# Workforce Needs of Health Care for the Homeless Projects

2012 Policy Statement

**SUMMARY OF RECOMMENDATIONS**

1. **Expand current funding levels for the National Health Service Corps** by restoring annual funding levels and maintaining the remaining $910 million in the National Health Service Corp Trust Fund to provide for an adequate health care workforce at community health centers and Health Care for the Homeless projects.

2. **Pass the Family Health Care Accessibility Act (or similar legislation),** extending the full malpractice protections provided to paid health center staff through the Federal Tort Claims Act to volunteer health care professionals, including mid-level providers, nurses and licensed social workers, at health centers.

3. **Expand community health worker programs in HCH projects through the establishment of dedicated and sustainable public funding** for health education, patient navigation, and especially outreach efforts to prepare for the expansion of Medicaid in 2014.

**Health care coverage does not ensure health care access.** The Patient Protection and Affordable Care Act (ACA) includes numerous provisions designed to expand health coverage to most Americans.[1] Homeless individuals will, however, still face barriers to accessing health services despite availability of health insurance. Sufficient numbers of health care providers, access to specialty care, a culturally competent workforce and assistance in navigating an increasingly complex health care system are all essential to providing vulnerable populations expanded access to health.

**The current health care workforce is inadequate.** Current projections estimate a physician shortage of 124,000 by 2025 based on current supply, use, and demand patterns. This shortage balloons to 160,000 when considering the expanded health coverage intended in the ACA. Meeting these workforce demands will be challenging in most communities but the difficulty will be more pronounced in areas with current shortages of health professionals. Simply meeting present demand in medically underserved areas will require an additional 16,000 primary care physicians.[2] An insufficient number of primary care physicians can limit access in these communities, leading to increased emergency room use, poor maintenance of chronic conditions, and poor health outcomes.[3] Individuals may face significant financial difficulty or disability as a consequence, leading to new or prolonged homelessness. Many of the national and state-level strategies to address workforce shortages for nurses, primary care physicians, dentists, and other providers are also relevant to the needs of individuals experiencing homelessness, but this policy statement focuses recommendations to issues that are especially applicable to HCH grantees and consumers.

**Health centers and Health Care for the Homeless projects face additional workforce challenges.** Community health centers and Health Care for the Homeless clinics are the front line providers in underserved communities. Challenges such as low pay, poor public schools, and the general lack of primary care providers can prevent these clinics from adequately addressing their workforce needs.[4] In addition to these current realities are the new goals and challenges

presented by the ACA. Health centers are charged to double their patients by 2015, from approximately 20 million served to 40 million served. This is an opportunity to improve health access and health disparities in underserved communities but a significant expansion of the health center workforce will be required to achieve this goal.

**Sufficient numbers of providers does not ensure health access or improved health.** The complexity of the health care system is often an obstacle to effective treatment. This obstacle is exacerbated for individuals experiencing homelessness due to cognitive limitations, limited education or distrust of institutions. Difficulty navigating the health care system results in poor treatment adherence and continued health disparities for homeless populations.[5] Specialized staff possessing the cultural competence needed to reach out to homeless individuals, assist them in navigating the health care and entitlements systems, and educate them about improved health behaviors should be an integrated part of homeless treatment teams.

1. **Expand current funding levels for the National Health Service Corps by restoring annual funding levels and maintaining the remaining $910 million in the National Health Service Corp Trust Fund.**

The National Health Service Corps (NHSC) provides scholarships and loan repayments to graduating health professionals in exchange for commitment to practice in underserved areas, to include all health centers. Financial assistance is invaluable to offset the loans and other investments needed to qualify as a practicing health care provider, and the incentives offered through the NHSC help build a workforce trained to work with homeless individuals or other underserved populations. An independent review of the NHSC found that over half of the alumni of the NHSC continue to practice in underserved areas, demonstrating that the NHSC is both a short- and long-term solution to workforce needs at Health Care for the Homeless projects.[6] Unfortunately, the annual appropriations for this program have been eliminated in recent years, relying instead on the NHSC Trust Fund established in the ACA. It is essential that this funding be restored to meet the increasing workforce demands facing Health Care for the Homeless projects.

2. **Pass the Family Health Care Accessibility Act (or similar legislation).**

Medical malpractice insurance is extremely costly but this expense is mitigated for paid health professionals at health centers through liability protection provided by the Federal Tort Claims Act (FTCA). A small portion of the annual appropriations for health centers is set aside for any potential damages awarded to health center patients and has been shown to be cost effective. This coverage saved health centers over $200 million in calendar year 2008 alone while only costing the federal government an average of $19 million per year.[7] Volunteer providers, however, are not currently covered by FTCA, causing malpractice insurance to be a significant barrier to volunteering.[8]

The use of volunteers could address some of the workforce shortages health centers and Health Care for the Homeless projects currently face. Providing FTCA coverage to volunteer health professionals at health centers could not only improve access to primary care for homeless individuals but also improve access to specialty care, behavioral health, and dental care. Individuals experiencing homelessness often have multiple conditions requiring care from multidisciplinary treatment teams. The opportunity to augment existing treatment teams with voluntary specialists would improve care and also minimize the impact of referral difficulties many patients of health centers and Health Care for the Homeless clinics often face.[9]

The Family Health Care Accessibility Act (H.R. 1629 & S. 1059 in the 112th Congress) would provide FTCA coverage to all health professionals volunteering at health centers, including nurse practitioners, physicians assistants, nurses, and social workers. Passing this bill would give health centers additional options for maximizing volunteer assistance, thus bolstering the workforce needed to provide care. For more information please refer to the Council's policy brief on extending FTCA coverage to volunteers.[10]

**3. Expand community health worker programs in HCH projects through the establishment of dedicated and sustainable public funding.**

Community health workers have been defined in numerous ways. One succinct definition provided by the CHIP program is: providers of outreach, education and enrollment in primary care.[11] Community health workers also have familiarity with the culture and experiences of the patient population they work with. These services are especially appropriate for Health Care for the Homeless projects where staff familiar with the experiences of homelessness can help consumers overcome difficulties navigating the health care system or trusting institutions. A community health worker can provide street outreach in a culturally competent way, assist in obtaining entitlements, provide health education, and coordinate the frequently complicated treatment needs of homeless patients in a way that traditional providers typically do not have the background or time to do. The benefits of community health workers have also been shown empirically. Studies have shown that integrating community health workers into health treatment teams improve treatment adherence, improve access to health services, reduce costs, and improve health outcomes in patients.[12]

There are currently thousands of community health workers working in communities today. Migrant health centers employ many such "*promotores de salud,"* who are community health workers specializing in linguistic and cultural familiarity with Hispanic migrant farm workers. Health Care for the Homeless clinics, however, do not have an especially robust community health worker program for homeless individuals. An expansion of such workers could improve the health of homeless patients and provide outreach and enrollment efforts needed to realize the full potential of the Medicaid expansion provided in the ACA.[13]

Policy changes could facilitate a larger adoption of the community health worker model and have been recommended by numerous sources.[14, 15, 16] Policy changes such as further standardization and licensing may facilitate expansion but also may serve as barriers for some individuals most familiar with the population served to work in the community health work field. The most pressing need simply is reliable funding for the services community health workers provide. Community health workers programs are most often funded through time-limited grants which can inhibit consistency and development of the program. Reliable funding through health center grants, Medicaid or direct state or local appropriations would be much preferred. Most of these reforms require state level action and some states have adopted these policies to varying degrees.[17] Further advocacy is needed, however, to fully utilize the opportunities community health workers represent for Health Care for the Homeless projects. For more information please refer to the Council's Policy Brief Community Health Workers: Financing and Administration.[18]

**NOTES:**

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