



## COVID 19 & FTCA Office Hour #1 – April 7, 2020

### Transcript

#### **Katja Laepke:**

Hello and good morning. I am Katja Laepke, Director of Clinical Trainings and Workforce at NACHC and on behalf of our faculty and NACHC team, I would like to warmly welcome you to today's office hour on COVID-19 and the FTCA. Along with Marty Bree, I will be serving as your moderator today. Please let us start by expressing our wholehearted gratitude for the critical important work you do every day. Thank you for your inspiring flexibility to quickly respond to the ever-changing needs and concerns amidst our current crisis and to pivot your priorities to take care of your patients, staff, and health centers. Thank you for proactively identifying the key issues that need further clarifications and for bringing them to our attention so thoroughly.

We carefully reviewed and prepared comprehensive answers to your pre-submitted questions. They fell into the following main topic areas; telehealth, provider coverage, volunteer providers, deeming applications, particularized determination, and general issues. In just a moment, I will turn it over to Dr. Michele Chambliss, Director of HRSA, Bureau of Primary Healthcare, FTCA division who will share key updates and relevant resources with you. Michele will then be joined by Marty Bree, Of Counsel and Molly Evans, Partner, both of Feldesman Tucker Leifer Fidell to address the questions.

Additionally, Dr. Yvonne Johnson, Chief Medical Officer of Medical Associates Plus in Augusta, Georgia and Dr. Keith Horwood, Associate Medical Director of Community Health Centers in Midvale, Utah, will weigh in on the issues. They both are experienced Clinical Leaders and Faculty for NACHC's Training for New Clinic Directors, with expertise in FTCA. To submit any additional questions that may arise, please submit them at any time to all participants via the chat box in the lower right hand of your screen. We will answer as many questions as we can today. We will follow up with any remaining questions after the office hour as well as in preparation for the next one. Again, thank you for joining us and I will now turn it over to Michele. Michele.

#### **Michele Chambliss:**

Thank you for participating in this FTCA Office Hour session. I'm delighted to be with you today. I want to first start by saying thank you for all that you do, especially during these unprecedented times. It's helping to strengthen us and challenge us on how we provide care to our patients. BPHC is trying to forecast the needs of the health centers during this time, so please realize that FTCA is not always a quick and easy yes or no answer. Some of the things that we've learned over the last several weeks, we've gotten numerous questions regarding telehealth, particularized determination, Risk Management activities, volunteer providers, FTCA deeming applications, and health center resources.

As you can see, it covers the gambit, I think, and hopefully you'll walk away today with the answers to questions. If you have not had the chance, please look at our website for BPHC COVID answers, Frequently Asked Questions. It's there, and like I said, there's a lot of questions that come in, some start out sounding the same and then others, the end of the sentence is a little bit different depending on the health center's circumstances. FTCA deeming particularized determination, we put out, edit, which is new, which I think one of the things people are saying, "Can you give it to us in layman's terms? What does it really mean?"

I think the takeaway message is, you have to ask yourself, does the service incorporate primary healthcare? Is it in scope of your grant? Is it on behalf of the health center? Note that it is not portable, so that means that the medical malpractice insurance does not travel with the provider, and health center patients, as well as non-health center patients, can be seen and serviced, and the service has to be



within the service area of the health center. If the community setting is off-site, then that's something that we say, that is acceptable. We have a lot of alternate hospital settings, COVID units that are being manned. That is something that is acceptable practice under FTCA.

Other things that it covers - it provides services that prevent, prepare, and respond to COVID-19. Your screening, your triage, your testing, your diagnosis, how you're treating, again, if it's in scope of your grant, it is covered. Provide services to individuals who are not your health center patients. We already talked about off-site and provide services in person or through telehealth is an acceptable practice. We had some dates originally for our deeming applications and based off of, like we were taking the pulse of what was happening across the country, we have opened it up. Now the application due date for regular deeming for calendar year 2021, the EHB will open up April 13th and it will be through May 14th.

I'm sorry. The actual new date has been extended to July 13th. The difference in the slides, I apologize. Currently, the volunteer deeming application is open through April 7th, which is today, and then the system will shut down and it will reopen April 9th for you to resubmit your volunteer application. The reason why we have to close it down is we have to get ready for the next deeming cycle within the EHB system.

Some of the resources that we have for you, which are free online services through our ECRI vendor, basically highlight some of the COVID-19 specific resources now available, such as COVID-19 outbreak preparedness center and checklist and algorithm to help you prioritize your infection prevention, and control activities. Many of the resources under ECRI are developed in collaboration with HRSA, including those that may be especially helpful when completing deeming applications, such as the Risk Management Manual and Toolkit, the Credentialing and Privileging Manual and Toolkit, the Fourth Level Ambulatory Risk Management Certification, which is all accessible to you.

It is under a password-protected website, which you do have the ability to access using that email that is provided to you in the link below. Just wanted to draw your attention to a live webinar from the Clinical Risk Management Program, again on behalf of HRSA. It is Tuesday and Wednesday. It will be recorded and archived if you cannot attend at that time, and I believe that it will be something that you'll find is very timely. Our FTCA Health Center Program Support is a really important feature at this particular time. I encourage you all to please utilize it. It's very easy to reach out to various people within HRSA, but to be the most efficient and to have a rapid response to your questions, please utilize these helpline services.

We have it Monday through Friday. There is the telephone number. There is a contact form that you can complete web based and again, we review all questions that are submitted to us, and we create FAQs on a daily basis. When questions are sent to various parts of HRSA, it just puts a delay in response, and we want to make sure that we are responsive to you during this time. Again, I just wanted to say thank you and express our deep appreciation for all of the work that you do to make sure that the American people are safe. Thank you.

**Marty Bree:**

Thank you, Michele. This is Marty and we're already getting questions coming in through the Q and A on the webinar, on the screen here, but we have a number of questions that have been submitted prior to. I think we ought to start with those that have been previously submitted. Many of the questions, I think Katja said it earlier, have a similar theme, so we may not answer every single question because we'll have answered it previously, but let's start with the first question. The panelists can chime in on this one. "Our question is about telehealth visits to patients in other states where our providers are not licensed. We are in DC and have clients in Maryland, Virginia, and actually several other states. I understand multi-state contracts are underway, but also that states have not gone so far as to waive license requirements in this time. Any guidance on FTCA coverage in these states?"

First, Molly and Michele, have you got thoughts on this?



**Molly Evans:**

This is Molly and I'm happy to give my thoughts, but I also would love to hear from Michele and her perspective. Michele and I talked last week, and I think I described it as drinking from a fire hose in terms of trying to understand the very rapidly changing world of providing services through telehealth. Although many health centers were expanding telehealth programs, they probably had a trajectory of two years that they accomplished overnight, and I think one of the questions that we've been getting a lot from the health centers we work with is this very question about out of state services.

From our perspective in looking at the rules, while the FTCA guidance around telehealth, which has been extremely helpful, gives us guidance about providers providing services from their homes or providing services to patients in their homes, even for the first time, we haven't seen guidance about the provision of telehealth services across state lines. What we would say is, because unfortunately, the FTCA division at HRSA is not the only Federal Government Agency that weighs in on your coverage. We also have the Office of General Counsel and the Department of Justice.

We could envision a circumstance that, to the extent that you had a provider providing services in a state in which that provider was not licensed, because the patient is located in that state and the providers providing services through telehealth, we could envision potential pushback in an FTCA case. What we would think would be a best practice on that in order to ensure that you have the ability to demonstrate scope of employment, is that you have clarity around your ability to provide services in a variety of jurisdictions where you might find your patients.

Because of this rapidly changing, and expansive mechanisms that have been put into place in order to provide telehealth services, I think that you will find that many states will recognize the licenses of other jurisdictions in providing services. It's just something to keep in mind. I think the reality of the provision of telehealth services, in terms of what that looks like in a medical record, you may not have an understanding of where the patient is when you're providing the services. So that's something to keep in mind, definitely a Risk Management concern of ours and something that we're keeping track of.

**Michele Chambliss:**

I think at this time, we cannot make any assurances because, like Molly said, the Department of Justice will make the final determination, and that is based on the facts of each situation. Health centers should proceed with caution and research other options for coverage for services that may fall into this area. I would like to draw your attention to the Health Center Program telehealth PAL, which helps out and highlights some of the relevant considerations for health centers in providing in scope services through telehealth. One of the things I was thinking, because we've had a lot of discussions about this, but I also draw your attention to, what is it that you're doing when your clinicians are on call? What are your state regulations on crossing over state? I think that's important for you to go back and look at to be able to answer some of these. Thank you.

**Marty Bree:**

Thank you, Michele. Let's finish that with a comment that in many cases, you don't know where your patient is if you're doing a telehealth visit with them. Of course, you could ask them, but you've really got no guarantee that you know where they are, and this has been going on for some time now. I guess the bottom line from us is, it's best if you can determine what the licensure laws are from those areas where you might expect to be providing telehealth too and do your best to meet those requirements. Then we also are hoping that states are going to get organized a little better around this telehealth issue to solve this question for us.

**Molly Evans:**

If you have GAP Insurance, and a health center that also carries GAP Insurance, that is probably a good activity to keep in mind, that you might be in touch with your GAP Insurance provider, and describe the



fact that that might be something that you're doing or you're exploring doing, to have understanding about your additional coverage on that.

**Marty Bree:**

Thanks Molly. Okay, next question, "What best practices in quality care have been seen for telehealth services and CHCs? Has there been much success that providers and overall the CHC teams have seen as processes they want to continue for future care of patients post pandemic?" I think I'm going to push that over to Keith and Yvonne and ask you guys to talk a little bit about best practices in telehealth.

**Keith Horwood:**

I'm not sure if I can claim to have a best practice, but I have been surprised at how pleased patients were with the service, recognizing that they were going to pay a copay and not actually get touched or examined, but to have a chance to ask questions and be answered, whether they were directly related to COVID or whether they were just their general healthcare questions, that they were pleased that we were making an effort to make sure that they didn't have to come to clinic in an area where they might be exposed to someone asymptomatic or not. I have been surprised at how consistently patients have recognized that as an effort on our part.

They have appreciated it and even the first week or so we did it, we weren't even charging. Once we even started asking them for a copay for some of those visits, I was impressed by the fact that the patients felt like that was a valuable service that they were willing to pay for and that they were quite appreciative of having a chance to have their questions asked and answered, and then sometimes be told, "Gee, I can't sort this out, we're going to need to figure out a face-to-face visit at some point here in the future." We have struggled with the technical support. Our EMR has a video link that works. It's called Hilo. Variably sometimes, we've not been able to use that.

We have used Apple FaceTime with patients who have that. We've used Zoom some, although with some trepidation regarding recent reports of Zoom being hacked by folks. But the freedom that we've gotten with the loosening of the regulations about what is or is not a HIPAA compliant way of communicating with patients. We have made an effort to try and say then to patients, when we're using the non-HIPAA compliant measures to let them know, "Gee, we're trying to be as careful as we can to protect your information, but we don't have the usual safeguards to be sure that somebody couldn't hack and hear information." I haven't had anybody say, "Oh let's terminate the visit." They've said, "Thanks for doing your best. Let's try and get our questions answered." Yvonne, I don't know what your experience has been.

**Yvonne Johnson:**

We are just launching it across our organization. We have multiple sites. We've started with a couple of our much older providers and as far as best practices, it's a best practice to keep the people who are most at risk, because of their age or because of having comorbidities, even in terms of our own practitioner, so it's positive in that way. One thing we're learning is really how everything we've developed has to be very thought out, like word-for-word scripted, this is how you talk to the patients on the front end, this is how you greet them into this process, this is how we do the different triages. It's improved, I think, our teamwork within the organization to make sure that everybody is on the same page. Don't assume that people understand what you say when you just throw something out for them to get rolling with. So, that's what I would say as far as a best practice.

**Marty Bree:**

All right. Thank you, Yvonne. Let's go on to the third question we had, and this is a similar question regarding telehealth services which I believe we've answered before. This is a question from Keith and Keith, do you want to ask that question again?



**Keith Horwood:**

What's happening is, we've been doing planning here in Utah. The Intermountain Healthcare has been busy for several weeks now projecting curves, worse and best-case scenarios and has said, "We're not really sure that we have adequate staff to man the hospitals and particularly the ICUs." They have been sending out communications to recently retired folks who have, perhaps, recently given up hospital practice, a variety of folks who are not currently in the hospital to say, "If you're willing, we're willing to train you and do an expedited privileging process to see if you can contribute, should the need come."

There's a large convention center that is now set up as an external overflow hospital and while it looks now like we may not need to be involved with these, a lot of my providers we're asking me, "Can we help? Can we get FTCA coverage for this?" We believe some of it, particularly in that system, they might get paid for and then they would cover, but we also were asking the question, how does this fit? I think the specialized determination you've talked about a little bit has been helpful, but a question that I had persistently is, what if the scope is not exactly the same?

We have a scope that includes hospital practice, but not the ICU and maybe not as complex of medicine, and how do we think about knowing, is this in scope or out of scope for our providers to go help out in the hospital, a role which they're not currently doing. if I could be asked to do.

**Marty Bree:**

Thanks Keith. Yeah, it's an interesting question because it pushes the issue into scope of project analysis as opposed to an FTCA question by itself. I don't want to put Michele on the spot because of that, but do you have any thoughts on that question of scope of project in these kinds of situations? If you're an internal medicine physician and you're providing internal medicine services at the health center and you have that in your scope of project, how far can you go in the provision of internal medicine if you're assisting in an ICU with COVID-19 patients?

**Michele Chambliss:**

I'll use a scenario, if you are a physician, and you have privileges at a hospital, and you go in to see one of your patients, and an emergency erupts, you are able to provide primary care services. I guess that's where the scope comes into primary care services. I think one of the questions were internist and working in the ICU. When a clinician is in the hospital setting, it's almost like all hands-on deck, and it's very hard to decipher what are just COVID-19 emergency issues. We just have to be careful and remember that the FTCA eligible coverage is going to be on behalf of the health center and I just keep reiterating that.

You almost have to think about it in an algorithm. Does this apply? Would this be covered under the health center program itself and the health center? It gets a little tricky when you go into the hospitals. Now if you have an offsite COVID hospital that's being manned, I think that that's easier to segregate out of this, but it's just when you go into the hospital and if you're going in under the hospital as an internist or working in ICU, then you have to say, "Are you now an employee, possibly, and not the health center."

**Marty Bree:**

Thank you. Okay, let's briefly talk about, because in your question Keith, you did talk about those who may want to volunteer and provide services under these circumstances and by volunteer, and I'm going to define that to be they're not doing this on behalf of the health center. This is on their off time, on the weekends or at night, that they're volunteering on their own to work in the hospital or work doing screening operator here, whatever.

In those circumstances, no, there's clearly not going to be protection under the FTCA program. But, I'll point out quickly that there is a language in the CARES Act that was passed, that piece of legislation that had a lot of money for everybody, Section 3215 I think, creates an immunity for healthcare practitioners who are providing certain kinds of services and that law, what it talks about is that you have no liability for any physical, non-physical, economic, or non-economic losses. You've got to be acting on behalf of a



Non-Profit Organization or a Governmental Entity. If you are acting on behalf of a Non-Profit Hospital or a Health Department that would qualify, you've got to be licensed or certified.

It doesn't apply to operation of motor vehicles or aircraft or anything like that, and there is an exception for willful misconduct, reckless misconduct, those sorts of activities that are not included in this immunity. There is an immunity built into the CARES Act for volunteers. You're going to want to look at it in more detail if policies or people are interested in volunteering to do this, but clearly, you're not going to be covered by the health center FTCA program.

**Molly Evans:**

I think Keith, the other important thing to do as you look at the generalized, particularized determination and evaluate what that means in terms of your ability to respond, and into the hospital or otherwise, is to ensure that in addition to the scope of project piece in the kinds of services that providers can provide within the health center scope of project, I think there is clear language about the treatment of COVID-19 as a responsibility of health center providers in the particularized determination.

The other piece is that, recalling the scope of employment piece as being important, and ensuring that provider's job descriptions, or employment agreements, or whatever the health center is describing, that this isn't something that the health center would like its providers to do, or rather more strongly a condition of their employment that that is articulated in writing somewhere, so that to the extent that you do find yourself in a claim about care provided during this time, you can evidence to the Department of Justice and otherwise that it was, as Michelle said, on behalf of the health centers, and at the behest of the health center, that the clinician went into the hospital or the field hospital or whatever the case maybe, on behalf of the health center.

**Keith Horwood:**

The provider is not tempted to hide under a table reading their copy of their guidelines, rather than just responding, if they think they can help. It should say in their contract, we expect you to help out when you can if it's within your set of skills.

**Molly Evans:**

Exactly.

**Marty Bree:**

The next question, I think we've talked about, so let's go on to this next point after that. "What is the definition being used for recovered? This is in the context of when a healthcare practitioner contracts COVID-19 and then is now "recovered" and can return to work." We have actually two questions related to that, so I'm going to again pass the buck on this one to our clinical experts.

**Yvonne Johnson:**

Yes. There are the two parts to the question? What was the second part of it?

**Marty Bree:**

How do you determine if someone is recovered? What's the definition that should be used or what other facets of this question should be considered?"

**Yvonne Johnson:**

Usually, they've been in isolation for 14 days and they've been fever free for 48 hours, and that means without taking Tylenol, Aleve or anything that lowers your temperature. That's usually what they're saying for whether or not somebody can come back.



**Keith Horwood:**

I think the current guidelines are split between tested and not tested. Although, because healthcare providers are getting priority testing now, I don't think we have many not tested. A person who has cough, fever or shortness of breath who tests negative for the COVID virus, can return to work when symptom free for 24 hours after a negative test. There's a second guideline I saw today that was two separate negatives after positive testing, or if you have a positive test, then you need to be three days of no symptoms with no medication to suppress symptoms. I think all of those suggest that they should be wearing droplet precaution masks to lower their chance of spreading to someone for seven days following that.

Honestly, I expect that tomorrow morning I will get up and I will read the guidelines, and they will have likely changed. Saying what Yvonne or I know to be current today is only good for the next 15 or 20 minutes, and it may have changed or developed already.

**Marty Bree:**

Thanks Keith, and I think that's actually good advice in the time period we're in right now. Check the CDC website on a regular basis to see what the current and most recent criteria for return to work is. They have a complete page on it, and it is somewhat detailed, so thanks for that. If anybody needs a link to that, they can email me or Molly, and we can give you the link to that CDC webpage. Okay, let's move along. "To prevent, prepare, respond to COVID-19 and to rapidly adapt to surge issues, can FTCA temporarily create a streamlined process? A fully privileged and credentialed provider at one FQHC can be deployed to another FQHC through a MOA or other streamlined mechanism.

Also, if a fully privileged and credentialed provider is needed to provide care at a state-run facility at a hospital, could FTCA be extended?" Well, the latter question we've answered. The former question, a streamlined process to allow an FQHC to deploy one physician to a different FQHC. I think I know the answer to that, but I'll let Michelle talk about it.

**Michele Chambliss:**

At this particular time, that is not a feasible recommendation. As I said earlier, the FTCA coverage is not portable. It cannot go from health center to health center. We do have a streamlined process for temporary privileging of clinicians and that's in PAL 2017-07 which streamlines the process. Thank you.

**Marty Bree:**

Thank you, Michele. I can't disagree with that. Even with my more liberal interpretation of it, the statute is pretty clear about that you have to be employed by the deemed entity, you can't necessarily share. The only way I could see a physician or a practitioner from one health center going to another one to work would be if that second health center then employees or contracts directly with that individual, but short of that, no, MOAs are not going to work out.

We have another question here. This is a good one and I'm not sure I can answer this one yet. "Do our furloughed staff members require rehiring and re-credentialing and re-privileging when they return? Does this depend on how long they're gone? If the provider was among those re-furloughed, then that means they have lost their privileges? Will they need to be rehired and start the credentialing and privileging process all over again?" That's a question that I've thought about, and I've queried the Joint Commission to see what their perspective was on that, and I have yet to hear back. If I hear back from them, we'll be updating you on what the Joint Commission's position is, and Michelle, has HRSA thought about that question?

**Michele Chambliss:**

No, not at this time.



**Marty Bree:**

Okay. It's an interesting question because a lot of folks, unfortunately having to furlough staff, and with the clear intention that they're going to be rehired in a month, in two weeks, who knows? It could be months. Would they have to go right away through the complete credentialing and privileging process? My logic tells me no, but logic sometimes isn't the right answer.

**Michele Chambliss:**

I agree. It's almost like you put it on pause and then it picks right back up.

**Molly Evans:**

I agree with that too and I would say that if you look at just a generic definition of furlough, although it may have different bells and whistles by jurisdiction, it is just a temporary leave. Until we hear otherwise, I would treat it as such, and to the extent that someone's re-credentialing and re-privileging is up during the period in which they're furloughed, I would treat that as though they were at the health center working, so you don't find yourself outside of your own rules in terms of when you're re-credentialing and re-privileging. I would treat it as a pause, but hopefully we'll hear back from Joint Commission as a guidepost on that.

**Keith Horwood:**

You're saying if your policy is to re-credentialing in 24 months, someone gets furloughed at 23 months and they're going to be gone for two months, you need to make sure and re-credential them on time, regardless of the pause button of being on furlough because otherwise, you're outside of your own rules that you're supposed to credential every 24.

**Molly Evans:**

Yes. I am saying that. I think Marty and I talked about this ahead of this call, and I think that otherwise, if you find yourself outside of that, then I think you're in a stronger argument for the fact that you have to do it all over again. You might as well keep them like they're currently privileged, but just on leave.

**Keith Horwood:**

Yes, and this seems to me like it has a relatively close parallel in folks who are taking sabbatical, which not a lot of folks do, but we have and we have some experience with people taking a month or two or three months, but coming back as long as, we just obey the rest of our rules about keeping them current.

**Molly Evans:**

Yeah, I think that's our best guess at this point.

**Marty Bree:**

Let's move on to the next question. "Is there anything we need to mention about Risk Management specifically with our staff? Meaning, I can see issues arising if staff providers end up being infected with COVID-19, presumably from being in the office. I don't know if this is more of an HR discussion than that of other Medical Directors may have a concern." There is a bit more to this question, but what are you doing, Keith and Yvonne, in the areas of Risk Management and Training in general with your staff? Have you had a lot of success with that? Give us your ideas on that.



**Keith Horwood:**

Well, it's a bit of a struggle because we're doing our own, but we work at two different hospitals, and the answer to the question, what mask am I supposed to use in this setting and how often do I do X, Y, or Z to protect myself, not only varies from day to day, but location to location. We're in this sweep of rumors saying, "Well, you must use an N95 mask for this, but at that hospital, you only use a surgical mask." It means that we're essentially having a phone call every single day to huddle for our clinics to say, "Who's wearing what masks for what's procedures," to make sure that we're getting as close as we can to adhering to the best guidance that we have, but we have a lot of people.

Sometimes the CDC report and the university report and the Intermountain report are all quoting similar resources and coming to different conclusions. I think all we can do is document our best efforts to be as current as we possibly can, and not only being cautious to protect our employees right now by being as conservative as possible, but also recognizing that we have limited supplies, and if we use them all up this week in ways that we don't really need to use them, then what are we going to do when we hit the peak?

**Yvonne Johnson:**

I'd like to add to that, I found a document by NIOSH and it says, "Understanding of selecting respiratory protective devices." It does state that it is your employer's responsibility to provide the policies, programs, training and guidance on the respirator use. We actually have, our Director of Quality actually knows how to do the FIT test and certified to do that. She did a FIT test on every single person in our organization across all the locations. But again, it's hard to make people wear them because they are uncomfortable, et cetera. However, when people hear that somebody came back positive, they're starting to be a little more diligent wearing it.

Anyway, on this document by NIOSH, it specifically goes through N95 filtering face piece, respirator versus surgical mask. It actually goes by diagnosis, seasonal influenza versus airborne precautions versus droplet precautions. So that's something from the CDC that can probably be helpful. Like Keith said, people are using them in different ways, but definitely, if you're involved with somebody where you're tested, when you're actually physically testing somebody for COVID, my understanding is you would actually use the N95. Is that not what you guys are doing to?

**Keith Horwood:**

There is one company that has an oropharyngeal swab, and they're particularly marketing to say, "You don't need to use aerosolized protection because this doesn't aerosolize." But, at least in our state, our two hospitals have said, "We think that has less sensitivity; therefore, we're going to continue to recommend the nasopharyngeal swabs." It will pay to know what you're doing and when you're doing it, but yeah, it will vary.

**Marty Bree:**

All right, thanks Keith and Yvonne. Let's go to some of the questions now that have come in during the webinar that we really haven't addressed yet, and here's a short one but important. "Thank you for having this presentation. So, for clarity, we have to add telehealth as an additional service for scope on Form 5C." I think I can answer that one. I like to say that HRSA has been fairly clear on this and in the PAL that they published on telehealth, they pointed out that telehealth is not a service per se. It's a means of delivering a service, so therefore you would not have to add it to the Form 5, neither Form 5C nor Form 5A. Correct Michelle?

**Michele Chambliss:**

Correct.



**Marty Bree:**

All right, this one, one of our audience is still not clear on a question. "Are inpatient services for non-health center patients' part of response to the public health emergency, and as part of the employment agreement with the provider?" I assume that means, "A health center provider is covered if this activity is not required by all staff of the hospital." I think that question is, "If the hospital doesn't have a specific requirement to maintain your privileges that you respond in this emergency, do you have FTCA coverage if you are responding in the hospital seeing non-health center patients as part of this COVID-19 activity?"

**Michele Chambliss:**

Who are you responding on behalf of? Is it on behalf of the hospital or is it on behalf of the health center?

**Marty Bree:**

What if I ask the question a little differently? Supposing the question was the health center is asked to respond and as a result, the health center directs some of its staff to go and respond at the hospital as part of the duties as a health center employee. Does that make a difference?

**Michele Chambliss:**

That is written in the employment contract?

**Marty Bree:**

Yes, absolutely. We always recommend a writing here so that if the health center is going to do that, they need to make sure that their PD, or their contract, or an addendum to it, directs the individuals to do that.

**Michele Chambliss:**

Again, that just gets to be very technical because this is supposed to be in relation to COVID-19 response. There are no guarantees if you are in the hospital, the role that you're going to play in relation to this response.

**Marty Bree:**

So, then you need to be very careful that if you're responding to COVID-19 emergency, that you don't get pulled into other traditional hospital activities?

**Michele Chambliss:**

Correct. There is greatness at doing so.

**Keith Horwood:**

Let me ask a specific question related to that. Because this came up, we requested the departments where we have privileges at our hospitals to put in their privilege and guidelines that you are expected to respond within the limits of your skillset and privileges to emergencies that occur. The specific thing that happened a lot to us would be taking care of kids in the emergency room at Primary Children's and when their father or grandfather faints watching somebody get stitches, no surprise the pediatricians all turn to the family doctors and go, "Hey, can you help out? This is a big person."

We didn't want to be quibbling over whether we were covered or not and so we said, "We wanted to say in your privileges, and it says in our contracts when we're in the hospital to take care of a health center patient, if there's an emergency that occurs, that we have the ability to respond to, we believe responding to it appropriately is a part of your job here at the health center." We tried to balance it against the other



emergency to say, "And we would expect other clinicians to do the same if it was your patient or if it was you."

**Michele Chambliss:**

That is acceptable. That is one of the examples that I started with earlier, but if you are an internal med physician and someone asks you to deliver a baby, I think we have a problem.

**Marty Bree:**

Okay, let's move along. "You've discussed telehealth visits for patients across state lines. However, what if the patient across state lines is an established patient with your health center? How does this apply? Can the health center provide the telehealth visit?" Yes, we still have this confusion over telehealth and whether it's an established health center patient or not. The issue that we are grappling with is the licensing requirements of the physician, and that doesn't change, whether it's an established patient or a new patient.

If you're in Vermont and the patient is in New Hampshire and New Hampshire requires that anyone providing telehealth to a patient who's located in New Hampshire must be licensed in New Hampshire, then that Vermont physician should be licensed in New Hampshire. You're going to have to have a knowledge and understanding of what the licensing laws are in those states where you might be providing telehealth visits too. Molly, anything else to add on that question?

**Molly Evans:**

The only thing I would add is, I had said earlier, to make sure that you look at your GAP Insurance on that to the extent that you could have coverage or additional protection through GAP. And I saw one of the comments by a participant to this webinar that their GAP Insurance provider explicitly told them that if they're providing telehealth services across state lines that they would not be covered. I thought that was interesting to note, and so all the more reason to make sure you are checking in and/or having a handle on that to have an understanding of where your patient is when you're providing services.

**Keith Horwood:**

I have a question. Is the question then the location of the patient defines where you're practicing medicine? I saw one of the participants was asking the question, they have a provider who's licensed in the state where they're practicing, but who lives in Canada and wants to know if, whether it's across a state line or a national border, if they just are practicing from outside of the area, but they're actually practicing in say Vermont. It seems to me like they're licensed in Vermont and they're practicing in Vermont. It doesn't matter whether the provider is over the border talking on the phone because they're practicing and taking care of a patient who's in the state where they're licensed. Is that a reasonable assumption?

**Marty Bree:**

That's a great question Keith, and it's a question I thought about over the years. Same question can apply to lawyers. The only way I understand this is that certain states, and actually the majority of states, took the position that if the patient is in their state, they don't care where you are as a physician, you've got to have a license in their state to care for that patient, and that creates the question. I'm licensed in New Hampshire, but if I'm sitting in California and I'm doing a FaceTime with that patient, and I don't have that New Hampshire license, and I'm using New Hampshire as an example, I don't know if this is the truth, but then I have a problem.



**Michele Chambliss:**

There are a lot of states that are temporarily amending their requirements for providing care through telehealth to address their whole needs. I think you're really going to have to look at what your state laws are saying.

**Marty Bree:**

I think that's correct. And it's very fluid right now, so you might check tonight, and the answer might be different tomorrow.

**Molly Evans:**

The other thing I would say is that this is, so the law has not caught up with the technology around telehealth, and so that's the other problem, and why some of these answers aren't as black-and-white as we'd like them to be, because we just don't have the law to look back on to see how courts are opining on this because it's so new. Then you have this public health emergency on top of it that creates these flexibilities that we're not used to having. It's a brave new world for sure in very many ways.

**Marty Bree:**

There's another question up here. There's a language and I think it's used in the particularized determination, but you respond to COVID-19. I think the language talks about individuals who provide grant supported health services to prevent, prepare, or respond to COVID-19, and the question is, "Does that mean that we can only care for COVID-19 patients?" I would think that that would mean that you're treating or diagnosing or determining COVID, if someone is a COVID-19 patient or not.

Not all the patients you're going to see while you're screening, while you're triaging, are going to necessarily have or become COVID-19 patients. My view that that phrase responds to COVID-19 doesn't limit to your patients who have COVID-19. Michele?

**Michele Chambliss:**

You're going to provide the service that is required for the patient that is in front of you, if that's helpful.

**Marty Bree:**

We've only got two minutes left. I know there are a couple of questions, Katja, about the slide's availability and perhaps about availability of this webinar later.

**Katja Laepke:**

Yes. I did answer those questions in the chat, so some people may have seen that. Also, the last slide we currently have up, gives you the link to the resource page hub for NACHC's COVID-19 related resources. We'll also be emailing all of you following up on remaining answers to questions we couldn't get to. We'll let you know when the next office hour is, and we'll send you the slides and make sure we let you know when the recording and everything is posted on the page.

**Michele Chambliss:**

Also please utilize our Frequently Asked Questions on the website. Every question that we get in, we do a Frequently Asked Questions for it and post it on the website, usually within the next day. We will look at the questions that you proposed, if they are different from what we already have on the website, then we will make sure the answer is provided in there. Also, just a correction because I had a typo, the deeming applications for 2021 is July 13th.



**Katja Laepke:**

Thank you very much Michele. We will make sure that all of you know where to access this information and especially the FAQs that Michele just mentioned.

**Marty Bree:**

I just like to thank Michelle and Yvonne, Keith, Molly, Katja, and Beth for putting this together, and turn it over to Katja and Beth for any final remarks.

**Katja Laepke:**

Yes. Again, thank you and just please stay in touch with us. We will also stay in touch with you. We'll let you know when the next office hour is and just stay well and strong please. Goodbye and until next time. Thank you to everyone. Bye-bye.

**Keith Horwood:**

Thank you. Be well.