



IMPACT OF COVID-19 ON PUBLIC HOUSING PRIMARY CARE (PHPC) HEALTH CENTER PATIENTS AND OPERATIONS

DISCLAIMER

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling \$668,800 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit [HRSA.gov](https://www.hrsa.gov).



Table Of Contents:

Executive Summary	Page 4
Introduction	Page 5
Methods	Page 12
Findings	Page 13
Conclusion	Page 25
References	Page 28

Executive Summary



When the COVID-19 pandemic reached the U.S., it was clear that the health inequities surrounding those living in public housing would put them at higher risk for contracting and developing severe symptoms of the disease. As a critical part of the health care safety net, patients served at health centers, and Public Housing Primary Care (PHPC) health centers in particular, would be impacted. However, the depth and breadth of that impact was unknown.

To understand the full scope of the effects on patients and operations, the National Center for Health in Public Housing (NCHPH) examined a survey developed by the Health Resources and Services Administration (HRSA) that was fielded to health centers weekly. Over the course of the pandemic, the survey chronicled the effects of the disease on patient outcomes, Health Center operations, and other important issues.

Findings from the analysis of the survey show that from April 2020 to May 2021, PHPC health centers had tested a higher percentage of racial and ethnic minorities for COVID-19; had a higher percentage of positive COVID-19 cases from racial and ethnic minorities and were vaccinating more racial and ethnic minorities for COVID-19 compared to all health centers. This, in spite of the fact that both groups of Health centers serve a similar proportion of patients that identified as a racial or ethnic minority. The implication is that PHPC health centers had a higher outreach and engagement with racial and ethnic minority patients, which is incredibly important for delivering equitable care during, after, and in anticipation of the next public health crisis. Findings also indicate that PHPC health centers may have been more financially impaired compared to all health centers, however more research is needed on that topic.

As a result, NCHPH recommends that PHPC health centers be included in federal, state, and local emergency response efforts to improve outreach and access to patients that live in communities with public housing. NCHPH also recommends that federal agencies prioritize outreach and resources to safety net organizations, such as health centers, that serve these targeted special populations. Finally, NCHPH recom-

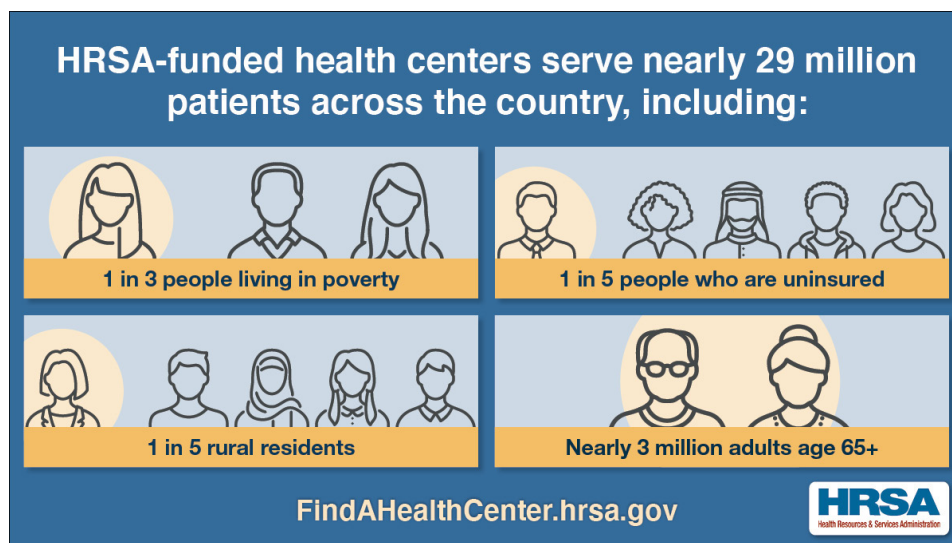
mends that an emphasis, in resources and support, be made to PHPC health centers in order to address and shift the paradigm on inequities facing public housing communities.

Introduction

The Health Center Program, funded by the Health Resources and Services Administration, is designed to improve the health of underserved and vulnerable populations. Sometimes referred to as Community Health Centers, Federally Qualified Health Centers (FQHCs), or Community Clinics, these health centers offer integrated access to primary care, behavioral health, pharmacy, and oral health services in areas where economic, geographic, or cultural barriers limit access to affordable health care.¹

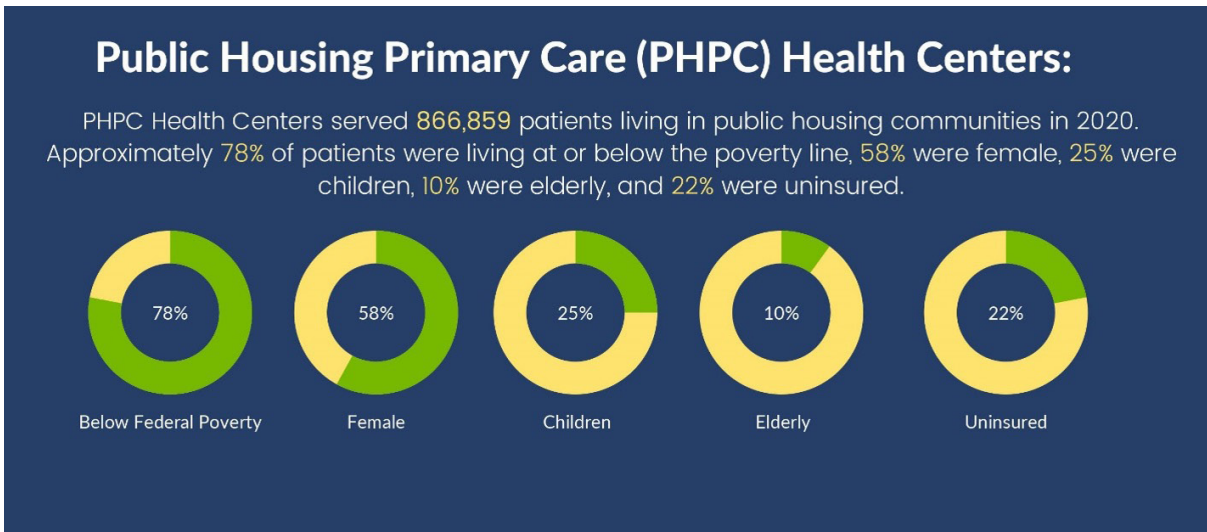


There are 1,375 health centers located across the country delivering high quality health services to individuals regardless of their ability to pay, and therefore serve as a critical part of the community health care safety net.² In 2020, they served 28.6 million patients, many of whom are living in poverty, are uninsured, and are over the age of 65.³



Source: Health Center Program: Impact and Growth | Bureau of Primary Health Care (hrsa.gov)

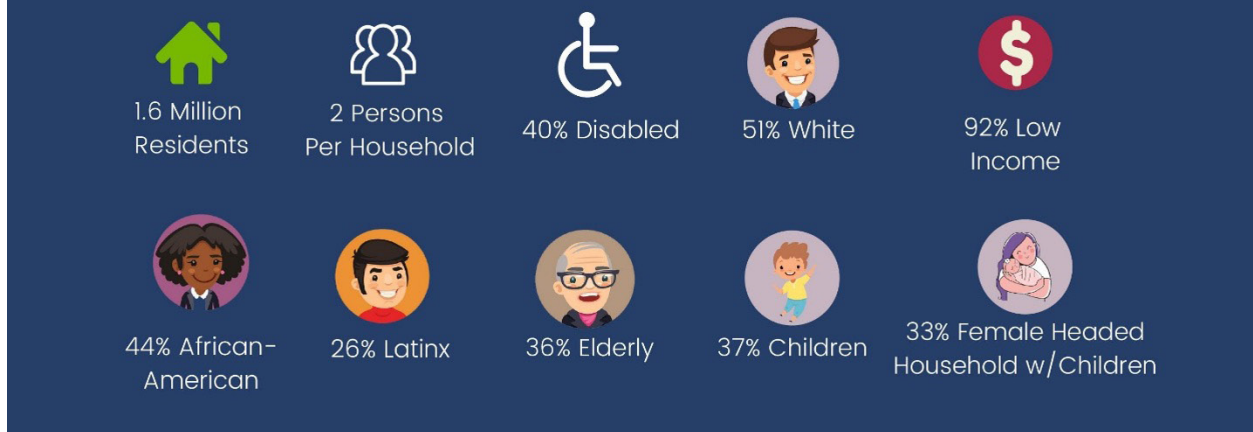
A small subset of health centers (107) received Public Housing Primary Care (PHPC) Grant-ee funding to focus on residents of public housing. These PHPC health centers are located either directly on public housing development sites or are immediately accessible to public housing residents. To view a map of PHPC Health Center locations and their proximity to public housing sites, go to [Interactive Maps - National Center for Health in Public Housing \(mybluehost.me\)](https://mybluehost.me).



Source: 2020 Special Populations Funded Programs (hrsa.gov)

According to the U.S. Department of Housing and Urban Development (HUD), there were roughly 1.6 million public housing residents in 2020.⁴ Most households were low-income, 36% had a member who was elderly, and 40% had a member who was disabled.⁵ Approximately a third is headed by single women with children.⁶

Public Housing Demographics:



Source: Resident Characteristics Report (RCR) - IMS/PIC - HUD | HUD.gov / U.S. Department of Housing and Urban Development (HUD)

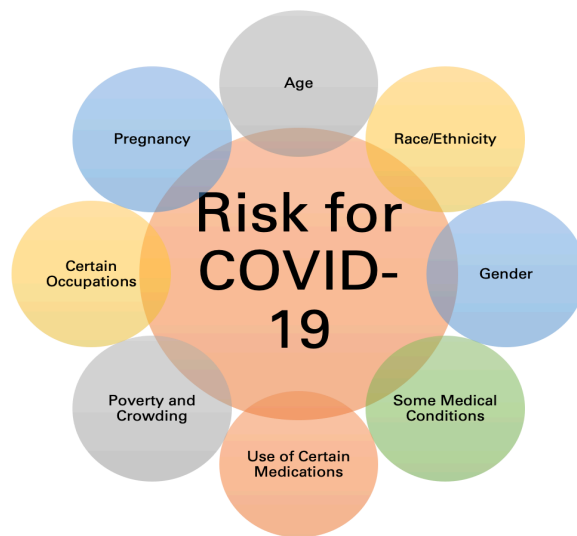
These demographic characteristics indicate broad inequities that disproportionately impact public housing residents and predict the risk they face for developing poor health outcomes. According to a report from HUD and the Centers for Disease Control and Prevention (CDC), adults that live in public housing have higher rates of chronic health conditions and are greater utilizers of health care than the general population.⁷ They are more likely to have asthma, diabetes, heart disease, Chronic Obstructive Pulmonary Disease (COPD), and they have higher smoking rates compared to the national average.⁸

Prevalence of select health conditions in HUD-assisted adults

	HUD-Assisted	Low-Income Renters	All Adults
Fair/Poor Health	35.8%	24%	13.8%
Overweight/ Obese	71%	60%	64%
Disability	61%	42.8%	35.4%
Diabetes	17.6%	8.8%	9.5%
Chronic Obstructive Pulmonary Disease (COPD)	13.6%	8.4%	6.3%
Asthma	16.3%	13.5%	8.7%

Source: A Health Picture of HUD-Assisted Adults, 2006–2012

When the COVID-19 pandemic became widespread in the U.S., it was clear that the health equity issues for those living in public housing, including the health status of HUD-assisted adults, put them at higher risk for contracting and developing severe symptoms of COVID-19. Severe illness is defined as hospitalization, need for intensive care, requiring a ventilator to breathe, and death. Public Housing residents often reside in urban areas, creating an additional challenge to abide by social distancing requirements.⁹ In November 2020, the CDC released guidance on assessing which populations were at higher risk for COVID-19, and the characteristics unequivocally overlapped with those of residents of public housing.¹⁰



Source: [People with Certain Medical Conditions | CDC](#)

The CDC discovered that more than 81% of COVID-19 deaths occurred in people over the age of 65.¹¹ The CDC also found that the risk of severe COVID-19 was higher in individuals with multiple chronic conditions and in groups with long-standing systemic health and social inequities, such as racial and ethnic minorities and the disabled.¹²

Study Objective



The National Center for Health in Public Housing (NCHPH) is funded by the Health Resources and Services Administration (HRSA) to provide training and technical assistance to health centers serving public housing residents. NCHPH was interested in determining the impact COVID-19 had on communities with public housing in order to provide meaningful and needed training and technical assistance to PHPC health centers. NCHPH was interested in determining whether racial and ethnic minority patients served by health centers were being impacted disproportionately by COVID-19, as well as

the broader impacts COVID-19 was having on health center operations and the ability of these health centers to serve residents in the community.

NCHPH examined the results of the Health Center COVID-19 Survey fielded by HRSA.¹³ HRSA developed the survey to collect information on COVID-19 testing and vaccination; track health center capacity and the impact of COVID-19 on operations, patients, and staff; and better understand training and technical assistance, funding, and other health center resource needs.¹⁴ NCHPH compared the responses from PHPC health centers and to the response of all health centers funded by HRSA.

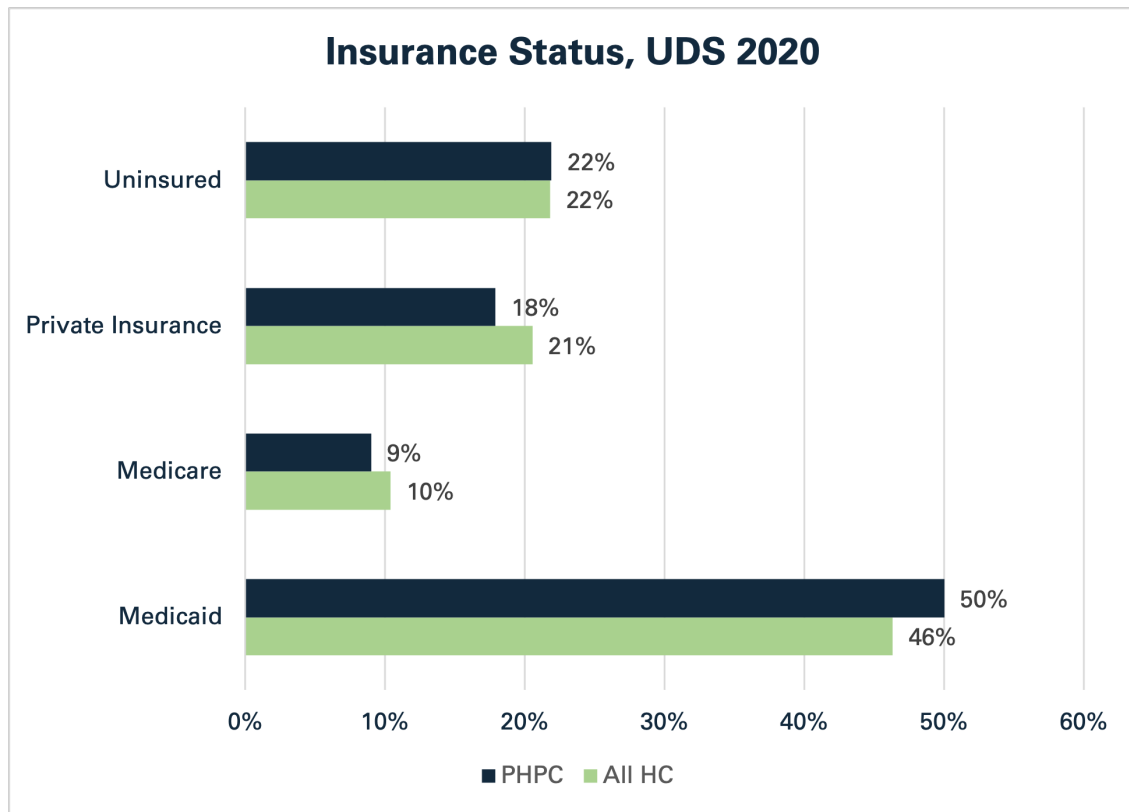
Why Compare PHPC Health Centers to All Health Centers?

There are slight differences in the patient population served at PHPC health centers compared to all health centers funded by HRSA. Findings from the Uniform Data System (UDS) from 2019, prior to the pandemic, indicated that PHPC health centers had slightly higher percentages of patients that live at or below poverty and on patients receiving Medicaid.¹⁵

The income difference can be critical for PHPC Health Cen-

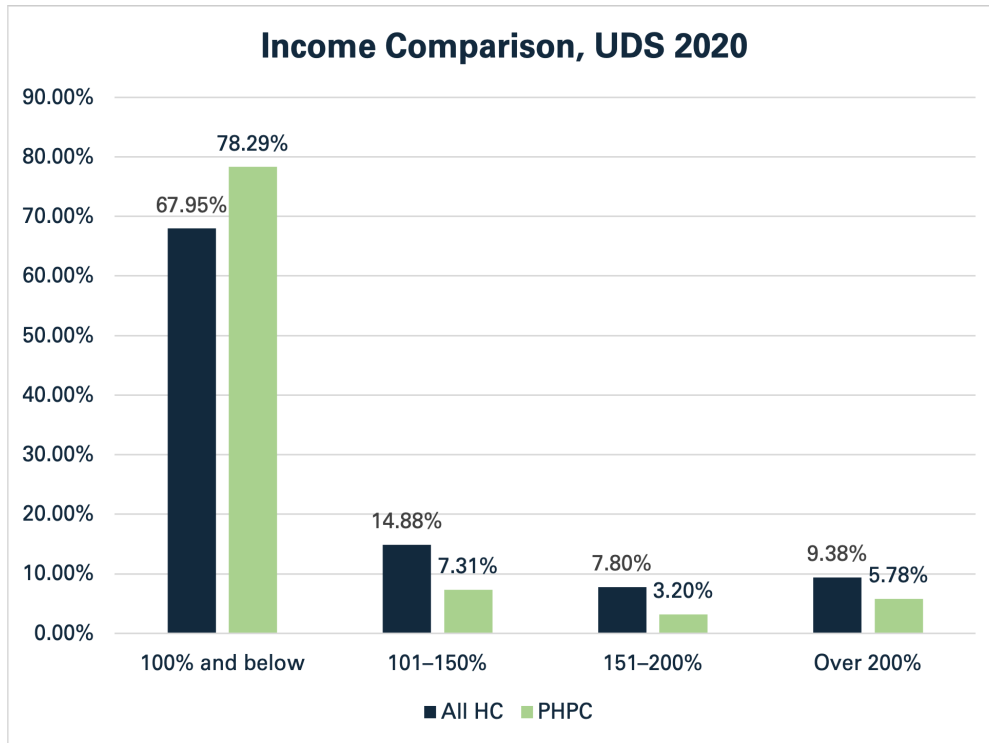


ter patients, relying on less disposable income to pay for supplies that are needed and recommended for prevention, like hand sanitizer and masks, as well as cleaning supplies. From a Health Center operations perspective, the data indicate the greater reliance of PHPC health centers on Medicaid reimbursements to maintain services and provide comprehensive care at little to no cost for their patients.

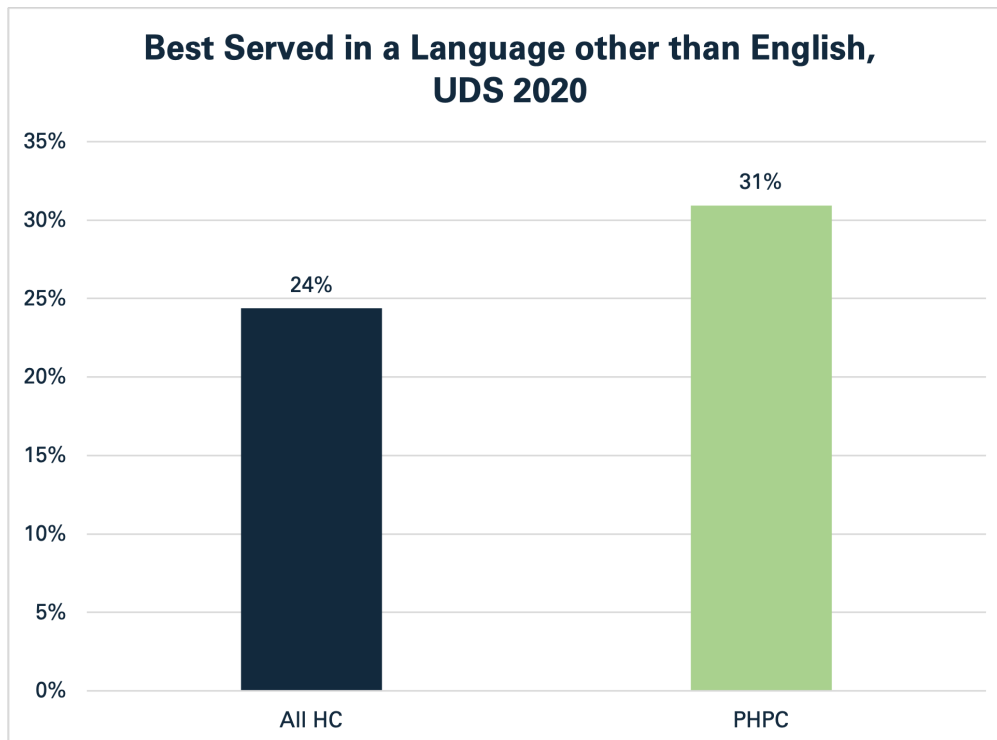


Source: 2020 Special Populations Funded Programs National Public Housing Primary Care Program Awardee Data

Health centers, including PHPC health centers, served a diverse patient population. They served nearly the same proportion of Hispanic patients (38% vs 37%) and PHPC health centers served slightly higher percent of Black patients (38% vs. 28%).¹⁶ While all health centers served vulnerable populations, PHPC health centers served a higher percentage of patients that are better served in a language other than English. Making it even more crucial, particularly during the early days of the pandemic, for PHPC health centers to ensure accurate information about COVID-19 was available to others in the language that they speak, as well as providing important logistical information, such as clinic hours and instructions on how to obtain follow-up care. This level of effort was required amid major strains and shortages that the pandemic placed on Health Center staffing and resources.



Source: 2020 Special Populations Funded Programs National Public Housing Primary Care Program Awardee Data



Source: 2020 Special Populations Funded Programs National Public Housing Primary Care Program Awardee Data

Research Questions



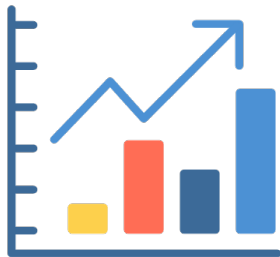
The following research questions were addressed in this study:

- Were PHPC health centers testing more racial and ethnic minority patients for COVID-19 compared to all health centers?
- Were those patients testing positive for COVID-19 at PHPC health centers more likely to be from a racial or ethnic minority group compared to the positive cases seen at all health centers?
- Were PHPC health centers vaccinating more racial and ethnic minority patients for COVID-19 compared to all health centers?
- Were PHPC health centers experiencing any differences in the number of weekly patient visits during COVID-19 compared to all health centers?
- Were PHPC health centers providing more/less virtual visits during COVID-19 compared to all health centers?
- Were PHPC health centers experiencing different vaccine challenges compared to all health centers?

Methods

The COVID-19 emergency response efforts from HRSA included a weekly survey to track Health Center capacity and the impact of COVID-19 on Health Center operations, patients, and staff. The survey was first launched in April 2020 and was fielded on a weekly basis until July 2021, and then on a bimonthly basis from then on. This analysis includes data from April 2020 to May 2021.

Statistical Analysis



HRSA provided all survey data to NCHPH in an Excel database. Secondary data analysis was conducted using Excel for descriptive statistics. Descriptive studies report summary data such as measures of central tendency including the percentage and correlation between variables. This descriptive study also employed methods of analyzing correlations between multiple variables by using two-sample t-test with equal variance for statistical significance. In this study, we examined the differences observed between PHPC health centers and all health centers funded by HRSA.

Findings in Brief

There were 1375 health centers surveyed on a weekly basis between April 2020 - May 2021. The overall response rate was 71% and 74% for all health centers and PHPCs, respectively. Findings for the analysis are divided into two categories: Health Center patients and Health Center operations.

Health Center Patients

The first set of findings describe Health Center patients: rates of COVID-19 testing, positive cases, and immunizations for racial and ethnic minority patients. The following categories were captured in racial and ethnic data for Health Center patients. Individuals that identified as Hispanic and/or Black, Asian, American Indian, Alaska Native, Native Hawaiian/Other Pacific Islander, or patients with more than one race were included in the analysis below.

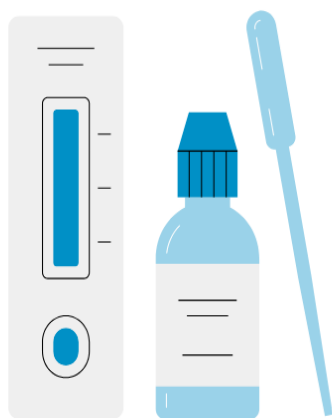


Racial/Ethnic Categories:

- White, Non-Hispanic/Latino Patients
- White, Hispanic/Latino Patients
- Black/African American, Non-Hispanic/Latino Patients
- Black/African American, Hispanic/Latino Patients
- Asian Patients

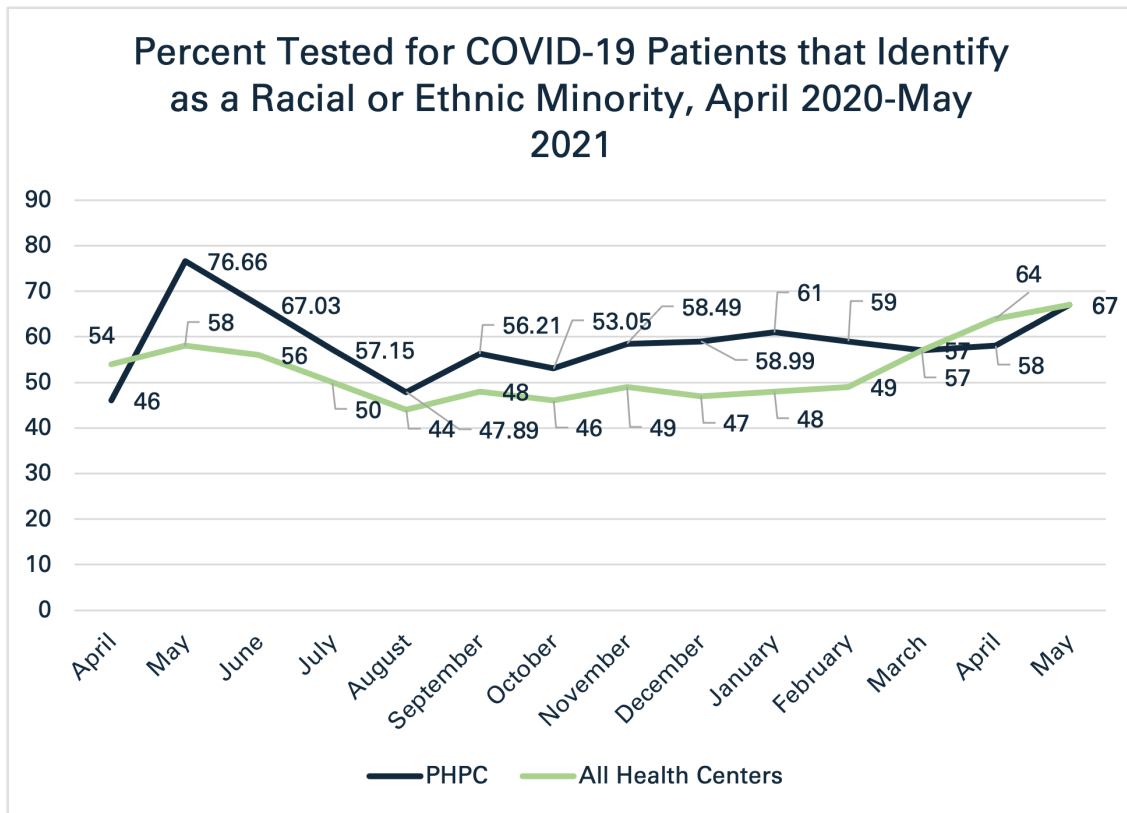
- American Indian/Alaska Native Patients
- Native Hawaiian/Other Pacific Islander Patients
- Patients with More than one race
- Hispanic/Latino Ethnicity Patients (Unreported/Refused to report race)
- Non-Hispanic/Latino Ethnicity Patients (Unreported/Refused to report race)
- Unreported/Refused to Report Race and Ethnicity

COVID-19 Testing



During the first half of 2020, there was limited COVID-19 testing capacity and availability in many jurisdictions. Many individuals were unable to access testing due to limited clinic hours as well as limited public transportation, and a lack of Personal Protective Equipment (PPE) at health agencies furthered those challenges. As a result, there was much concern about outreach to vulnerable populations, like racial or ethnic minorities, on testing. However, PHPC health centers were testing a significantly higher percentage of racial and ethnic minorities compared to all health centers ($t=2.2$; $p=.01$). The chart below demonstrates that PHPCs were in fact reaching a higher proportion of racial or ethnic minorities.

A significantly higher proportion of patients tested at PHPC health centers identified as a racial or ethnic minority compared to those tested at all health centers.

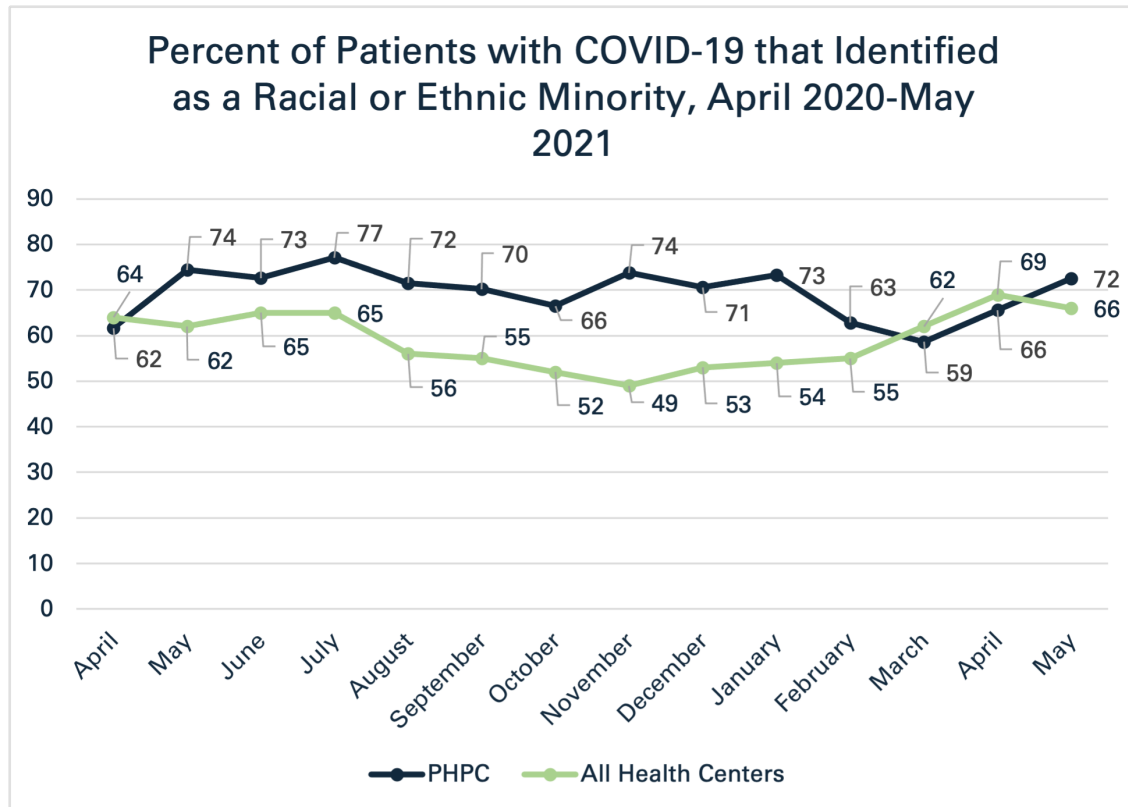


Source: HRSA Health Center COVID-19 Survey

In addition to a higher percentage of patients tested for COVID-19 that identified as a racial or ethnic minority, PHPC health centers were also seeing a significantly higher proportion of their COVID-19 positive patients that identified as a racial or ethnic minority ($t=5.8$; $p<0.05$). This finding supports other data sources showing disproportionate rates of COVID-19 among minorities. However, while it is not unexpected, it is still alarming.



A significantly higher proportion of patients with positive COVID-19 test at PHPC health centers identified as a racial or ethnic minority compared to those testing positive at all health centers.

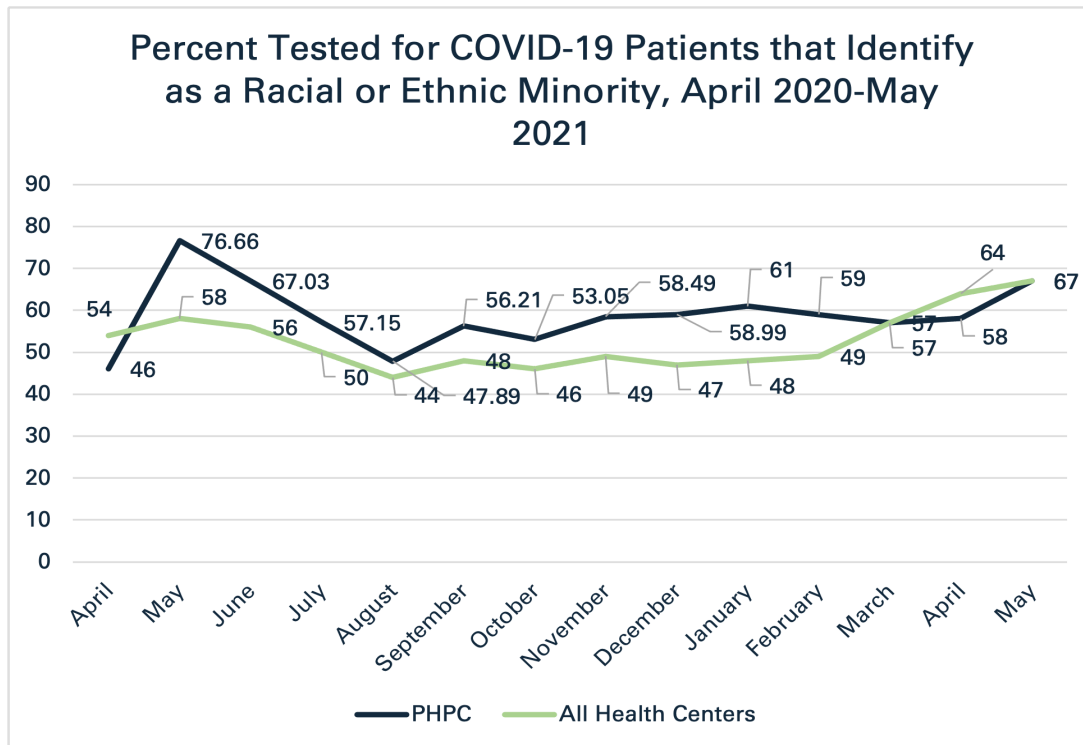


Source: HRSA Health Center COVID-19 Survey

Because the Pfizer and Moderna vaccines were administered in a series of two doses with 2-3 weeks between doses, vaccination for COVID-19 was captured in two ways: immunizations initiated, and immunizations completed. Findings from January 2021 to May 2021, when vaccines became available widely, showed a slightly larger difference in the percent of racial or ethnic minority patients initiating immunization at PHPC health centers ($t=1.39$; $p \leq .10$) with the gap beginning to narrow as the year continued.



A slightly higher proportion of patients that initiated COVID-19 immunization at PHPC health centers identified as a racial or ethnic minority compared to those initiating the immunization series at all health centers.



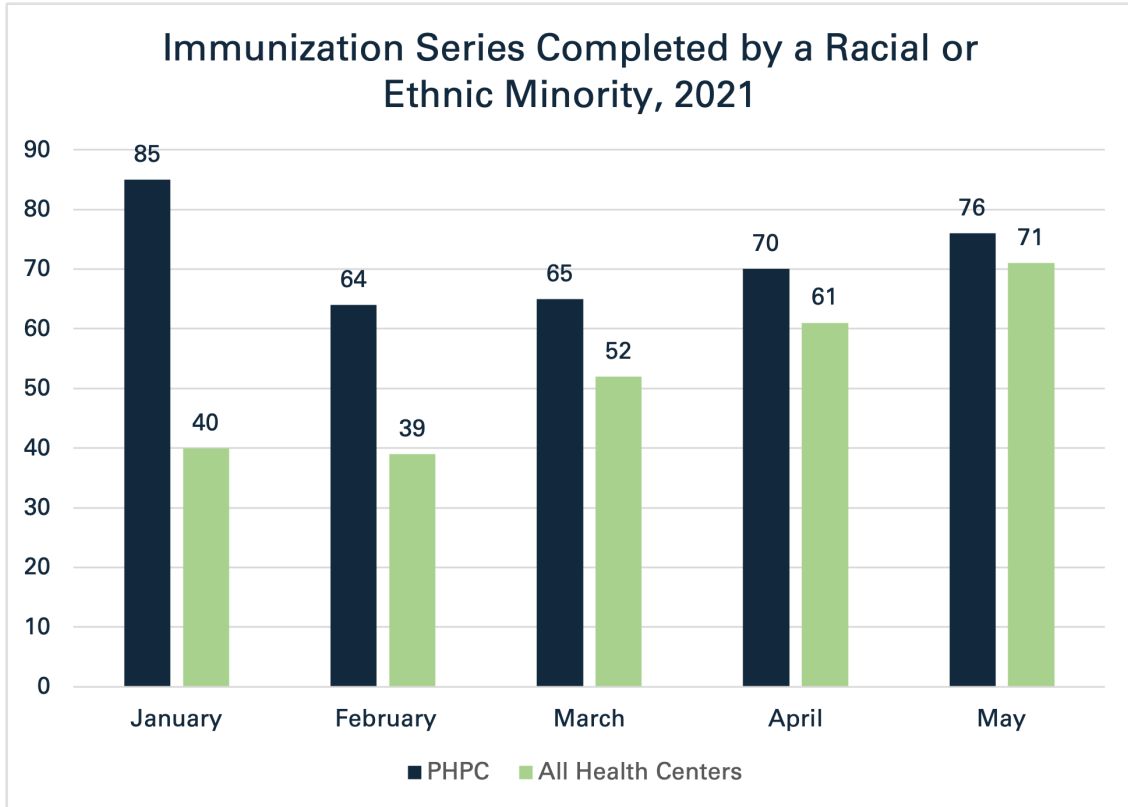
Source: HRSA Health Center COVID-19 Survey

The same was true for immunizations completed. A significantly higher proportion of patients that completed COVID-19 immunizations at PHPC health centers identified as a racial or ethnic minority compared to those completing the immunization series at all health centers ($t=2.67$; $p=.01$).

In summary, PHPC health centers were testing more, had higher proportion of COVID-19 cases that were racial and ethnic minority patients, and were vaccinating more racial and minority patients compared to all health centers.



A significantly higher proportion of patients that completed COVID-19 immunizations at PHPC health centers identified as a racial or ethnic minority compared to those completing the immunization series at all health centers.



Source: HRSA Health Center COVID-19 Survey

Health Center Operations

The next set of findings describes differences in weekly visits, virtual visits, and vaccine logistics among PHPC health centers compared to all health centers.



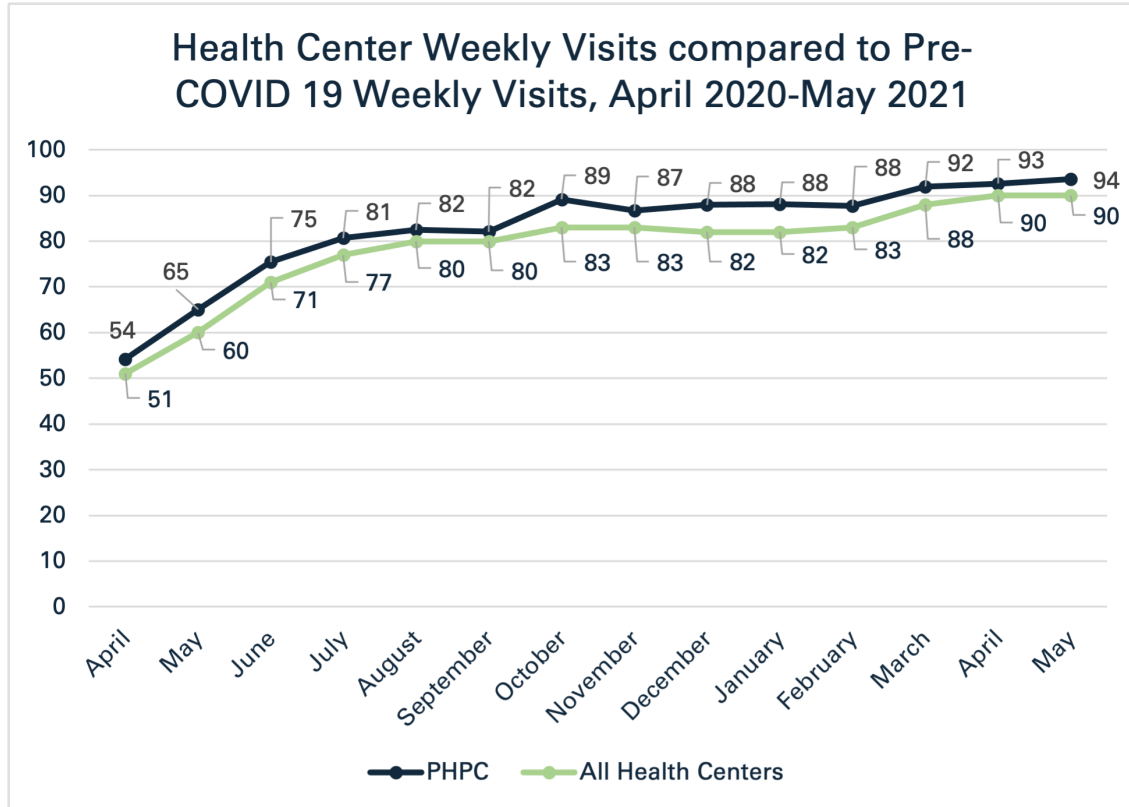
Weekly Visits

HRSA's survey of health centers asked them to compare their total weekly in-person patient visits to pre-pandemic estimates to document changes in patient caseloads. For example, if a Health Center reported 100% for that indicator, it would suggest the Health Center's total weekly in-person patient visits were equal to the number of in-person patients they were seeing in a typical week before COVID-19.

During the early stages of the pandemic, when much about transmission and risk of the disease was unknown or evolving, many health centers changed or reduced their hours of operation. Findings from the survey showed that all health centers, including PHPC health centers, saw a reduction in their weekly visits compared to pre-COVID-19 days. As protocols and policies on cleaning, distance, masks, etc. became more common place, weekly visits started to increase, approaching pre-COVID-19 levels in May of this year. However, findings indicate that early months were particularly devastating to health centers because of the huge losses in revenue due to reimbursement reduction.

NCHPH was interested in learning whether COVID-19 was having the same impact on weekly visits at PHPC health centers compared to all health centers. There was a slight difference, however it was not significant. PHPC health centers were experiencing the same impact as all health centers.

All health centers, including PHPC health centers, have seen a reduction in their weekly visits compared to pre-COVID-19 days. PHPC health centers are slightly better off in terms of their weekly visits compared to pre-COVID-19.



Source: HRSA Health Center COVID-19 Survey



Virtual Visits

Prior to the pandemic, only 42% of PHPC health centers reported ever using telehealth service.¹⁷ However, because many health centers had to close their doors or limit in-person visits during the early stages of COVID-19, there was a dramatic increase in need and response of virtual telehealth services. All health centers, including PHPC health centers, have had to pivot to virtual visits during the COVID-19 pandemic.



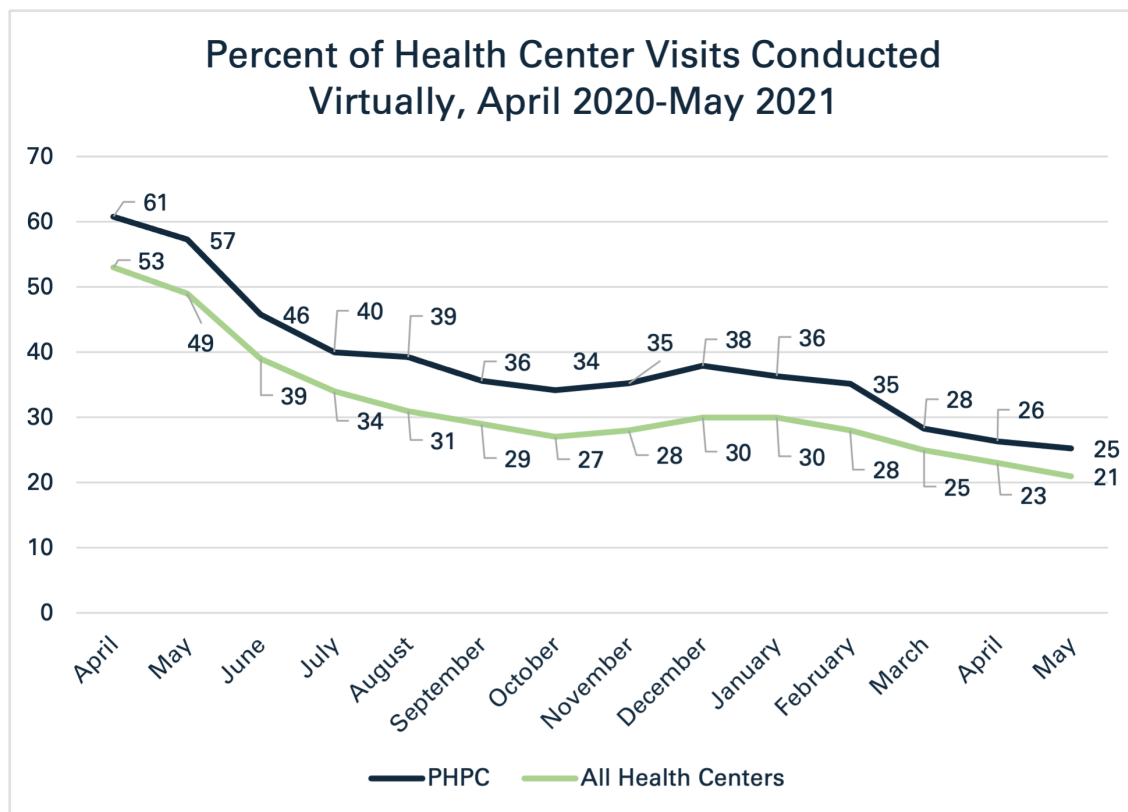
In April 2020, 61% of PHPC Health Center visits were virtual compared to 53% at all health centers. The graph below shows that PHPC health centers had a significantly higher percentage of virtual visits compared to all health centers ($t=1.74$; $p=.04$). Over the course of the pandemic, those numbers decreased and resumed to their pre-COVID-19 amounts by May 2021.

A lot of attention has been given to the importance of telehealth services to vulnerable populations during the pandemic. For individuals that were not able to travel due to restrictions in public transportation, or to the Health Center because of limited in patient services, telehealth offered much needed continuity in care, particularly for diabetes management and behavioral health services, conditions that are more prevalent among public housing residents.



Prior to COVID-19, PHPC health centers cited several challenges to initiating or broadening their telehealth programs, including lack of reimbursement for telehealth services (34%) and lack of training for telehealth services (24%).¹⁸ But all health centers were able to quickly overcome that obstacle in the beginning in part because of flexibility in reimbursement for those services.¹⁹ While CMS responded by making allowances for telehealth, many health centers had trouble understanding what was reimbursable and also needed more flexibility to provide care for their patients. PHPC health centers have a slightly higher percentage of Medicaid patients, making their reliance on Medicaid reimbursement more pronounced, with implications for a larger revenue loss compared to all health centers.

PHPC health centers had a significantly higher percentage of virtual visits compared to all health centers.



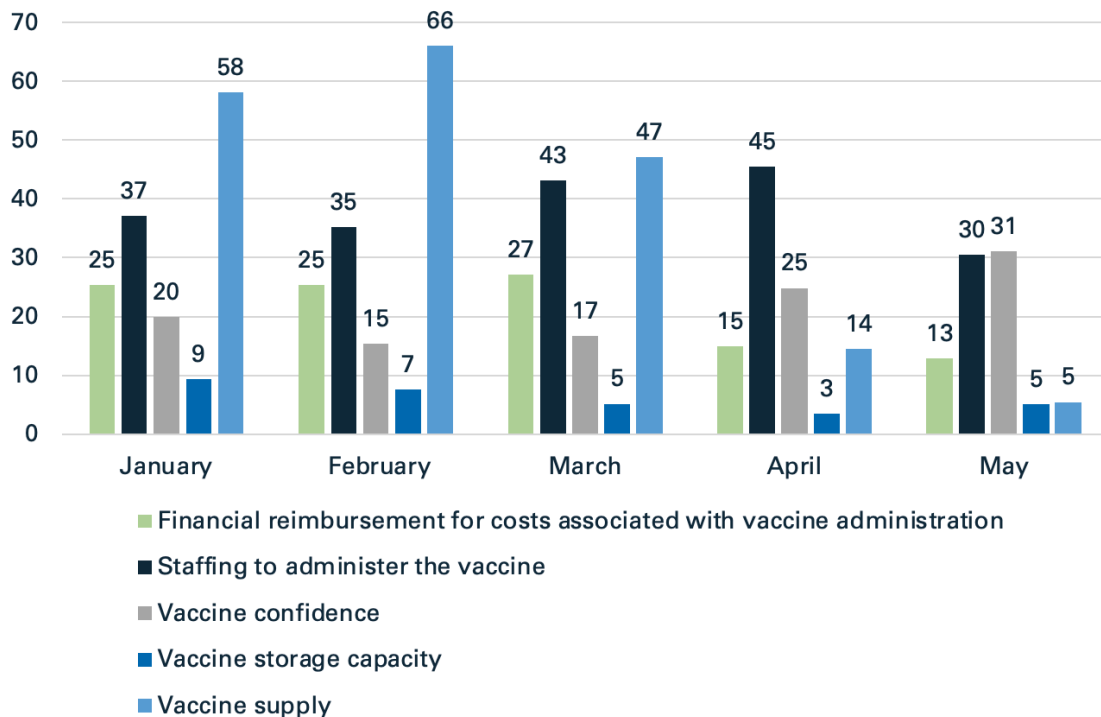
Source: HRSA Health Center COVID-19 Survey

Vaccine Challenges

The final category of findings covered logistical challenges for distributing vaccine. The five challenges included in the survey were: financial reimbursement for costs associated with vaccine administration, staffing to administer the vaccine, vaccine confidence, vaccine storage capacity, and vaccine supply.

The top vaccine challenges faced by PHPC health centers included obtaining vaccine supply, staffing to administer the vaccine, financial reimbursement. After vaccine became readily available, PHPC health centers encountered challenges with vaccine confidence.

PHPC Vaccine Challenges, 2021

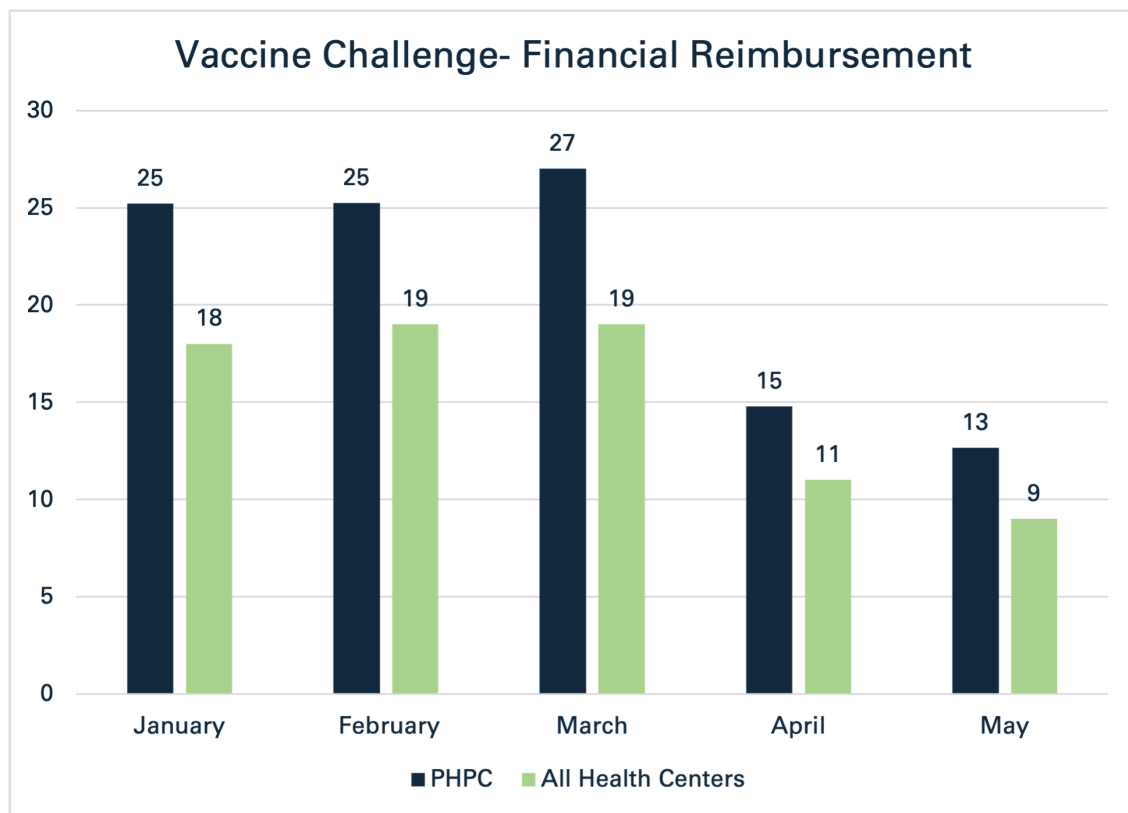


Source: HRSA Health Center COVID-19 Survey



However, there was one area that was significantly different for PHPC health centers - financial reimbursement. While it was not the leading challenge described by PHPC health centers, a significantly higher percentage of PHPC health centers were reporting it as a challenge compared to other health centers ($t=1.56$; $p=.07$). Particularly in the first part of Jan-March 2021. Again, implying that PHPC health centers were more impacted financially by COVID-19 compared to all health centers.

PHPC health centers were more likely to report a challenge with financial reimbursement to administer the vaccine compared to all health centers.



Source: HRSA Health Center COVID-19 Survey

Conclusions:

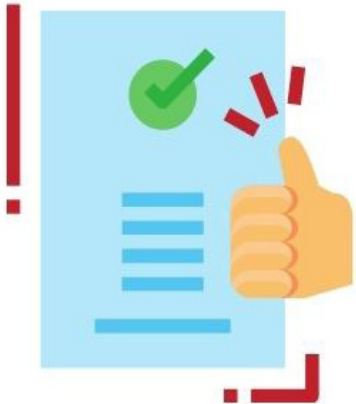
In summary, PHPC health centers tested a higher percentage of racial and ethnic minorities, saw a higher percentage of positive COVID-19 cases from racial and ethnic minorities, and were vaccinating more minorities than all health centers.

Implication #1



PHPC health centers have higher outreach and engagement with racial and ethnic minority patients compared to all health centers. This can partially be explained by a slightly higher patient population that identified as Black, however the proportion of patients that identified as Hispanic, Asian or Pacific Islander, or Native American was nearly the same as all health centers. Therefore, this finding on outreach is incredibly valuable for delivering equitable care. However, it is also important to understand the reasons why PHPC Health Center efforts were more successful than all health centers. Was it because of their location, rooted in their communities, was it because of trust, better partnerships with housing authorities and other community organizations? More research is needed on the impact of patient composition, health center approach to patient outreach, and community engagement.

Recommendations



1. Federal, state, and local agencies should engage and coordinate with PHPC health centers to address health equity and provide targeted outreach and services to vulnerable populations, including the elderly, disabled, or racial and ethnic minorities living in communities with public housing.

2. PHPC health centers should be included as a primary partner in state emergency preparedness plans.
3. PHPC health centers should reinforce collaborations with public housing agencies to address health equity.
4. Health centers, including PHPC health centers, should employ standardized Social Determinants of Health (SDOH) screening tools to identify patients that may be at higher risk for illness.

Implication #2



PHPCs may have been more impacted financially compared to all health centers. More research understanding those financial costs and their implications for the health center workforce is needed.

Recommendations



1. HRSA should provide additional training and technical assistance to PHPC health centers on improving workforce training and education on telehealth services.

Conclusion

Finally, PHPC health centers are a vital part of the health care system and are critical to eliminating health inequities. Public housing residents face complex conditions that impact their health, resulting in higher rates of chronic conditions, need for behavioral health services, and need for wrap around support services.

References:

1 Health Services and Resources Administration. (2021, August). *What is a Health Center?* Retrieved March 17, 2022, from <https://bphc.hrsa.gov/about/what-is-a-health-center/index.html>

2 Health Resources and Services Administration. (n.d). *Health Center Program Uniform Data System (UDS) Data Overview*. Retrieved March 17, 2022, from <https://data.hrsa.gov/tools/data-reporting/program-data>

3 Health Resources and Services Administration. (n.d). *Health Center Program Uniform Data System (UDS) Data Overview*. Retrieved March 17, 2022, from <https://data.hrsa.gov/tools/data-reporting/program-data>

4 U.S. Department of Housing and Urban Development. (n.d.). *Resident Characteristics Report*. RCR Start Page. Retrieved March 17, 2022, from <https://pic.hud.gov/pic/RCRPublic/rcrmain.asp>

5 U.S. Department of Housing and Urban Development. (n.d.). *Resident Characteristics Report*. RCR Start Page. Retrieved March 17, 2022, from <https://pic.hud.gov/pic/RCRPublic/rcrmain.asp>

6 U.S. Department of Housing and Urban Development. (n.d.). *Resident Characteristics Report*. RCR Start Page. Retrieved March 17, 2022, from <https://pic.hud.gov/pic/RCRPublic/rcrmain.asp>

7 Office of Policy Development and Research. (2017, March 16). *A Health Picture of HUD-Assisted Adults, 2006–2012*. U.S. Department of Housing and Urban Development. <https://www.huduser.gov/PORTAL/publications/Health-Picture-of-HUD.html>

8 Office of Policy Development and Research. (2017, March 16). *A Health Picture of HUD-Assisted Adults, 2006–2012*. U.S. Department of Housing and Urban Development. <https://www.huduser.gov/PORTAL/publications/Health-Picture-of-HUD.html>

9 Office of Policy Development and Research. (2017, March 16). *A Health Picture of HUD-Assisted Adults, 2006–2012*. U.S. Department of Housing and Urban Development.

<https://www.huduser.gov/PORTAL/publications/Health-Picture-of-HUD.html>

10 Centers for Disease Control and Prevention. (2020, November 30). *Assessing Risk Factors for Severe COVID-19 Illness*. Retrieved March 17, 2022, from <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/assessing-risk-factors.html>

11 Centers for Disease Control and Prevention. (2022, February 25). *People with certain medical conditions*. Retrieved March 17, 2022, from <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>

12 Centers for Disease Control and Prevention. (2022, February 25). *People with certain medical conditions*. Retrieved March 17, 2022, from <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>

13 Health Resources and Services Administration. (2022, February 25). *COVID-19 data collection survey tool questions*. Retrieved March 17, 2022, from <https://bphc.hrsa.gov/emergency-response/covid-19-survey-tools-questions>

14 Health Resource and Services Administration. (2022, February 25). *Health Center COVID-19 survey*. Retrieved March 17, 2022, from <https://bphc.hrsa.gov/emergency-response/coronavirus-health-center-data>

15 Health Resources and Services Administration. (n.d.). *2020 Special Populations Funded Programs*. Retrieved March 17, 2022, from <https://data.hrsa.gov/tools/data-reporting/special-populations>

16 Health Resources and Services Administration. (n.d.). *2020 Special Populations Funded Programs*. Retrieved March 17, 2022, from <https://data.hrsa.gov/tools/data-reporting/special-populations>; Health Resources and Services Administration. (n.d.). *National Health Center Program Uniform Data System (UDS) Awardee Data*. Retrieved from <https://data.hrsa.gov/tools/data-reporting/program-data/national>

17 Health Resources and Services Administration. (n.d.). *2020 Special Populations Funded Programs*. Retrieved March 17, 2022, from <https://data.hrsa.gov/tools/data-reporting/special-populations>; Health Resources and Services Administration. (n.d.). *National Health Center Program Uniform Data System (UDS) Awardee Data*. Retrieved from <https://data.hrsa.gov/tools/data-reporting/program-data/national>

[hrsa.gov/tools/data-reporting/program-data/national](https://data.hrsa.gov/tools/data-reporting/program-data/national)

18 Health Resources and Services Administration. (n.d.). *2020 Special Populations Funded Programs*. Retrieved March 17, 2022, from <https://data.hrsa.gov/tools/data-reporting/special-populations>; Health Resources and Services Administration. (n.d.). *National Health Center Program Uniform Data System (UDS) Awardee Data*. Retrieved from <https://data.hrsa.gov/tools/data-reporting/program-data/national>

19 U.S. Department of Health and Human Services. (n.d). Billing for telehealth during COVID-19. <https://telehealth.hhs.gov/providers/billing-and-reimbursement/>