Being "low on the totem pole"

Being "low on the totem pole": What makes work worthwhile for medical assistants in an era of primary care transformation

Alden Yuanhong Lai • Bram P. I. Fleuren • Jennifer Larkin • Lynda Gruenewald-Schmitz • Christina T. Yuan

Background: Primary care is undergoing a transformation to become increasingly team-based and multidisciplinary. The medical assistant (MA) is considered a core occupation in the primary care workforce, yet existing studies suggest problematic rates and costs of MA turnover.

Purpose: We investigated what MAs perceive their occupation to be like and what they value in it to understand how to promote sustainable employability, a concept that is concerned with an employee's ability to function and remain in their job in the long term.

Approach: We used a case of a large, integrated health system in the United States that practices team-based care and has an MA career development program. We conducted semistructured interviews with 16 MAs in this system and performed an inductive analysis of themes.

Results: Our analysis revealed four themes on what MAs value at work: (a) using clinical competence, (b) being a multiskilled resource for clinic operations, (c) building meaningful relationships with patients and coworkers, and (d) being recognized for occupational contributions. MAs perceived scope-of-practice regulations as limiting their use of clinical competence. They also perceived task similarity with nurses in the primary care setting and expressed a relative lack of performance recognition.

Conclusion: Some of the practice changes that enable primary care transformation may hinder MAs' ability to attain their work values. Extant views on sustainable employability assume a high bar for intrinsic values but are limited when applied to low-wage health care workers in team-based environments.

Practice Implications: Efforts to effectively employ and retain MAs should consider proactive communications on scope-of-practice regulations, work redesign to emphasize clinical competence, and the establishment of greater recognition and respect among MAs and nurses.

Key words: Health workforce, medical assistant, primary care, sustainable employability, turnover

Medical assistants (MAs) are allied health personnel who typically provide clinical and administrative support in primary care clinics in the United States, such as taking patients' medical histories or arranging for patients to receive laboratory services (American Association of Medical Assistants [AAMA], n.d.). Compared to other health occupations like nurses, MAs are not licensed, are unable to provide medical advice, and have more variation in their training duration and curricula (Bodenheimer et al., 2014). The effective employment of MAs is, however, associated with cost reductions and outcome improvements in primary care, allowing health care organizations to cope with pressures of operating in low-margin environments while delivering high-value care (Hoff, 2013). This is in part because MAs act as the "invisible glue" by bringing members of the primary care team together through interdependent tasks (e.g., assisting clinicians with examinations), coupled with responsibilities that have expanded to require more specialized skills such as panel management and health coaching (Bodenheimer et al., 2014; Tache & Hill-Sakurai, 2010). Over the last decade, the number of employed MAs in the United States has grown by 43.6% to 712,430, contrasting with 15.4% for registered nurses and −4.3% for licensed practice nurses (Bureau of Labor Statistics, 2020). This growth reflects the increasingly significant role of MAs amid the transformation of primary care delivery (Bodenheimer, 2007). In

Alden Yuanhong Lai, PhD, MPH, is Assistant Professor, Department of Public Health Policy and Management, New York University School of Global Public Health, and Department of Management and Organizations, New York University Stern School of Business, New York City. E-mail: aldenlai@nyu.edu.
Bram P. I. Fleuren, PhD, is Assistant Professor, Department of Work and Social Psychology, Faculty of Psychology and Neuroscience, Maastricht University, the Netherlands.
Jennifer Larkin, MSN, RN, CNML, is Director of Clinical Nursing Practice, Tower Health Medical Group, Wyomissing, Pennsylvania.
Lynda Gruenewald-Schmitz, DNP, RN, CENP, is Owner and Principal Consultant, Embrace Leadership Consulting, Hales Corners, Wisconsin.
Christina T. Yuan, PhD, MPH, is Assistant Scientist, Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland.

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particular, primary care has become increasingly team-based and multidisciplinary, with MAs being considered as core members of the primary care team (National Academies of Sciences, Engineering, and Medicine [NASEM], 2021).

Despite the increasing significance of MAs in primary care, research in health care management has not fully studied their occupational needs to identify ways to sustain their functioning and participation as part of the primary care workforce. Sheridan et al. (2018) demonstrated that the work experiences of MAs can improve with the transition to team-based care among clinics, but recent studies continue to suggest that more than half of MAs intend to leave their jobs within 5 years and that each MA turnover costs their employing organization 40% of their annual salary (Friedman & Neutze, 2020; Skillman et al., 2020). The alarming rate and cost of turnover likely reflect several challenges that MAs face in their occupation. First, with a median annual salary of $35,850 in 2020, MAs are among the lowest paid in the health workforce despite their rapidly expanding labor demand and job responsibilities (Bodenheimer et al., 2014; Bureau of Labor Statistics, 2021). Second, because MAs do not belong to a licensed profession, they often lack systematic means for continuous education and professional advancement (Giannitrapani et al., 2016). Third, similar to other health care professionals, the tasks that MAs can perform at work (i.e., scope of practice) continue to vary by states and employing organizations, which can preclude them from optimizing their skill set as well as engaging in innovative ways to deliver care (Dill et al., 2021; Frogner et al., 2020). Fourth, primary care physicians may not have sufficient trust in MAs to let them perform tasks at the top of their competency and training (Chapman & Blash, 2017; Fraher et al., 2021). These issues related to salary, professional development, and task performance reflect what employees generally value the most at work and therefore create various sources of strain that may be pushing MAs—a vulnerable group of low-wage workers—to exit their occupations (see van der Klink et al., 2016).

To better understand MAs as an occupational group and to foster their sustained participation in the workforce, this study explores what MAs perceive their occupation to be like and what they value in it. The study's contributions are fourfold. First, it generates qualitative understanding of an occupation in primary care that has yet to receive significant scholarly attention yet is increasingly prominent and evolving. Second, this study uses the MA context to elaborate sustainable employability, an emerging concept in occupational studies, to enrich current perspectives in health care management research. Third, this study was conducted in an organizational setting that is already practicing team-based care and therefore reflects emerging trends related to MAs' evolving occupational needs and challenges at a time when other health care organizations are still shifting toward team-based care models. Fourth, studying MAs also renders the historically invisible "visible" because they receive more voice as an occupation.

Theory

Sustainable employability is concerned with employees' long-term ability to function and remain in their job (Fleuren et al., 2020). To achieve sustainable employability, both employees and employers must continuously pursue and maintain approaches to work that are mutually beneficial over time. Scholars have conceptualized sustainable employability in several ways, with the capability approach being the most dominant (Fleuren et al., 2016; van der Klink et al., 2016). This approach proposes that employees need to achieve seven capabilities at work to move toward sustainable employability, which include (a) using knowledge and skills, (b) developing knowledge and skills, (c) being involved in decision-making, (d) building meaningful relationships, (e) setting own goals, (f) earning a good income, and (g) contributing to something valuable (Abma et al., 2016). The premise of the capability approach is that individuals have universal dimensions of work they value and that their employability is more likely to be sustained when opportunities to achieve these capabilities are made available *and* attainable by their employers (Sen, 1993). In return, when employees attain these universal values at work, employers stand to benefit in terms of a more engaged, skilled, and stable workforce, thus creating mutually sustained and positive relationships between the employee and employer.

Sustainable employability contributes to efforts that seek to prevent employee turnover because it adopts a long-term perspective to workforce management and retention (Fleuren et al., 2020). The concept is especially relevant to low-wage workers, where employers may be more primed to adopt a "hire and replace" versus a "develop and retain" workforce strategy (e.g., see Neumark & Wascher, 2001). Low-wage health care workers in the United States are expected to engage in professional development to increase their employability but typically must do so without adequate financial and educational support from their employing organizations (Dill & Morgan, 2018). Instead of letting low-wage workers increase employability on their own, sustainable employability signals the mutual employer–employee benefits of taking a long-term perspective to enable, for example, the development of workers' knowledge and skills regardless of their skill or wage levels (see Cappelli & Keller, 2014). Furthermore, with an emphasis on intrinsic work values, sustainable employability complements existing literature on how external work factors such as extrinsic reward systems (e.g., wages and benefits), working conditions (e.g., excessive workloads), occupational norms (e.g., status hierarchy), and organizational structures (e.g., levels of accountability) collectively influence turnover among health care workers (Morgan et al., 2013; Temple et al., 2009).

Listing the capabilities that constitute sustainable employability alone, however, has its limitations because not all capabilities may be equally valued by employees and not all capabilities can be readily made available and attainable by employers. These limitations mirror those of the concept of meaningful work, which can be defined as "the subjective experience of existential significance resulting from the fit between the individual and work" (Both-Nwabuwe et al., 2017, p. 12). Much like what constitutes meaningful work is subjective, what is valued among employees also varies across individuals, because it is ultimately dependent on the *fit* between what an employee values and what the working environment offers (Lai &

Fleuren, 2021). A pivotal step in understanding what drives sustained participation in the workforce is therefore to identify what employees specifically value at work in conjunction with the occupational and organizational context that may be shaping their work experiences.

One approach to elucidate these values is to examine an employee's responses to the intrapsychic questions of "What am I doing?" and "Where do I belong?" (Pratt & Ashforth, 2003). Identifying the roles and tasks that employees are performing (or want to be performing) and the groups and categories that they perceive to be members of (or want to be members of) provide insight into how employees seek to fulfill certain needs at work such as meaningfulness. Building on research on sustainable employability and the meaning of work, this study centers on identifying what MAs value in their work. Consequently, such understanding is expected to provide a basis on which the fit between particular low-wage health workers and their work environments can be elaborated and therefore to predict organizational outcomes like personnel turnover (Both-Nwabuwe et al., 2017; Lai & Fleuren, 2021).

Methods

Study Setting and Participants

We conducted the study with MAs working in primary care clinics in a regional, integrated health system in the United States that provides health services to a population of approximately 2.5 million people (Health Corp). Health Corp was ideal as a case for this study because (a) it was already practicing team-based care across its primary care clinics, which in theory affords a more central role for MAs in care delivery, and (b) it had created a career development program (i.e., clinical ladder) that MAs could participate in at the time of study, which to our knowledge is a rare practice in the industry (see Dill et al., 2021; Sheridan et al. 2018). Team-based care in Health Corp is defined as shared responsibilities between primary care physicians or advanced practice professionals, nurses, MAs, clinical social workers, and pharmacists in the clinic in accordance to the patient-centered medical home guidelines, which refer to activities in place to ensure patient access, team-based care, care management and support, care coordination, quality improvement, and population health management (National Committee for Quality Assurance, 2021). Health Corp had been implementing team-based care through the patient-centered medical home model for 2 years prior to the point of data collection.

MAs in Health Corp work exclusively in the ambulatory setting across primary care clinics that are spread across the region. They typically receive training at a technical institute that is located within 10 miles of Health Corp's main hospital. As part of the MA curriculum, trainees at this technical institute also complete internships at Health Corp, which creates a feeder relationship between both organizations. Newly employed MAs in Health Corp undergo a centralized orientation program that lasts approximately for a week before joining their site of employment. At their primary care clinics, they then go through an apprenticeship where they will shadow more experienced MAs and/or nurses before they are considered fully functional in their employed position. In clinics that are hiring nurses for the first time, new nurse hires may also shadow experienced MAs to complete their orientation. The MA career development program comprises three hierarchical levels that have commensurate annual requirements for continuing education and involvement in quality improvement projects, which are linked with predesignated increments in MA's hourly salary.

Data Collection

We sent e-mail invitations to all MAs working across Health Corp's primary care clinics to participate in the study. We limited participants to those with at least 1 year of experience working as an MA, although not necessarily in Health Corp. Data collection occurred in two stages. First, we conducted semistructured interviews with MAs in December 2019. We started the interviews by asking the MAs to describe their role and work environment generally, followed by questions on what they find important in their own work and job, particular situations at work that are either negative (e.g., stressful) or positive (e.g., rewarding), and the various work aspects that are related to how MAs can better perform or enjoy their work. Although we used current perspectives on sustainable employability and meaningful work to situate this study, we did not specify any preexisting concepts of interest during data collection and analysis to align with its inductive design. We conducted the interviews in an off-site facility, separate from where the MAs worked, and, when not logistically feasible, in designated meeting rooms without the presence of other staff. The duration of the interviews ranged from 31 to 82 minutes, with an average of 49 minutes. We audio-recorded all interviews, which were then professionally transcribed. Two researchers (AL and CY) conducted the interviews. AL and CY first conducted four interviews together to foster a common understanding that would allow a subsequent discussion of memos, as well as to understand which interview probes could be used and how. AL and CY then conducted the remaining interviews individually. Throughout the process of data collection, the researchers performed memoing to capture the gestalt of each interview as well as emerging observations and questions that may relate to the research question (Miles et al., 2014). In addition, AL and CY met regularly to discuss their memos. The MAs did not receive direct incentives for study participation, although clinics were compensated for the time taken for MAs to complete the interviews. In the second stage, after the emergence of initial themes, AL and CY conducted a member-checking interview with another MA to enhance the trustworthiness of our findings (Birt et al., 2016; Charmaz, 2006). This MA was a member of Health Corp's "float pool," which was a group of MAs that did not have a primary care clinic as their permanent site of employment. Instead, float pool MAs could be deployed to any Health Corp primary care clinic that required additional MA human resources for a designated period. We purposively sampled this MA to conduct the member-checking interview because they could discuss our findings in the context of multiple clinics in Health Corp given the rotational nature of their work. During the member-checking interview, we shared the emerged themes (see Data

Analysis) to ascertain whether they aligned with the participant's perspectives and to elicit further examples where possible. The institutional review boards at the health system and Johns Hopkins Bloomberg School of Public Health approved this study protocol.

Data Analysis

We used an inductive approach to qualitative data analysis and created a data structure that shows a distillation from categories to themes to reflect the analytical process (Gioia et al., 2012; see Table 1). The categories represent terms and codes that are grounded in participants' narratives. To derive these categories, AL read all transcripts in detail and performed an open coding process, which resulted in the emergence of broad codes that were used to create a preliminary codebook (Strauss & Corbin, 1998). These broad codes included, for example, "MA identity," "recognition," or "connecting with patients." AL and CY then discussed these broad codes to ascertain whether the emergent codes reflected the memos written during data collection and to generate a codebook for subsequent coding (MacQueen et al., 2008). The codebook underwent one round of refinement, with which AL recoded all transcripts to generate meaningful categories. AL then distilled the categories into themes, which involved asking "whether the emerging themes suggest concepts that may help us describe and explain the phenomena we are observing" (Gioia et al., 2012, p. 20). At this stage, BF, who was not involved in data collection, critically reviewed the data to ensure that the analytical process had retained the higher level perspective needed instead of adopting the participants' perspectives entirely (Gioia et al., 2012).

Results

Sixteen MAs participated in this study. Fifteen MAs participated in the initial interviews, followed by one MA for the member-checking interview. The participants were all female,

TABLE 1: Data structure showing examples of categories and their associated themes

Categories	Themes
Receiving validation from patients for clinical skills	Using clinical competence
Helping patients gain access to care	
Being "first line of defense" for patients	
Helping patients with medication management	
Contributing to patient satisfaction ratings	
Being unable to do what MAs have been trained to do	
Being unable to do what MAs have been doing previously	
Differing expectations between what MAs can do during training and in practice	
Being unable to use clinical skills to the fullest	
Being "facilitatory"/"middleman" of everything in the clinic	Being a multiskilled resource in clinic operations
Being the "right hand of the doctor"	
Being "cross-trained" and able to "do everything"	
Being important to office operations	
Having long-term relationships with patients	Building meaningful relationships with patients and coworkers
Listening and providing comfort to patients in need	
Seeing improvement in clinical outcomes among patients	
Having direct contact with patients in everyday jobs	
Being the "little (sic) man on the totem pole"/"bottom of the food chain"	Being recognized for occupational contributions
Equating MA job with other low-wage jobs	
Salary differences with nurses despite overlapping tasks	
Lack of recognition in comparison to others	

Note. MA = medical assistant.

had a mean of 15 years of working experience, and had worked in Health Corp for a mean of 7 years. Most of the participants identified as White (87.5%), and two (12.5%) identified as Hispanic or Latino. The MA participants represented eight primary care clinics across Health Corp, as well as the float pool. Six primary care clinics and the float pool had two participants each, whereas the remaining two clinics had one participant each. All participants received their MA credentials from the AAMA, American Medical Technologies, or National Healthcareer Association.

Our analysis revealed four themes on the work values of MAs in primary care (Table 1). They include (a) using clinical competence, (b) being a multiskilled resource for clinic operations, (c) building meaningful relationships with patients and coworkers, and (d) being recognized for occupational contributions.

Theme 1: Using Clinical Competence

All MAs valued being able to use their clinical competence at work. Such competence refers to the ability to perform "the clinical side of things, doing injections, bloodwork," which represent "a little gem" among their everyday tasks (ID 12). One participant described the task of rooming patients, which typically involves taking vital signs and recording the chief complaint of patients before the physician encounter as a highlight: "I think that rooming [patients], the clinical part of it, is what medical assistants love…I love rooming my patients. It's their home away from home" (ID 05). MAs also valued receiving validation from patients about their clinical competence. Having their skills (e.g., drawing blood and giving injections) recognized and appreciated by patients reinforced MAs' perceptions of how their clinical competence enhanced the patient care experience:

> *Lots of patients like how I draw blood so I would get a lot of followers. A lot of people would schedule [their visits] on days when I was drawing blood. So that was rewarding to me because I felt needed, I felt wanted, I felt validated that I'm doing well. That this particular MA never pokes you twice, something along those lines. And a lot of times people (patients) would tell the doctor, can I have [participant's name] draw me, I would prefer her to draw me. (ID 13)*

However, some MAs viewed the enforcement of scope-of-practice regulations, an aspect of implementing team-based care, as limiting their use of clinical competence at work. One participant described that MAs are "trained to do anything from surgery assistance to phlebotomy, to just rooming patients, to specialty practices, meaning gynecology, colonoscopies, anything of that nature" (ID 02). However, because scope-of-practice enforcements were in place to determine what MAs can and cannot do in their clinics, some MAs felt that they were not always able to use the skills they had training in, which resulted in perceptions of limited use of competence:

> *Ear flushes and suture removals and things like that… when I went to school, that was part of the training I had to go through. They taught you how to do it, you did it. I've always done it…I went to school to get the associate's degree where they taught you a lot of that stuff…I can do [these tasks] on the back of my hand and yet now I'm not allowed to. (ID 01)*

These perceptions occurred not only when MAs were unable to perform the tasks they had been trained in but also when they were no longer permitted to perform what they had been doing previously. The same participant elaborated that "what's really been frustrating with the whole thing because so many things that we have been always doing has been taken away from us that we just can't do anymore" (ID 01). Similarly, another participant detailed the tests that MAs could no longer administer in her clinic:

> *Wanting to test a urine, wanting to do a strep (streptococcus) test, a pregnancy test, we were able to just order it, sign it, do it. Now medical assistants can collect a urine, or [give] a flu shot…but strep tests and A1C tests (blood test for diabetes), POCTs (point-of-care testing), you can't do that, you can't sign them…. But we could do that years ago. (ID 08)*

Theme 2: Being a Multiskilled Resource for Clinic Operations

Many MAs also valued their multiskilled capacity in supporting and ensuring smooth operations within their clinics. Participants described performing both clinical and administrative support for multiple segments of the clinic's operations, including those related to visit planning, documentation, patient care, patient communication, population health, and quality improvement. Furthermore, they also discussed their responsibilities in overseeing the availability of medical supplies and covering medical receptionists when needed. MAs valued being an adaptive resource for clinic operations, which reflected their role in "basically running the office" and "keeping it all together" operationally:

> *Medical assistants do a lot. If they (patients) need mammograms or colonoscopies, then knowing which lab work to get if it's a six-month follow-up or if it's a three-month follow-up [is needed]. It's all different. And there are a lot of providers that want you to know what they want…I've seen plenty of offices where it was like a medical assistant that was basically running the office because if the Patient Service Representative was out, they were at the front checking in patients and they were rooming them. And they are helping with ordering supplies and they are scanning everything in… MAs do a really good job of just keeping it all together… you're stocking the rooms, you're making sure that the providers have everything they need for their patients. If [a patient is] doing a Pap smear or something, you're getting the vitals and you are also autoclaving. (ID 16)*

This theme can be further explained by how some MAs viewed themselves in primary care: "being the right hand of

the doctor" (ID 11). One participant provided an analogy for the working relationship between MAs and doctors in the primary care setting and nurses and doctors in the hospital setting:

> *Our purpose is that ultimately we are the right hand of the doctor. The nurses are the right-hand and/or the hand only to a doctor in a hospital setting. In an office (primary care clinic) setting, it's definitely more MA-driven as we are the people that room patients and refill meds, help prepare the refill for the provider to sign. We are doing phone calls back and forth with patients. (ID 11)*

Theme 3: Building Meaningful Relationships With Patients and Coworkers

All MAs valued building meaningful relationships with their patients, which are afforded by their ability to interact, listen, and connect with patients as part of their daily tasks. This theme reflects their role as someone who can provide "any little word of comfort, any little effort [that] makes a huge difference to patients when they are in need" (ID 02). To describe this aspect of being an MA, a participant arrived at a single word after contemplation: "What's the word I am looking for here? Care" (ID 02). One MA further recalled how an interaction with a patient with suicidal thoughts created a positive and meaningful work experience eventually:

> *I had a patient come in, I was just rooming her, I had never met her and I was like, hi, how are you doing? We got into a conversation and she said, you're so nice and she started crying. I was like, what's going on? Did I make you cry? She said, no, she felt like she had not been heard at her last visit. She was very depressed and wanted to talk to the provider about it but she hadn't been heard. She was like, I was ready to commit suicide because no one had heard me. We ended up switching her to a different provider who would understand her needs. We cried together. It sounds like crying but it was a very happy moment because she felt like she could talk to someone. I still see the patient, she comes and gives me a hug every time, even though I'm not the MA that is rooming her. (ID 06)*

Many MAs also expressed the value of building meaningful relationships with coworkers. One participant likened coworkers to "second family" (ID 15), whereas another participant stated that they "spend more waking hours with them than [their] family" (ID 10). An MA explained how such coworker relationships provided assurance that she would be able to get the support needed when dealing with challenging situations at work:

> *If you had an unruly patient on the phone or they're really upset and you can't calm them down, that's definitely something that gets you a little flustered. And that's where [coworker name] and I are really good. [I would let my coworker know], I can't [do this], can you take this [call] for me? Just so that I can take a breather in that moment to catch myself, collect myself, not put all those emotions into it…I know I can depend on them through anything. I know she's going to do it, I've no doubt… That's because of who I am working with, definitely. It's such a big aspect. (ID 12)*

Theme 4: Being Recognized for Occupational Contributions

Many MAs described feeling underrecognized for their contributions when positioning themselves with other occupations. More striking is how MAs often compared themselves with nurses, especially given perceptions of overlapping tasks between both occupations in the primary care setting. One participant stated, "we are cross-trained in administrative duties, clinical duties. And we do basically everything a nurse does. We are calling in medications, we are giving injections, we are drawing blood" (ID 12). This view was echoed by others: "We do the same job as a nurse, we just don't have the title…but [we] do a lot of the same tasks" (ID 08).

It Is important to note that not all tasks between MAs and nurses, however, are perceived to be overlapping. Several MAs also noted responsibilities that uniquely belong to nurses because of their training, such as the ability to perform triage in the clinic:

> *When we didn't have a nurse we had to take every single phone call that came in…with that being phone triage. I definitely think that it does belong to the nurse. They are the experts in that. If we were taking a phone triage now, we can't give any recommendations or any advice, we have to just type it all up and then send it to the doctor, wait for the doctor's response and then call the patient back. As opposed to the nurse, they are allowed to give advice. (ID 08)*

However, to the MAs, *many* of their tasks did overlap with those of nurses in primary care, and the similarity in tasks did not always translate to similar levels of recognition. Such recognition most often manifested in the form of income. Many MAs regarded their income as low: "I wish I made more money, of course. I definitely know medical assistants are so underpaid for all that they do" (ID 12). In juxtaposing the income discrepancies and task similarities with nurses, some MAs therefore highlighted a lack of recognition for MAs' contributions:

> *An RN (registered nurse) can start at $35 an hour and I am at the top of the pay scale after 34 years making $21 an hour and I'm doing, yes, I don't have the [RN] license, but I'm doing everything that an RN in our office is doing. I couldn't go into a hospital and do what the RNs do, but in the [primary care] office I can do everything that your RN is doing. And that makes me feel not necessarily valued. (ID 14)*

Another participant further explained, "people associate themselves with a number. So what you are getting paid

you associate yourself, well, that's what I'm worth" (ID 12). With a low income and lack of recognition, many MAs thus often regarded themselves as being unimportant at work, using terms such as "the little (sic) man on the totem pole" (ID 01) or being "at the bottom of the food chain" (ID 14).

Discussion

MAs are encountering shifts in the ways they are expected to work as the delivery of primary care becomes increasingly team-based and multidisciplinary in the United States. In contrast, other health care support occupations with similar levels of education and salary, such as emergency medical technicians, medical transcriptionists, paramedics, and phlebotomists, that do not work in primary care are not experiencing comparable levels of change in their roles (Bureau of Labor Statistics, 2021). As the role of MAs continues to evolve in primary care, more attention should be directed toward their occupational needs as well as approaches to facilitate their sustained participation in the workforce. This study responds to the underlying shift in primary care delivery by exploring what MAs perceive their occupation to be like and what they value in it using the case of Health Corp, a regional integrated health system in the United States that has transformed its primary care delivery by practicing team-based care and developing a career program for MAs, which theoretically afford MAs a more central role in primary care delivery. The findings indicate what MAs value at work can become impinged as primary care transforms to become more team-based and multidisciplinary, especially because of the organizational requirement of enforcing scope-of-practice regulations for various occupations. However, this study also indicates an opportunity for health care managers to redesign the work scope for MAs, as well as to allow MAs to develop and use new clinical competencies so that they can not only meaningfully remain in the primary care workforce but also sustainably remain so.

MAs value using their clinical competence at work, but they also perceive this value to be under threat because of scope-of-practice regulations. Clarifying these regulations is a necessary aspect of primary care transformation so that additional roles like nurses and clinical social workers can be appropriately integrated into clinical workflows to deliver multidisciplinary care. Our findings identify two reasons behind such threat perceptions among MAs: being unable to perform particular tasks despite having the training to do so and being unable to perform tasks despite having the ability to do so previously. This study of Health Corp reveals that even as team-based care has been the underlying model of primary care practice for 2 years, MAs are still experiencing an autonomy loss effect where they are no longer able to work in ways they used to. This phenomenon further reflects how MAs have historically shouldered the responsibilities of performing particular clinical tasks that current scope-of-practice guidelines no longer allow, and that shifts in mindsets among MAs of what they can or cannot perform at work may have not kept pace with industrial consensus on the appropriate utilization of MA talent. Consequently, clarifying scope-of-practice for MAs in Health Corp was perceived as an organizational activity that restricted their competence, even when scopes of practice are used as a tool to allow professionals to practice at the "top of license" (Buck et al., 2018). Simultaneously, it is important to note that, although MAs value using their clinical competence work, they are also trained to perform administrative tasks as reflected in the second theme of being a multiskilled resource for clinic operations (AAMA). That MAs are trained to perform both clinical and administrative tasks generates a tension in how MAs are deployed now versus how they may be deployed in the future as primary care clinics become increasingly specialized (NASEM, 2021). Specifically, when health care organizations clarify MAs' scope of practice, their work scope is at risk of becoming narrower and more administrative in nature. This in turn reduces opportunities for MAs to enact the third theme: building meaningful relationships with patients and coworkers. Our findings therefore highlight clear tensions between the work reality that MAs are facing and the ability to remain sustainably employed as primary care becomes increasingly specialized.

One solution to mitigate this tension, as well as the autonomy loss effect, is to identify and designate an area of work that MAs can perform while fulfilling these themes. Such an approach draws from work design theory, which suggests that work can be kept motivating and worthwhile by ensuring skill variety, task identity, task significance, autonomy, and feedback in work (Hackman & Oldham, 1976). When work for MAs is designed as such, it fulfills three of their main psychological needs—the need for competence, relatedness, and autonomy—thereby ensuring intrinsic motivation and facilitating MA retention (see Ryan & Deci, 2000). Our findings suggest that the task of rooming patients is often seen as a highlight in MAs' work because it provides them with opportunities to use their clinical competence and build meaningful relationships with patients. These aspects of rooming reflect what is currently expected of MAs at work as well as fulfill MAs' needs for competence and relatedness respectively (see Dill et al., 2021). However, the task of rooming can also be further redesigned and expanded in ways to leverage MAs as a multiskilled resource for clinic operations. For example, MAs' tasks can be redesigned to not only allow them to oversee the supplies and equipment required for rooming but also be more involved in decision-making around the workflows of rooming and how they relate to the overall operations of the clinic. Health care managers and leaders should therefore consider experimenting with work redesign approaches to designate an area of work within which MAs can perform with an appropriate level of autonomy. Our findings suggest that the segment of rooming will be a fruitful start.

The study shows that MAs value recognition for their occupational contributions but also feel a diminished sense of importance when compared to others. This comparison is especially prominent with nurses, with whom MAs note an overlap of tasks being performed in the primary care setting, yet a difference in the recognition being received. Such perceptions may be complicated by the practice in Health Corp of having experienced MAs serve as mentors for newly hired nurses in primary care clinics as part of orientation without explicit recognition given to this responsibility. However, our findings suggest that MAs do not see their tasks as

completely overlapping with those of nurses in primary care—they acknowledge that nurses have the training and position to perform triage, for example. Although Health Corp had created a career development program, which may serve to elevate MAs' sense of recognition within the organization, interestingly, our participants did not associate them with the enactment of the four themes that have emerged in this study. Future research will need to explore the design and implementation of workforce management practices that can provide MAs with appropriate recognition of their occupational contributions.

The four themes that emerged on what MAs value at work are largely aligned with the capabilities needed to achieve sustainable employability, which allow workers to see their jobs as worthwhile (van der Klink et al., 2016). The themes of using clinical competence and being a multiskilled resource for clinic operations match with the capability of using one's knowledge and skills at work. The third theme is fully aligned with the capability of building meaningful relationships at work. Our findings, however, highlight two areas in which the capability approach to sustainable employability does not align with what MAs value at work. First, the capability of setting own goals is not clearly represented in our data. This may be a consequence or an accepted norm of MAs' work function, given that their central responsibility is to provide "assistance" in the clinic. However, the capability approach articulates that all seven capabilities are universal dimensions of what employees value at work. Such norms are, however, expected to shift in the future as MAs take on more advanced tasks like panel management, where it is expected for them to have some accountability in meeting certain patient outcome or organizational performance metrics, although MAs largely remain confined to the assistant function today. Second, our fourth theme of being recognized for occupational contributions suggests that the capability on earning a good income should not be based on a monetary definition alone. Although income was very important, MAs also sought a greater level of performance recognition, particularly given perceptions of task similarity with nurses. This suggests that employees' values related to recognition and rewards are intertwined with perceptions of fairness and that adjustments to absolute income may not be sufficient to promote sustainable employability among low-wage health care workers that are embedded in team-based care models and where tasks can overlap among occupations (see Colquitt, 2001). In summary, our findings reveal that the capability approach to sustainable employability assumes a high bar when it comes to values that are linked to self-determination but falls short when it comes to values that are subject to unique interpersonal or team dynamics such as those with nurses. As such, our findings indicate that the seven capabilities proposed by van der Klink et al. (2016) may be useful but insufficient in articulating the concept of sustainable employability as a whole (cf. Fleuren et al., 2020).

The findings are limited in their generalizability across other health care organizations because the MAs in this study are recruited from a single health system. The emergent findings may therefore reflect specific workforce management practices of Health Corp that are shaping how MAs perceive their values at work. Because Health Corp had embraced the need for team-based care and an MA career development program, it is also possible that our case paints a more optimistic picture of MAs' work experiences compared to those in other health care organizations. Consequently, the work values of MAs, in general, may be eroding in more ways than what we have presented. Furthermore, there may be a potential for self-selection bias among our participants. Although our sample mirrors the U.S. MA workforce in terms of gender (89.7% of MAs were female in 2019), it reflects to a less extent the national composition in terms of race (48.9% of MAs identified as White in 2019; Data USA, 2021). More diverse MA populations across racial and ethnic categories, as well as from various organizational settings (e.g., primary care clinics operating under academic medical centers or in rural areas), are therefore needed in future qualitative studies to generate more nuanced understanding of the individual and/or organizational conditions that may influence how MAs perceive their occupation and identify their work values. Using Health Corp as a case, however, contributes to the literature because the health system was already practicing team-based care and had created a career development program for MAs. With shifts toward value-based and high-performance care models where professional competencies are continuously being optimized, we expect Health Corp's practices to become increasingly prevalent across other health care organizations. Our findings may therefore act as a harbinger of MAs' needs amid efforts to reform primary care delivery through the expansion, specialization, and optimization of the workforce, as well as to inform future research on MA wellbeing at work.

Practice Implications

To mitigate MAs' perceived threat of restricted clinical competence, stakeholders can engage in strategic ways to better communicate the discrepancy that MAs may experience between their training and what they can actually perform, and at different time points of MAs' careers. For example, leaders of MA training institutes or programs can communicate that MAs are learning a broad range of skills that *will eventually be* subject to scope-of-practice regulations both at the state and organizational levels, and managers can provide the same messaging during recruitment and orientation. Health care managers can therefore proactively manage MA turnover by explaining how and why wider industrial shifts (e.g., team-based care) have led to certain organizational requirements (e.g., enforcing scope of practice) at strategic time points that can mitigate MAs' perceptions of restricted competence. To achieve systemic change, however, it may be more useful to update state- and/or organizational-level MAs' scope of practice to reflect the ways in which MAs' roles have been evolving or are envisioned to evolve (Dill et al., 2021, NASEM, 2021).

In addition to identifying existing areas of work that MAs can be responsible for while achieving their values, health care organizations can also consider facilitating the development of new competencies so that MAs can fully maximize

the *clinical* aspect of their work and training within the boundaries of MA scope of practice. For example, an internal strategy could be to train MAs as health coaches to enhance chronic disease management among patients (Nelson et al., 2010; Willard-Grace et al., 2015). As health care managers gain deeper understanding of the intersection between what MAs value at work (i.e., using clinical competence as a health coach and building meaningful relationships with patients through coaching), as well as what employers value (e.g., better control of diabetes and hypertension among patients), an external strategy could be then to strengthen ties with MA professional associations or training institutes to specifically support the attainment of health coaching competencies. Subsequently, these coaching competencies can be tied to career mobility or career development programs (see Dill et al., 2021).

Finally, health care managers should also address more directly the working dynamics between MAs and nurses to foster greater recognition and respect. In addition to clear communication on scope-of-practice regulations as an organizational requirement, this can include the assignment of MAs and nurses (and other members of the primary care team) into smaller fixed groups or "pods" within the clinic so that they can develop deeper connections in the workplace (see Gunn et al., 2015; Yuan et al., 2021). We foresee that a neglect of MAs' work values in the short term will increase turnover and, in the long term, create workforce gaps at a time when MAs are expected to serve as core members of primary care teams that can provide interdisciplinary and high-quality care. We therefore hope that the strategies highlighted here will help foster a long-term perspective on MA management that is mutually beneficial to the employee as well as the employer.

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