

FTCA COVERAGE FOR VOLUNTEERS & HEALTH CARE FOR THE HOMELESS

POLICY BRIEF

SEPTEMBER 2010

GROWING THE NATIONAL HEALTH CARE WORKFORCE: EXTENDING FTCA COVERAGE TO VOLUNTEERS AT HEALTH CENTERS

With the passage of Health Reform, millions of previously uninsured individuals will be accessing care regularly for the first time, which not only will test the limits of the nation's health care infrastructure overall, but will also have a dramatic effect on the health care safety net. Community Health Centers are charged with doubling the number of patients served to 40 million by 2015. The health reform law provides financial resources for both new locations and more providers, but much work remains to be done to develop all the resources needed to meet this new rise in demand.

Workforce shortages already exist at Health Centers for most types of providers and this trend will likely continue under expansion. Traditional recruitment alone will not be able to meet the rising tide of demand, and additional tools are needed to help meet patient needs. Using volunteers at Health Centers by extending Federal Tort Claims Act (FTCA) liability coverage would help alleviate this strain on the safety net and expand access to medical care for underserved populations.

Benefits to Volunteer Clinicians at Health Centers:

- ✓ Cost-efficient
- ✓ Helps meet workforce shortages
- ✓ Circumvents traditional barriers to hiring such as low salary
- ✓ Assists in both urban and rural locations
- ✓ Keeps retired workforce active and engaged in community
- ✓ Improves the care provided to the underserved
- ✓ Promotes economic growth
- ✓ Better integrates Health Centers into their communities

Background

Health Centers form the backbone of the U.S. health care safety net, serving nearly 19 million patients in urban and rural settings in 2009. Of these patients, just over a million were homeless; Health Care for the Homeless (HCH) projects (a special populations type of health center that focuses on care for individuals experiencing homelessness) served the vast majority of these patients (81%, or just over 800,000 individuals). Patients at HCH projects are disproportionately poor and uninsured, with 91% under 100% of the federal poverty level and 66% lacking health insurance.¹

All types of Health Centers not only fulfill an unmet need, but they are also cost efficient economic drivers in the communities where they are located. Health Center patients' cost of care has been

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shown to be 41 percent less than patients seen in other settings, producing annual of savings of between \$10 billion and \$18 billion.² Planned Health Center expansion in Health Reform will result in further savings projected at an estimated \$122 billion from 2010 to 2015.³ Health Centers contribute to economically disadvantaged areas, employing over 143,000 individuals and having a \$12.6 billion impact annually.⁴ As Health Centers expand an impact of \$31 billion in direct benefits and \$23 billion in indirect economic and job growth is expected through 2015.⁵ Sufficient numbers of providers are needed, however, to fully realize these benefits.

Workforce Crisis

The crisis this nation faces in primary care is pervasive. A recent study anticipates a shortage of 124,000 physicians by 2025 if current supply, use and demand patterns remain steady. When considering the changes in use and demand that will take place with expanded health coverage, the nation is expected to experience a shortage of nearly 160,000 physicians by 2025.⁶ As Table 1 illustrates, Health Centers are already experiencing this shortage of primary care providers. National and international benchmarks generally suggest one physician for every 1,500 patients.⁷ Based on this ratio, Health Centers only employed 9,125 of the 12,503 physicians needed in 2009 and will need approximately 26,500 physicians to serve 40 million by 2015.⁸ Lessons from the Massachusetts coverage expansion show that the lack of provider capacity can result in several month long waiting lists and poor access.⁹ Strategies to grow the nation's health care workforce will be essential to meeting the increased demand for services.

Table 1: Workforce Shortages at Health Centers, 2004¹⁰

Provider Type	Total Open FTEs	Rural Grantees Reporting Recruitment is Difficult	Urban Grantees Reporting Recruitment is Difficult	Rural Grantees Reporting Current Open Position Unfilled for Seven Months	Urban Grantees Reporting Current Open Position Unfilled for Seven Months
Physicians	427.6	41.8%	20.8%	35.6%	23.8%
OB/GYN	117.1	66.3%	49.2%	25.1%	18.8%
Pediatrician	100.0	46.8%	18.7%	22.1%	18.9%
Psychiatrist	47.6	81.5%	52.1%	20.9%	18.7%
Nurse Practitioner	193.4	8.8%	11.9%	12.9%	7.7%
Physician Assistant	79.8	8.3%	9.1%	11.4%	6.7%
Registered Nurse	375.9	25.1%	48.9%	20.7%	24.8%
Mental Health Professional	154.5	42.5%	23.8%	23.4%	14.8%
Dentist	313.0	62.4%	40.7%	47.9%	6.7%

The most consistent barrier to recruitment and retention of paid providers is low compensation, with rural locations facing additional barriers such as lack of housing and poor public schools.¹¹ The use of scholarships or loan repayment programs such as the National Health Service Corps is a common strategy for recruitment but still leaves many grantees reporting that recruitment is very difficult (see table 1). Mid-level practitioners are commonly employed at Health Centers but similar barriers persist for these professionals as well.

Homeless Patients and Specialty Care

Patients seen at HCH projects have especially complex health care needs both as a cause and a consequence of their homelessness. Multiple chronic medical conditions, coupled with behavioral health needs are common and often require multiple specialty providers such as dentists, psychiatrist, or podiatrists. Due to difficulties with referrals, Health Centers and HCH projects are increasingly trying to address these needs

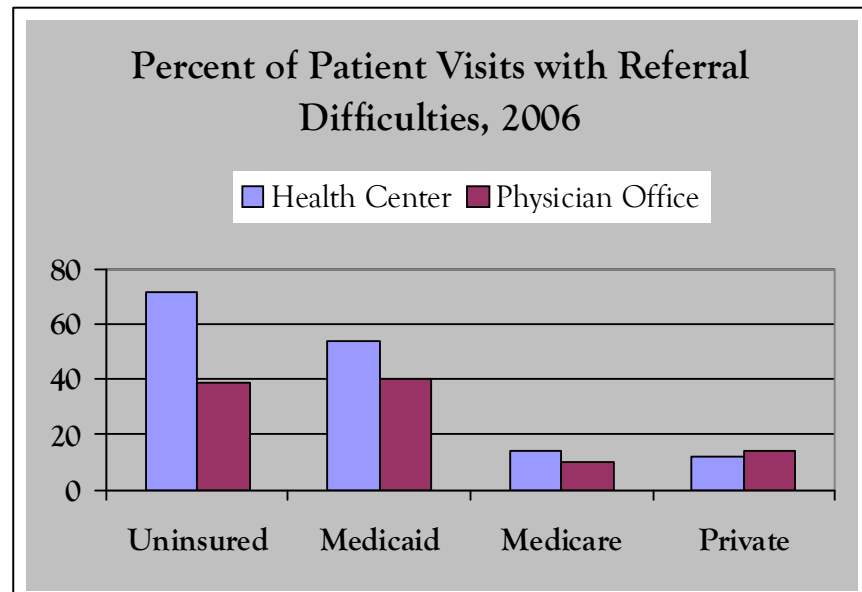
in house; for example, the number of patient visits for dental care and mental health care increased 123 percent and 225 percent respectively.¹³

Because HCH projects rarely have specialists on staff, referrals are often needed to access specialty care. Patients at Health Centers experience more difficulties with referrals than their counterparts at private physicians' offices if they are uninsured or insured through Medicaid (see Table 2). Virtually all patients at HCH are uninsured with less than 25% enrolled in Medicaid, making referral barriers even more pronounced at such projects.¹⁴ This issue will persist in spite of Medicaid expansion.

Use of Volunteers: An Opportunity

Volunteer providers could be an effective way to help build a portion of the needed workforce and specialty care needs of Health Centers and HCH projects; however, only 78 of 1,100 Health Centers currently use volunteers.¹⁵ Most of those surveyed found that lack of malpractice coverage was either a very significant or somewhat significant barrier to volunteerism and in a survey administered to HCH projects medical malpractice insurance was found to be the most commonly cited barrier to volunteerism.^{16, 17}

Table 2: Referral Difficulties¹²



There are other state and federal laws aimed at protecting volunteers, but these are inadequate for fully protecting against liability and are not a replacement for full FTCA coverage. For example, the Volunteer Protection Act protects volunteers from ordinary negligence but not from gross negligence or punitive damages.¹⁸ As a result, volunteers still need to purchase coverage or have coverage from some other institution that covers voluntary work. Attempts have been made at the state level and vary significantly from one state to the next. For the most part, however, the provider is still liable for malpractice under certain conditions, necessitating additional malpractice insurance and creating further barriers to volunteering. Federal efforts are needed to create an equitable and uniform solution.

Other barriers exist to volunteerism, such as lack of awareness of Health Centers, lack of capacity to utilize volunteers effectively, and misinformation regarding the patients served, but these could be addressed through training, education, and advertisement. The National Health Care for the Homeless Council has the capacity and expertise to assist HCH grantees in overcoming these barriers and other organizations would likely be able to do the same for Health Centers that serve broader populations.

FTCA Claims to Date: It's Less Than You Might Think

FTCA liability coverage was first extended to paid employees and contractors of Health Centers and HCH grantees in 1993. A GAO study found that in calendar year 2008, 85 percent of all Health Centers utilized FTCA coverage, saving \$204 million.¹⁹

The significant savings realized by Health Centers have not come at a huge cost to the Federal Government. FTCA claims from 1993 to 2009 were approximately \$298 million (or almost \$19 million per year) and the Congressional Budget Office estimates this legislation will cost \$18 million dollars over five years with an annual appropriation of \$6 million dollars.^{20, 21} This modest level of funding would be a small price to pay for growing the workforce and providing additional health resources for the underserved.

Recommendation

In light of the existing provider shortage, the goals of Health Center expansion under health reform investments, and the unique needs of low-income patients, the National Health Care for the Homeless Council strongly recommends Congress pass H.R. 1745, the Family Health Care Accessibility Act. This bill would extend malpractice coverage to volunteer providers at Health Centers using the existing FTCA structure that works so well for paid staff. There are currently amendments to extend this coverage to all volunteer health care providers, which the Council supports. The unique needs of individuals experiencing homelessness and the reliance of Health Centers on non-physician providers make these amendments essential to the success of this initiative. In these ways, the major barrier of malpractice insurance can be overcome for the betterment of patients everywhere.

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