



Table 5: Staffing and Utilization

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

Changes to 2011 Report: None.

Key Terms:

FTEs:

- “1.00 FTE” is defined as being the equivalent of one person working full-time for one year.
- Each agency defines the number of hours for “full-time work.”
- FTEs are based on employment contracts for clinicians and exempt employees.
- FTEs are calculated based on paid hours for non-exempt employees (e.g., 2080 hours/year or 1820 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 face to face between the patient and the provider. (An exception is provided for behavioral health 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.

PATIENTS:

- *Service Patient:* An individual who receives one or more documented “visits” of any specific service type: Medical, Mental Health, Dental, Substance Abuse, Other Professional, Enabling, and Optometry. Patients may be counted up to once per service category.

How Data are Used:

- Staffing Ratios: FTEs are used to calculate staffing ratios per provider FTE
- Provider Productivity: Visits per provider FTE
- Continuity of Care: Visits per patient
- As denominators for performance measures:
 - Service cost per service patient
 - Service cost per service visit
 - Charges per visit
 - Collections per visit
 - Average costs per FTE by type

Table Tips:

- Table 5 is completed for the “universal” report and for grant specific reports. However, grant reports include only visits (column b) and patients by service category (column c). FTEs are not reported on the grant report.

FTE:

- Report FTEs on lines corresponding with work performed and licensure, not by job title.
- Include as FTEs: employees, contract personnel (not paid by unit of service), volunteers, and residents based on hours worked.
- Do not reduce clinical FTEs for vacation, CME, meetings, paid leave, holidays, etc.
- Do not allocate a portion of MDs’ and midlevel practitioners’ time to non-clinical functions except for the Medical Director.

VISITS:

- Report visits on lines corresponding with staff performing the service.
- Medical visits are provided by physicians, mid-level practitioners, and licensed nurses only.
- Dental visits are provided by dentists and dental hygienists only.
- Include visits: provided by paid and volunteer staff; provided by a third party and paid for in full by grantee, including paid managed care referrals or voucher program visits and those performed by staff rounding on health center patients in 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.

PATIENTS:

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



Table 5: Staffing and Utilization

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. *(Shown at right)*
- Visits and patients reported in any cell of the grant Tables cannot exceed the number reported on the universal Table.
- Tables 5 and 9D: Billable visits reported on Table 5 should relate to patient charges reported on Table 9D *(Shown on Table 9D)*, although non-billable visits can also be counted assuming they meet the visit criteria.
- The sum of patients on Table 5 should be greater than the total number of patients reported on Table 3A unless only one type of service is offered! This is an indication of the comprehensiveness of care provided to health center patients.

FTE's reported on Table 5, Line:	Have costs reported on Table 8A, Line:
1 – 12: Medical (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 – 20: Mental Health	6: Mental Health
21: Substance Abuse	7: Substance Abuse
22: Other Professional (e.g., nutritionists, podiatrists, etc.)	9: Other Professional
22a-22d: Vision Services (ophthalmologist, optometrist, optometric assistant)	9a: Vision
23: Pharmacy	8a: Pharmacy
24 – 28: Enabling (e.g., case management, outreach, eligibility, etc.)	11a – 11g: Enabling
29a: Other programs / services (e.g., non-health related services including WIC, job training, housing, child care, etc.)	12: Other related services
30a – 30c and 32: Administration and Patient Support (e.g., corporate, intake, medical records, billing, fiscal, and IT staff)	15: Administration
31: Facility (e.g., janitorial staff, etc.)	14: Facility

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 - Universal

PERSONNEL BY MAJOR SERVICE CATEGORY		FTE's (a)	CLINIC VISITS (b)	PATIENTS (c)
16.	Dentists	8.70	21,455	
17.	Dental Hygienists	2.45	4,044	
18.	Dental Assistance, Aides, Techs	15.44		
19.	Subtotal Dental Services (Sum lines 16-18)	26.59	25,499	10,616

Table 8A: Financial Costs

	Accrued Cost (a)	Allocation Of Facility And Administration (b)	Total Cost After Allocation Of Facility And Administration (c)
Financial Costs for Other Clinical Services			
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

