shared that the one-on-one support from the nurse educator contributed to building their confidence during the training program.

“I’m the type of person that really likes new challenges, and I love to learn different stuff, so I attend[ed] the class.” (MA 3)

“If I had a question about the class, she [the nurse educator] was just phenomenal. She got back to you right away, she always made you feel comfortable with the questions you were asking. She was very patient with us; she held my hand at times I felt overwhelmed with things.” (MA 2)

“[Having the nurse educator come to clinic] was great. It was amazingly beneficial, because again, she would be able to look at exactly what I was doing and help

### Table 3. Interdisciplinary communication and collaboration responses by role (percent agree or strongly agree).

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<tr>
<th></th>
<th>MA</th>
<th>Manager</th>
<th>Clinician</th>
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<tbody>
<tr>
<td><strong>Communicate effectively</strong></td>
<td></td>
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<td></td>
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<tr>
<td>with team</td>
<td>73%</td>
<td>91%</td>
<td>82%</td>
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<tr>
<td><strong>Knows clinician</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>expectations, asks</td>
<td>91%</td>
<td>91%</td>
<td>82%</td>
</tr>
<tr>
<td>questions</td>
<td>0%</td>
<td>0%</td>
<td>37%</td>
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<tr>
<td><strong>Respected by team</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>for contributions</td>
<td>46%</td>
<td>73%</td>
<td>82%</td>
</tr>
<tr>
<td><strong>Use all training/skills</strong></td>
<td>55%</td>
<td>73%</td>
<td>64%</td>
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<table>
<thead>
<tr>
<th>Diff (Pre n = 11)</th>
<th>Post (n = 11)</th>
<th>Diff (Pre n = 9)</th>
<th>Post (n = 11)</th>
<th>Diff (Pre n = 7)</th>
<th>Post (n = 9)</th>
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<td>18%</td>
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Diff = difference.
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Diffusion of Knowledge

Though not the intent of the program, participation facilitated the transfer of knowledge between MAs who attended the training and their peers in their home clinics. The program evolved into a train the trainer model. Some MAs who completed the training continue to mentor MAs in their home clinics on QI projects.

“[The nurse educator] did a really excellent job of engaging [our MA] and the project, and keeping [our MA] motivated towards it, and [our MA] ran that project.” (Manager 1)

Job Satisfaction

Each MA interviewed stated that satisfaction with their role improved as a result of the training. Responses indicated that being chosen to participate in a training, designing and carrying out QI projects, and having pride in their increased knowledge and capacity contributed to increased satisfaction with their professional role.

“Healthcare is very, very important to me. I want to continue my education. It was a chance for me to grow, a chance for me to be a part of something bigger, a chance for me to prove that something bigger can be done. When I’m at work and I do something and my clinician doesn’t question it, I learn I’m doing something right.” (MA 6)

“The training motivated me… I realized I can put a project together, it can be successful. I realized I want more challenges; I want to be able to do more and I want to be asked to do more… [The training] helped me get a little more focused and a little more excited about what I do.” (MA 1)

“I think my attitude has improved, I think my job has improved, I think that patient care has improved since I’ve taken this class.” (MA 2)

“I’m so excited; I’m just very happy about [the training] because being an MA for a while, I never knew I can do all this stuff that I’m doing now. It just makes me happy and motivates me more… Being an MA at this time, I’m proud of it.” (MA 3)

DISCUSSION

MAs need training and support to participate fully in new models of team-based care. A predominantly virtual 12-week program built the skills and confidence of MAs in proactive population management, self-management support and health coaching, and collaboration and communication. MAs appreciated the flexibility afforded by the virtual learning platform and the opportunity for peer-to-peer learning with limited to no travel time needed. Through the program, MAs led clinical QI activities, and improvements in their ability to contribute to team-based care were recognized by their managers and clinician partners. The costs for this program included capital expenditures for software and hardware (approximately $1,500), administrative costs ($500), MA backfill (approximately $10,000), and costs for instruction, curriculum development, and course material (approximately $5,500) for a total of $17,500.

Team-based care is an essential for high-performing, patient-centered primary care.5 QI initiatives to augment team-based care demonstrate improvements in chronic disease outcomes, reduce inappropriate healthcare utilization, and can decrease healthcare costs.46–48 Others have found that efforts to expand the MA role are acceptable to care team members, increase clinic workflow efficiency, and contribute to improvements in prevention and chronic care.4,10,49 MAs working in team-based models report improved job satisfaction, improved relationships with physicians and other colleagues, and greater efficacy,50 all of which were common themes in our study. Interventions that reduce provider burden by promoting team-based care and expanded roles for MAs (eg, scribing) have potential to reduce physician burnout.51 Successful health professional education programs are those that promote team-based care, build competency in promoting patient self-management, and include learner-based QI initiatives.52 Our experience is consistent with these findings, suggesting the high potential for successful health care delivery system improvements.
The MA training program offered an opportunity for KPWA clinics to improve the skills of promising MAs. Training both acquainted MAs with existing tools and deepened their ability to engage in higher order thinking. MAs in the program shared their new skills and learnings with other MAs in their clinics, extending the reach of the training program. MA knowledge skills and attitudes improved after the training, and those who participated felt more committed to their role as a career after the training. Though career development opportunities were not developed as part of this training, it may be that a training like this could be helpful in supporting advancement along an MA career ladder, enhancing the ability of practices to retain high performers.

Self-management support and health coaching were the most difficult competencies for MAs to master. Health coaching may require skills or an approach that go beyond what was available in this training. In addition, there may be opportunities to expand skill development in all areas by more intentionally supporting joint training between the clinician and their MA partner.

Limitations

This small descriptive study has several limitations to note. The focus on high-performing MAs and the fact that 27% did not complete the training may limit the generalizability of our findings. There was variability in clinician and manager participation in the training and evaluation due to competing clinic demands. This may limit their ability to assess MA skills and performance. And, in some cases, the clinician and manager respondents were not the same pre/post. Despite these limitations, this descriptive study highlights a feasible MA training program that can be implemented in the context of a busy clinical organization. Qualitative and survey findings offer some insight into the staff and clinician experience and serve to generate hypotheses about effective MA training. Further research needs to be done to generate more robust statistical results findings.

Finally, though the study was not designed to explore sustainability of the training, recent work with health system partners shows that the core components of the MA training have continued to gain traction. Specifically, a further training emphasizing physician and MA partnership has been developed. A new “guide” role has been piloted at two innovation clinics that build in the core competencies of a high-performing MA described here, and ongoing work to optimize primary care has focused on role clarity for MAs, especially in the area of proactive population management.

CONCLUSION

Enhancing MA training and competencies is widely recognized as an important part of advancing team-based care. Though some certification programs and community colleges are rethinking their MA curricula to meet these needs, most programs are not adequately preparing MAs for current practice in a team-based primary care setting. New programs like the National Institute for Medical Assistant Advancement are creating partnerships between education and practice to enhance training and skills. Even still, it is largely incumbent on individual health care organizations to train MAs to have a more impactful role in the clinic if they want to deliver on the benefits of team-based care. Some forward-thinking organizations like Cambridge Health Alliance, Kaiser Permanente, and others have created internal MA training programs and grants have supported development in smaller practices after seeing its potential to improve care. This is a heavy lift, with little publicly available information on content, structure, participation. Few are evaluated. This program shows the promise of a virtual approach that identifies, trains, and recognizes high potential MAs. More needs to be done to assure career ladders and remuneration are in place as MAs take on more responsibility for QI, care delivery, and leadership within teams.

Supplemental Material


Disclosure and Sources of Funding

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Author Contributions

Marlaine Figueroa Gray, PhD, led study design, data collection, data analysis, and all aspects of manuscript preparation. Katie Coleman, MSPH, contributed to study design, data collection, data analysis, and in the critical review, drafting, and submission of the final manuscript. Callie Walsh-Bailey, MPH, participated in data collection, data analysis, critical review, drafting, and submission of the final manuscript. Samantha Girard, PhD, RN, contributed to critical review, drafting, and submission of the final manuscript. Paula Lozano, MD, MPH, collaborated on study design, critical review, drafting, and submission of the final manuscript. All authors gave final approval for the manuscript.

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References

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