Law and the Public's Health

ENSURING THE USE OF FEDERAL ASSETS IN PUBLIC HEALTH EMERGENCIES: THE ROLE OF THE FEDERAL TORT CLAIMS ACT IN ENABLING THE RESPONSIVENESS OF FEDERALLY FUNDED COMMUNITY HEALTH CENTERS

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A question that has taken great importance in modern public health policy and practice is whether, to the maximum extent possible, the law enables the rapid and seamless deployment of health service assets and resources during public health emergencies. This installment of *Law and the Public's Health* examines the role of the Federal Tort Claims Act (FTCA), which provides legal liability coverage for federal government employees, in aiding the emergency deployment of first-responder health-care workers employed by federally qualified health centers.

Following an overview of federally funded health centers and the FTCA, this article examines the issues raised by a recent federal ruling regarding the scope of FTCA coverage for health center workers during declared public health emergencies. The article concludes with a discussion of the ruling's public health policy and practice implications for communities nationwide.

BACKGROUND

Preparing for effective emergency response involves carefully examining the capabilities of different health system sectors to act as first responders. Ensuring that a nation's health-care system is capable of meeting the needs created by manmade or naturally occurring disasters represents a public health challenge. Although health policy has made strides in meeting population health needs during disasters, much work remains. One aspect of this topic centers on the legal issues that surround the effective deployment of clinical staff working at the nation's more than 1,000 community health centers.

FEDERALLY FUNDED HEALTH CENTERS

In 2006, more than 1,000 federally funded community health centers, with locations in more than 5,000 urban and rural communities, furnished comprehensive primary health-care services to more than 16 million people.[1] Health center funding and operations are authorized as part of the Public Health Service Act (PHSA, 42 U.S.C. §254c), and administered by the Bureau of Primary Health Care (BPHC) within the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS).[2] Annual federal appropriations are pursuant to Section 330 of the PHSA, and total annual federal appropriations in fiscal years 2006 and 2007 (Continuing Resolution) stood at more than $1.7 billion.[3]

Health centers share certain key characteristics: (*1*) location in an area designated as medically underserved or as having a health professions shortage; (*2*) comprehensive health and related services (especially enabling services such as outreach and translation, whose purpose is to ensure access); (*3*) availability to all residents of their designated service area regardless of ability to pay, with charges prospectively adjusted based on income; (*4*) adherence to strict performance and accountability standards for administrative, clinical, and financial operations; and (*5*) governance by community boards, a majority of whose members are patients of the health center.[2] Health centers are widely recognized for their role in improving population health and reducing racial, ethnic, and socioeconomic health disparities.[4]

Health centers' expertise in caring for isolated and medically underserved populations assumes importance as a matter of public health emergency preparedness policy because substantial evidence suggests that during public health emergencies, the already elevated access barriers experienced by vulnerable populations become even more so, as resources become strained community-wide.[5] In these situations, the unique knowledge, capabilities, and cultural skills of health center staff have an elevated value, as these health-care workers are versed not only in clinical care, but also in reaching underserved populations.

The National Association of Community Health Centers reports that 80% of health centers have a disaster plan and 43% have developed their plans in collaboration with their local health departments. These

health centers have also reached out to their local communities to conduct disaster drills and training. Furthermore, in 23 states, the Primary Care Associations that represent health centers have a seat on the state Senior Advisory Committee for the National Hospital Bioterrorism Preparedness Program.[6] Individual health center expertise combined with local and state-level collaborations make health centers a vital partner in disaster management.

THE FEDERAL TORT CLAIMS ACT

The Federal Tort Claims Act (FTCA) (28 U.S.C. Secs. 1346, 2671) provides a limited waiver of the federal government's sovereign immunity when its employees commit negligent acts within the scope of their office or employment.[7] The FTCA is the federal parallel to state tort claims acts, in place as a matter of law in all U.S. jurisdictions. The FTCA makes it possible for injured people to obtain recoveries in the event that their injuries are the proximate cause of the "sovereign" (i.e., government), which otherwise would be immune from suit under ancient principles of common law. Under the FTCA, therefore, recovery can be had against the federal government "if a private person or entity would be liable to the claimant in accordance with the law of the place where the act or omission occurred."[8] Uniquely governmental acts (e.g., law enforcement) are not covered; the FTCA is instead designed to provide liability coverage when the government undertakes functions (such as health care) that technically speaking could be performed purely in the private sector, but that are carried out by the government because of their social importance.

The FTCA protects federal employees in the event that they are determined to have negligently caused injury when acting within the scope of their employment (i.e., when their conduct is carried out as part of their jobs). In the case of health workers with FTCA coverage, this means that the FTCA takes the place of commercially purchased malpractice liability insurance, and legal recovery takes place through a special federal process.[9]

The Federally Supported Health Care Assistance Act of 1992 specified that even though health centers assisted under §330 are private not-for-profit clinics, their workforce will be considered employees of the federal government for FTCA coverage purposes.[10] This designation, enacted with overwhelmingly bipartisan support, ensures that health center resources are preserved for investment in community care, and that owing to their essential services, health center staffs are accorded federal status.

Health center employees are eligible for FTCA coverage only when they furnish care within their federally approved project scope. The scope of project is specified in the award of funds to each health center; it is defined by the site, services, providers, target populations, and service area for which HHS grant funds may be used. If an employee provides services outside of the approved scope of project, FTCA coverage does not apply. In the absence of alternative malpractice insurance coverage, the loss of FTCA coverage effectively prohibits the individual from furnishing care, as under virtually all state laws, evidence of malpractice coverage or its equivalent is a fundamental prerequisite to clinical practice and the securing of hospital admitting privileges.

THE FEDERAL RULING

After Hurricanes Katrina and Rita, the federal government assured that health center grantees could respond to requests from overwhelmed health centers in the affected regions. Through Policy Information Notice (PIN) 2005-19, "Federal Tort Claims Act Coverage for Deemed Consolidated Health Center Program Grantees Responding to Hurricane Katrina,"11 health center workers from around the country were able to deploy nationally to provide essential disaster assistance working under their FTCA coverage. Indeed, HRSA Administrator Elizabeth Duke stated in an October 2005 speech: "The response by HRSA grantees to the emergency was incredible. HRSA-supported health centers in 37 states and the District of Columbia treated more than 46,000 evacuees, most of them in Texas, Louisiana, and Mississippi."[12]

Despite this earlier policy, in 2007 the BPHC issued a new PIN (2007-16) that interprets the legal provisions of the FTCA in such a way as to make it virtually impossible in the future for health centers to assist in a national response to a local emergency.[13] The purpose of the PIN is to "describe and clarify the circumstances under which FTCA-deemed Health Center Program grantees are covered under the FTCA as they respond to emergencies."[14] PIN 2007-16 points out that, in some emergency cases, health centers that have been destroyed or whose populations have been displaced may need to set up temporary sites. The PIN also acknowledges that other health centers whose locations are geographically adjacent to the site of an emergency event may be needed to assist in an emergency response. In both of these cases, the PIN makes the necessary allowances to ensure that FTCA coverage can be maintained, thereby acknowledging that the "scope of project" standard is sufficiently flex-

ible in an FTCA context to permit health centers to mount an emergency response.

However, the policy does not allow for a response by noncontiguous health centers, thereby eliminating the ability of health centers from, say, Ohio to assist along the Gulf Coast region, even if their boards are in full support and their staff can be safely deployed to an affected region without unreasonably straining their own project sites. Essentially, the new interpretation prevents health centers from switching to a national scope of project when a public health disaster hits. By narrowly defining service areas for health centers, the ruling eliminates the FTCA's legal liability protections that are an essential prerequisite to health-care services.

Nothing in either the FTCA statute or implementing regulations would appear to prohibit HHS from permitting health centers temporarily to augment their scope of project in the event of a national emergency to enable their participation in a national emergency response. A decision of whether or not to temporarily augment the scope of project during a national emergency would be a policy determination, presumably to be made by the health center board and staff in accordance with applicable federal criteria. This is different from prohibiting the determination entirely. A more appropriate approach would appear to be the development of federal criteria for taking such action, particularly because of the serious dangers during emergencies that confront vulnerable populations.

Indeed, HRSA appears to have more than ample authority under federal law, which permits the agency (on the behest of the Secretary) to "deem an entity or an officer, governing board member, employee, or contractor of the entity to be an employee of the Public Health Services for purposes of [FTCA coverage]." It also states that, for such employees, a remedy against the U.S. "shall be exclusive of any other civil action or proceeding."[14,15]

Interpretive guidelines would appear to advance the policies that underlie both health centers and the FTCA, while also positioning federal emergency response policy to more systematically reduce racial, ethnic, and socioeconomic disparities during public health emergencies. By permitting health center scope of project augmentation to encompass a national scope during declared emergencies, federal law would permit the deployment of resources and personnel to respond to emergency situations. It would also eliminate the need for each grantee to submit a request to temporarily change its scope of project, thereby increasing the policy's efficiency. If HRSA were to determine that a full national response were not essential, it could consider allowing selected subgroups of health centers to undergo emergency project scope redefinition based on specific grantee characteristics, such as location/proximity, capacity, and specialty strengths, as opposed to limiting scope redefinition to those centers contiguous to the location of the emergency.

POLICY IMPLICATIONS

Rear Admiral Vanderwagen, Assistant Secretary for Preparedness and Response, has underscored the importance of identifying "what the Department can do in response to disaster to meet the health needs of the Nation."[16] With this change in interpretation of an obscure federal law, whose purpose in a health center context is to ensure the targeting of resources where most needed, this department-wide goal would appear to be set aside in favor of less flexibility over the deployment of public health assets. The implications of this new direction are serious for communities nationwide, which depend on the mobilization of all available resources to meet the challenges of an emergency threat.

Federally funded health centers are uniquely positioned to serve as a national asset for assisting vulnerable populations during public health emergencies. The revision of federal policy to enable such responsiveness would seem essential to sound emergency preparedness. Indeed, the PIN offers an opportunity to develop a model approach for rapid and accountable community health decision-making in response to a large-scale disaster. By establishing standards for a community board decision-making process focusing on the emergency deployment of staff and resources, the federal government could significantly advance emergency public health policy-making as it relates to ensuring that liability coverage is able to seamlessly travel with the federal health workforce, as it may be needed.

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