

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**OFFICE OF REFUGEE RESETTLEMENT
ENSURED THAT SELECTED
CARE PROVIDERS WERE PREPARED
TO RESPOND TO THE
COVID-19 PANDEMIC**

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Office of Inspector General

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Report in Brief

Date: November 2020

Report No. A-04-20-02031



Why OIG Did This Audit

On July 1, 2019, the Emergency Supplemental Appropriations for Humanitarian Assistance and Security at the Southern Border Act, 2019 (P.L. 116-26) appropriated \$2.9 billion for the Unaccompanied Alien Children (UAC) Program. Title IV provided \$5 million for the Department of Health and Human Services, Office of Inspector General (HHS-OIG), to conduct oversight of the UAC Program. On January 31, 2020, in response to the coronavirus pandemic in the United States, the Secretary of HHS declared a public health emergency. Following this declaration, Congress appropriated \$12 million to HHS-OIG to conduct oversight of HHS's response to the COVID-19 pandemic.

Previous HHS-OIG work has focused on the Office of Refugee Resettlement's (ORR's) efforts to ensure the health and safety of children in the UAC Program, including when the UAC Program experiences a sudden change in the number or needs of children. This report builds on our oversight of ORR's efforts to protect children and is one of two reports addressing emergency preparedness at ORR facilities. This report specifically addresses communicable disease preparedness.

Our objective was to determine whether ORR ensured that selected care provider facilities (facilities) followed ORR requirements in preparing for and responding to communicable diseases, such as COVID-19.

How OIG Did This Audit

We conducted this communicable disease preparedness audit of 11 selected facilities from March through June 2020 during the COVID-19 pandemic in the United States. Because most States were under stay-at-home orders, we sent questionnaires to the 11 selected facilities and requested documentation from each. We also interviewed ORR regarding its oversight responsibilities during the COVID-19 pandemic.

Office of Refugee Resettlement Ensured That Selected Care Providers Were Prepared To Respond to the COVID-19 Pandemic

What OIG Found

ORR ensured that the 11 facilities we selected for review followed ORR requirements in preparing for and responding to communicable diseases and were prepared to respond to the COVID-19 pandemic. Specifically, ORR provided detailed COVID-19-response guidance, encouraged telehealth visits, and updated the UAC Portal.

The 11 selected facilities that we reviewed were generally prepared to respond to an emergency event, such as the COVID-19 pandemic, in accordance with Federal guidance. Specifically, they had policies and procedures, the capability to quarantine COVID-19 cases in their facilities, and adequate personal protective equipment.

ORR officials stated that, since 2006, ORR has had a policy in place that required its facilities to prepare for and respond to a communicable disease outbreak; therefore, the facilities were generally able to quickly pivot to respond to the COVID-19 pandemic.

What OIG Recommends and Administration for Children and Families Comments

This report contains no recommendations.

In response to our draft report, the Administration for Children and Families (ACF) stated that ORR's standard operating procedures for communicable diseases follow the Centers for Disease Control and Prevention's (CDC's) surveillance and outbreak guidelines for each specific disease. ACF also stated that ORR will continue to monitor the situation around COVID-19 and coordinate all response efforts with CDC and local public health officials. We included ACF's comments as an appendix to this report.

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INTRODUCTION

WHY WE DID THIS AUDIT

On July 1, 2019, the Emergency Supplemental Appropriations for Humanitarian Assistance and Security at the Southern Border Act, 2019 (P.L. 116-26) appropriated \$2.9 billion for the Unaccompanied Alien Children (UAC) Program. Title IV of P.L. 116-26 provided \$5 million for the Department of Health and Human Services, Office of Inspector General (HHS-OIG), to conduct oversight of the UAC Program. On January 31, 2020, in response to the coronavirus pandemic in the United States, the Secretary of HHS declared a public-health emergency. Following this declaration, Congress appropriated \$12 million to HHS-OIG to conduct oversight of HHS's response to the COVID-19 pandemic.

The UAC Program serves children who have no lawful immigration status in the United States and who have no parent or legal guardian in this country available to assume custody and care for them.¹ The UAC Program serves children who arrive in the United States unaccompanied, as well as children who are separated from their parents or legal guardians by immigration authorities within the Department of Homeland Security (DHS). Previous HHS-OIG reports have focused on ORR's efforts to ensure the health and safety of children in the UAC Program, including when the UAC Program experiences a sudden change in the number or needs of children.

This audit is intended to provide a snapshot of communicable disease preparedness and response capabilities at selected Administration for Children and Families (ACF) Office of Refugee Resettlement (ORR) UAC care provider facilities (facilities). By responding to a questionnaire and followup questions that we posed in subsequent interviews, facilities explained their preparedness and response capabilities during the COVID-19 pandemic. In this report, we summarize this information, along with information about ORR's efforts to assist the facilities that it funds to administer the UAC Program at the Federal level.

This is one of two reports addressing emergency preparedness at ORR facilities. This report specifically addresses communicable disease preparedness, and our second report will address emergency preparedness for disasters.²

¹ 6 U.S.C. § 279(g)(2).

² *Emergency Preparedness and Response at Care Provider Facilities in the Office of Refugee Resettlement's Unaccompanied Alien Children Program (A-04-20-02025)*.

OBJECTIVE

Our objective was to determine whether ORR ensured that selected facilities followed ORR requirements in preparing for and responding to communicable diseases, such as COVID-19.

BACKGROUND

The Unaccompanied Alien Children Program

Federal law requires the safe and timely placement of children in the least restrictive setting that is in the best interest of the child.³ To that end, ORR funds a network of facilities that provide shelter, counseling, medical care, legal services, and other support services to unaccompanied children until they are released to a sponsor or otherwise leave ORR's care and HHS custody. Throughout the time that unaccompanied children are in ORR's care, they are in the legal custody of HHS and the physical custody of the facility. ORR has several types of facilities in its network. The continuum of placement options in this network includes foster care,⁴ shelter,⁵ staff secure,⁶ secure,⁷ and residential treatment centers.⁸ Facilities are ORR-funded programs that are generally licensed, certified, or accredited by an appropriate State agency to provide residential care for children. To ensure that these facilities provide a safe environment, ORR imposes requirements for preventing and addressing potential dangers. The *ORR Guide: Children Entering the United States Unaccompanied* (the Guide) states that facilities are responsible for safety planning, including development of a written safety plan for all children in the UAC Program and program staff. This written plan should address emergency situations such as evacuations (e.g., due to hurricane, fire, or other emergency), medical and mental health emergencies, and disease outbreaks (such as COVID-19) (the Guide § 3.3.4). Facilities must also have policies and procedures for identifying, reporting, and controlling communicable diseases that are consistent with State and local laws and regulations (the Guide § 3.4.6). In addition, each licensed facility must adhere to State licensing requirements regarding emergency preparedness and response.

³ 8 U.S.C. § 1232(c)(2)

⁴ ORR foster care consists of therapeutic foster care for children with exceptional needs that cannot be met in a regular foster family; transitional foster care, which is synonymous with short-term foster care; and long-term foster care, which is for children who will be in care an extended period of time.

⁵ A shelter is a residential facility in which all programmatic components are onsite, in the least restrictive environment.

⁶ A staff secure facility maintains stricter security measures, such as higher staff-to-child ratios for supervision.

⁷ A secure facility has a physical security structure and is the most restrictive placement option for children.

⁸ A residential treatment facility provides children who need more intensive mental health treatment with sub-acute therapeutic care through a structured 24-hour-a-day program and services that are highly customized to individual needs.

Division of Health for Unaccompanied Children

Within ORR, the Division of Health for Unaccompanied Children (DHUC) is responsible for the health of unaccompanied children in ORR care, including public health response activities associated with communicable diseases. DHUC's medical and public health professionals include physicians, epidemiologists, nurses, social workers, and quality assurance specialists. DHUC is available to assist ORR facilities 7 days a week and provides management guidance on infectious diseases, serious mental health conditions, and complex medical cases.

During a pandemic like COVID-19, DHUC's responsibilities include real-time tracking of changes in Federal, State, and local public health guidance, and public health understanding of the virus. ORR created guidance for its facilities and has updated that guidance based on current changes in understanding of the virus.

ORR monitors the reported COVID-19 cases when facility staff report infectious disease events through ORR's electronic case management system (UAC Portal). DHUC receives an automatic notification when an infectious disease of public health concern is entered into this system, allowing DHUC to track and provide individual-level guidance on reported cases. DHUC advises facility staff on infection prevention, infection control, and public health reporting in line with local, State, and Federal disease-specific public health guidelines.

COVID-19 Cases at Facilities

COVID-19 is caused by a highly contagious coronavirus. Disease severity ranges from mild to lethal, with some demographic groups at heightened risk for more severe disease. Common symptoms include fever, fatigue, dry cough, sore throat, and shortness of breath. The World Health Organization (WHO) issued a global health emergency on January 30, 2020,⁹ and HHS declared a public health emergency for COVID-19 on January 31, 2020.¹⁰ On March 11, 2020, the WHO characterized COVID-19 as a pandemic, which refers to an epidemic that has spread over several countries or continents, usually affecting a large number of people.

In accordance with ORR guidance, facilities were required to report to ORR (via the UAC Portal) suspected and confirmed cases of COVID-19 in children in ORR care (the Guide § 3.4.6). Facilities were also instructed to report self-reported cases in staff. ORR only documents cases

⁹ WHO, *Statement on the second meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of novel coronavirus (2019-nCoV)*. Accessed at [https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-\(2019-ncov\)](https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov)) on August 18, 2020.

¹⁰ HHS, *Secretary Azar Declares Public Health Emergency for United States for 2019 Novel Coronavirus*. Accessed at <https://www.hhs.gov/about/news/2020/01/31/secretary-azar-declares-public-health-emergency-us-2019-novel-coronavirus.html> on August 19, 2020.

for those staff members who have direct contact with children as part of their job responsibilities.

Using ORR data available as of July 2020, we determined the number of children in ORR care during our audit period. For the month ending April 30, 2020, ORR reported an average of 2,331 children in its care. By the end of May 2020, ORR's reported average of children in its care dropped to 1,396 children. We also determined the number of reported COVID-19 cases at facilities as of May 1, 2020. ORR reported a total of 198 positive cases of COVID-19 for *both* children and staff at its more than 170 facilities. These positive cases occurred at 45 of the more than 170 facilities as follows:

- 32 facilities reported positive COVID-19 cases for staff only,¹¹
- 4 facilities reported positive COVID-19 cases for children only, and
- 9 facilities reported positive COVID-19 cases for both staff and children.

HOW WE CONDUCTED THIS AUDIT

We conducted our communicable disease preparedness fieldwork at 11 selected facilities from March through June 2020 during the COVID-19 pandemic in the United States. We used a purposive selection process¹² to achieve a wide coverage of facilities participating in the UAC Program. We sought to ensure that our selection included a diverse set of facilities based on facility capacity, type of care provided, and location. Using this method, we selected facilities in California, Florida, Illinois, New York, Texas, and Washington.

We sent questionnaires to the 11 selected facilities and requested documentation pertaining to the following: policies and procedures specific to emergency preparedness for communicable diseases, guidance related to COVID-19 that ORR and local health entities provided, access to personal protective equipment supplies, space within the shelter facility that may be used for quarantine or isolation, and confirmed COVID-19 cases in children and staff.

Because most States were under stay-at-home orders, we were unable to visit each of the 11 facilities that were the subject of this audit to verify all of the information that they provided. However, all 11 facilities submitted documentation to support their responses to our questionnaire.

¹¹ Staff members may have underreported positive COVID-19 cases because they were asked to self-report positive tests for COVID-19 if their work duties placed them in contact with children in the program. If staff members did not have duties that placed them in contact with children, they were not counted in ORR's total.

¹² Purposive sampling, also known as judgmental or expert sampling, is a type of nonprobability sampling. The main goal of purposive sampling is to focus on particular characteristics of a population that are of interest to the research being conducted.

After reviewing this information, we also interviewed ORR personnel regarding their oversight of UAC facilities' preparedness and response in light of the COVID-19 pandemic. We compared data that ORR provided to the information provided by the 11 selected facilities. (See Appendix A for our Audit Scope and Methodology.)

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

RESULTS OF AUDIT

ORR ensured that the 11 facilities we selected for review followed ORR requirements in preparing for and responding to communicable diseases and were prepared to respond to COVID-19. Specifically, ORR provided facilities with COVID-19-response guidance, encouraged telehealth visits, and updated the UAC Portal.

The 11 selected facilities that we reviewed were generally prepared to respond to an emergency event, such as the COVID-19 pandemic, in accordance with Federal guidance. Specifically, they had policies and procedures, the capability to quarantine COVID-19 cases in their facilities, and personal protective equipment (PPE).

ORR officials stated that, since 2006, ORR has had a policy in place that required its facilities to prepare for and respond to a communicable disease outbreak; therefore, the facilities were generally able to quickly pivot to respond to COVID-19.

OFFICE OF REFUGEE RESETTLEMENT QUICKLY TOOK STEPS TO ENSURE THAT FACILITIES PREPARED FOR THE COVID-19 PANDEMIC

After receiving from the Centers for Disease Control and Prevention (CDC) early notifications about a new virus causing a disease outbreak in China, ORR began issuing COVID-19-specific guidance to its facilities. ORR also encouraged the use of telehealth to facilitate and expand access to services and updated its online electronic database, known as the UAC Portal, to capture COVID-19-related information.

ORR Provided Guidance to Unaccompanied Alien Children Program Facilities

Under 6 U.S.C. section 279, ORR has the authority to make decisions related to children in its care and oversee the structure and personnel at facilities. Additionally, ORR is legally mandated to provide health care services for unaccompanied children under the terms of the *Flores*

Settlement Agreement.¹³ Although ORR’s authority over its facilities is broad, facilities are also subject to the jurisdiction of their respective State licensing and public health authorities. Accordingly, ORR officials stated that ORR’s ability to mandate certain actions during any public health emergency could be constrained by directives from these other authorities. In that regard, ORR instructed facilities to contact local clinics or hospitals to confirm procedures for evaluating and treating children with symptoms of acute respiratory illness and for reporting and managing children with suspected COVID-19.

On January 8, 2020,¹⁴ an alert from the CDC Health Alert Network (HAN) notified ORR of a pneumonia cluster of unknown causes with no known cases outside of China. After a second HAN alert issued on January 17, 2020,¹⁵ ORR directed its facilities to identify children entering the program that had traveled from or through China. In January and February 2020, as CDC identified more countries with widespread transmission of COVID-19, ORR instructed its facilities to also identify children entering the program from those countries.¹⁶ ORR began instructing its facilities to quarantine children based on a child’s exposure and specific travel history. Specifically, unaccompanied children arriving from these identified countries were to be quarantined in ORR care for up to 14 days before being placed with other children in facilities.

ORR provided other guidance, both written and verbal, to its facilities. Beginning March 2, 2020, and ongoing as the COVID-19 pandemic was constantly evolving, ORR issued COVID-19-specific guidance to its facilities. Some examples of this guidance are in Table 1:

Table 1: ORR Guidance Issued to Facilities

Date	Guidance Document
March 2, 2020	COVID-19 Interim Guidance for ORR Programs
March 12, 2020	HHS COVID-19 Update (03.12.20)
March 13, 2020	COVID-19 Guidance: Initial Medical Exam Documentation
March 13, 2020	COVID-19 Guidance: Contact Investigation Documentation

¹³ The *Flores* Settlement Agreement outlines the standards for the placement and release of unaccompanied children. Among other things, it requires unaccompanied children to be placed in facilities with certain standards and be provided with physical care, food, clothing, and medical and dental services (*Flores v. Reno* Stipulated Settlement Agreement, Case No. CV 85-4544-RJK(Px), Jan. 17, 1997).

¹⁴ “Outbreak of Pneumonia of Unknown Etiology (PUE) in Wuhan, China,” distributed via the CDC Health Alert Network on January 8, 2020. Available online at <https://emergency.cdc.gov/han/han00424.asp>. Accessed on August 27, 2020.

¹⁵ “Update and Interim Guidance on Outbreak of 2019 Novel Coronavirus (2019-nCoV) in Wuhan, China,” distributed via the CDC Health Alert Network on January 17, 2020. Available online at <https://emergency.cdc.gov/han/han00426.asp>. Accessed on August 27, 2020.

¹⁶ ORR instructed facilities to identify children who had been in Iran, Italy, Japan, and South Korea.

Date	Guidance Document
March 13, 2020	COVID-19 Interim Guidance for ORR Programs –Staff and visitor symptom screen –UAC discharge and transfer symptom screen –COVID-19 educational materials for sponsors/discharge
March 13, 2020	PPE Calculation Guidance and Spreadsheet
March 19, 2020	ORR Field Guidance: COVID-19 Temperature Checks
March 20, 2020	ORR COVID FAQ #1
March 23, 2020	ORR Field Guidance: COVID-19 Temperature Checks
March 25, 2020	COVID-19 Guidance: Paper Fingerprint Cards (03.25.20)
March 28, 2020	COVID-19 Guidance: Initial Medical Exam Documentation
March 28, 2020	COVID-19 Guidance: Contact Investigation Documentation
April 6, 2020	ORR Field Guidance #4: COVID-19 Discharge Guidance
April 16, 2020	ORR COVID FAQ #2
May 6, 2020	ORR Field Guidance #5: Home Study/Post Release Services COVID Practice Guidance
May 28, 2020	CDC Health Advisory
June 12, 2020	ORR COVID FAQ #3
July 16, 2020	COVID-19 Symptom and Temperature Check at The Time of Discharge or Transfer
July 16, 2020	ORR Field Guidance #2, COVID-19 Verbal Screening and Temperature Check for Staff and Visitors
July 16, 2020	ORR Field Guidance # 3, Temperature Checks and Reporting
July 16, 2020	ORR Field Guidance # 4, COVID-19 Discharge Guidance

The above listed guidance included information for facilities such as:

- information pertaining to the transmission, symptoms, diagnosis and treatment, and prevention of COVID-19;
- instructions to contact their local clinics or hospitals to confirm procedures for evaluating and treating children with symptoms of acute respiratory illness and for reporting and managing children with suspected COVID-19;
- instructions to contact their local health departments to confirm procedures for reporting suspected and confirmed COVID-19 cases;
- instructions to ensure that sick employees with symptoms of an acute respiratory illness such as fever, cough, or shortness of breath stay home and consult with their primary facilities and State or local health departments about further evaluation and testing;
- instructions requiring the screening of all staff and visitors for COVID-19 risk factors before entering an ORR facility;

- explanation and instructions on new fields that were added to the Initial Medical Exam, Medical Complaint, and Update Visit forms in the UAC Portal;
- instructions to check the temperature of each child twice daily; and
- as an enhanced precaution, instructions to screen all children when discharged or transferred for symptoms of acute respiratory illness such as fever, cough, or shortness of breath.

ORR Encouraged Telehealth and Telephone Calls To Facilitate COVID-19 Response

ORR worked with certain facilities to facilitate and expand access to telehealth services. Telehealth services allowed children to meet with their primary care physicians, as needed, during the COVID-19 pandemic.

In addition, ORR actively communicated with its facilities via telephone calls. Both ORR headquarters and ORR field staff¹⁷ contacted facilities to discuss implementation and understanding of new guidance and procedures. ORR also provided individualized guidance to facilities who reported a positive case or possible exposure to COVID-19. Twice a month, ORR held conference calls with its facilities to discuss COVID-19-related updates and to address any questions these facilities might have.

Electronic Portal Updates Related to COVID-19

DHUC worked with the ORR Systems Team to add health data fields to ORR’s online electronic database, the UAC Portal. ORR added these fields in March 2020 to capture unaccompanied children travel history, COVID-19 laboratory testing, and COVID-19 diagnoses. ORR issued guidance and instructions to facilities on completing these fields for newly arriving children and for those who were tested for or exposed to individuals with COVID-19. (See Table 1 guidance on March 13 and March 28.) Once facilities entered this information into the UAC Portal, ORR received an automatic notification for any COVID-19-related issues. This information allowed ORR to contact the facilities and provide individual-level guidance as needed.

FACILITIES WERE PREPARED TO RESPOND TO THE COVID-19 PANDEMIC

Facilities were prepared to respond to the COVID-19 pandemic. Specifically:

- All 11 facilities had policies and procedures pertaining to communicable diseases.

¹⁷ Field staff, or Federal Field Specialists, act as the local ORR liaisons with facilities. Field staff are assigned to multiple facilities within a determined region and serve as the regional approval authority for child transfer and release decisions.

- All 11 facilities were prepared to manage possible COVID-19 cases by quarantining children¹⁸ who were suspected of having or diagnosed with COVID-19 and managing staff-to-child ratios due to COVID-19 related illnesses.
- Generally, all 11 facilities had PPE and were able to purchase more PPE and hand sanitizer without much difficulty.

Facilities Had Policies and Procedures To Address Communicable Diseases

ORR officials stated that, since 2006, ORR has had a policy in place requiring its facilities to prepare for and respond to an outbreak of communicable disease. Specifically, the Guide, section 3.3.4, requires all facilities to have a written safety plan that includes policies and procedures that address emergency situations such as disease outbreaks. Furthermore, section 3.4.6 sets forth the basic requirements each facility must implement and specifically states that “[f]rom intake to release, [facilities] must observe all children for signs or symptoms of communicable diseases and act accordingly to protect others against possible infection.” Finally, section 3.4.6 requires facilities to have policies and procedures that are consistent with State and local laws and regulations for identifying, reporting, and controlling communicable diseases.

All 11 facilities we selected for review had policies and procedures pertaining to communicable diseases, as required by ORR policy, and some even had specific policies and procedures pertaining to COVID-19. All 11 facilities implemented measures specifically pertaining to COVID-19. These measures included:

- instructions for handwashing, coughing, and sneezing;
- physical distancing protocols to include physically distanced physical education activities;
- a daily cleaning checklist with additional cleaning instructions beyond routine cleaning such as disinfecting staff offices, heater knobs, windows, cabinet handles, chairs, sofas, stairwells, vehicles, computers, keyboards, desks, and phones;
- plans for cleaning the facility with medical-grade cleaner;

¹⁸ During an interview, ORR defined “quarantine” as the practice of confining individuals who have had close contact with a COVID-19-infected individual to determine whether they develop symptoms of the disease. Medical isolation refers to confining a confirmed or suspected COVID-19-infected individual to prevent contact with others and to reduce the risk of transmission.

- a rotating telework shift where staff with direct child care responsibilities and those with supporting responsibilities alternated 1 week at the facility and 1 week remotely to achieve physical distancing and employees were required to complete a risk questionnaire and a temperature check before returning to the facility;
- implementing psychiatric/psychological evaluations using telehealth; and
- training staff and children on disease awareness.

One facility submitted pictures of a facility's classrooms, exits, hallways, and exterior to show that COVID-19 protocols were in place (Appendix B).

Facilities Were Prepared To Manage Possible COVID-19 Cases

Facilities Had Quarantine or Isolation Rooms

The Guide, section 3.4.6, states that facilities must have an identified space within their facility that may be used for quarantine or isolation if a child must be separated from the general population for a medical reason. This space must be able to house a child for days or weeks. All 11 facilities reported that they either had quarantine rooms or isolation rooms available at their facilities to care for children who were suspected of having or diagnosed with COVID-19, and, in the case of foster care, foster families had the ability to quarantine children or parents.

All 11 facilities we reviewed provided examples of the types of available space they had for use if they identified COVID-19 cases. (See Table 2 on the next page.)

Table 2: List of Available COVID-19 Space and Positive COVID-19 Cases at 11 Selected Facilities as of May 1, 2020

SITE NUMBER	STATE	SERVICES PROVIDED	QUARANTINE ROOMS	CHILD COVID-19 CASES	STAFF COVID-19 CASES	FOSTER FAMILY COVID-19 CASES
1	CA	Shelter and Long-Term Foster Care (LTFC)	Shelter: 11 bedrooms available to isolate or quarantine. LTFC: family homes can isolate and quarantine.	0	0	0
2	CA	Shelter	One facility can hold four children in quarantine and can move children around to open more space.	0	0	0
3	FL	Shelter	One dorm available for quarantine.	0	0	0
4	FL	Shelter	Four quarantine rooms, all on one hall.	0	1	0
5	FL	Shelter	One house designated for quarantine.	0	0	0
6	IL	Shelter	One floor designated for quarantine or isolation (16 rooms per floor) and another floor available.	38	15	0
7	NY	Transitional Foster Care	Foster families have the ability to quarantine.	0	3	2
8	NY	Residential Treatment Center and Shelter	Unused cottage space for quarantine or isolation with one-on-one supervision.	0	12	0
9	TX	Shelter	Two isolation rooms, one with negative pressure ventilation.*	0	0	0
10	TX	Shelter	One isolation room.	0	0	0
11	WA	Long-Term Foster Care	Foster families have the ability to quarantine a child with access to a designated bathroom.	0	0	1

* Negative pressure ventilation is a technique used to prevent cross-contamination from room to room by isolating patients with airborne contagious diseases. It allows air to flow into the room but not to flow out of the room thus preventing contamination from escaping.

Quarantine Efforts at One Facility That Had 38 Child COVID-19 Cases

The physician for the one facility that experienced a higher level of COVID-19 cases in children isolated some positive cases in the same room based on symptomology, the date of symptom onset, and symptom resolve.

The first child who tested positive for COVID-19 had symptoms such as a sore throat and fever. When that child tested negative for other ailments, a COVID-19 test was administered. Because several other children showed various symptoms within days of each other, the facility then tested all the children and staff regardless of contact or known exposure.

According to the facility, children who tested positive for COVID-19 were quarantined for 14 days and placed on the “isolation floor.”¹⁹ The facility’s in-house pediatrician and two nurses, along with contracted medical assistance from a local children’s hospital, monitored the isolated children’s health.

While in isolation:

- the children showered and used the washrooms one-at-a-time, and the washrooms were disinfected between uses;
- meals were provided in the children’s rooms using disposable plates, cups, and utensils;
- closed-circuit televisions were installed in each bedroom so that the children could participate in virtual classes;
- religious activities were conducted via teleconference; and
- staff on the isolation floor were required to wear full PPE (cap, N95 mask, gloves, gown, and booties).

Children who were quarantined were not returned to regular activities for 72 hours after the 14-day quarantine period ended and were cleared by the in-house medical team and the local health department.

¹⁹ Although ACF defines the terms “quarantine” and “isolation” differently (previous footnote), the facilities sometimes use these terms interchangeably.

Facilities Did Not Report Problems Maintaining Staffing Ratios Related to COVID-19

Facilities are required to ensure that facilities are staffed 24 hours a day. ORR requires facilities to staff their facilities in accordance with State licensing requirements, which vary by State. However, ORR mandates a minimum staff-to-child ratio of (a) one staff for every 8 children during waking hours and (b) one staff for every 16 children during sleeping hours (section 4.4.1 of the Guide).

None of the 11 facilities reported problems with staff-to-child ratios because of COVID-19-related illnesses. For facility staff that tested positive, facilities implemented measures such as requiring staff to notify a supervisor and identify other staff members who may have been exposed, stay home and seek medical treatment in accordance with CDC guidelines, and quarantine for 14 days. To assist facilities during the pandemic, ORR stopped placing unaccompanied children with facilities that experienced high staff absences.

In addition, because the number of UAC referrals decreased significantly during the first several months of the pandemic,^{20, 21} staff shortages at some facilities caused by illness did not affect staffing ratios or the ability to place children in their care. Table 3 shows the number of unaccompanied children referrals to ORR during March, April, and May 2019, compared to the number of such referrals during the same months in 2020.

Table 3: Change in Unaccompanied Children Referrals From 2019 to 2020

Month	Referrals 2019	Referrals 2020
March	7,946	1,852
April	8,586	62
May (as of May 27, 2020)	9,084	31

²⁰ Unaccompanied children are referred to ORR by another Federal agency, usually by DHS, which has taken custody of the child at the border. By law, DHS is required to transfer custody of the child to ORR within 72 hours.

²¹ On March 20, 2020, in response to the COVID-19 pandemic, the director of CDC issued a public health order suspending entry of individuals into the United States at or near the border with Canada or Mexico if entry would result in their being placed in a “congregate setting,” such as those used by DHS for immigration processing. On March 24, 2020, HHS issued an interim final rule that amended its Foreign Quarantine regulations to create a procedure for CDC to suspend the introduction of persons from designated countries or places, if required, in the interest of public health. The CDC order was implemented for an initial period of 30 days, was extended in April for an additional 30 days, and was extended again in May for an indefinite period. As noted in the May order, the actions have significantly reduced the number of “covered aliens” placed in congregate care settings, including children placed at facilities in the UAC Program.

Facilities Had Personal Protective Equipment and Supplies

Generally, all 11 facilities reported having PPE on hand (e.g., masks, gowns, and gloves) and were able to purchase more PPE and hand sanitizer without much difficulty. Although there were no shortages, some facilities overcame possible future PPE shortages as follows:

- One facility reported difficulty purchasing hand sanitizer; however, this facility overcame the problem by establishing a connection with a local brewery that started making hand sanitizer.
- One facility collaborated with sister agencies to expand access to supply chain partners.
- One facility worked with other local child care agencies (State agencies) to identify new vendors and use bulk purchase orders.
- One facility allowed some staff to use homemade masks while onsite.

CONCLUSION

ORR ensured that the 11 facilities that we reviewed followed ORR requirements in preparing for and responding to communicable diseases, such as COVID-19. Specifically, ORR provided COVID-19-response guidance, encouraged telehealth visits, and updated the UAC Portal. Since 2006, ORR has had a policy in place that required its facilities to prepare for and respond to a communicable disease outbreak, so the facilities quickly pivoted to responding to COVID-19.

The 11 selected facilities that we reviewed were generally prepared to respond to this pandemic by implementing existing communicable disease protocols and COVID-19-specific guidelines at each site and by finding ways to overcome potential problems locating PPE. Therefore, this report contains no recommendations.

In response to our draft report, ACF stated that ORR's standard operating procedures for communicable diseases follow the CDC's surveillance and outbreak guidelines for each specific disease. ACF also stated that ORR will continue to monitor the situation around COVID-19 and coordinate all response efforts with CDC and local public health officials. We included ACF's comments as an appendix to this report. ACF also provided technical comments, which we incorporated as appropriate.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We selected 11 facilities to conduct our fieldwork for communicable disease preparedness. We used a purposive selection process to achieve a wide coverage of facilities participating in the UAC Program. We sought to ensure that our selection included a diverse set of facilities based on facility capacity, type of care provided, and location. Using this method, we selected facilities in California, Florida, Illinois, New York, Texas, and Washington. We conducted our communicable disease preparedness fieldwork at these 11 facilities from March through June 2020 during the COVID-19 pandemic in the United States. However, we were unable to conduct onsite visits because most States were under stay-at-home orders. We also interviewed ORR staff members regarding their oversight of the facilities’ preparedness and response in light of the COVID-19 pandemic.

Using the U.S. Government Accountability Office publication *Standards for Internal Control in the Federal Government* as guidance, we assessed the internal controls listed in Table 4—components and principles—that we determined significant to our audit objective.

Table 4: Significant Internal Control Components and Principles

Component	Principles
Control Environment	Management should establish an organization structure, assign responsibility, and delegate authority to achieve objectives.
Risk Assessment	<p>Management should define objectives to enable the identification of risks and define risk tolerances.</p> <p>Management should identify, analyze, and respond to risks related to achieving objectives.</p> <p>Management should identify, analyze, and respond to significant changes that could impact the internal control system.</p>
Control Activities	<p>Management should design control activities to achieve objectives and respond to risks.</p> <p>Management should implement control activities through policies.</p>
Information and Communication	<p>Management should use quality information to achieve objectives.</p> <p>Management should internally communicate the necessary quality information.</p>
Monitoring	<p>Management should establish and operate monitoring activities to monitor and evaluate results.</p> <p>Management should remediate identified control deficiencies timely.</p>

METHODOLOGY

To accomplish our objective, we:

- reviewed Federal and State policies and guidance applicable to UAC Program facilities' planning and implementation of emergency events, specifically communicable diseases;
- sent questionnaires to the 11 selected facilities and requested information and documentation pertaining to communicable diseases;
- reviewed facility policies and procedures for emergency preparedness, specifically pertaining to communicable diseases;
- conducted an interview with ORR officials to understand ORR's oversight of the UAC Program pertaining to monitoring and communicating with its facilities regarding the COVID-19 pandemic;
- obtained and reviewed information that ORR sent to its facilities pertaining to COVID-19; and
- obtained the number of COVID-19 confirmed child and staff cases from ORR and the 11 selected facilities.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: EXAMPLES OF PHYSICAL DISTANCING AND HAND SANITIZATION

Photograph 1—Hand sanitizing station near entrance/exit doors.



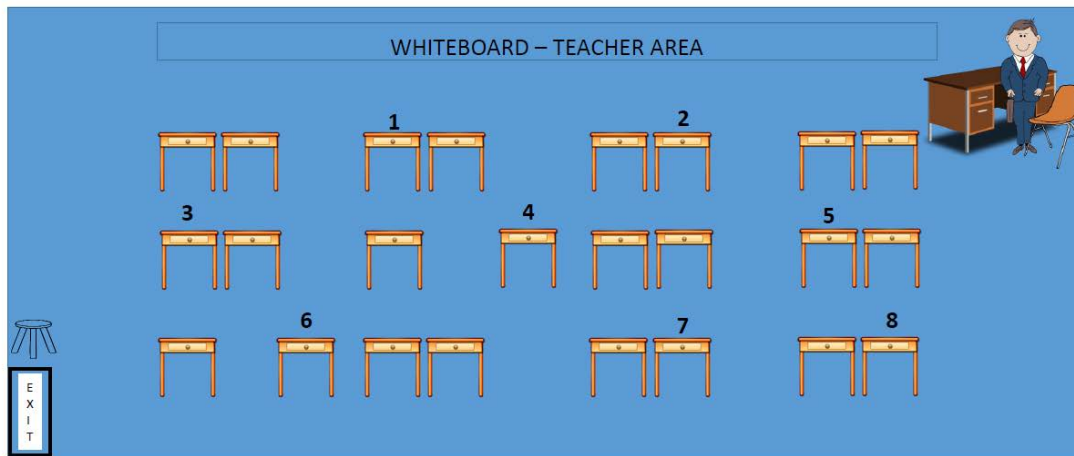
Photograph 2—Hand sanitizing station near entrance/exit doors (opposite wall).



Photograph 3—Employee and visitor screening station at the facility entrance.



Photograph 4—Physical distancing plan in the classroom.



Photograph 5—Visuals demonstrating 6 feet for physical distancing.



Photograph 6—Physical distancing floor markers (yellow tape).



Photograph 7—Outdoor hand washing station.





ADMINISTRATION FOR
CHILDREN & FAMILIES

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October 9, 2020

Christi A. Grimm
Principal Deputy Inspector General
U.S. Department of Health and Human Services
330 Independence Avenue, SW.
Washington, DC 20201

Dear Ms. Grimm:

The Administration for Children and Families (ACF) appreciates the opportunity to respond to the Office of Inspector General's report entitled, *Office of Refugee Resettlement Ensured That Selected Care Providers Were Prepared to Respond to the COVID-19 Pandemic* (A-04-20-02031).

ACF's Office of Refugee Resettlement (ORR) has standard operating procedures for communicable diseases commonly and uncommonly seen among the population of unaccompanied alien children (UAC) served by ORR care providers. ORR's standard operating procedures follow the Centers for Disease Control and Prevention (CDC) surveillance and outbreak guidelines for each specific disease, with consideration given to the congregate setting and programmatic requirements of the UAC program. In addition to existing procedures, ORR has routinely issued COVID-19 guidance, in accordance with the CDC's recommendations, to its network of care provider facilities.

ORR will continue to monitor the situation around COVID-19 closely and coordinate all response efforts with the CDC and local public health officials to ensure the safety and well-being of UAC, staff at the facilities, and their respective communities within ORR's network of care providers.

Again, thank you for the opportunity to review this report. Please direct any follow-up inquiries on this response to Scott Logan, Office of Legislative Affairs and Budget, at (202) 401-4529.

Sincerely,

A handwritten signature in blue ink that reads "Lynn A. Johnson".

Lynn A. Johnson,
Assistant Secretary
for Children and Families