



HFA policies for disease outbreaks and health crises:

HFA/PCAA policies follow the CDC's recommended guidelines for prevention, treatment and travel when there is a health outbreak or risk of outbreak. Please note: While we can give guidance on HFA model expectations during such health outbreaks, we know local agencies are also providing guidance and new expectations. Please follow agency protocol as needed.

HFA day-to-day activities:

Agencies implementing HFA services and all state-level leaders and administrators should practice prevention when it comes to COVID-19, or any other outbreaks or potential outbreaks.

If local community leaders or health departments take actions to decrease the spread of a virus, such as dismissing schools, HFA day to day activities should be performed remotely for the duration of such restrictions. In addition, if families being served by HFA have recently traveled to an identified area of outbreak and is exhibiting symptoms, it is advisable to visit with that family remotely until they are well (and refer them to care).

For Home Visiting Services:

The HFA Best Practice Standards allow for exceptions to in-person home visits in situations such as this, and these exceptions have been utilized in the past when sites have been affected by natural disasters. Within the definition of a home visit, we learn:

Also, in very limited, special situations such as when severe weather, natural disaster or community safety advisory impedes the ability to conduct a home visit with a family, a virtual home visit, via phone (skype, FaceTime, doxy.me or other video technology preferred), can be counted when documented on a home visit record and the goals of a home visit are met including some of the focus areas.

Some families have limited access to minutes for phone calls or data for video chats. Texting can be a very effective way to maintain contact with families can be a powerful way to connect with vulnerable families during this crisis. Dr. Bruce Perry talks about the therapeutic value of texting, especially now. It is important to note that a text conversation, even one of significant length, does not "count" as a home visit. Despite this, we encourage sites to maintain contact and relationship with families, using whatever methods they find to be effective, whether or not they are able to "count" these connections as home visits.

For more guidance, including the goals of a home visit, please refer to the glossary section of the HFA Best Practice Standards, under "Home Visit".

[See more about "What makes a virtual visit a visit? here.](#)



If needed, please consult with your local team about legal requirements / compliance issues. Texting services such as pMD, and cloud services such as Box/Dropbox/Google Drive may be other helpful tools to use in providing virtual visits.

FAQs about Home Visiting Services

If virtual home visits are impossible, or if the regularity of such visits are affected due to disease outbreak, then sites should consider placing families on a Creative Outreach Level.

- Level TR. While Level TR is usually reserved for times when sites are unable to offer regular visits due to staff transition, in the case of disease outbreak when staff are unavailable for visits due to being out of the office due to illness, or if they are temporarily reassigned to another area of the agency to help with community level care, Level TR is also allowable. This will exempt sites from the requirement of regular home visits. As guidance for TR suggests, sites should still support families as needed (and as able) throughout this time frame. Periodic virtual visits in the manner described above is recommended when feasible.
- Level TO: While TO is usually reserved for times when families are traveling out the area, if a family is refusing to receive services for the duration of this pandemic, or is themselves ill or is quarantined, TO may be advisable for a period of time. As the threat of illness decreases, families recover, and communities begin to return to normal, sites will want to think about moving families into CO to re-engage or moving families to TR for periodic contact while the site re-stabilizes.
- Level CO: In some instances, CO may be the best fit for families during this time, especially if the site has capacity for in-person or virtual visits, and yet families are becoming disengaged (but not refusing) to receive such visits. The types of Creative Outreach may differ in a virtual capacity, but the intent would be the same – to be a stable presence in the lives of families, and to communicate genuine interest. Please see the intent of Standard 3-3 for more guidance in this area.

TR Level During COVID-19: Whether to Extend time on TR beyond 3 months*

- A national health crisis like we find ourselves now with COVID-19 was not an expected use of HFA's TR level (Temporary Reassignment) at the time the level was created. However, TR can be used during this time and sites should adhere to the expectations of this level as described on the TR level change form. TR is not to be used as the initial level that families are placed on at the time of enrollment. Sites without the capacity to provide home visits should not continue enrolling new families. TR is a temporary level for already enrolled families, and as such, the level change form specifies sites

formally review all families on TR when the length of time on this level extends beyond 3 months.

- Related to this review and within the context of COVID-19, HFA encourages sites to carefully consider family strengths, risks and needs, as well as organizational capacity and the likelihood the program will be able to return the family to their original level of service in the near future. Supervisors and FSS staff (when the family is assigned to an FSS) should consider whether the family can a) resume visiting at their previous level, b) continue on TR for a period of time, or c) should be referred to other services.
- The determination about whether families should remain on the site's caseload for an extended time beyond three months is based on family needs, rather than programmatic or organizational priorities. The review of a family on TR should take place during supervision. Supervisors will document the review on the level change form itself or in weekly supervision notes, and will document the decision to either retain the family on level TR or return to previous level. Things to consider in making this determination for families on level TR:
 1. Family strengths and level of risk - If the site is not able to give the family the level of support they desire or require, sites should consider connecting them to other community services with the capacity to serve them.
 2. Site staffing over the next few months - If the organization anticipates HFA staff to return to full time work within the program in a reasonable amount of time, sites may opt to continue the family on Level TR until that time.
 3. Whenever possible, sites should return families to their previous level as soon as caseload capacity becomes available.

Sites with significant numbers of staff redeployed for COVID-related work will serve fewer families. Families should not be retained on TR beyond three months for the purpose of preserving caseload numbers. Families should instead be connected to alternate services to ensure their needs are met in a timely way.

Focus of Home Visits

- The focus of the visit may shift to the immediate needs of the family as they deal with impacts owing to COVID-19, and this is okay. We need to be sure we are helping the family manage this stressor as we do with other stressors, supporting the parent to understand the impact of parental stress on their child(ren), even unborn and newly born babies, and supporting the parent-child relationship in the context of what is happening

Length of Home Visits

- HFA has never mandated the length of a home visit. In the BPS glossary we see: Typically, home visits occur in the home, last a minimum of an hour and the child is present. Extenuating circumstances may occur where visits take place outside the home, be of slightly shorter duration than an hour, or occur with the child not present.

Enrolling New Families + What to do if you're not enrolling per usual

Things probably look very different in your program right now! FSSs and FRSSs who are used to being out in the field all day suddenly find themselves working from home. Instead of grabbing curriculum and materials to take on home visits, they are now sitting in front of a screen, trying to connect with families virtually. It's a whole new world out there.

Families, too, are dealing with a changing world. While some families will be eager to visit remotely, others may not have access to the internet, may not have the ability to connect via Facetime or other apps, or may just find it difficult to spend an hour sitting down with you while feeling so stressed. Their needs may increase at the exact moment that it becomes harder to get those needs met.

Some of your sites may continue with "business as usual"—at least in terms of continuing to enroll new families. And, for a variety of reasons, other sites may not be able to enroll new families. If that's the case for you, here are some different ways to look at serving families:

- If your referral sources close down for a while (e.g., the WIC office or a local medical practice), consider whether you can develop new referral sources during the interim. If nothing else, most pregnant parents will continue to deliver at a hospital, which could serve as a new or more prominent referral source for your program.. Many hospitals are not allowing birth partners in, so new moms may be delivering alone and then be kept in quarantine for the next 14 days. So, they might be very eager to hear from you!
- If your staff have fewer scheduled visits, put them in charge of tracking the availability of resources in your community. Ask them to find out how to access social services (whether in person or online), which parks or libraries are closed, whether food pantries are still open, how to apply for unemployment benefits, etc.
- If your program is not enrolling new families, or has decided to decrease the number of new enrollments related to the COVID-19 pandemic, staff who ordinarily reach out to new referrals to determine eligibility can continue to contact referred families and learn about their needs and strengths. For sites that determine eligibility using the

Parent Survey, FRS staff can continue to complete Parent Surveys as a service to families, and if enrolling in your HFA program is not possible, families can be connected to other supportive services based on their needs.

We are all concerned about the families who are already enrolled in our programs—and rightly so. At the same time, all those new parents you would ordinarily meet with are still out there waiting for the opportunity to tell their stories to someone who will listen and support them. They need us now as much as ever!

Family Consents

- Work with your agency to determine what constitutes a valid consent (e.g., can parents text you a picture of a signed consent?). If your agency is bound by HIPAA laws, check here for more information: <https://www.hhs.gov/hipaa/for-professionals/special-topics/hipaa-covid19/index.html>
- We know sites are using a variety of mechanisms to obtain family consent. Some online services such as Docusign can be helpful. We also know it is possible to arrange for a contact-less / consent form dropoff in some instances. We know others have been successful in using text messages and online file sharing to obtain consent.

Administering the Parent Survey

- During this time of COVID-19 restrictions, the Parent Survey can be administered virtually. Because of the sensitivity of information we ask, the value of observing non-verbal cues, and the timing of the conversation, which occurs during the very early stages of relationship building, having a face-to-face visual can be very important. However, many staff report they are having success with phone calls because parents can talk while doing other tasks like washing dishes or folding laundry. In addition, some staff find it easier to bring up sensitive topics because parents cannot see the discomfort evident on staff's face. Use what works.
- It is important to offer to schedule the Parent Survey for a separate day or time, since many parents can't drop everything to spend an hour on the phone with you without prior planning—and, at the same time, be prepared if the parent is eager to talk right then. If your agency or program requires consent forms in order to complete the Parent Survey, talk through how this can occur. Some suggestions include: using electronic signatures, dropping consents off or sending forms via snail mail and then asking parents to text consent with a photo of the signed form, etc.
- It can be harder to build a relationship when you aren't sitting in the same room together, so consider the following:
 - Consider using digital business cards as a way of showing that staff are professionals from legitimate community agencies.

- Take time to check in on how the family is doing. Things are probably more stressful now than in normal times and many parents welcome someone to talk with.
- It may be easier to engage both parents, now that more people are staying at home. Invite dad or partner to be involved in the call too.
- Pay attention to cues that the parent may not be comfortable and check out your perceptions. Even if you can't see the parent, you can listen for changes in volume, energy level, background noise, etc. If someone suddenly starts speaking more quietly, acknowledge what you are noticing and then ask if this is still a good time to talk or if the parent needs to move to another room.
- Be sure to let the family know, throughout the conversation, what information you can share at the end. For example, if they tell you right away that they are running out of food, let them know that you have information on which food banks are still open right now and that you'll give them that info before you hang up. That way the family sees immediate benefit to your call.
- Some families may not have enough minutes or cell service to complete the whole Parent Survey in one call. This is one of those times when it may take more than one visit—and the standards allow for that!
- Normally we ask you to provide any information or referrals at the end of the Parent Survey. However, if you need to schedule a second call to complete the conversation, it is okay, at the end of the first call, to give them any referral information you have already promised them, so they are not left waiting. When you start the second call, check in on those earlier referrals to see if the family has been successful.
- With higher incidences of DV/IPV now that more people are following stay-at-home orders, we want to be very careful not to put anyone at increased risk. Our priority is to keep families safe. It is understood that portions of the Parent survey may not be completed until an in-person contact can occur. If this impacts the timing of when a family is determined eligible, this must be documented. All other expectations for documentation of the Parent Survey remain the same.

Administering Screening Tools

It may be possible to continue administering regular screenings in remote or virtual visits and possibly even for families on a level such as TR, CO or TO. Some things to consider when administering “remote” screenings:

- For some families, continuing with regular screenings may bring a feeling of familiarity or normalcy in a time where things are changing quickly. Screenings are a part of our relationships with families and are expected. In some cases, this may help the family and the FSS feel some consistency and stability.

- To administer a virtual screening involving parent answers, home visitors may read questions to parents over the phone or video. In some cases, home visitors may be able to take a picture of the blank tool and text it to parents so that they have a copy as well. It may also be possible to mail a hard copy of the screening tool to the parent ahead of the visit so that they have a hard copy to look at.
- For some families, screenings may be overwhelming or challenging due to their current living situation. The home may be more crowded than previously, and parents may not be able to find a private place for screenings on sensitive topics such as mental health and domestic violence.
- Reading questions aloud to complete a screening tool over phone or video may present a challenge as well. Families under stress may lack the concentration and listening skills needed to participate in a screening at times. The FSS should check in with families about readiness before completing any screening and should be willing to pause the screening if they notice the parent is struggling to participate in the screening.
- Documentation for any screening should include that it was completed on a virtual visit and the modality of the visit (phone, video).
- Intervals for administration of ASQs, ASQ-SEs, CCI tools, depression screens and other tools may be missed during this time. Again, note the reason in family file documentation, and administer the tool at the next possible interval (vs what may be current policy). For example, if you miss the 4 month ASQ and policy says the next one due is at 8 months, but you have an opportunity when the COVID-19 crisis resolves to re-establish regular home visits the closest possible ASQ interval should be used rather than waiting until 8 months.

CHEERS Check-In Tool (validated parent child observation tool)

- Sites have had success administering this tool virtually using video functions. In some cases, parents record themselves interacting with their child in a playtime or daily routine for 6-10 minutes and share this video with the FSS. The FSS can then use this video to complete the ratings for CCI, and also to have a conversation with the parent about what each saw and the strengths that the parent displayed. It is also possible for the FSS to invite the parent to interact with their child during a video virtual visit, while the FSS quietly observes (as is done for a “normal” CCI). This tool cannot be completed via a phone visit. Staff and supervisors should keep in mind that this tool is only required once per year for each child, so they may consider pushing back the completion of this tool to when in-person home visiting resumes. Sites should put special effort into regular CHEERS observations for families with whom they are not able to complete a CCI Tool.

ASQ-3 and ASQ:SE-2

- These developmental screening tools were designed to be parent administered which makes them a great fit for virtual home visiting. Sites

may share the appropriate screen with parents at an earlier visit, mail parents a hard copy, or may opt to text them images of the tool itself. Whenever possible, encourage parents to complete the activities on the tool with their child as part of the visit.

Perinatal depression screenings, domestic violence screenings, others

- Screening tools that ask parents for potentially sensitive or particularly private information may be more difficult to complete over the phone or through video. Staff should discuss with parents the nature of the screening and ensure that the parent feels they are in a space that private enough to make the administration of the tool safe and comfortable for them. Parents who are used to responding to the questions on these screenings in writing, might feel less comfortable discussing them out loud. Sites may opt to drop off or mail hard copies of these screening, but only with parent permission. Supervisors and home visitors may want to role-play the administration of these tools in supervision and consider each family's potential reaction to a virtual screening.

CHEERS

- It is permissible per the Best Practice Standards for CHEERS not to be included if the child is not present during the visit. Even with visits by video, it will sometimes be hard to observe Parent-Child Interactions (PCI). We encourage as much CHEERS-related conversation with the parent as possible and offer the following guidance and instruct peers to use contextual decision-making if needed when looking at HV documentation during this time:
 - For all documentation of virtual visits, sites should note the type of visit, including the mechanism (phone, video, app, etc.)
 - Ideally, all CHEERS domains will be documented. When this is not possible, Family Support Specialists (FSS) should capture a minimum of 2.
 - Generally, Expression and Smiles are the easiest to observe and document during phone and video visits.
 - Frequency is not relevant during phone and video visits.
 - CHEERS during virtual visits is not based specifically upon a behavioral observation. Documentation can include facts from the conversation with the parent (such as quotes and what the FSS sees and/or hears during the visit) and parent descriptions of their experiences with their child.
 - The intent is to identify and document the ways that the parent is aware of and interacting with their child as well as to identify specific CHEERS domains the FSS wants to promote and address with the parent to strengthen the parent-child relationship.

- For more help with CHEERS during virtual visits, [see additional resources here.](#)

Family Goals

- The expectation for all families to have an initial family goal established within 3 months of the first home visit, and an active goal at all times subsequently, may be affected by reduced in-person visits. However, it is possible to “suspend” a current goal and work together with the parent on a new goal that has emerged in response to the current crisis.

Technology challenges:

- While not all videoconferencing and technology tools are HIPAA compliant, HIPAA is relaxing its guidelines during COVID-19. See resources for more info:
- HIPAA Suspension of Penalties:
<https://www.healthcareittoday.com/2020/03/17/hipaa-penalties-suspended-for-telehealth-during-covid-19-national-emergency/>
- HIPAA and tele-intervention information and resources:
<https://ectacenter.org/topics/disaster/tele-intervention.asp>
- Families may not have internet or data on their phones to support virtual visits (though if you can help families connect, that is awesome. Here is a list of companies who are offering [free internet and other services](#)).
- Phone calls are still great ways to connect with families, if possible.

- For supervision:

In a similar fashion to home visiting, supervision should be provided for all direct service staff who are serving families (even if home visits are occurring virtually). Supervisors should be on call as needed to help staff manage their responsibilities in a virtual capacity. As we know, home visiting can already be a high-stress job, and virtual home visiting during a time when there is an outbreak of disease in the community is no different. Supervisors have a critical role of offering guidance, emotional support, and insight into the impact of the work on the worker.

It has long been the case that under extenuating circumstances, supervision can be conducted virtually, though use of video technology is highly preferred when possible (vs phone contact). If supervision sessions are occurring in a virtual capacity, supervisors should maintain documentation of such sessions.

Please see the intent of Standard 12-1.B for more details. Also please note: While the intent of 12-1.B states that at least one in-person monthly supervision is required, if

that level of contact is not possible, supervisors and sites should document this detail as well.

If the site decides to place families on a Creative Outreach level (see above for more guidance) until the community advisories have been lifted, supervisors should assist staff on check-ins with families and keep staff updated about community-level responses.

FAQs about Supervision:

What is the frequency and duration of supervision required for direct service staff?

- Supervision remains crucial as we support our staff during this time. However, at some sites, we know roles may be shifting as staff are required to take on other duties, resulting in lesser amount FTE dedicated to HFA direct services. Therefore supervision may also look different. For frequency and duration requirements, you should reference the intent of Standard 12-1.B.
- For all full-time and part-time staff who are .75 FTE to 1.0 FTE, the requirements are 1.5 to 2 hours weekly. For part-time staff who are .25 FTE to .74 FTE, the requirements are 1 hour weekly. For staff or contractors working less than .25 FTE, supervision may be provided according to occurrence of services.
- For example if a full-time home visitor is now required to spend a third of their time working as part of a crisis response team within the organization or any other non HFA direct service role, they now need 1 hour of supervision instead of 1.5 hours. If this is happening at your site, just be sure to keep notes regarding the FTE shift and the start and end date of the shift.
- If a significant portion of families are placed on various creative outreach levels, this will impact the content of supervision sessions. Please see guidance in home visiting section (above) about what Creative Outreach Level is appropriate. As a reminder of how level changes impact caseloads:
 - Families placed on Level TO or CO maintain the same case weight as when on the previous active service level.
 - So if a family was on Level 1, and is changed to Level TO or CO, then they will still be maintained at two points each.
 - For families placed on Level TR, family case weight shifts to .5.
 - As a result, if a staff has 20 families which are all placed on Level TR, who they are still responsible for contacting as able, then they will have $(.5 * 20)$ 10 caseload points. 10 case weight points approximates 35% FTE (in accordance with HFA guideline of no more than 30 case weight points per full-time

- home visitor), and so we would require 1 hour of supervision weekly.
- If families are moved to TR and then re-assigned to another member of the team, leaving the direct service staff member with between 0 - .25 FTE, then as-needed supervision would occur instead of 1 hour/wk.
- As a reminder, HFA allows supervision sessions to be split into 2 contacts per week instead of just one, which may be a good fit for this period where things are changing frequently and staff may have more questions about expectations and site practices.

Recommendations on the Content of Supervision

- As it relates to how the content of supervision sessions may change or “what are we supposed to talk about”- here are some suggestions:
 - Shadowing virtual visits and using supervision time to reflect on how it went.
 - Develop individualized professional development plans with staff.
 - Update Service Plans for families experiencing new or significant stress as a result of the situation. Update service plans with strategies specific to family’s new level of service (such as TR) or strategies that would be effective in virtual visits.
 - Develop resource lists for community-level supports related to the outbreak.
 - Consider impact of the outbreak on Family Goals and opportunities to revisit goals to keep them meaningful and relevant to the current time.
 - Reflect on the impact of remote work and reduced family contacts on the FSS/FRS and their experience of the work.
 - Role-play virtual visits, including CHEERS observations, use of Reflective Strategies and use of curriculum.
 - Attend to work-life balance for staff who are potentially responsible for children now at home who would be in school or if caring for loved ones who are ill.
 - Reflecting on family culture and the impact of specific family values and family structures at this time (such as families that value independence, or families with older generations living in the home).
 - Review CCI tool ratings for trends and opportunities for inter-rater reliability discussions. (for example, an FSS who consistently rates all families with all 7s- what are the opportunities to learn about PC observations and identifying areas to strengthen?)
 - Gathering informal responses from staff related to the program acceptance or retention rates and getting input towards plans to increase these rates.

- Work together with staff to identify ways to maintain an open-door policy when all staff work remotely.

For program managers, TA/QA, and state level leaders:

Managers are encouraged to follow the CDC's guidelines on infectious disease outbreak response plans: <https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/guidance-business-response.html> Select text is pasted here:

Employers should:

- Ensure the plan is flexible and involve your employees in developing and reviewing your plan.
- Conduct a focused discussion or exercise using your plan, to find out ahead of time whether the plan has gaps or problems that need to be corrected.
- Share your plan with employees and explain what human resources policies, workplace and leave flexibilities, and pay and benefits will be available to them.
- Share best practices with other businesses in your communities (especially those in your supply chain), chambers of commerce, and associations to improve community response efforts.

Recommendations for an Infectious Disease Outbreak Response Plan:

- Identify possible work-related exposure and health risks to your employees. OSHA has more information on how to [protect workers from potential exposures](#) to COVID-19.
- Review human resources policies to make sure that policies and practices are consistent with public health recommendations and are consistent with existing state and federal workplace laws (for more information on employer responsibilities, visit the [Department of Labor's](#) and the [Equal Employment Opportunity Commission's](#) websites).
- Explore whether you can establish policies and practices, such as flexible worksites (e.g., telecommuting) and flexible work hours (e.g., staggered shifts), to increase the physical distance among employees and between employees and others if state and local health authorities recommend the use of social distancing strategies. For employees who are able to telework, supervisors should encourage employees to telework instead of coming into the workplace until symptoms are completely resolved. Ensure that you have the information technology and infrastructure needed to support multiple employees who may be able to work from home.
- Identify essential business functions, essential jobs or roles, and critical elements within your supply chains (e.g., raw materials, suppliers, subcontractor services/products, and logistics) required to maintain business operations. Plan for how your business will operate if there is increasing absenteeism or these supply chains are interrupted.
- Set up authorities, triggers, and procedures for activating and terminating the company's infectious disease outbreak response plan, altering business operations

(e.g., possibly changing or closing operations in affected areas), and transferring business knowledge to key employees. Work closely with your local health officials to identify these triggers.

- Plan to minimize exposure between employees and also between employees and the public, if public health officials call for social distancing.
- Establish a process to communicate information to employees and business partners on your infectious disease outbreak response plans and latest COVID-19 information. Anticipate employee fear, anxiety, rumors, and misinformation, and plan communications accordingly.
- In some communities, early childhood programs and K-12 schools may be dismissed, particularly if COVID-19 worsens. Determine how you will operate if absenteeism spikes from increases in sick employees, those who stay home to care for sick family members, and those who must stay home to watch their children if dismissed from school. Businesses and other employers should prepare to institute flexible workplace and leave policies for these employees.
- Local conditions will influence the decisions that public health officials make regarding community-level strategies; employers should take the time now to learn about plans in place in each community where they have a business.
- If there is evidence of a COVID-19 outbreak in the US, consider canceling non-essential business travel to additional countries per [travel guidance](#) on the CDC website.
 - Travel restrictions may be enacted by other countries which may limit the ability of employees to return home if they become sick while on travel status.
 - Consider cancelling large work-related meetings or events.
- Engage [state](#) and [local](#) health departments to confirm channels of communication and methods for dissemination of local outbreak information.

Individuals:

Individuals should follow the community mitigation guidance as provided by the CDC for COVID-19, <https://www.cdc.gov/coronavirus/2019-ncov/preparing-individuals-communities.html>, including:

- Voluntary Home Isolation: Stay home when you are sick with respiratory disease symptoms. At the present time, these symptoms are more likely due to influenza or other respiratory viruses than to COVID-19-related virus.
- Respiratory Etiquette: Cover coughs and sneezes with a flexed elbow or with a tissue, then throw it in the trash can.
- Hand Hygiene: Wash hands often with soap and water for at least 20 seconds; especially after going to the bathroom; before eating; and after blowing your nose, coughing, or sneezing.
- If soap and water are not readily available, use an alcohol-based hand sanitizer with 60%-95% alcohol.
- Environmental Health Action: Routinely clean frequently touched surfaces and objects

Helping communities respond to a disease outbreak:

While there is not any suggestions or evidence that COVID-19 has more or a different effect on pregnant women and children, “Pregnant women experience immunologic and physiologic changes which might make them more susceptible to viral respiratory infections, including COVID-19.” (CDC). Please continue to watch the CDC’s page for pregnant women and children for more details as they become available:

<https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/pregnant-women.html>

While maintaining staff safety as priority number one, HFA sites should take seriously their role in helping to distribute important information about any disease outbreak to families and community members. HFA staff have developed trusting relationships with community members who may not have information that is accessible. Please help to keep families updated and informed and connect to medical care as needed. Families may need to know:

- How to help prevent the spread of disease
- Where to go if they or their children start to feel sick
- What symptoms to be aware of
- Which populations are most at-risk
- How to plan for school closures or other shut-downs

The CDC has released handouts and posters, which you can download here:

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