

Table 5: Staffing and Utilization

PURPOSE:

Table 5 identifies personnel full-time equivalents (FTEs), patient visits, and total patients by service category. It also provides data on mental health services provided by medical providers as well as substance use disorder services provided by medical and mental health providers.

CHANGES:

- There are no changes to Table 5 reporting requirements for 2022.

KEY TERMS:

FTEs:

- “1.0 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 other personnel.
- FTEs are calculated based on paid hours as a percentage of full-time hours for 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 count as a visit, the following criteria must be met:

- Must be between the patient and a licensed or credentialed provider and can be in-person or virtual (telemedicine);

- Must be interactive, synchronous, and/or real time communication;
- Medical and dental providers must be licensed;
- Provider must be acting independently;
- Provider must be exercising independent professional judgment;
- Service must be documented in the patient’s chart.

PATIENTS:

- Individuals who have one or more in-person clinic or virtual UDS-countable visit(s) of any service type: Medical, Mental Health, Dental, Substance Use Disorder, Other Professional, Enabling, and Vision. Patients are counted once per service category.

HOW DATA ARE USED:

Table 5 is part of the Staffing and 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.

PERFORMANCE MEASURES:

- Service cost per service patient
- Service cost per service visit
- Charges per visit
- Collections per visit
- Average costs per FTE by type

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- The sum of mental health and substance use disorder services visits reported in the main part of Table 5 and the addendum to Table 5 provide a **combined** count of mental health and substance use disorder **services** across all provider types.
- The addendum will include duplication across service categories. Some visits may include both mental health and substance use disorder treatment and will be reported as such.
- A nurse practitioner seeing a patient for diabetes and who is also treating them for signs of anxiety.
- 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 and substance use disorder.

SELECTED SERVICE ADDENDUM

Note: Please see the [Mental Health and Substance Use Disorder Services Detail Addendum Guidance](#) for additional information on this section of Table 5.

Medical providers in health centers often provide mental health (MH) services as part of medical visits, and both medical providers and mental health providers provide substance use disorder (SUD) services.

The Selected Service Detail Addendum to Table 5 asks health centers to report on medical providers who address mental health and substance use disorders, and mental health providers who address substance use disorders 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/or substance use disorder sections (Lines 20a – 22) 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.

In Column a1, report the number (not FTEs) of individual 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 the addendum.

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

- Treatment for mental health services are reported on Lines 20a01 – 20a04.
- Treatment for substance use disorder services are reported on Lines 21a – 21h.
- 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. (See Table 6A Lines 18 – 20d)
- 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 ADDENDUM					
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	Certified Nurse Midwives				
	Substance Use Disorder Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
21a	Physicians (other than Psychiatrists)				
21b	Nurse Practitioners (Medical)				
21c	Physician Assistants				
21d	Certified Nurse Midwives				
21e	Psychiatrists				
21f	Licensed Clinical Psychologists				
21g	Licensed Clinical Social Workers				
21h	Other Licensed Mental Health Providers				

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TABLE TIPS:

Table 5 is completed for the Universal Report and the grant-specific reports (if applicable). 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 grant reports. 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.
- Count loan-repayment recipients as full-time.
- FQHC Medicare intermediary has different definitions for full-time providers; these are not to be used in reporting on the UDS.
- 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 chief medical officer/medical director.
- A difference between the addendum and the main part of Table 5 is that in addition to counting personnel employed directly by your health center, the addendum also counts those contracted on an hourly basis when calculating personnel for Column a1.
- In Column a1 of the addendum report the number of individual providers who provided mental health and/or substance use disorder services. If the provider is contracted on a

fee-for-service basis, do not count FTEs on the main part of Table 5, but count the provider in the addendum.

PATIENTS:

In the main part of Table 5, 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 personnel 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 personnel.
- 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 personnel; provided by a third party and paid for in full by the health center, including paid managed care referrals or voucher program visits; and those performed by personnel 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.)

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- A provider counts only one visit with a patient during a day regardless of the number of services provided to that patient.
- Do not report encounters that are screenings, tests, or vaccines (e.g., COVID-19) as reportable visits.
- For services and individuals not reported on the UDS report, please review the [2022 UDS Manual](#), page 20 for additional information.

VIRTUAL VISITS

- A virtual visit 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 a licensed or credentialed 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 of this fact sheet.
- See the [Mental Health and Substance Use Disorder Services Detail Addendum Guidance](#) for more information on reporting virtual visits on the Select Service Detail Addendum.

CROSS TABLE CONSIDERATIONS:

- **Tables 5 and 8A:** Costs associated with personnel (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, Column c, should be greater than the total number of patients reported on Table 3A (unless only one type of service is offered).
- Table 6A activity reported for SUD and MH treatment are compared to the Table 5 addendum and the main part of Table 5 mental health and substance use lines.
- Visits and patients reported on the Table 5 addendum must also be included in the main part of Table 5, medical plus mental health lines.
- 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 Requirements for 2022 Health Center Data, pages 51 – 71.

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FTE's reported on Table 5, Line:	Have costs reported on Table 8A, Line:
1-12: Medical Personnel (e.g., physicians, mid-level providers, nurses)	1: Medical Personnel
13-14: Medical Lab and X-ray	2: Medical 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 Disorder	7: Substance Use Disorder
22: Other Professional (e.g., nutritionists, podiatrists, etc.)	9: Other Professional
22a-22c: Vision (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-11h: Enabling
24: Case Managers	11a: Case Management
25: Patient and Community Education Specialists	11d: Patient and Community Education
26: Outreach Workers	11c: Outreach
27: Transportation Personnel	11b: Transportation
27a: Eligibility Assistance Workers	11e: Eligibility Assistance
27b: Interpretation Personnel	11f: Interpretation Services
27c: Community Health Workers	11h: Community Health Workers
28: Other Enabling Services	11g: Other Enabling Services
29a: Other Programs and Services (e.g., non-health related services including WIC, job training, housing, childcare, etc.)	12: Other Program Related Services
29b: Quality Improvement Personnel	12a: Quality Improvement
30a-30c and 32: Non-Clinical Support Services (e.g., corporate, intake, medical records, billing, fiscal, and IT staff)	15: Non-Clinical Support Services
31: Facility Personnel (e.g., janitorial staff, etc.)	14: Facility

For more detailed information see UDS Reporting Requirements for 2022 Health Center Data, pages 51 – 71.

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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

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

Line	Cost Center	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 Use Disorder	446,473	217,386	663,859

For more detailed information see UDS Reporting Requirements for 2022 Health Center Data, pages 51 – 71.

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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.
 - If the first or only visit is a countable virtual visit, the health center must register the patient and collect and report all relevant demographic, service, clinical, and financial data on the UDS tables.
- 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.

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.