



# THE UTILIZATION OF MEDICAL ASSISTANTS IN CALIFORNIA'S LICENSED COMMUNITY CLINICS

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## Overview

Medical Assistants (MAs) play a key role as clinical support staff in California's licensed community clinics. This issue brief examines patterns in community clinic utilization of MAs over the period 2005-2007. Key themes presented in this brief include overall community clinic growth relative to other licensed health care facilities, growth in the number of clinics by type of clinic, overall increase in the reported use of MAs, and differences in the utilization of MAs based on clinic location and clinic size.

## Definition of the Database

California's licensed community clinics are a vital component of the state's health care safety net. They serve an at-risk population that is frequently low-income and non-English speaking. Clinic services include primary care, oral health care, mental health care, women's health services, limited specialty care, health education, and community services such as transportation and translation. The legal status of these clinics is established by the California Health & Safety Code and they are licensed by the state's Department of Public Health. By statutory requirement, they all have tax-exempt, not-for-profit status and are "supported and maintained in whole or in part by donations, bequests, gifts, grants, government funds or contributions, that may be in the form of money, goods, or services."<sup>1</sup> These clinics file utilization data reports with the California Office of Statewide Health Planning and Development (OSHPD) on an annual basis. These reports are the basis for the analysis presented in this issue brief.<sup>2</sup>

## Types of Clinics

In broad terms, there are 4 types of clinics represented among licensed community clinics in California:

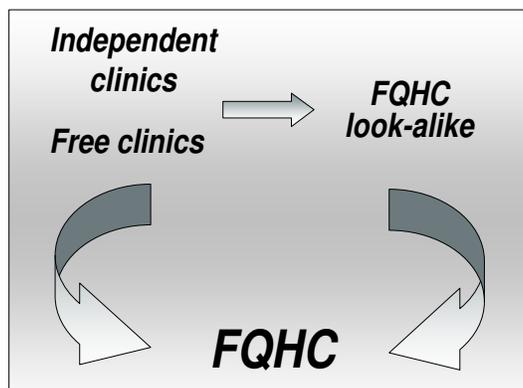
- *Federally Qualified Health Center (FQHC)* sites
- *Federally Qualified Health Center look-alike* sites
- *Free Clinic* sites
- Independent, non-profit clinic sites that are neither *FQHC*, *FQHC look-alike*, nor *Free Clinic* sites<sup>3</sup>

A key distinction among these different designations is the type of public funding support that each receives. *FQHC* sites and *FQHC look-alike* sites are operationally very similar. Both types of clinics have met the eligibility requirements for two critical sources of funding support: enhanced Medi-Cal reimbursement rates, and a federal operating grant made available by Section 330 of the Public Health Service Act.<sup>4</sup> Only *FQHC* clinics receive Section 330 operating grants, which are nationally competitive; not all eligible clinics that apply for one, receive one. Conversely, *FQHC look-alike* status is non-competitive.

*Free Clinics* are defined by their statutory requirement that patients not be directly charged for receipt of treatment.<sup>5</sup> *Free Clinics* are not supported by enhanced Medi-Cal reimbursements or a Section 330 operating grant. They are supported largely by private donations.

The enhanced Medi-Cal reimbursement rates and Section 330 operating grants can be critical to the financial viability of a clinic.<sup>6</sup> As a result, licensed clinics are typically motivated to obtain *FQHC* or *look-alike* status, and many of

California's licensed community clinics are *potentially* eligible.<sup>7</sup>



Both *Free Clinics* and independent, non-profit clinics, whether they are new or existing clinic sites, may compete for *FQHC* status (given they meet Section 330 eligibility requirements). Alternatively, such clinics may become certified as *look-alike* sites, perhaps ultimately obtaining *FQHC* status. Existing *FQHC look-alike* sites are often referred to as “mature” candidates for full *FQHC* status. The OSHPD data indicate that in recent years, all of these scenarios have occurred and the number of *FQHC* sites among licensed community clinics in California has grown.

Regardless of the types of funding a clinic receives, all licensed community clinics in California are an important part of the state's health care safety net. They deliver essential primary and preventive health care services to communities representing underserved geographic areas and populations. They play a critical role in delivering care on a local level.

### Other Clinic Designations<sup>8</sup>

In addition to the clinic types described above, we recoded the OSHPD data to identify two subsets of clinics (meaning they are one of the clinic types described above):

- 1) Clinic sites operating under the direction of the *Indian Health Service*, and *Tribal clinics*<sup>9</sup> operating under the direction of federally recognized American Indian or Alaska Native tribes themselves (some of which are part of the *Urban Indian Health Program*);<sup>10,11</sup>
- 2) Clinic sites located in rural areas.

There is a formal category of clinics that are designated *Rural Health Centers (RHC)*.<sup>12</sup> However, most of these clinics are unlicensed

for-profit operations, part of a hospital, or a private practice, none of which are represented in the OSHPD data. Because we were interested in potential differences in medical assistant utilization based on geography, we geo-coded clinic addresses to identify sites located in rural parts of the state. The purpose was to identify any differences in utilization between clinic sites in rural and urban settings.

Our notion of a *rural clinic* is intended to be broad. It includes all clinic types and designations, and is based simply on the physical location of the clinic site.<sup>13</sup>

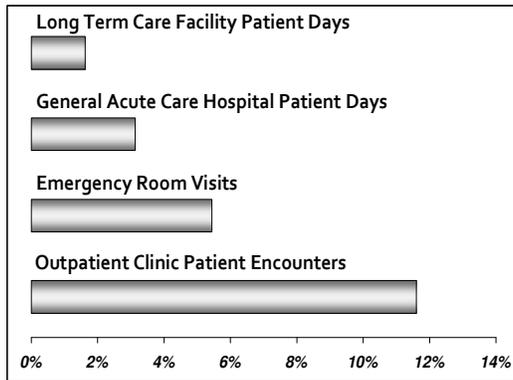
### Data Limitations

Licensed community clinics represent only a portion of the entire universe of community clinics in California.<sup>14,15</sup> The types of clinics not identified by these data include: for-profit clinics operated by private providers; clinics operated by any federal, state, or local government agency or entity (including counties and cities); tribal clinics located on federally recognized tribal land; and clinics that are owned and operated by hospitals.<sup>16</sup> Therefore, the scope of our analysis of the utilization of medical assistants is limited. The other main limitation of these data is that they are self-reported; they are not independently verified for accuracy. In conducting analysis for this brief, there were several instances of what appeared to be data reporting errors.<sup>17</sup>

### Community Clinic Growth

**Figure 1** uses typical measures of patient volume to compare growth rates among general acute care hospitals, emergency rooms, long-term care facilities, and community clinics, all licensed by the state of California, over the period 2005-2007.

**Figure 1. Growth in Patient Volume by Type of Licensed Health Care Facility: 2005-2007**



Source: Office of Statewide Health Planning & Development

California's licensed community clinic sites have grown both in number and in patient volume over the past several years. In 2007, there were 63 more clinic sites reporting 1.3 million more patient encounters compared with 2005. Relative to other licensed health care facilities in the state, the growth rate in patient encounters at community clinics was roughly twice the growth rate of emergency room visits, 3 times the growth rate of patient days at general acute care hospitals, and nearly 6 times the growth rate of patient days at long-term care facilities.

**Table 1** shows growth in the number of licensed community clinic sites over the period 2005-2007, by clinic type and by geography (rural versus urban).

**Table 1. Growth in Clinic Sites by Type & by Geography: 2005-2007**

Clinic Type	2005	2006	2007
FQHC	378	420	450
Look-alike	76	64	56
Neither*	369	382	380
Rural	155	155	156
Urban	678	711	730
Free	35	34	30
IHS/Tribal	39	39	39
<b>Total</b>	<b>823</b>	<b>866</b>	<b>886</b>

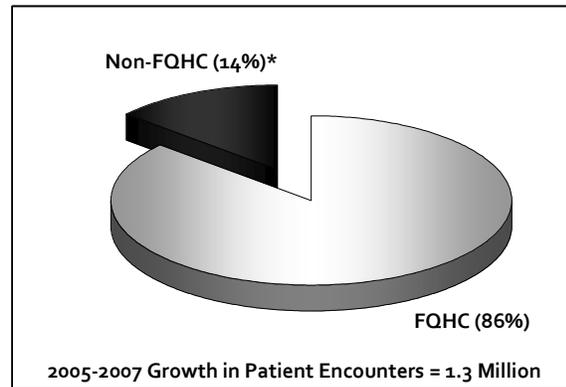
Source: Office of Statewide Health Planning & Development  
 \* Includes the 2% of clinics for which clinic type is unknown

Licensed community clinics in California are increasingly becoming *Federally Qualified Health Center (FQHC)* sites. **Between 2005 and 2007, the number of FQHC clinic sites grew from 378 to 450.** Roughly, one-half of this increase is due to established *FQHC look-alike* sites, independent non-profit clinic sites,

and *Free Clinic* sites gaining *FQHC* status. The table also shows that the number of urban clinic sites has increased significantly while the number of rural clinic sites has remained the same (as has the number of *IHS/Tribal clinic* sites).

**Figure 2** shows that most of the growth in volume of patient encounters over the period 2005-2007 occurred at *FQHC* clinic sites.

**Figure 2. Growth in Total Patient Encounters by Clinic Type: 2005-2007**

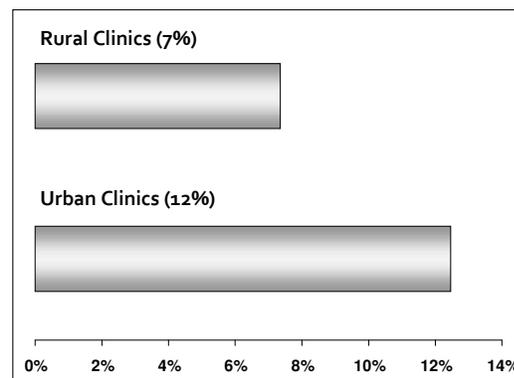


Source: Office of Statewide Health Planning & Development  
 \* Non-FQHC includes *FQHC look-alike* sites, *Free Clinic* sites, independent non-profit sites, and the 2% of clinic sites for which clinic type is unknown

**Figure 2** underscores the data shown in **Table 1**. The number of *FQHC* clinic sites has grown significantly between 2005 and 2007, which resulted in substantial growth in patient volume at these sites. 86% of the total growth in patient encounters over the period 2005-2007, occurred at *FQHC* sites.

**Figure 3** compares the relative growth in total patient encounters at urban and rural clinics over the period 2005-2007.

**Figure 3. Growth in Total Patient Encounters by Clinic Site Geography: 2005-2007**



Source: Office of Statewide Health Planning & Development

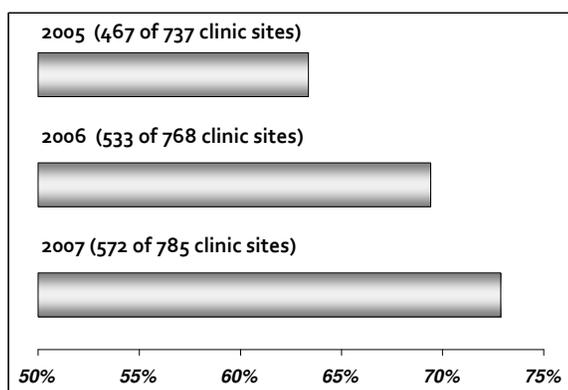
These data highlight the fact that patient volume has grown more rapidly at clinic sites in urban settings, versus clinic sites in rural settings. However, as seen in **Table 1**, there has been a corresponding increase in the number of urban clinic sites (678 in 2005 and 730 in 2007). In contrast, the number of rural clinic sites (155) has remained stable in each of the past three years, although these sites reported roughly 140,000 more patient encounters in 2007, compared to 2005. This is also true of *Indian Health Service/Tribal clinic* sites, although on a smaller scale. The number of clinic sites (39) has remained stable, and although not shown here, these sites reported roughly 30,000 more patient encounters in 2007, compared to 2005.

### Utilization of Medical Assistants

In this section, we excluded 23 clinic sites because of suspected data reporting errors specific to medical assistant utilization. We also excluded 83 clinic sites because dental or mental health diagnoses/procedures represented 90% or more of the total number of procedures or diagnoses (where we wouldn't expect to find medical assistants working).

**Figure 4** shows the proportion of licensed community clinic sites reporting utilization of medical assistants over the period 2005-2007.

**Figure 4. Proportion of Clinic Sites Utilizing Medical Assistants: 2005-2007**



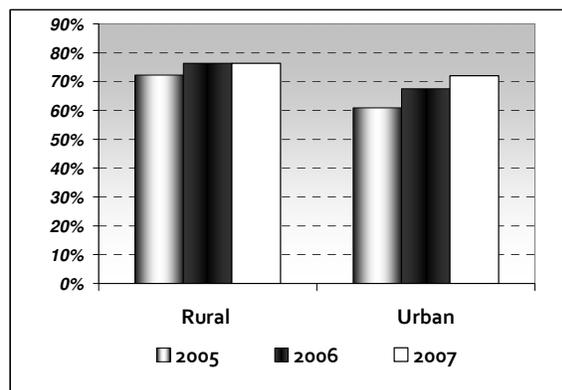
Source: Office of Statewide Health Planning & Development

As the number of licensed community clinic sites in California, and the volume of patients they serve, grew in recent years, the use of medical assistants increased. In 2005, there were 467 licensed clinic sites reporting utilization of medical assistants, which by 2007 had grown to 572. **Figure 4** illustrates this growth. In 2007, just over 70% of all licensed

community clinic sites were utilizing medical assistants. Data not shown here indicate that the state-wide total FTE for medical assistants increased 30% between 2005 and 2007, and that in 2007 medical assistants represented roughly one-half of all clinical support staff utilized by licensed community clinics.<sup>18</sup>

**Figure 5** compares the proportion of clinic sites reporting utilization of medical assistants by geographic setting (rural vs. urban).

**Figure 5. Proportion of Clinic Sites Utilizing Medical Assistants by Geography: 2005-2007**



Source: Office of Statewide Health Planning & Development

In comparing the use of medical assistants by geographic setting (rural vs. urban) over the period 2005-2007, we found that a greater proportion of rural clinic sites consistently reported the use of medical assistants. However, the use of medical assistants at urban clinic sites has been steadily increasing. In 2005, just 61% of all urban clinic sites reported utilization of medical assistants, but by 2007, the proportion had grown to 72%. This corresponds with the pattern of general clinic site growth; in both number and patient volume, absolute growth has been concentrated among urban clinic sites.

**Table 2** shows the distribution of clinic sites by clinic size, as measured by total reported patient encounters.<sup>19</sup>

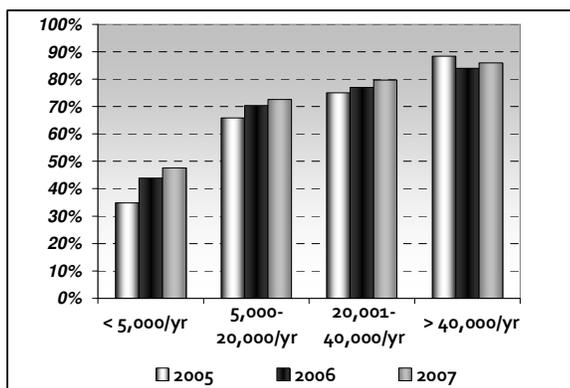
**Table 2. Distribution of Clinic Sites by Clinic Size: 2005-2007**

Clinic Size	2005	2006	2007
< 5,000	217	233	233
5,001-20,000	367	379	385
20,001-40,000	111	107	112
> 40,000	42	49	55
<b>Total</b>	<b>737</b>	<b>768</b>	<b>785</b>

Source: Office of Statewide Health Planning & Development

**Figure 6** shows the proportion of clinic sites that reported utilization of medical assistants by clinic size (as measured by total patient encounters per year).

**Figure 6. Proportion of Clinic Sites Utilizing Medical Assistants by Clinic Size: 2005-2007**



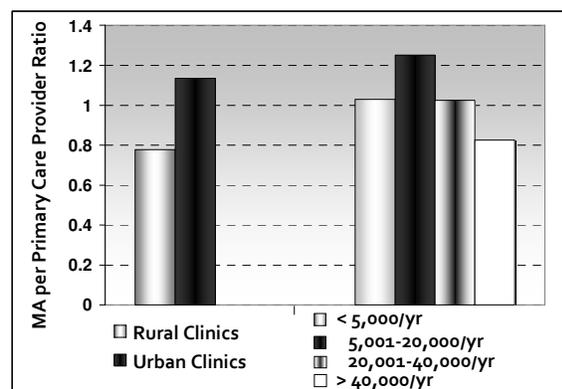
Source: Office of Statewide Health Planning & Development

**Figure 6** illustrates two key pieces of data regarding the pattern of medical assistant utilization in licensed community clinics. First is the relationship between patient volume and utilization. As patient volume increases, the proportion of clinic sites that reported use of medical assistants increases. In each of the past three years, well over 80% of clinic sites with total patient encounters greater than 40,000 per year have utilized medical assistants. This figure also demonstrates that between 2005 and 2007, in relative terms, the general use of medical assistants grew most rapidly among small clinic sites (fewer than 5,000 patient encounters per year).

**Figure 7** shows the differences in the 2007 ratio of medical assistants to primary care providers in licensed community clinic sites, by geographic setting (rural vs. urban) and by clinic size (as measured by total patient encounters per year). *Only clinic sites that*

*reported the use of medical assistants are included in this figure.*

**Figure 7. MA per Primary Care Provider by Clinic Site Geography & by Size: 2005-2007**



Source: Office of Statewide Health Planning & Development

**Figure 7** suggests that there are differences in the utilization of medical assistants based on geography and patient volume. These data indicate that the average ratio of medical assistants to primary care providers<sup>20</sup> among clinic sites in urban settings is approaching 1.2:1. Among clinic sites in rural settings, this ratio is roughly 0.8 FTE medical assistants for every primary care provider.

In **Figure 6**, the data show that among the largest clinic sites (in terms of patient volume) the proportion of clinic sites reporting utilization of medical assistants is greatest. However, **Figure 7** suggests that there is a scaled relationship between the staffing of medical assistants, primary care providers, and overall patient volume. In the smallest clinic sites (fewer than 5,000 patient encounters per year), the average ratio of medical assistants to primary care providers is roughly 1:1. This ratio increases as the volume of patient encounters increases, but then diminishes as the volume of patient encounters exceeds a certain number. The average ratio of medical assistants to primary care providers is smallest among the very largest clinic sites.<sup>21</sup>

**Conclusion**

OSHPD primary care clinic utilization data for the period 2005-2007 were examined to identify basic patterns in the use of medical assistants among California's licensed community clinics. These data suggest that medical assistants are utilized differently by clinic sites, depending on location (rural vs. urban) and size (as measured by volume of patient encounters). Understanding

these differences and how they relate to clinic characteristics, beyond clinic site location and patient volume, will require further investigation.

### Summary of Key Findings

- Patient volume at licensed community clinic sites has grown more rapidly compared with other licensed health care facilities in the state.
- Growth in the number of clinic sites and overall patient volume has been concentrated among *Federally Qualified Health Center* clinic sites located in urban geographies.
- Rural clinic sites have experienced growth in patient volume with no increase in the number of clinics.
- Although not shown by figure or table, the state-wide total FTE for medical assistants increased 30% between 2005 and 2007. In 2007, medical assistants represented roughly half of all clinical support staff utilized by licensed primary care clinics.
- Compared to urban clinic sites, rural clinic sites were more likely to have reported use of medical assistants, but rural clinic sites also reported fewer medical assistants per primary care provider.
- The relationship between the utilization of medical assistants and primary care providers appears to be scaled. Beyond a certain level of patient volume, utilization of medical assistants diminished relative to primary care providers.

### Notes

<sup>1</sup> California Health & Safety Code, Division 2, Chapter 1, Article 1, Section 1204.

<sup>2</sup> Source of data is the Office of Statewide Health Planning and Development, State Utilization Data File for Primary Care Clinics, 2005-2007. These data files are derived from the Automated Licensing Information & Report Tracking System (ALIRTS)-based *Annual Utilization Report of Primary Care Clinics*, filed annually by California's licensed community clinics.

<sup>3</sup> Planned Parenthood clinics are an example of licensed, independent non-profit clinics that are neither *FQHC* nor *FQHC look-alike* clinics (although they may receive *Title X* family planning grants).

<sup>4</sup> *California Community Clinics: A Financial Profile*. March 2009. Capital Link® (prepared for the California Healthcare Foundation).

<http://www.chcf.org/topics/almanac/index.cfm?itemID=133890>

<sup>5</sup> According to California statute, at a designated *Free Clinic*, "there shall be no charges directly to the patient for services rendered or for drugs, medicines, appliances, or apparatuses furnished." California Health & Safety Code, Division 2, Chapter 1, Article 1, Section 1204.

<sup>6</sup> The recent California Health Care Foundation report, prepared by Capital Link®, (see previous note) found that Medi-Cal reimbursement accounted for 46% of total clinic revenues, and Section 330 operating grants accounted for 14% of total clinic revenues in 2006.

<sup>7</sup> Certain clinics may be prevented from seeking *FQHC* status by their mission (e.g. certain *Free Clinics*).

<sup>8</sup> For a detailed description of the different designations that identify clinic types see: *California's Safety-Net: A Primer*. March 2009. California Healthcare Foundation. <http://www.chcf.org/documents/policy/SafetyNetClinicPrimer2009.pdf>.

<sup>9</sup> These clinics aren't identified in the OSHPD data. We created our own unique identifier in the data for these clinics using information from the following sources: California Department of Health Care Services, Indian Health Program; U.S. Department of Health & Human Services, Indian Health Service; California Rural Indian Health Board.

<sup>10</sup> The *Urban Indian Health Program* delivers services to federally recognized American Indian and Alaskan Native populations living in urban areas (non-Tribal lands).

<sup>11</sup> *Indian Health Service* clinics are not *FQHCs*, but do receive other forms of federal funding. *Tribal Clinics* operated by federally recognized American Indian or Alaska Native tribes are eligible for either *FQHC* status or certification as a *look-alike* site. *Urban Indian Health Program* clinic sites are automatically *FQHC* sites.

<sup>12</sup> *RHCs* are supported by enhanced Medi-Cal reimbursement rates, but not Section 330 operating grants.

<sup>13</sup> We geo-coded the address of each clinic using the Rural Health Grants Eligibility Advisor tool (a searchable database made available by the Health Resources and Services Administration) to determine whether the clinic was eligible for federal, rural health grants. If the clinic was grant-eligible, we identified it as being located in a rural setting. For more info see:

<http://datawarehouse.hrsa.gov/RuralAdvisor/ruralhealthadvisor.aspx?ruralByAddr=1>

<sup>14</sup> For example, only 24 Rural Health Centers are identified in the 2007 OSHPD data. According to the Centers for Medicare & Medicaid Services, as of March 12, 2009, there were 263 Rural Health Centers in California.

<sup>15</sup> SB 1260, which was chaptered into law in September 2008, takes note of the fact that no agency in the Department of Public Health is currently able produce a list of hospital-based clinics in California because there is no requirement to identify them. This new law adds to section 1253.5 of California's Health & Safety Code, relating to health facilities, and will require "upon issuance or renewal of a general acute care, acute psychiatric, or special hospital license" that outpatient sites and services are identified and that by July 1, 2010 this information be made publicly available.

<sup>16</sup> For a full listing of the types of clinics not licensed by the state, see California Health & Safety Code, Division 2, Chapter 1, Article 1, Section 1206.

<sup>17</sup> In those cases where a perceived data entry error directly affected our analysis, we opted to exclude the clinic in question; these cases are noted in the brief.

<sup>18</sup> Clinical support staff identified in the OSHPD data include: Medical Assistant, Licensed Vocational Nurse,

Registered Nurse, Patient Educator, Marriage & Family Therapist, Substance Abuse Counselor, Registered Dental Hygienist, both Registered and Unregistered Dental Assistant, and "other" clinical support staff.

<sup>19</sup> We excluded 23 clinics because of suspected data entry errors specific to medical assistant utilization. We also excluded 83 clinics because dental or mental health diagnoses/procedures represented 90% or more of the total number of procedures/diagnoses (where we wouldn't expect to find medical assistants working).

<sup>20</sup> Primary care providers identified in the OSHPD data include: Physician, Physician Assistant, Nurse Practitioner, Nurse Midwife, Visiting Nurse, Dentist, Psychiatrist, Clinical Psychologist, Licensed Clinical Social Worker, and "other" primary care provider (Medi-Cal billable)

<sup>21</sup> Further analyses will be required to determine the robustness of this finding. (It may be an artifact of the OSHPD data.)

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