COVID-19 and FTCA Office Hour #2 – April 22, 2020

Transcript

Katja Laepke: Hello! I'm Katja Laepke, Director of Clinical Trainings and Workforce at NACHC, and on behalf of our faculty and the NACHC team I would like to warmly welcome you to today's office hour on COVID-19 and the FTCA. To many of you welcome back if you also joined us for our first office hour. You continue to have our whole-hearted gratitude for your inspiring work and passionate commitment to the work you do every day. This is the second office hour in our series of four. Our next one will be on May 13th, followed by the last one on June 3rd.

Along with Marty Bree, Of Counsel, I will be serving as your moderator today. We are joined by Molly Evans, Partner at Feldesman Tucker Leifer Fidell, and Dr. Michelle Chambliss, Director of HRSA's BPHC FTCA division, and Dr. Yvonne Johnson, Chief Medical Officer of Medical Associate's Plus in Augusta, Georgia, and Dr. Keith Horwood, Associate Medical Director of Community Health Centers in Midvale, Utah. Both of whom are experienced Clinic Leaders and Faculty for NACHC's Training for New Clinical Directors, with expertise in FTCA.

During today's Office Hour we will continue to answer your specific questions. Please submit them at any time. Please don't hesitate. When you do submit your questions, please do so in the chat box in the lower right-hand corner of your screen and please send them to all participants. We also will be addressing questions related to Telehealth, drive through screening, hospital search, and other available liability protection. We will be sharing today's slides, including all links and resources, right after this office hour, and the recording and transcript will be posted on NACHs COVID-19 webpage next week. You can also find these materials in the Health Center Resources Clearing House.

Thank you, and I'll now turn it over to Marty, Marty?

Marty Bree: Thank you, Katja. Today we're going to be talking about a number of issues that are related to your response to the COVID-19 emergency and the FTCA implications of it. This is the second Office Hour that we've had, and, as usual, a number of questions have come up regarding some of the issues that we previously discussed, and some new questions have come up. We've got a number of slides that we're going to run through today that are going to address some of the questions that I know you may have, and, as Katja asked, please send your additional questions into us via the chat box in the lower right-hand corner of your screen.

To start with, today we're going to discuss provision of services to non-health center patients via Telehealth. We'll talk about the provision of services at temporary locations via Telehealth. We'll talk about providing services to patients via Telehealth when the provider is located in a different state. These are just the beginning of some of the items we can talk about today. The next slide, Molly are you going to take over and start with that first slide?

Molly Evans: Sure. Thanks Marty, and I hopefully will tag team with Dr. Chambliss to make sure that we're getting her very important thoughts on these questions as well. As we try to answer these questions for the health centers that we work with, I find it necessary to go back to the Bureau’s FAQs. Almost every time I look at them, even though I read them 150 times at this point, and just reorient myself with this world that we’re living in. The first question is, with respect to Telehealth and providing In-Scope services
through Telehealth to individuals who are not current health center patients. That question is actually addressed in the FAQs, and you'll note that the answer was addressed more than a month ago, that health centers are permitted to provide In-Scope services via Telehealth to individuals who were not previously health center patients or haven't previously presented for care at the health center site and are not current patients of the health center, during the public health emergency.

This includes triage services and initial consultations. We have clarity that during this time of pandemic response, health centers can see patients via Telehealth that were not otherwise current health center patients. We continue to get that question. I think the important pieces to note, which we can look at on the next slide, is that there is some guidance around this that we should be keeping track of each time. The first is that the service, regardless of whether or not it's a new patient or an existing patient of the health center, the service has to be In-Scope. It's not a time to add services that are not on your Form 5A as either required or additional.

And to keep in mind that if you are going to do that, if you're going to start providing Behavioral Health Services that you haven't otherwise provided, that you need to be taking a look at whether or not what you're doing is represented by your current Form 5A services, or if you need to add a service. Say you're going to start providing Psychiatry and you don't have that listed as a service. Keep that in mind. The provider documents the service in a patient medical record, so again documentation is going to be key throughout your response to the COVID pandemic, and keeping in mind that how you document and demonstrate that someone is a patient of the health center will be supported in documentation in the medical records.

Note that there is clarification that the provider can be physically located at the health center service site or at another location including the provider's home, so that again has been clarified for us. And finally, that you should continue to focus on providing services to patients inside your service area or adjacent to. However, within this question there is also guidance that to the extent that you find that your target population has moved outside of the service area, that it is permissible on an occasional basis to provide those In-Scope services via Telehealth to individuals outside the areas.

But again I really think, and I think Marty probably would agree, that documentation is going to be the name of the game on all of these COVID activities that you're doing that are maybe not usually done in your "normal work", so that you can have a clear understanding and sort of narrative in terms of how these services were provided, that you provided them on behalf of the health center, that your providers, either within their employment agreement or their general descriptions or your employee handbook, it's clear that they are providing these services on behalf of the health center even if they're working from home because they themselves are quarantined, etc.

Keeping in mind all those pieces and really with the Telehealth question, I think it's a good example of the kind of question that the Bureau has spent a lot of time trying to address in these FAQs, and so going back to them makes a lot of sense. If Dr. Chambliss wants to add anything that I've missed, I'm happy to hear it if there's some other things we should be keeping in mind on that.

**Marty Bree:** I want to add just a little something to your remarks about record keeping. Let's keep in mind that the questions we're asking about are related to malpractice protection for activities we're engaged in today, but in all likelihood the protection that we're asking about won't come into play until a year or two down the road when a claim may be filed against us. So, we're talking about two years from now, being able to have the documentation that we're going to need to show that what we were doing was consistent with the statute and the regulations and all of the other guidance that's been put forward today.
I can't express the importance of the documentation, particularly when you find yourself in unusual situations that may require some difficulty in documenting what you're engaged in, but it's still very important to do that.

**Keith Horwood:** As I read this, although this is a specific finding for the duration of the COVID-19 epidemic, the services are not limited to COVID related services. So, if a patient called and said, "My mental healthcare provider has closed their office for whatever reasons. I need to seek care," as long as it's within Scope it's still allowed, even though it's a question that's unrelated to COVID itself?

**Molly Evans:** That's correct. Yes, as long as they're In-Scope services.

**Michele Chambliss:** Because remember, the service that you provide is primary care so it would fall into that bucket.

**Molly Evans:** Right, and I would recommend that you take a look at the Service Descriptor Guide if you have any questions about whether or not what you're doing is in your Scope. After you look at your Form 5A and then you say, "Oh, are these Behavioral Health Services in line with what I'm doing," etc., or whatever the case may be. Likely you're not going to be doing some sub-specialty care that you weren't doing before but particularly around the behavioral health side, making sure that you have the appropriate pieces in your Scope.

**Yvonne Johnson:** I'd like to add something here. We have Behavioral Health and we've had it for a while, and they've been using Telehealth for a while. And our senior person in Behavioral Health, the Psychiatrist, said one concern she had about taking new patients was, people could actually say they were somebody. They could identify themselves as somebody who they actually weren't, and she could end up treating them and then ultimately having a problem. So, what they've actually done now is they actually see a driver's license in the screen with the person when they start evaluation, so they have Government issued ID to identify that they are actually talking to the person.

Because at first it was going to have anybody that was new have to make an onsite visit, but we're really trying hard to keep people out of the office as much as possible and use as much Telehealth as possible. So that was just an issue, to make sure that you're actually talking to who you think you're talking to, because people are kind of creative in how they do things sometimes.

**Marty Bree:** That's a great tip, Yvonne. People maybe who don't have insurance may be using a different identity, so that's a valuable piece of information. Thank you.

**Keith Horwood:** That would match our process on any given day when the person came to clinic as well.

**Michele Chambliss:** Yvonne, a quick question for you. When you see a non-health center patient, do you automatically document in the EMR?

**Yvonne Johnson:** I document the visit, yes. Anybody that's seen is documented in the EMR. Anybody that's seen, yes. They become a patient and they're managed, yes. In a sense that it's coded as a Telehealth visit, etc.

**Michele Chambliss:** Thank you.
Yvonne Johnson: We've only been doing this for a few weeks but yes, that's what we're doing.

Molly Evans: This is the second question, and I think we can move more quickly to the extent that we've addressed these. Can a health center use Telehealth to provide services to a patient that is not at an In-Scope site? Can this occur if neither the health center provider nor the patient is at an In-Scope site?

Again, the answer to this question, which comes up a lot and we want to make sure that we're clear on this, is that the answer to that is yes. The patient can be at home and the provider can be at home, but again there is guidance that the service is permissible from a Scope of Project perspective. If the service is provided within the health center's approved Scope of Project, it is provided on behalf of the health center, and then the individual receiving the service is a health center patient. We have that standing alone, I think may make you say, "Wait a minute, we just said that we don't have to be a non-health center patient."

I would like to pose the question to Marty about how that works in tandem with the previous question about the non-health center patient.

In this question on slide nine, it says that the individual receiving the service is a health center patient, to the extent they're not in an In-Scope site. How does that align with the fact that we know any non-health center patient can be seen via Telehealth and still have it be permissible?

Marty Bree: Good question, and I think the answer is found in the Particularized Determination that was published that deals specifically with care to non-health center patients during this emergency, where Jim Macrae stated that you're protected for grant supported health services to prevent, prepare or respond to COVID-19, including, but not limited to screening, triage, testing, diagnosis and treatment to individuals who are not established patients of the health center, whether at the health center or off site, including at offsite programs or events carried out by the health center and whether in person or through Telehealth.

So, the particularized determination clearly states that you can provide it onsite, offsite, to health center patients, or to non-health center patients, and use Telehealth as a means to do it.

Michele Chambliss: That's how I would interpret it too, Marty.

The only difference in this and the regular Particularized Determination is usually health centers are writing via email into our mailbox portal and they ask permission to do something. It could be a physician that has learned a new skill and wants to go somewhere else and train other people. That's the type of things that would come under this Particularized Determination. Community health fairs or screening under tents in the parking lot, all of that is something that you're eligible for FTCA coverage.

Yvonne Johnson: But to do that, we also had to make that change on Form 5C, column three, right?

Marty Bree: I don't think that the Particularized Determination requires that you do that. But it's always advisable to add these items to Form 5C.

Yvonne Johnson: Not Particularized Determination, but just because we're using tents. We're screening people before they get in, and then if we end up not having them to come in we're dealing with them in the parking lot. That's something you have to specify, correct?
Michele Chambliss: You don't have to change it on the H80 side, no.

I think the rule of thumb is, and I think Molly or Marty said this, is anyone who is deviating from their normal process, needs to document that, because if something does happen and litigation comes up, then you would have to be able to show that documentation of why you deviated from that. But no, that was the reason why we issued the Particularized Determination specifically for COVID-19 and public health emergencies, was so that it was more flexible as far as non-health center patients. And as long as you're In-Scope, you're fine with that so you don't need to submit a request for a Particularized Determination. That one that we gave, that we just published two weeks ago, is basically a blanket for Particularized Determination.

Molly Evans: And I think the other important point that we talked about with that is that, to the extent that what you're doing is during this period of time but is not related to responding, reacting, or treating around COVID-19, that you also need to be taking a closer look at this. A lot of the flexibilities that are available now are really intended to be specific to this program, so keep that in mind as well.

And on the last piece on the Telehealth I would just say that within the FAQs there's guidance also to make sure that you have policies around what you're doing and that those policies are compliant with not only the health center program or 330 program, but also the federally supported health centers assistance act or FTCA program but also all your other Federal, State and local requirements and standards of practice.

I think we have some resources at the end of the presentation around questions about Scope of Practice for providers depending on what state you're in, who's permitted to provide services via Telehealth, states that are extending flexibility around waivers for licensure, etc.

Okay, I think we covered this question so I'm going to move along, Marty if that's okay, to the drive through screening?

Marty Bree: Yes, I'll take this question here. The question is, if we are doing a drive through testing clinic, are there any concerns if the driveway or parking lot does not belong to the clinic? Are we in a different site and thus Scope is affected? I think Michele was very clear in that answer, that so long as you're providing the services in your Scope of Project, it's something that you already do, it would be on Form 5A, then the response by providing it at a testing clinic is going to be covered.

There's a lot of ways to look at that, but one way is if you look at a testing site as a screening mechanism or you can also describe it as a health fair, you could argue that it's protected that way. And you could also argue it's protected via the temporary response, the emergency response policies that HRSA's put in place. Michele, do you have any comments on that particular question?

Michele Chambliss: Specifically looking at the question or the example that was there in the second paragraph, so I guess this would be primary care services that you would be conducting ordinarily, so I believe that that is something that you're eligible for FTCA coverage on that.

Keith Horwood: Thank you. That was originally my question and I really appreciate that answer. We have had staff who were doing A1Cs in the parking lot but burning through a lot of PPE to do it. So, our staff came to us and said, "Listen, these people all know how to draw their blood. We want to stop putting on all of our gear. We're just going to take a sealed container out to the patient, hand it to them through..."
the window, let them draw the blood and hand the cartridge back.” And so, we’re salvaging PPE, but it's good to know. It sounds like it's been a very clear answer. It's part of our primary care if they're established patients, and FTCA should have no problem with it. I appreciate that.

**Michele Chambliss:** You have a clear waiver, so it doesn't interfere with those rules and regulations?

**Keith Horwood:** Yes, it's the same people running the test, it's just that the patients are drawing the blood. And they're already doing that on their own for glucose sticks, and they're under the direct supervision of the staff member to make sure that they've filled the container appropriately.

**Marty Bree:** I'm going to go on to next question. Will a Deemed health center's providers remain covered by liability protections under the FTCA if they are directed to provide continuous or permanent services to non-health center in-patients at a local hospital as part of a community wide response during the declared COVID-19 public health emergency? And this, we will confess that Molly and Michele and I had a somewhat lengthy discussion on this one and tried to tease out what you can and what you can't do and expect FTCA protection.

I think I'm going to ask Michele to answer this question as it's stated here. Someone is asked to go to a hospital and be stationed there on a continuous basis, let's say for the duration of this emergency, and should you expect FTCA protections on an assignment like that, that you got from your health center.

**Michele Chambliss:** Sure. I think one of the fundamental things that I start out with in trying to respond to all of these questions is one, who's paying for the provider, who holds the contract for the provider? And whatever services are being done, you have to be In-Scope, so you can't go in and do a different specialty in the hospital for which you've been Credentialed and Privileged. Say Internal Medicine, you're not going to necessarily be able to go into a hospital and deliver a baby.

Again, look at all of those things and ask yourself those questions. Is it In-Scope service? I think we're okay with whether it is or is not a patient. That's fine. And then, what setting is it in? This has been a difficult question because everyone comes to the table with just a slight variation to the question. But I try to give analogies and descriptors and scenarios, so that you can fit it into your applications.

So, I am a health center. Did the health center reach an agreement with the hospital? Is the hospital paying for it? Is the **health center** paying for it? What does it say in the affiliation agreement between all parties? You have to look at that, because one thing that is important is, FTCA coverage is not portable, so it doesn't go with the provider. We deemed health centers, and the word deemed means that that health center has the ability to receive medical malpractice coverage for providers, boards, but in this case, providers is what we’re talking about.

If a hospital comes to the health center and says, “I would like you to send some of your providers out. We have an offsite facility for just COVID patients.” Fine, that's clear cut, and that's an easy answer. It just gets a little bit murky when we send health center providers into the hospital and it's all hands-on deck at that point. So, will you be able to segregate just the COVID-19 patients at that particular time? Probably not.

So, you would not be covered under that, and I think you have to work with your general counsel to see what is feasible for the health center at that particular time. Did that answer the question?
Marty Bree: Yes, I think that was very helpful. Let's also remember that these questions, once we start talking about placing our health center staff into a hospital setting, we start to move away from the area where we're pretty confident around FTCA coverage and you're getting into the area where our level of confidence is less than high. And also keep in mind that if a claim arises, that there's going to be another party who's got a big say in whether there's going to be coverage, and that's the Department of Justice.

We're going to want to be certain, no matter what we do, that we're showing that we are actually responding to this emergency and we're not supplanting or supplementing a traditional hospital activity. And that's important I think as well.

Michele Chambliss: Now, if you're entering into a contract with the hospital, then you're going to fall under their medical liability insurance.

Marty Bree: Yes, absolutely. If a health center contracts with a hospital for the services, then it's going to be difficult to argue for FTCA coverage.

Molly Evans: Right. And by the same token, I would say, because I've seen this recently, that your local hospital is trying to get your providers to come to support hospital activities. You do have the ability to negotiate coverage for your providers for those activities, to the extent that it's not going to fall within one of these clearly designated FTCA pieces. So, to the extent the hospital is self-insured and can provide the coverage for your providers, in some cases that's not going to be possible because of the hospital's own medical staff by-laws, but in other cases, that might be a possibility or there might be a way to make an exception in this case. Between that or GAP Insurance, to the extent you fall outside the realm from what a normal, traditional healthcare activity would be in responding in a hospital, you need to start looking at other sources of liability protection.

Keith Horwood: It relates to the sort of emergency exception. Let's say, for example, there's 10 doctors working at the hospital and we need to take two unassigned emergency room calls every month in order to keep our privileges. If the hospital were to come to us and say, "Three of our 10 doctors are now out sick and cannot see patients. We need you to up your game to four unassigned shifts a month, and if you're not willing to do that, now your privileges are at risk and your ability to admit your health center patients is at risk." Would that potentially put that within the emergent coverage exception, or should we be shopping for GAP to cover that? Or should we be saying to the hospital, "Sure, but you cover the malpractice."

Marty Bree: A good question Keith, and what you're referring to is the exceptions for care to non-health center patients that was published originally in 1995, and republished in a Federal Register in 2015, I believe. That exception, and I'm just looking for it right here, I want to see the exact wording of it, talks about requirements for hospital call based upon your privileges. And the language in it is, "Periodic hospital call or hospital emergency room coverage is required by the hospital as a condition for obtaining hospital admitting privileges. There must be documentation for the particular healthcare provider that this coverage is a condition of employment."

The operative sentence is, "Periodic hospital call or hospital emergency room coverage is required by the hospital as a condition for obtaining hospital admitting privileges." I would think that if, because of illness, some physicians can't take their required call on a particular day and the hospital then requires someone else to do it and it's consistent with their by-law, then I would think it falls into this and you'd be protected. It's always going to be important to make sure that the hospital does in fact have a written by-law, or
some kind of rule, that requires it. Either a department rule, a medical staff by-law or hospital by-law or something, that specifically applies to what you're doing.

Molly Evans: I would agree with that, and I would add that I think that what Keith has described is in line with that exception for participation in order to maintain privileges. I would just caution you against, not you Keith, but a hospital and health center trying to be too cute and saying, "Oh, this is a responsibility in order to maintain privileges," but the only people it applies to are the health center providers. It doesn't apply across the community to all providers that have privileges, that we're both in on it because we want this to happen, so we're just going to try to fit it in as exception because an industrious US attorney could find out that and then say that that's a reason that this is not within that exception and is not covered.

It needs to be truly something that the hospital is requiring of all people that have privileges, not just the health center.

Marty Bree: Thank you. Let's go on to the next slide. This is again, talking about that same issue of responding to the hospital surgeries by providing permanent and/or continuous service within the hospital.

Molly Evans: These just have the remainder of the commentary on the hospital services question and FAQs to the extent anyone wants to take a look at this, but we can move on to the other liability protection which fits in here with our current question.

Marty Bree: And the first item is, there's immunity provided under the CARES Act, specifically for volunteers. And I know we've had questions about, will the FTCA cover our physicians, if they volunteer after their health center duties are finished, to go and work in a hospital ER for COVID-19 activities, or go volunteer to do screenings that the Health Department has set up in a football stadium. That sort of question, and the CARES Act does provide for immunity from suit for volunteers who are providing those kinds of services.

There are exceptions in that, immunity for gross negligence, willful misconduct etc., that you need to be aware of. If you have anybody that believes they want to utilize that, they need to take a good look at the CARES Act, talk to their counsel about what it does cover and what it doesn't cover.

Yvonne Johnson: I'm going to make a quick comment on that. I think that one of the things that we've noticed here in Georgia, and I think you've probably noticed this all over the place, are that people that are working in the nursing homes, a whole lot of people have been dying in nursing homes and we've had several deaths here in Augusta, Georgia. There've been a lot of deaths in Atlanta at some nursing homes. So, one of the things we've even been concerned about is some of our staff, especially MAs or LPNs, etc., may moonlight in nursing homes.

This is not, "Are they covered?" This is, "We also have to think about what people are bringing back into our organization and try to get people to limit going out into the world to do additional risky behaviors if they can limit them." We want to also be aware of who's working, if anybody's working, at the nursing homes, etc., because we know those are places where there's seemingly some lack of control over what's going on and more people are getting infected.

That's another way to view it. It's just thinking about your staffing. Yes, people want to volunteer. Yes, people may or may not need additional help. But we also can't, especially places that have very small
staffing, you don't want to be sending out your providers and then ending up losing the people that are managing your patients on your own site. It sounds selfish, but it's also something to think about.

Michele Chambliss: To answer that Yvonne, moonlighting is not a covered service under FTCA.

Molly Evans: Yes, and just from a HR perspective, if that's a problem that health centers are struggling with because they have providers that want to be out in the world helping when they're not working at the health center. That is a general risk management issue for the health center's consideration, and maybe taking a look at the employment agreement. A lot of times, at least when we write employment agreements, we have language about how the provider needs to devote his or her whole time to the health center and get permission for any moonlighting, that they have to have their own liability protection for. But aside from the fact that you don't have FTCA coverage for that, you're bringing in, potentially, a greater risk to the health center patient population if the provider is moonlighting at a nursing home etc. I didn't even think about that sort of a headache that the health center might have to deal with.

Marty Bree: It's just another headache that we have to deal with.

Remember, if you're using volunteers within your health center, healthcare professional volunteers, they don't have the protection of the FTCA program unless you have applied and sponsored that volunteer via an application to HRSA. I think you can find all of that information in PAL 2020-03.

Let's talk briefly about some other immunities under state law. As this emergency has evolved, many states have passed laws granting immunity to healthcare practitioners who are providing services to COVID-19 patients. Each of these state laws, and these immunities provided by the states, are different. It's hard to generalize about them. Some include provision of services to COVID-19 patients or patients who might have it. Some include immunity for care to all patients during the emergency. Most all of them have exceptions for willful misconduct, gross negligence, criminal behavior, etc.

If you're concerned about whether or not something is covered under the Federal Tort Claims Act program, you might, and I stress you might, have some relief under your state law. You need to have your local counsel examine what that new state law immunity may be and how it might affect what you're doing. I'm sure it's also going to be something in the future that the United States is going to look at, because of course United States can take advantage of that state law immunity in cases of an FTCA claim, so we'll see what happens a couple of years from now with that.

Molly Evans: I know we've already had time to talk about GAP Insurance, but I would just mention that depending on the jurisdiction, the state law immunity, while it may be effective for some of these types of services, may not necessarily come with attorney's fees awards. So, to the extent that you have GAP Insurance, consider whether or not that GAP Insurance can pay counsel to assert the state law immunity or the CARES Act immunity just like it might in the FTCA immunity which we see oftentimes that health centers that have GAP Insurance can use that coverage to have counsel assert immunity and/or participate in the litigation of the case under the state law immunity, even if that's not necessarily what the GAP Insurance provider may think that their role is at the outset.

Yvonne Johnson: One really quick point on this too. The other thing I've noticed during this time is the laws, the rules, the edges keep changing. Like literally, you can read something today, and by Friday it can be slightly different. When we were doing this call a couple of weeks ago, I looked through what the laws were for Georgia for Telehealth, both doing it in the state and doing it with your patients when they
go outside of the state. And I'm just mentioning this, that you really need to keep going back and looking. You need to document, "Okay, we were doing this based on what was documented on this date. It's April 22nd, 2020, and at this point Georgia state says we can do blah, blah, blah, blah, blah." But you need to look back, because it could be next week that they make a minor change and it's not like they're going to send you out necessarily some announcement.

**Molly Evans:** That's a great point, yes. Absolutely. It is a moving target to say the least, and presumably, to the extent that you have some additional flexibility during this time, that you noted in your state law, that I'm assuming that you wouldn't have to check back every week to make sure that was still in place but on the other hand, in Georgia you guys are going back to status quo and hat could mean a change in the law in terms of the flexibility, or changes in payment protections etc. So that's a great point, yes.

**Marty Bree:** Thank you, Yvonne. Okay, let's talk briefly about GAP Insurance. Many of you carry GAP Insurance, and you carry it to provide protection for those instances where you're not covered by the Federal Tort Claims Act program. And as Molly pointed out, another benefit of your GAP Insurance is that it is designed to pay for the defense costs of any claims, and the defense courts can include an assertion of your immunity under the FTCA, or you want to make sure it's available to assert your immunity under any of the state laws where it exists.

GAP Insurance, there are a number of insurers around the country who provide GAP Insurance. It is not inexpensive. In most cases it costs around 25% of what a full professional liability policy would cost, and you can design GAP Insurance policies tailored to meet your needs. Most of the ones that I've run across are basically policies that say, "We cover all of your professional liability, with the exception of anything covered by the FTCA." So, it's a blanket policy that virtually wraps around your operation, and just carves out the FTCA. What the FTCA covers, they don't. And that's why the premium is reduced to only 25% on average.

That may be high, quite frankly, but that's typically the way it is. Now you can also, and I've seen this, buy GAP Insurance for specific activities that you're engaged in. If you're confident that, "I am covered because I'm a small health center, I'm only doing a small number of things, but I need GAP Insurance for the one activity that I do," you can tailor GAP Insurance to a specific activity or group of activities. The value of GAP Insurance in an environment like this COVID-19 emergency is, as we were talking, and we have been in the other office hours, there is some uncertainty about FTCA protections and uncertainty about how you're going to be providing care from day to day.

In an era of uncertainty, a GAP Insurance policy can provide you with some assurances. I'd recommend that you discuss this with your GAP carrier or your GAP Insurance agent to make sure that the policy that you have does provide protection for what you're doing in the event there isn't any FTCA protection.

**Marty Bree:** We do have some questions that have come in so let's start with them.

I'll ask them, and everybody else can answer them. First one we have is, "Can we write prescriptions for non-patients we haven't seen, even through Telehealth? That is, can we write partner pack RXs for STD treatments?" This sounds like we're talking about the expedited partners therapy question, and how all of our new policies relate to the decision around FTCA coverage in the expedited partner therapy situation.

**Molly Evans:** Can we write prescriptions for non-patients we haven't seen? I don't think that you can do that and have an expectation of FTCA coverage at this moment. I think that there are often times in
expedited partner therapy laws, in states there are state law immunities that attach to the extent that you are providing expedited partner therapy, even through Telehealth or not. But I don't think that at this moment, that the FTCA program has a mechanism in which you prescribing for non-patients, and in this case I mean people that you haven't even seen via Telehealth, that you're going to run into a coverage problem there. We haven't seen one of these cases. I mean, I haven't seen one, I don't think Marty has either.

Marty Bree: No, I have not.

Molly Evans: I've been doing this for a shorter period of time than Marty, but I have been doing it for 18 years at this point, so that's some period of time. I haven't seen it. I guess my question would be, can we get the partner to have a visit through Telehealth if they're in the home with the partner that we're treating? Because I don't think that we have a mechanism right now. If I'm wrong about that, I would love to know that. I would love to be corrected on that, but I don't think so.

Marty Bree: I'm not going to correct you.

Yvonne Johnson: I'm not going to correct you either, but I think it's very interesting. We have the expedited partner therapy done in our women's health department and what I was thinking just listening to you is, could you use the Telehealth check in type of visit? Like have the patient's partner call and make the contact with the provider, and in that way become the provider's patient. You know, without having to come in. You can actually just have the discussion about it and do a quick visit and go on and get them treated.

Molly Evans: I think that that seems like that could work.

Marty Bree: I would think so, because then you're not really doing expedited partner therapy. You're just using a system where the one partner convinces the other partner to call and have an encounter, be it a Telehealth encounter. I would say that, that's a distinction that matters now, and that you could have protection under those circumstances.

Yvonne Johnson: So glad Marty brought that up. That's an important point. There are so many things to think about.

Marty Bree: Yes, there is. Here's another question. “What about dentists or other specialty providers working in triage tents and trained to collect swabs and working under the order of an adult provider?” So, we're talking about folks who are doing things that they may not typically be doing in their day to day work within the health center, and doing them under the order of an adult provider. Does anyone want to tackle that one?

My thoughts on this would be that if the individual who's collecting swabs or doing swabs, is doing something within the confines of their license, that's permitted by the state, and working on the direction of another provider, I think it should be covered. Michele?

Michele Chambliss: Yes, it looks like that on the surface when I read the question. I would say yes.
Marty Bree: Yes. I think the key is, does the state licensing agency permit you to do this? And then secondly of course, is it in the Scope of Project? Well, taking swabs to determine if you have COVID-19 is part of primary care, so I think that's not the issue.

Keith Horwood: I think there may be some variation by state. At least I know in Utah, we have very generous laws, allowing for even uncertified MAs to do what they do under the LIPs license, where there are other states where there are certain things that Medical Assistants are not allowed to do, for instance, IM injections. Those have to be done by a nurse, or they have to be done by an LPN or an RN. And I wonder if those states that are more restrictive might say, “No, a dentist is allowed to do local anesthesia, but not a whatever.”

And in a state where you're allowed to do something under the supervision of another LIP who directs you, that state, I think, would have more safety measures, but it sounds like it may be a question for local counsel.

Marty Bree: Exactly Keith, and thank you for that.

Yvonne Johnson: I just have one quick thing. I'm looking at this a little bit differently. I don't know if folks realize that there is Teledentistry. If you're actually using your dentist out in the parking lot to do this, probably because you're not doing routine dental care, you're probably only doing emergency care. But there is Teledentistry, and there are trainings around that. And I'm sure we can provide some resources on that, and just a thought to keep using your dentist in other ways.

Katja Laepke: Yes, thank you Yvonne. We will make sure in our follow up email that we share those resources from our partners on Teledentistry. No problem at all. Thank you.

Molly Evans: I would just add, in addition to Keith's point, about the whole checking local counsel in terms of what is permitted under the dentist or other specialist license, that to the extent that you are asking providers to provide services that they don't customarily provide consider how that is documented. We come full circle to the beginning of the webinar about documentation. Consider how you document that in expedited privileging or otherwise, so that you are able to maintain clear documentation that they are doing that with the health center's blessing after analyzing it as being a permissible activity. That's all.

Marty Bree: Now we've posted, and we have at the end of the slide presentation, a number of resources that you can use if you have questions about what state licensure requirements are, particularly regarding Telehealth. You can go to the Federation of State Medical Licensing Boards, and there's a link for that, and there are a number of other links on those two pages that can help you and provide useful information for you. Katja, I think we're nearing the end.

Katja Laepke: Yes, thank you very much Marty. Thank you, Michele, Molly, Yvonne and Keith. We will share the slides, and that includes of course all these resources, links to the resources. We will email those to you, and then the recording and transcript will be available on our webpage and in the clearing house in about a week or so. To confirm our next office hour will be on Wednesday, May 13th, again at 2:00 PM Eastern time, and please join us again. In the meantime, please keep your questions coming. Make sure too, to daily check the FAQ on the HRSA BPHC FTCAs website. Michele and her team keep that up to date, and as Molly said it's very helpful to check it daily. Thank you, and we will be back in touch. Please stay safe and well. Until next time, thank you.