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Table 5: Staffing and Utilization

PURPOSE:

Table 5 identifies staff full-time equivalents (FTEs), patient visits, and total patients by service category.

CHANGES:

- **Addition of Column B2, Virtual Visits.** In this column you will report documented virtual (telemedicine/telehealth) contacts between a patient and a licensed or credentialed provider who exercises their independent, professional judgement in the provision of services to the patient as a visit in Column B.
- **Selected Services Detail Addendum.** The Table 5 addendum provides data on mental health (MH) services provided by medical providers as well as substance use disorder (SUD) services provided by medical providers and mental health providers. It is reported on the Universal Report only.
- Many of the requirements have been further clarified in this version of the UDS Manual.

KEY TERMS:

FTEs:

- "1.00 FTE" is defined as being the equivalent of one person working full-time for one year.
- Each health center defines the number of hours for "full-time work" for each position.
- FTEs are based on employment contracts for clinicians and exempt employees.
- FTEs are calculated based on paid hours as a percentage of full time hours for non-exempt employees (e.g., 2,080 hours/year or 1,820 hours/year).
- FTEs are adjusted for part-time work or for part-year employment.

VISITS:

To qualify as a visit, the following criteria must be met:

- Must be between the patient and the provider and can be face-to-face or virtual (telemedicine);
- Medical and dental providers must be licensed;
- Provider must be acting independently;
- Provider must be exercising professional judgment;
- Service must be documented in the patient's chart;
- Must be synchronous and/or real time.

PATIENTS:

- An individual who receives one or more documented "visits" of any service type: Medical, Mental Health, Dental, Substance Use, Other Professional, Enabling, and Vision. Patients may be counted once per service category.

HOW DATA ARE USED:

Table 5 is part of the Staffing & Utilization Profile for the UDS Report. The data are used to evaluate staffing of key health center leadership, clinical staff, and providers:

STAFFING RATIOS: FTEs are used to calculate staffing ratios per provider FTE.

PROVIDER PRODUCTIVITY: Visits per provider FTE.

CONTINUITY OF CARE: Visits per patient.

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 46-61.

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PERFORMANCE MEASURES:

- Service cost per service patient
- Service cost per service visit
- Charges per visit
- Collections per visit
- Average costs per FTE by type
- The sum of mental health and substance use disorder services/visits reported in the main part of Table 5 and this addendum to Table 5 provide an **unduplicated** count of mental health and substance use disorder ***services*** across all provider types.

SELECTED SERVICE ADDENDUM

Primary care providers in health centers often provide mental health (MH) services as part of medical visits, and a wide range of both primary care and mental health providers provide substance use disorder treatment services. In the past, these mental health and substance use disorder services were not clearly captured in the UDS. As a result, the breadth of mental health and substance use disorder treatment services being provided in health centers has been understated.

The Selected Services Addendum to Table 5 asks health centers to report on health care providers who address mental health and substance use disorders, and mental health providers who address substance use disorders in order to better reflect the comprehensive, integrated model of care provided in health centers.

The information in this section only reflects providers and their mental health and substance use disorder treatment services not already reported in the mental health and substance use disorder sections on the main part of Table 5.

Examples of provider activity reported in the addendum are as follows:

- A physician who sees a patient for treatment of depression.
- A nurse practitioner seeing a patient for diabetes who is also showing signs of depression.
- A physician assistant providing MAT services to a patient with an opioid use disorder.
- A licensed clinical psychologist seeing a patient for mental health problems exacerbated by a substance use disorder.

In Column a1, report the *number* (not FTEs) of providers by type of MH and/or SUD services.

- Providers are to be counted in multiple service categories, as appropriate.
- Providers contracted on a fee-for-service basis should be counted.

In Columns b and b2, report the number of MH and/or SUD clinic or virtual visits by providers type.

- Treatment for mental health services are reported on Lines 20a01-20a04.
- Treatment for Substance use disorder services are reported on Lines 21a-21g.
- Use ICD-10 diagnostic codes associated with the visit to document/count the delivery of MH or SUD treatment services by medical and mental health providers.
- Include only visits documented with acceptable ICD-10 MH or SUD diagnosis codes.
- Exclude visits in which the only MH or SUD services provided included: screening, medication delivery or refill, patient education, referral, or case management

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In Column c, report the number of patients seen for clinic or virtual MH and/or SUD services for each type of provider listed.

Selected Service Detail					
Line	**Mental Health Service Detail**	**Personnel (a1)**	**Clinic Visits (b)**	**Virtual Visits (b2)**	**Patients (c)**
20a01	Physicians (other than psychiatrists)				
20a02	Nurse Practitioners				
20a03	Physician Assistants				
20a04	Clinical Nurse Midwives				
	Substance Use Disorder Detail	**Personnel (a1)**	**Clinic Visits (b)**	**Virtual Visits (b2)**	**Patients (c)**
21a	Psychiatrists				
21b	Physicians (other than psychiatrists)				
21c	Nurse Practitioners				
21d	Physician Assistants				
21e	Clinical Nurse Midwives				
21f	Licensed Clinical Psychologists				
21g	Licensed Clinical Social Worker				

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Table 5: Staffing and Utilization

TABLE TIPS:

Table 5 is completed for the Universal Report and for grant-specific reports. However, grant reports include only clinic and virtual visits (Column b and b2) and patients by service category (Column c); FTEs are not reported on the grant report. Appendix A of the UDS Manual contains a list of personnel categorized as providers and non-providers.

FTEs:

- Report FTEs on lines corresponding with work performed and licensure, not by job title.
- Include as FTEs: employees, contracted personnel (not paid by unit of service), volunteers, and residents based on hours worked.
- Do not reduce clinical FTEs for vacation, continuing education, meetings, paid leave, holidays, etc.
- Do not allocate a portion of MDs' and mid-level practitioners' time to non-clinical functions, except for the medical director.
- A difference between the Addendum and the main part of Table 5 is that in addition to counting staff employed directly by your health center also count those contracted on an hourly basis when calculating FTEs.
- In the column (a1) of the Addendum you are reporting the number of providers who provide services that are contracted on a fee-for-service basis, not FTEs.

PATIENTS:

A patient is counted only once in each category in which they receive services (e.g., medical, dental, substance use, etc.) regardless of the number of clinic or virtual visits received.

VISITS:

- Report visits on lines corresponding with staff performing the service.
- Medical visits are provided by physicians and mid-level practitioners only.
- Dental visits are provided by dentists, dental therapists, and dental hygienists only.
- Mental Health visits can be provided by psychiatrists, licensed clinical psychologists, licensed clinical social workers, other licensed mental health providers and other mental health staff.
- Substance use service providers do not require licenses or credentials for visits to be included on the UDS.
- Include visits provided by paid and volunteer staff; provided by a third party and paid for in full by health center, including paid managed care referrals or voucher program visits; and those performed by staff rounding on health center patients in the hospital.
- One visit per patient, per service category, per day. (exception: two visits of the same type with two different providers at two different locations within one service category may both be counted).
- A provider counts only one visit with a patient during a day regardless of the number of services provided to that patient.

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VIRTUAL VISITS

- A virtual visit is one that meets all other requirements of a UDS visit except that it is not an in-person interaction between a patient and provider. Just as with in-person visits, not all virtual visits are countable.
- Virtual visits must be provided using interactive, synchronous audio and/or video telecommunication systems that permit real-time communication between the provider and a patient.
- Virtual visits should use telemedicine-specific CPT or HCPCS codes with:
  - GT — Via interactive audio and video telecommunications systems
  - .95 — Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system
- State and Federal telehealth definitions and regulations regarding acceptable modes of care delivery, types of providers, informed consent, and location of patient are not applicable in determining virtual visits for UDS reporting.
- See What Counts as a Virtual Visit on page 8
- See ***Mental Health/Substance Use Disorder Services Detail Handout***

CROSS TABLE CONSIDERATIONS:

- **Tables 5 and 8A:** Costs associated with staff (FTEs) reported on Table 5 must be included in the corresponding cost center on Table 8A (example shown on next page).
- Visits and patients reported in any cell of the grant tables cannot exceed the number reported in the same cell on the Universal table.
- **Tables 5 and 9D:** Billable visits reported on Table 5 should relate to patient charges reported on Table 9D. However, non-billable visits can also be counted assuming they meet the visit criteria.
- Total patients on Table 5 should be greater than total number of patients reported on Table 3A (unless only one type of service is offered).
- All medical patients on Table 5 are eligible for inclusion in clinical quality measures on Tables 6B and 7.

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 46-61.

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Table 5: Staffing and Utilization

FTE's reported on Table 5, Line:	Have costs reported on Table 8A, Line:
1-12: Medical (e.g., physicians, mid-level providers, nurses)	**1:** Medical staff
13-14: Lab and X-ray	**2:** Lab and X-ray
16-18: Dental (e.g., dentists, dental hygienists, etc.)	**5:** Dental
20a-20c: Mental Health	**6:** Mental Health
21: Substance Use	**7:** Substance Use
22: Other professional (e.g., nutritionists, podiatrists, etc.)	**9:** Other professional
22a-22c: Vision Services (e.g., ophthalmologist, optometrist, optometric assistants, other vision care)	**9a:** Vision
23: Pharmacy	**8a:** Pharmacy
24-28: Enabling (e.g., case management, outreach, eligibility) – relationship of the detail follows. Note the cost categories on Table 8A are not in the same sequential order as they appear on Table 5.	**11a–11g:** Enabling
24: Case Managers	**11a:** Case Management
25: Patient/Community	**11d:** Patient and Community Education
26: Outreach Workers	**11c:** Outreach
27: Transportation Staff	**11b:** Transportation
27a: Eligibility Assistance Workers	**11e:** Eligibility Assistance
27b: Interpretation Staff	**11f:** Interpretation Services
27c: Community Health Workers	**11h:** Community Health Workers
28: Other Enabling Services	**11g:** Other Enabling Services
29a: Other programs/services (e.g., non-health related services including WIC, job training, housing, child care, etc.)	**12:** Other related services
29b: Quality Improvement Staff	**12a:** Quality Improvement
30a-30c and 32: Non-Clinical Patient Support (e.g., corporate, intake, medical records, billing, fiscal, and IT staff)	**15:** Administration
31: Facility (e.g., janitorial staff, etc.)	**14:** Facility

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Table 5: Staffing and Utilization

SELECTED CALCULATIONS:

Dividing total cost/service by FTEs, visits, and patients for that service yields AVERAGE COSTS:

- Average cost per FTE: $5,757,876/26.59 = $216,543
- Average cost per visit: $5,757,876/25,499 = $226

Average cost per patient: $5,757,876/10,616 = $542

TABLE 5 — STAFFING AND UTILIZATION

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
16	Dentists	8.7	21,422	33	
17	Dental Hygienists	2.45	4,044		
17a	Dental Therapists				
18	Other Dental Personnel	15.44			
19	**Total Dental Services (Lines 16–18)**	25.59	25,466	33	10,616

TABLE 8A — FINANCIAL COSTS

Line		Accrued Costs (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
5	Dental	3,986,773	1,771,103	5,757,876
6	Mental Health	1,356,455	652,157	2,008,612
7	Substance Abuse	446,473	217,386	663,859

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Table 5: Staffing and Utilization

WHAT COUNTS AS A VIRTUAL VISIT?

THE FOLLOWING VIRTUAL VISITS WILL COUNT ON THE UDS:

- Health center provider provides in-scope services via telemedicine to a patient not physically present in the same location as the provider.
- A patient at the health center is provided services by a non-health center provider not physically present at the health center through telemedicine, and the health center covers the cost of the services by the other provider.

THE FOLLOWING VIRTUAL VISITS WILL NOT COUNT ON THE UDS:

- Health center provider provides out-of-scope services via telemedicine to a patient not physically present in the same location as the provider.
- A patient at the health center is provided services by a non-health center provider not physically present at the health center through telemedicine, and the health center does not pay for the services.
- A provider at the health center confers with a provider at a different health center via video chat regarding a patient's care.
- A patient and a provider discuss a patient's health concerns via a secure email through the EHR.
- A staff member at the health center takes a photograph of a patient's skin condition and sends it through the portal to a provider not physically present at the health center for diagnosis (i.e., "telederm" or "store and forward" model).
- A patient at the health center is provided services through telemedicine by a provider not physically present at the health center and who does not have access to the health center's HIT/EHR. The health center pays for the services.
- Interaction is not coded or charged as telehealth services.

For more detailed information see UDS Reporting Instructions for the 2019 Health Center Data, pages 46-61.

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