VIEWPOINT

Expanding the Roles of Medical Assistants
Who Does What in Primary Care?

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Adult primary care in the United States faces a dilemma. Many patients report poor access to their primary care clinician. Yet the growing demand for primary care leads to high levels of clinician burnout. A commonly voiced solution is to increase the numbers of adult primary care clinicians—physicians, nurse practitioners, and physician assistants. However, most workforce projections find that there will not be enough clinicians to meet the increasing demand.[1] At the same time, many primary care activities do not require a clinician's expertise, creating dissatisfied practitioners working well below their skill level. To meet the demand for primary care and to improve the work life of clinicians, it is sensible to redistribute responsibilities to other members of the primary care team.

Some primary care practices expand the roles of nurses, pharmacists, social workers, and behavioral health professionals to improve patient access without further stressing clinicians. Many primary care practices, however, do not have nurses, pharmacists, or social workers. The clinical workforce in many practices consists of clinicians and low-paid unlicensed staff, in particular medical assistants. According to the Bureau of Labor Statistics,[2] the median salary for medical assistants in 2012 was $29 370 compared with $65 470 for registered nurses. To utilize the staff that actually exists in most practices, clinicians should consider expanding the roles of medical assistants.

The Medical Assistant Workforce

The 560 000 medical assistants working in the United States are a fast-growing allied health occupation, projected to increase by 29% from 2012 to 2022.[3] Medical assistants are ubiquitous in primary care, ethnically and linguistically diverse, and culturally concordant with a variety of patient populations.

Medical assistants are not licensed but work under the license of a physician. They cannot make medical assessments, offer medical advice, or triage patients. They may, however, provide information to patients and follow a wide variety of physician-approved protocols provided that training and supervision are in place.[4] The duration of training, typically at a community college or a commercial training program, varies from 3 months to 2 years, with little standardization of curricula. Few existing programs address the skills needed for expanded roles.

Emerging Roles for Medical Assistants

Panel management, health coaching, and team documentation (also called clinical scribing) are emerging roles for medical assistants.

Panel Management

Panel managers are nonclinician team members who provide proactive, evidence-based preventive and chronic care based on standing orders. Panel managers comb clinical registries to identify and contact patients with care gaps—overdue services such as mammograms, immunizations, or laboratory tests for diabetes mellitus. In addition to this "out-reach" function, panel managers provide "in-reach" by using alerts in the electronic medical record to address care gaps for patients at the time of office visits.

At Kaiser Permanente's Southern California region, all medical assistants—when placing patients in examination rooms—review the health maintenance screen in the electronic health record, advise patients of care gaps, and enter orders based on protocols to address the care gaps. As a result, performance improved for cancer screening, timely diabetes mellitus laboratory studies, smoking cessation counseling, and percentage of hypertensive patients with controlled blood pressure.[5]

At the University of Utah Community Clinics, medical assistants, functioning as panel managers, identify and counsel patients needing colorectal cancer screening and—with patients' approval—place an order for colonoscopy in pending status before the patient sees the clinician. After implementation of this program, colonoscopy rates for patients older than 50 years and overdue for colorectal cancer screening more than doubled, from 6.0% to 13.4%.[6]

Health Coaching

Health coaching is the provision of self-management support to patients with chronic conditions. Health coaches provide information to patients about their condition, assist patients with lifestyle changes and medication adherence, and encourage patients to be active participants in their care. Studies of programs using medical assistants as health coaches have found positive trends for hemoglobin A_{1c} (HbA_{1c}) levels, blood pressure, cholesterol levels, body mass index, and rates of smoking cessation.[7] At Union Health Center in New York City, some medical assistants coach up to 12 patients per day. From 2005 to 2009, the percentage of coached patients with diabetes mellitus who had their HbA_{1c} levels, blood pressure, and cholesterol levels all under control increased from 13% to 36%.[8] At Cabin Creek Health Systems in rural West Virginia, trained medical assistants visit frail elderly patients in remote areas, review their medications, and connect the patients with needed services. The organization partnered with a community college to train medical assistants; the assistants received a pay bonus and college credit.

Team Documentation (Clinical Scribing)

When medical assistants are responsible for documenting the clinical encounter, they may meet with the patient prior to the clinician visit to take a medical history using symptom-specific templates within the electronic health record and to document medications, vaccinations, and whether the patient smokes. During the visit, as the clinician notes physical examination findings, diagnoses, and needed laboratory and imaging studies and prescriptions, the medical assistants enter the information and the orders. Practices implementing team documentation require 2 or 3 clinical assistants per clinician; the additional staffing costs can be offset by increasing the number of patients seen each day.

At the University of Utah, new medical assistants train to become scribes for 6 months. Scribes spend 30 to 35 minutes with the patient; the clinician spends 15 to 20 minutes. This innovation has been associated with increased patient and physician and clinician satisfaction, improved clinical quality, and better financial outcomes because clinicians see more patients per day.[9] At California's Shasta Community Health Center, team documentation is associated with improved clinician satisfaction, higher clinic revenues, and a 90% rate of patient acceptance.[10]

Challenges to Expanded Roles for Medical Assistants

To fully realize the potential of expanded roles for medical assistants, important challenges should be addressed.

Protecting Quality and Safety

Medical assistants should receive adequate training for expanded roles; physicians should observe their performance with patients and provide feedback. Before assuming expanded roles, medical assistants should properly perform them under supervision and pass competency examinations. A practice must invest time in training and mentoring.

Uncertainty About the Effects on the Number of Patient Visits

Additional evidence is needed to understand the impact of expanded roles for medical assistants on the number of patient visits. Documentation by medical assistants seems to allow clinicians to see more patients while reducing the clinician's workload. Panel management and health coaching may add services, thereby improving the quality of care but not enhancing the capacity of clinicians to see patients.

Scope of Activities

Confusion about the scope of activities for medical assistants is likely. A legal analysis of California's scope of practice laws concluded that medical assistants have considerable flexibility as long as their work is authorized and supervised by a physician, adequate training is provided, and the work they perform is documented.[3]

Physician Acceptance

Physicians vary in their degree of comfort with expanded medical assistant roles. Stable teams increase the physician comfort level. An 2012 survey[11] of 231 primary care clinicians in 18 primary care practices found that clinicians working with the same assistant every day were more confident that the assistant would adequately perform panel management compared with clinicians working with different assistants.

Payment Models

If clinicians are able to see more patients per day and to see more patients for comprehensive visits, increased revenues may cover the cost of hiring additional medical assistants. This economic model, however, should be rigorously evaluated. Alternatively, payment reform—such as payments for care coordination, physician performance, and shared savings programs—could help to fund such positions.

In sum, enhanced roles for medical assistants is an innovative approach that could help increase primary care capacity and at the same time relieve clinicians of less clinically demanding tasks. Although early evidence from research studies and real-world experience is promising, more and better evidence is needed about how to best utilize medical assistants to improve patient care. It is time to rethink who does what in primary care.

ARTICLE INFORMATION

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REFERENCES

1. Bodenheimer TS, Smith MD. Primary care: proposed solutions to the physician shortage without training more physicians. *Health Aff (Millwood)*. 2013;32(11):1881-1886.

2. US Bureau of Labor Statistics. Occupational employment statistics: occupational profiles, May 2012. http://www.bls.gov/oes/current/oes_stru.htm. Accessed March 31, 2014.

3. US Bureau of Labor Statistics. Bureau of Labor Statistics Occupational Outlook Handbook. http://www.bls.gov/ooh/healthcare/medical-assistants.htm. Accessed March 5, 2014.

4. Dower C. Medical assistants in California: legal scope of practice. http://futurehealth.ucsf.edu/Public/Publications-and-Resources/Content.aspx?topic=Medical_assistant_scope_of_practice. Accessed March 31, 2014.

5. Kanter M, Martinez O, Lindsay G, Andrews K, Denver C. Proactive office encounter: a systematic approach to preventive and chronic care at every patient encounter. *Perm J*. 2010;14(3):38-43.

6. Baker AN, Parsons M, Donnelly SM, et al. Improving colon cancer screening rates in primary care: a pilot study emphasising the role of the medical assistant. *Qual Saf Health Care*. 2009;18(5):355-359.

7. Willard-Grace R, DeVore D, Chen EH, Hessler D, Bodenheimer T, Thom DH. The effectiveness of medical assistant health coaching for low-income patients with uncontrolled diabetes, hypertension, and hyperlipidemia: protocol for a randomized controlled trial and baseline characteristics of the study population. *BMC Fam Pract*. 2013;14:27.

8. Nelson K, Pitaro M, Tzellas A, Lum A. Practice profile: transforming the role of medical assistants in chronic disease management. *Health Aff (Millwood)*. 2010;29(5):963-965.

9. Blash L, Dower C, Chapman S. University of Utah Community Clinics: medical assistant teams enhance patient-centered, physician-efficient care. http://www.futurehealth.ucsf.edu/Content/11660/2011_04_University_of_Utah_Community_Clinics--Medical_Assistant_Teams_Enhance_Patient-Centered_Physician-Efficient%20Care.pdf. Accessed March 31, 2014.

10. Blue Shield of California Foundation. Adapting the EHR Scribe Model to community health centers. http://www.blueshieldcafoundation.org/sites/default/files/publications/downloadable/Shasta%20EHR%20Scribes%20Final%20Report.pdf. Accessed March 31, 2014.

11. University of California, San Francisco, Center for Excellence in Primary Care. Teamlets and the provider experience. http://familymedicine.medschool.ucsf.edu/cepc/. Accessed March 10, 2014.