

COVID-19 Frequently Asked Questions (FAQs)

NACHC will periodically update these FAQs as new information is learned in regard to COVID-19. Responses may include links to additional resources or the best gathered information from subject matter experts. Look at the top right corner for the most recent version of this document. New FAQs/Responses will be in **red text** for at least one cycle of updates.

Updated sections added on 04/03/2020

- BPHC / COMPLIANCE / 330 REQUIREMENTS
- TELEHEALTH
- ETC (new section, at the end)

RESOURCES

1) Where can I find the most up-to-date and accurate resources on COVID-19?

Overall, www.coronavirus.gov has now been established (managed by CDC)

The **Centers for Disease Control and Prevention's** (CDC's) website:

- <https://www.cdc.gov/coronavirus/2019-ncov/index.html>
- FAQs (Available in English, Spanish, and Chinese):
<https://www.cdc.gov/coronavirus/2019-ncov/faq.html>
- *Many other government sites (including HRSA) refer directly to CDC's pages*

NACHC has a dedicated page on its website with resources specifically geared toward community health centers and the communities and populations they serve:

<http://www.nachc.org/coronavirus/>

The **Centers for Medicare and Medicaid Services** has created a coronavirus information page with FAQs and resources related to coverage, health care facility inspection, etc:

<https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>

Dental resources: [Infectious Diseases 2019 Novel Coronavirus](#)

Homeless resources:

- <https://nationalhomeless.org/coronavirus-covid-19/>
- <https://www1.nyc.gov/assets/doh/downloads/pdf/imm/guidance-for-homeless-shelters-covid19.pdf>

Asian American (AA), Native Hawaiian and Pacific Islander (NHPI) community health centers:
https://www.aapcho.org/resources_db/public-health-alerts/#sec1

The Health Center Resource Clearinghouse will add relevant resources related to COVID-19 under the Emerging Issues heading:
<https://www.healthcenterinfo.org/quick-finds-emerging-issues/?sort=Creation+Date>

BILLING / INSURANCE / CODING

1) Will individuals in high deductible plans (the underinsured) be able to be tested and get care for COVID-19 if they have not hit their deductibles first?

Per [IRS guidance published on March 11](#), patients with “high deductible health plans” may be able to get both testing and treatment for COVID-19 covered by their insurance before they meet their deductibles. While high-deductible plans are not required to provide COVID-19 services outside of the deductible, the IRS guidance eliminated the tax penalties that would normally result from this type of change.”

Additional billing and coding guidance from CMS:

- [Frequently Asked Questions to Assist Medicare Providers \(PDF\)](#) (3/6/20)
- Fact sheet: [Medicare Coverage and Payment Related to COVID-19 \(PDF\)](#) (3/5/20)
- Fact sheet: [Medicaid and CHIP Coverage and Payment Related to COVID-19 \(PDF\)](#) (3/5/20)
- [COVID-19: New ICD-10-CM Code and Interim Coding Guidance](#) (2/20/20)

BOARD MEMBERS

1) Must health center boards continue to meet monthly?

Yes. Monthly board meetings are a Section 330-statutory requirement. There is flexibility for virtual meetings, which are recommended at this time especially given limitations on public gatherings and recommendations regarding social distancing.

2) Can health center boards conduct the required monthly meetings virtually instead of in-person?

The Health Resources and Services Administration (HRSA) addressed this question in its own FAQ document available [here](#). HRSA’s response is as follows:

Yes, as indicated in the Health Center Program Compliance Manual, where geography or other circumstances make monthly, in-person participation in board meetings burdensome, health centers may conduct monthly meetings by telephone or other means of electronic communication where all parties can both listen and speak to all other parties.

Health centers should also ensure compliance with state laws related to virtual meetings and ensure the center’s bylaws permit virtual meetings.

3) Where can I locate information on virtual meetings?

Tips on virtual meeting participation can be found in NACHC's [Governance Guide for Health Center Boards](#), Chapter 9: Effective Board Functioning and from [BoardSource](#). Additionally, BoardSource is temporarily offering its online publication, [Virtual Meetings Untangled](#), at no cost; this publication provides information on planning for, facilitating, and conducting virtual board meetings. NACHC will be sharing additional information in the coming days.

4) Do we still need to have a quorum for board meetings?

Yes. Monthly board meetings must still have a quorum present as required in [Chapter 19: Board Authority](#) of HRSA's Health Center Program Compliance Manual.

If a board is unable to meet quorum, it may wish to document its attempt and the reason quorum could not be met. The board can look to its bylaws for the process and notice required to call another meeting.

It is also important to acknowledge that this is a time of tremendous stress. Board members may be balancing work, childcare or eldercare, and other demands. If a board is having difficulty attaining quorum, it may need to consider changing the timing of its meetings and addressing other barriers to participation.

BPHC / COMPLIANCE / 330 REQUIREMENTS (updated 04/03/2020)

1) If an individual comes to a health center only for COVID-19 testing and treatment, do they count as a health center patient?

Any individual who comes to a health center for COVID testing counts as a health center patient for purposes of both UDS and FTCA coverage.

UDS: The BPHC UDS Manual defines a patient as anyone who has "at least one reportable visit during the reporting year". A reportable visit is defined as a "documented, individual, face-to-face, or virtual contacts between a patient and a licensed or credentialed provider who exercises independent, professional judgment in providing services."

FTCA: BPHC addressed this issue in a FAQ published on 3/15/2020, as follows:

"For purposes of FTCA coverage, patients served by covered individuals at temporary locations included in the covered entity's scope of project are considered the covered entity's patients. As such, the covered entity and its providers are covered by FTCA for services provided during the emergency at temporary locations." (See the [FTCA Health Center Policy Manual](#) (PDF – 408 kb) Section F: A record of the services provided for each patient should be maintained.)

In addition, please see: Section (I) C.3 of the [FTCA Health Center Policy Manual](#) (PDF – 408 kb), Provision of Services to Health Center Patients, which

states in part: "To meet the FTCA requirement of providing services to health center patients, a patient-provider relationship must be established. For the purposes of FSHCAA/FTCA coverage, the patient-provider relationship is established when: ...Health center triage services are provided by telephone or in person, even when the patient is not yet registered with the covered entity but is intended to be registered."

Please also see the [FTCA Health Center Policy Manual](#) (PDF – 408 kb) Section (I) C.4 regarding Coverage in Certain Individual Emergencies."

2) I have a 340B Audit scheduled with HRSA. Is HRSA postponing these audits?

HRSA's Office of Pharmacy Affairs (OPA) advises that a health center email their 340B Auditor and request a postponement or cancellation based on a description of the operating circumstances at your Center which would prohibit the Center's participation in the audit. If you do not hear from your 340B auditor or are not satisfied with their response, please contact the HRSA Office of Pharmacy Affairs directly via Ann Pierpoint at APierpoint@hrsa.gov

CLINICAL PROTOCOLS

1) Can you please include the screening algorithms?

See the Updated Guidance on Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19) March 8, 2020 from the CDC website:

<https://emergency.cdc.gov/han/2020/han00429.asp>

DONATIONS (added 03/16/2020)

1) Can Health Centers donate supplies and prescription drugs in emergency situations?

Generally not. Specifically:

- No supplies that were purchased with 330 funds can be donated
 - There are even more rules around donating prescriptions. The donation has to comply with the Prescription Drug Marketing Act, and if the Rx were purchased under 340B (highly likely) then HRSA approval is also needed.
 - Health centers may be able to donate supplies (NOT prescriptions) if:
 - They can document that the supplies were not purchased with 330 funds
AND
 - The donation will benefit the individual health center's patient/target population.
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EMERGENCY PAID SICK LEAVE AND EMERGENCY FAMILY LEAVE (updated 03/26/2020)

- Please refer to: <https://www.nachc.org/wp-content/uploads/2020/03/FFCRA-Emerg-Leave-Summ-Chart-FAQs-As-of-3-25.pdf>
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ENVIRONMENTAL

1) For health care settings with no negative pressure room, how long should we wait before entering and cleaning the room?

See the Information for Healthcare Professionals page on the CDC website:

https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fguidance-hcp.html

IMMIGRATION/PUBLIC CHARGE *(last updated 3/14)*

1) We have immigrant patients who are concerned that seeking care for COVID-19 could negatively impact their immigration status. What should we tell them?

Individuals should not refrain from seeking medical care for COVID-19 (testing or treatment) due to concerns about their immigration status. We know of no circumstances under which seeking COVID-19 testing and treatment would negatively impact a patient’s immigration status, for the following reasons:

- The only time that using any public benefit (e.g., Medicaid, SNAP) could impact the immigration status of a person currently residing in the US is if that person is subject to a “public charge test.”
- Few immigrants will ever be subject to a “public charge test.” For example, refugees, victims of trafficking, persons without documentation, and persons who already have Legal Permanent Residency will never be subject to a public charge test.
 - For those immigrants who could potentially be subject to a public charge test, this would only occur if and when they apply for Legal Permanent Residency status (aka their first Green Card). These individuals should know that:
 - Sliding fee discounts at a health center will never be considered in a public charge test.
 - “Emergency Medicaid” (see question below) will never be considered in a public charge test.
 - While regular Medicaid will generally be considered in a public charge test, on March 14, 2020, the US Customs and Immigration Service (USCIS) announced that Medicaid coverage for services related to COVID-19 (prevention, testing, or treatment) will not be considered in a public charge test.

2) What is “Emergency Medicaid”? Will it count in a public charge test?

Emergency Medicaid is Medicaid coverage for “emergency” services that is provided to individuals who would otherwise would have qualified for regular Medicaid except for their immigration status. For example, persons with Temporary Protected Status (TPS), DACA recipients, and persons without documentation are ineligible for regular Medicaid. However, if

they meet all other Medicaid eligibility requirements (e.g., income and assets) they are eligible for “emergency Medicaid”.

The public charge rule explicitly states that Emergency Medicaid will not be considered in public charge tests.

3) How does Emergency Medicaid define “emergency services”?

An emergency means the sudden onset of a medical condition, including labor and delivery, which shows acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in one or more of the following:

- Serious jeopardy to the patient’s health;
- Serious impairment to bodily functions; or
- Serious dysfunction of a bodily organ or part.

4) We have an immigrant patient who is eligible for regular Medicaid, and plans to apply for a Green Card soon. She is concerned that enrolling in Medicaid to cover her COVID-19 testing and treatment could negatively impact her public charge test. What should we tell her?

As long as she limits her Medicaid use to services related to the prevention, testing, and treatment of COVID-19, the USCIS has stated that this use of Medicaid will not negatively impact her public charge test. Also, public charge tests do not consider the use of Medicaid and other public benefits that fall below a certain threshold (e.g., 12 months, certain dollar amounts.) If the patient chooses to remain on Medicaid after completing COVID-19 treatment, she should review the public charge rule, including the range of factors considered and the minimum thresholds for use of public benefits that would be considered.

IMPACT/REPORTING

1) What are HRSA’s requirements for health centers in the areas of emergency preparedness and emergency response? (*From HRSA FAQs*)

- [Program Assistance Letter \(PAL\) 2014-05](#) provides information regarding the process for requesting a change in scope to the federal scope of project to add temporary locations in response to emergency events.
- [PAL 2017-07](#) clarifies the credentialing and privileging documentation required to support temporary privileging of clinical providers by health centers in response to certain declared emergency situations.
- The Federal Tort Claims Act Health Center Policy Manual in [Section F: FTCA Coverage When Responding to Emergency Events](#) provides additional guidance related to emergencies.

2) Do we know when HRSA will be releasing their expectations on PCAs re: tracking impact? (*referred from HRSA FAQs: How can Primary Care Associations (PCAs) assist in ensuring that*

states integrate health centers in COVID-19 preparedness planning and in supporting health centers during a COVID-19 pandemic?)

PCAs can facilitate the sharing of important information with health centers through electronic alerts, can conduct outreach to increase awareness and participation in various regional/state pandemic planning and response activities, and can learn from the health centers what issues they face and what assistance may be needed.

PCAs have established mechanisms to engage with health centers in collecting critical information during and after an emergency situation. In addition, PCAs can work to ensure that health centers are included in COVID-19 response plans by tapping into regional/state pandemic planning and response activities.

HRSA expects PCAs to also coordinate with State Primary Care Offices (PCOs) and to routinely report in their annual funding applications the status of their efforts regarding emergency preparedness planning and development of emergency management plans, including participation or attempts to participate with state and local emergency planners. Many PCAs play active roles in the state as coordinators, managers, and disseminators of real-time information during emergencies.

Referenced from HRSA's Novel Coronavirus (COVID-19) Frequently Asked Questions:

<https://bphc.hrsa.gov/emergency-response/coronavirus-frequently-asked-questions.html>

PERSONAL PROTECTION EQUIPMENT (PPE) / INFECTION CONTROL

1) Can you please provide advice on the practical use of PPE in an ambulatory setting, particularly among health centers that do not have the resources to implement airborne precautions?

There are several resources from the CDC to become familiar with:

- Personal Protective Equipment page on the CDC website for any available information on PPE: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/healthcare-supply-ppe-index.html>
 - Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>
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TELEHEALTH (updated 04/03/2020)

1) Did President Trump’s recent announcement on Medicare and telehealth allow FQHCs to provide telehealth services as “distant providers?” What about the first supplemental funding bill passed by Congress?

Unfortunately, neither the first supplemental bill signed on March 9 nor Trump’s announcement on March 17, 2020 allows FQHCs to provide and be reimbursed for telehealth services as distant providers in Medicare. This is a long-standing issue that CMS believes it does not have the authority to address. **As of March 22, 2020, Congress is considering a legislative fix to allow FQHCs and RHCs to provide these services. You can read more on NACHC’s recent blog post [here](#).**

2) How are health centers reimbursed by Medicaid for telephone services?

On March 18, 2020 CMS issued a [FAQ document for State Medicaid and CHIP Agencies on COVID-19 related issues](#). Included in that FAQ are several questions on FQHC telehealth and telephone visit issues. Please see page 10 of the FAQ for specifics on the guidance provided to states on these issues.

3) What does the most recent CMS guidance on telehealth under Medicaid mean?

In [the guidance issued on](#) March 17, 2020, CMS states that “States have a great deal of flexibility” with respect to which Medicaid services they provide through telehealth. This means a state may elect to pay for FQHC services provided through telehealth but is not required to do so.

A State is not required to submit a State Plan Amendment (SPA) to implement payment for telehealth services, *unless there is a change in the level of payment from what it would pay for the service if it were “furnished in a face-to-face setting.* Thus, it appears that a state would not have to submit a SPA if it chooses to pay an FQHC for a telehealth service the same PPS or APM rate that it would pay if that service was provided as a face to face visit, but a State would need to file a SPA if it chooses to pay an FQHC other than its PPS rate for the telehealth service.

Providers rendering services through telehealth must be Medicaid qualified practitioners within the scope of their State Practice Act, and CMS provides guidance on payment for ancillary costs, such as technical support.

4) Do modifications to state telehealth policy require a State Plan Amendment?

As noted above, “States are not required to submit a State plan amendment (SPA) to pay for telehealth services if payments for services furnished via telehealth are made in the same manner as when the service is furnished in a face-to-face setting. “

5) What specific steps should an FQHC take to ensure they will receive Medicaid telehealth reimbursement?

Health centers should work directly with their PCAs on any policy-related changes to telehealth policy. Doing so will ensure that the PCA is able to communicate a uniform and clear message and

request to their state Medicaid agencies and policy makers. Allowing the PCAs to serve as the point of contact with the state allows the PCA to also share the message with all health centers in the state on state policies on coverage of telehealth services.

6) Is there any template language for states looking to expand telehealth under Medicaid? For example language from states who have applied for telehealth expansion?

From the CMS guidance, below are examples of language states have used, and CMS has approved, to describe telehealth payment policies within the Medicaid state plan.

- **Example 1:** *For services provided via telehealth, the billing provider will code the service using modifier (x). The provider will receive an add-on fee of \$x, which is effective for services on or after xx/xx/xxxx; all rates are published at [state’s website]. Payment is made at the lower of the actual charge or the Medicaid rate on file. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers.*

The distant site provider will also be reimbursed in accordance with the standard Medicaid reimbursement methodology for the allowable Medicaid services performed.

- **Example 2:** *Qualifying patient sites are reimbursed a facility fee. The fee is set at x% of Medicare and is effective for services on or after xx/xx/xxxx; all rates are published at [state’s website]. Payment is made at the lower of the actual charge or the Medicaid rate on file. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers.*

Distant site providers are reimbursed in accordance with the standard Medicaid reimbursement methodology. While the above paragraphs may be useful to consider in working with your State (as the State may have a certain comfort level with them since CMS has approved them), we think it important that PCAs try to get their state to insert **specific FQHC payment language**. For example, in Example 1 above, we recommend adding the following language:

“Notwithstanding the previous paragraphs, for services provided via telehealth by FQHCs, payment for such services shall be the same per visit amount that the FQHC would receive for such services if they were provided by the FQHC in a face-to-face visit”

7) Did HHS recently announce new guidance related to telehealth and possible HIPAA restrictions?

On March 17, HHS announced that “healthcare providers may use Skype, FaceTime, Zoom, Doxy.me, Updox, VSee, Google G Suite Hangouts Meet, and similar technologies for real-time audio/video communications with their patients, without fear that OCR might levy a penalty,” according to Jeffery P. Drummond, a partner with the Jackson Walker law firm. Normally, the use of these platforms was restricted under HIPAA because they lacked stringent security protections. [This article](#) provides more information.

8) What did the CARES Act include for FQHCs and Medicare telehealth? When will we know how to bill for these services?

For the duration of the COVID-19 crisis, health centers and rural health clinics (RHCs) will be authorized for Medicare reimbursement as distant sites in visits provided via telehealth (meaning that FQHC or RHC providers will be paid for telehealth services provided to patients at home). The reimbursement will not be at the Medicare PPS rate, but rather at payment rates similar to the national average payment rates for comparable telehealth services under the Medicare Physician Fee Schedule. This provision went into effect immediately and we expect guidance from CMS on these services and reimbursement shortly.

9) Does Medicare reimburse FQHCs for telephone-only visits?

On March 30, 2020, CMS issued an interim final rule, providing flexibilities to providers in response to COVID-19. Included in this interim final rule was a provision that allowed providers paid on the Medicare Physician Fee Schedule (which does not include FQHCs) to provide evaluation services over the telephone. At this point, these services do not apply to FQHCs, however NACHC will continue to advocate for these services to be allowed at FQHCs.

10) What did CMS' Interim Final Rule include for FQHCs?

The [interim final rule](#) included a provision to allow FQHCs to provide “[e-visits](#)” which are services provided via an online portal. These services will be added to the “G0071” code, which is the code FQHCs can currently use to bill Medicare for “[virtual communication services](#).” We will share more detail when we learn more about the specific rate for these codes.

TEMPORARY SITES, SCOPE, AND FTCA (updated 03/20/2020)

On March 17, BPHC published FAQs on this issue, available [here](#). While NACHC's FAQs are consistent with BPHC's, note that BPHC's FAQs are the official ones.

Based on the following BPHC documents:

- [FTCA Manual](#), Section F, “FTCA Coverage When Responding to Emergency Events”
- [PAL 2014-15](#), “Updated Process for Requesting a Change in Scope to Add Temporary Sites in Response to Emergency Events”
- [PIN 2008-01](#), “Defining Scope of Project and Policy for Requesting Changes”

1) Our health center wants to provide COVID-19 care in patients' homes and cars. Can services provided in these locations be covered under FTCA?

Yes, provided that certain requirements are met. In emergency situations such as the COVID-19 outbreak, FTCA coverage can be extended to cover services provided at temporary locations. Section F.2.1. of *BPHC's FTCA Manual* defines a temporary location as “any place that provides shelter to... victims of an emergency”, including locations where “medical care is provided as part of a coordinated effort to provide a temporary medical infrastructure”.

NACHC interprets this definition as incorporating services (such as mouth swabs for COVID-19 testing) provided to patients who remain in their cars, regardless of whether the cars are located on health center property, or are located at “drive-in” testing sites elsewhere, as such sites would be “part of a coordinated effort to provide a temporary medical infrastructure.”

Regarding care for patients in their homes, health centers are currently permitted to include such services in scope. Specifically, “home visits” may be listed as an “Other Activity/ Location” on Form 5C. Section B(1)(g) of PIN 2008-01 states that:

“If it is the policy of the grantee that providers occasionally make home visits to health center patients, the grantee should list the activity as “home visits,” the location as “patients’ homes” and the frequency as appropriate (e.g., as required for patient care, five times per month).”

2) What must our health center do to get a temporary site covered under FTCA?

Your health center must get the temporary site added to your scope of project in a timely manner. This requires:

- Ensuring that the site meets certain requirements;
- Providing the appropriate information to BPHC; and
- Meeting the deadline for submitting this information to BPHC.

Each of these steps is discussed below. Note that the rules vary based on whether a temporary site is located within your service area or an adjacent area, versus outside that area.

3) What are the requirements for getting a temporary site included in our scope of project?

Per PAL 2014-05:

For temporary locations within the health center’s service area or adjacent areas, the following four requirements must be met:

1. Services provided by health center staff at such locations are on a temporary basis;
2. Services provided by health center staff are within the approved scope of project;
3. All activities of health center staff are conducted on behalf of the health center.
4. All applicable State licensure requirements must be met.

For temporary locations outside the health center’s service area or adjacent areas, the four criteria listed immediately above (for within the service area/ adjacent area) must be met. In addition:

“The health center must demonstrate that the purpose of the temporary site is to provide services primarily to its original health center target population which has been displaced by the emergency, and if appropriate for the health center, to other medically underserved populations that may have been displaced by the emergency.”

4) What information must we provide to BPHC to get a temporary location included in our scope?

If the criteria above are met, the health center must provide the following information to HRSA by email or phone:

- a. Health center name.
- b. The name of a health center representative and this person's contact information.
- c. A statement that this temporary location is being established in response to the COVID-19 outbreak.
- d. A brief statement on how the health center, the target population, and/or a medically underserved population have been impacted. (This should be no more than one to two sentences.)
- e. A brief description of the emergency response activities. The request must include a summary of the requested change in scope of project, including:
 - o Temporary address information, and
 - o The date emergency response activities at the site were initiated (if they have already started); and
- f. Verification and/or assurance that each of the applicable requirements for adding temporary locations will be met. These links provide discuss the requirements for [Adding Temporary Sites Within or Adjacent to the Service Area](#), and for [Adding Temporary Sites Outside the Service Area](#).

5) What is the deadline for requesting that BPHC add a temporary location to our scope?

- For temporary locations located within the health center's service area or adjacent areas (see FAQ below), PAL 2014-05 states that "Health centers must submit this information as soon as practicable but ***no later than 15 calendar days after initiating emergency response activities***. HRSA will determine on a case by case basis whether extraordinary circumstances justify an exception to the 15-day notification requirement."
- For temporary locations located outside the health center's service area or adjacent areas, Section F.5. of the FTCA Manual states that "***prior approval is necessary*** for changes in scope described in F.2.2 FTCA coverage outside the service area."

6) How long will a temporary location be included in our scope of project?

For ninety days from the onset of the emergency. Section F.5. of the FTCA Manual states: "Health centers expecting to operate at a temporary location beyond 90 days from the onset of the emergency must submit a request for a change in scope of project. Health centers are encouraged to submit the formal request well in advance of the 90-day limitation for a temporary site to allow for processing and to ensure FTCA coverage continues beyond the 90 days."

7) There are different rules for temporary sites located outside our health center's service area and "adjacent areas". How are "adjacent areas" defined?

BPHC defines "adjacent areas" as including areas "such as neighboring counties, parishes, or other political subdivisions."

WORKFORCE/HUMAN RESOURCES

1) What is a good resource/site to understand the HR legal issues pertaining to pandemics?

CDC Pandemics Preparedness:

<https://www.cdc.gov/flu/pandemic-resources/planning-preparedness/regulations-laws-during-pandemic.htm>

Get Your Workforce Ready for Pandemic Flu:

<https://www.cdc.gov/nonpharmaceutical-interventions/pdf/gr-pan-flu-work-set.pdf>

Occupational Safety and Health Administration pandemic information:

https://www.osha.gov/Publications/influenza_pandemic.html

2) Where can we find guidance on communications materials for patients and for staff?

CDC's Communication Resources page:

<https://www.cdc.gov/coronavirus/2019-ncov/communication/index.html>

ETC

1) Will health center patients using Lifeline phone and internet services be charged extra for telehealth?

The Federal Communications Commission (FCC) has not provided guidance and is leaving it up to the private providers. According to the [Verizon website](#): "No internet and voice charges for Lifeline customers. Starting April 3, Verizon will also offer two months of waived internet and voice service charges for current Lifeline customers and a new affordable internet option for low-income households." It is important for patients to confirm this with their own providers, but in the past, most align with similar policies.