

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**OFFICE OF REFUGEE RESETTLEMENT'S
INFLUX CARE FACILITY AND
EMERGENCY INTAKE SITES DID NOT
ADEQUATELY SAFEGUARD
UNACCOMPANIED CHILDREN FROM
COVID-19**

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A-06-21-07002

Office of Inspector General

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The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief

Date: June 2022

Report No. A-06-21-07002

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

In Federal fiscal year 2021, an unprecedented number of unaccompanied children began arriving at the U.S. southern border, coinciding with the Nation's ongoing efforts to control the spread of COVID-19. The Office of Refugee Resettlement (ORR) had to act quickly to increase the number of shelter beds because its care provider network could not handle the increase in children. As a result, ORR reactivated one existing influx care facility (ICF) and opened emergency intake sites (EISs).

Our objective was to determine whether the ICF and EISs had procedures in place to test for, and protect against the spread of, COVID-19 and report testing and results to ORR and State and local health entities, as appropriate.

How OIG Did This Audit

We conducted site visits at 1 ICF and 10 of the 14 EISs in 3 States in May and June 2021. The 11 sites were fully operational at the time of our audit start. We conducted our site visits when ORR was experiencing a surge of children into custody and trying to control the spread of COVID-19 within the ICF and EISs. Our goal was to identify vulnerabilities and opportunities for improvement within the Unaccompanied Children Program that could help ORR prepare for future surges or public health emergencies and respond to the COVID-19 pandemic.

Office of Refugee Resettlement's Influx Care Facility and Emergency Intake Sites Did Not Adequately Safeguard Children From COVID-19

What OIG Found

During our site visits, we found that most facilities could have done more to meet the Centers for Disease Control and Prevention (CDC) and HHS recommendations and requirements designed to keep children safe and protect against the spread of COVID-19. We found that these facilities lacked: (1) procedures for COVID-19 testing of children, employees, and volunteers; (2) measures to protect against the spread of COVID-19; and (3) procedures to report required testing and results to ORR and State and local health entities.

These issues occurred, in part, because ORR was rapidly expanding capacity, setting up EISs, and developing COVID-19 protocols and guidance for their use. However, ORR did not have a process in place for widely disseminating the guidance and frequent updates to appropriate staff at the EISs. In addition, ORR contracted with several organizations that had little or no experience providing shelter and services to children, and the contracts did not contain adequate details about COVID-19 protocols. Moreover, ORR did not effectively monitor facilities to ensure compliance with guidance on COVID-19 testing, mitigation, and reporting requirements. As a result, facilities did not fully implement procedures related to COVID-19, thereby potentially placing the health and safety of children, employees, and volunteers at risk.

What OIG Recommends and the Administration for Children and Families Comments

We recommend that ORR: (1) develop a process to clearly communicate COVID-19 guidance and updates to the appropriate staff at the EISs so that staff have a full understanding of what is required of them to help protect against the spread of COVID-19, (2) reiterate to facilities that they must comply with ORR's COVID-19 testing and reporting requirements and with State reporting requirements, (3) improve and increase training provided to facilities regarding COVID-19 mitigation strategies, and (4) perform routine oversight of facilities to reinforce implementation and compliance with all requirements related to COVID-19.

In written comments on our draft report, the Administration for Children and Families (ACF), commenting on behalf of ORR, concurred with our recommendations and described the actions it has taken to address the findings. For example, ACF stated that ORR is committed to improving training on COVID-19 mitigation strategies and, as part of its routine oversight, perform remote monitoring and site visits as needed.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Office of Refugee Resettlement (ORR), a program office of the Administration for Children and Families (ACF) within the Department of Health and Human Services (HHS), manages the Unaccompanied Children Program (UC Program).¹ In Federal fiscal year (FFY) 2021, an unprecedented number of unaccompanied children began arriving at the U.S. southern border, coinciding with the Nation's ongoing efforts to control the spread of COVID-19. ORR had to act quickly to increase the number of shelter beds because its care provider network could not handle the increase in children. As a result, ORR reactivated one existing influx care facility (ICF)² and opened emergency intake sites (EISs).³

This report builds on the Office of Inspector General's (OIG's) previous oversight of ORR's efforts to protect children and is one of two audit reports that focuses on health and safety at the ICF and EISs. This report specifically addresses the procedures for COVID-19 testing and for protecting children and staff against the spread of COVID-19 at the ICF and EISs. The second report will address whether the ICF and EISs conducted required background checks on employees and volunteers.

OBJECTIVE

Our objective was to determine whether the ICF and EISs had procedures in place to test for and protect against the spread of COVID-19 and report testing and results to ORR and State and local health entities, as appropriate.

BACKGROUND

The number of children entering ORR custody grew significantly from FFY 2019 to FFY 2021. In FFY 2019, the Department of Homeland Security (DHS) referred 69,488 unaccompanied children to HHS. In FFY 2020, the number of referrals fell to 15,381 because of a U.S. public health order responding to the COVID-19 pandemic—implemented in March 2020—to suspend entry of certain non-citizens at or near the U.S. borders, resulting in the expulsion of most unaccompanied children upon attempting to enter the United States. Following a court

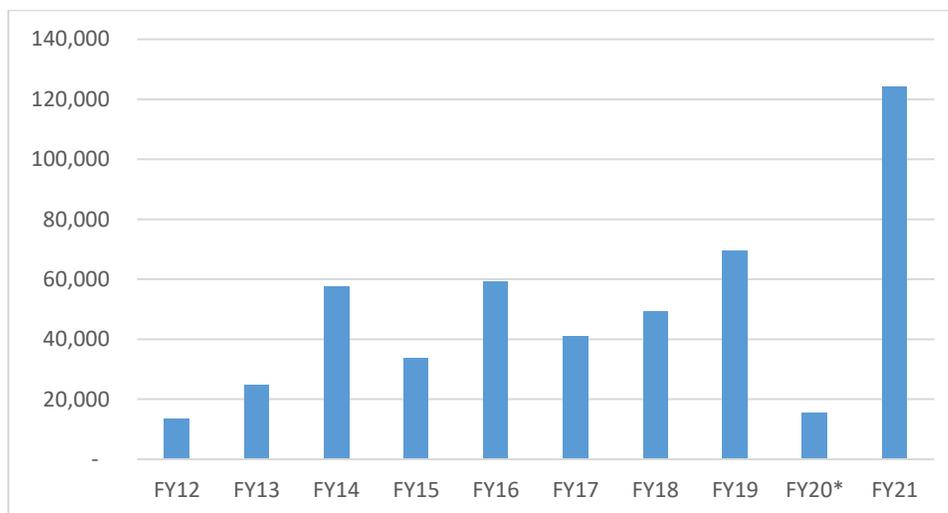
¹ Unaccompanied children have no lawful immigration status in the United States and have no parent or legal guardian in this country, or not one available, to assume custody and care for them (6 U.S.C. § 279(g)(2)).

² During an influx, ORR may not have sufficient bed space available within its licensed care provider network to place unaccompanied children. In this situation, ORR arranges for the use of an ICF to provide supplemental bed capacity.

³ EISs are a new type of provider facility designed to meet immediate sheltering needs for mass care with basic standards when there is a severe shortage of licensed facilities and ICFs.

injunction and a change in policy, the number of unaccompanied children surged in FFY 2021. The total number of children referred to HHS in FFY 2021 was 124,047, as shown in the exhibit.

Exhibit: Unaccompanied Children Referred to HHS



* Referrals in FFY 2020 were the lowest since FFY 2012 because of the implementation of the COVID-19 public health order that limited entry at U.S. borders.

A surge in the number of unaccompanied children at the U.S. southern border—such as the FFY 2021 surge—presents several urgent challenges that ORR must address to protect the health and safety of children in its custody. These challenges include quickly adding bed capacity and ensuring that new facilities hire sufficient staff and train them appropriately.

Office of Refugee Resettlement Care Provider Network

Federal law requires the safe and timely placement of children in the least restrictive setting that is in the child’s best interest.⁴ To address the needs of children, ORR provides funds through cooperative agreements or contracts to several types of facilities in its care provider network, including shelters, foster care or group homes, staff secure or secure facilities, and residential treatment centers.⁵ In FFY 2021, ORR provided funding to approximately 200 facilities and programs in 22 States. Most are licensed or accredited under the laws of their respective States. Because of the large fluctuations in the number of children arriving throughout the year, ORR maintains a mix of “standard” beds, which are available year-round at licensed care facilities, and “temporary” beds, including those at ICFs that can be added or removed as needed. This bed management strategy allows ORR to accommodate changing

⁴ 8 U.S.C. § 1232(c)(2).

⁵ A staff secure facility maintains stricter security measures, such as higher staff-to-child ratios for supervision; a secure facility has a physical security structure and is the most restrictive placement option for children.

flows in unaccompanied children referrals. A child typically remains in ORR's care until an appropriate sponsor, who can assume custody, is found in the United States.

During the COVID-19 pandemic, ORR modified its operations to comply with Centers for Disease Control and Prevention (CDC) guidelines, including quarantining and testing newly arrived children and adhering to physical distancing protocols in ORR care provider facilities. Although ORR has worked to build up its capacity to include more than 13,500 licensed beds (the highest in the UC Program's history), additional capacity was needed to manage the increasing numbers of unaccompanied children referred from DHS and to implement COVID-19 mitigation strategies.

Therefore, ORR reactivated one ICF and, in conjunction with the Federal Emergency Management Agency, the Department of Defense, and HHS, opened a total of 14 temporary EISs along the U.S. southern border and in the interior of the country. The EISs were intended to provide ORR with the needed capacity to accept children from DHS into facilities where the children could be safely processed, cared for, and either released to a sponsor or transferred to an appropriate ORR shelter for longer-term care. The EISs were intended for use as a temporary measure.

Influx Care Facilities

ORR opens an ICF when its licensed care provider network does not have sufficient bed space available to provide shelter and services for children during an influx or emergency. Because ICFs are intended to be a temporary response to an influx or emergency, they may not be licensed or may be exempted from licensing requirements by State or local licensing agencies, or both. However, ICFs must meet ORR policies and must comply to the greatest extent possible with State child welfare laws and regulations. Among other things, ICFs must provide children with proper physical care and maintenance, appropriate routine medical and dental care, an individual needs assessment, educational services appropriate to their levels of development and communication skills, recreation and leisure activities, mental health services, and case management services designed to identify a sponsor who can take custody of the child.

Emergency Intake Sites

EISs are a new type of care provider facility that ORR quickly opened during March–April 2021 to reduce the number of children in DHS custody while greatly expanding ORR's capacity. EISs are meant to be short-term facilities, generally opened for less than 6 months.⁶ EISs are not licensed by the State and are opened in the event of a severe shortage of beds in ORR's licensed care provider network and ICFs. A severe shortage occurs when ORR is unable to accept referrals of children for placement in State-licensed facilities and ICFs, which would

⁶ ORR Field Guidance #13, Emergency Intake Sites (EIS) Instructions and Standards. Effective Apr. 30, 2021.

result in children remaining in DHS custody for more than 72 hours without a placement designation.⁷ According to ORR, EISs must provide basic standards of care to ensure the child’s physical safety, access to legal services information, and access to emergency clinical services. Additionally, ORR encourages EISs to offer case management services, educational services, and as much recreational time as practicable.

Concerns About the Health and Safety of Children at Office of Refugee Resettlement Care Facilities

EISs have been the subject of multiple news articles and reports citing concerns and complaints from members of Congress, child advocates, and staff at the facilities. Most of the concerns and complaints involve ORR’s management of the facilities, quality of care, living conditions, the length of time children remain in care, and COVID-19 and its impact on public health. Four EISs closed before we began our onsite visits, and two of these EISs closed before their scheduled closure dates due to concerns about the children’s health, safety, and care.⁸

COVID-19 Guidance

On November 30, 2020, ORR issued Field Guidance #6, “*COVID-19 Intake Procedures for UAC Newly Admitted into ORR Custody.*” This guidance was updated on March 23 and July 20, 2021, and was applicable only to licensed ORR care provider programs and ICFs, not to EISs. The guidance related to COVID-19 quarantine, medical isolation, and testing procedures for unaccompanied children initially placed (newly admitted) into ORR custody.

CDC and HHS issued COVID-19 guidance with recommendations and requirements for the ICF and EISs to follow to help keep children safe and protect against the spread of COVID-19. On or around March 1, 2021,⁹ CDC issued “*Safely Increasing Capacity for Unaccompanied Children at Administration for Children and Families (ACF), Office of Refugee Resettlement (ORR) Facilities*” (March 1 guidance). CDC drafted this guidance to safely increase capacity of ORR care provider facilities during the COVID-19 public health emergency through implementation of specific disease mitigation measures.

In the March 1 guidance, CDC states that ORR care providers should continue to administer COVID-19 tests to children upon their arrival at an ORR facility and that the providers should

⁷ DHS is required to transfer unaccompanied children to HHS within 72 hours, except in the case of exceptional circumstances (8 U.S.C. § 1232(b)(3)).

⁸ Kay Bailey Hutchinson Convention Center, Freeman Coliseum, National Association of Christian Churches (NACC), and Pennsylvania International Academy (PIA) all closed before we began our site visits; NACC and PIA closed before their scheduled dates.

⁹ The guidance was not dated; CDC gave us this estimate.

follow quarantine and isolation guidelines.¹⁰ The March 1 guidance also states that ORR care providers should undertake additional mitigation precautions to enable ORR facilities to temporarily increase capacity to their full, licensed capacity (or, in the case of non-licensed facilities, capacity up to what ORR and the contractor determine to be a safe occupancy for influx), provided there is adequate space to isolate and quarantine, while continuing to maintain a safe environment for children and staff. In addition, the March 1 guidance states that ORR should consider the following when making decisions about increasing bed capacity:

- the type of beds immediately needed (e.g., based on the children’s ages and special needs);
- the ability to strengthen mitigation strategies (e.g., using masks correctly and consistently, testing capacity for children and staff, ensuring isolation and quarantine space, and PPE training, access, and use); and
- demonstrated preparedness for rapidly responding to positive COVID-19 cases and outbreaks.

On March 22, 2021, HHS issued “*COVID-19: Interim Guidance for Shortening Quarantine Duration and Increasing Testing for Office of Refugee Resettlement Facilities*” (March 22 guidance).¹¹ According to ACF officials, the March guidance “was mainly developed for the standard ORR program network to increase critical bed capacity and decrease overcrowding at CBP [DHS] facilities. The document emphasized that all current mitigation recommendations should be continued, and recapped mitigation strategies outlined in ORR COVID-19 field guidance documents for standard programs.”¹² This document also provides guidance on the quarantine of children and required that each COVID-19 test result be recorded in the child’s medical records.

On March 30, 2021, CDC issued to ACF “*COVID-19 Interim Guidance to Reduce the Risk of COVID-19 spread at Administration for Children and Families (ACF), Office of Refugee Resettlement (ORR) Temporary Influx Care Facilities (ICF) and Emergency Intake Sites (EIS)*” (March 30 guidance). CDC issued this guidance based on its experience at several EISs and the one ICF in March 2021. The guidance contained critical recommendations for COVID-19 prevention that CDC stated should be implemented rapidly and to the fullest extent possible to help protect the health and safety of children, employees, and volunteers. The guidance also

¹⁰ The March 1 guidance referred to Field Guidance #6 and its COVID-19 intake procedures for children newly admitted into ORR custody.

¹¹ The guidance was issued on the letterhead of the Office of the Assistant Secretary for Public Affairs and includes the insignias of CDC and ACF/ORR.

¹² According to ACF officials, the March 22 guidance was attached as a reference document to the March 30 guidance (addressed in the next paragraph) but was applicable to EISs only if specifically incorporated by reference in the March 30 guidance. However, this is not clearly indicated in the March 30 guidance.

stated that all ICF and EISs should immediately adopt and strictly implement mitigation measures, including the universal and proper wearing of masks, physical distancing, frequent handwashing, cleaning and disinfection, improved ventilation, increased testing for COVID-19, and vaccination.

On August 24, 2021, CDC issued to ACF “*Interim Guidance to Reduce the Spread of COVID-19 and Other Communicable Diseases at Administration for Children and Families (ACF), Office of Refugee Resettlement’s (ORR) Emergency Intake Sites (EIS)*” (August 24 guidance). According to a CDC official, the August 24 guidance finalized an informal version of the guidance from the previous month. The guidance was based on continued on-the-ground experience of the CDC at several EISs and was intended for medical contractors, CDC deployers, and other individuals supporting infection prevention and control for COVID-19 and other communicable diseases at EISs. The purpose of the guidance was to share real-time, critical recommendations for COVID-19 prevention that should be implemented rapidly and to the fullest extent possible to help protect the health and safety of the children, facility staff, and contractors. Because the August 24 guidance was issued after our site visits to the EISs, it is not applicable to our audit. However, the recommendations contained in it do not differ from the guidance in effect during our site visits and used to support our findings.

Related Office of Inspector General Work

Since responsibility for unaccompanied children was transferred to HHS by the Homeland Security Act of 2002, OIG has examined various aspects of the UC Program, including ORR’s preparedness to take children into HHS custody, examining whether ORR grantees met safety standards for the care and release of children in their custody, and whether ORR grantees are addressing children’s medical and mental health needs. A November 2020 OIG report examined select care provider facilities’ compliance with ORR requirements in preparing for and responding to communicable diseases, such as COVID-19.¹³ In May 2021, OIG issued a toolkit providing insights largely drawn from audits and evaluations of the UC Program conducted since 2008, including reports that were issued following site visits at 45 facilities during the 2018 surge of children entering the UC Program.¹⁴ In addition, OIG is currently examining ORR’s placement and transfer of children, emergency preparedness and response at care provider facilities, safe and efficient release of children to sponsors, and reported experiences of staff at the Fort Bliss EIS.¹⁵

¹³ [Office of Refugee Resettlement Ensured That Selected Care Providers Were Prepared To Respond to the COVID-19 Pandemic](#) (A-04-20-02031).

¹⁴ [Toolkit: Insights From OIG’s Work on the Office of Refugee Resettlement’s Efforts To Care for Unaccompanied Children](#) (OEI-09-21-00220).

¹⁵ Current OIG Work Plan Items: [Audit of Office of Refugee Resettlement’s Placement and Transfer of Children in the Unaccompanied Alien Children Program; Emergency Preparedness and Response at Care Provider Facilities in the Office of Refugee Resettlement’s Unaccompanied Alien Children Program; Safe and Efficient Release of Unaccompanied Children to Sponsors; and Reported Experiences of Staff at Fort Bliss Emergency Intake Site.](#)

HOW WE CONDUCTED THIS AUDIT

We conducted site visits at 1 ICF and 10 of the 14 EISs in 3 States in May and June 2021. In total, we visited 11 sites that were fully operational at the time of our audit start. The remaining four sites were either closed or closing at the time of our audit start. Appendix B includes a table that lists the ICF and EISs we visited.

We conducted our site visits when ORR was experiencing a surge of children into custody and trying to control the spread of COVID-19 within the ICF and EISs. Our goal was to identify vulnerabilities and opportunities for improvement within the UC Program that could help ORR prepare for future surges or public health emergencies and respond to the COVID-19 pandemic.

We developed interview protocol questions that focused on the following five areas:

- general overview of the facility,
- intake and initial COVID-19 testing of children,
- serial COVID-19 testing¹⁶ of children and employees,
- reporting of COVID-19 testing and results, and
- challenges the facilities faced related to COVID-19.

We interviewed the contracting officer representative; Federal field specialists; contract staff, including the prime contractors and medical contractors; and other knowledgeable officials to obtain an understanding of the ICF and EISs COVID-19 protocols and the mitigation strategies used to combat the spread of COVID-19. We also interviewed ORR and CDC officials to obtain an understanding of the guidance that was applicable to the ICF and EISs. We reviewed the guidance related to COVID-19 recommendations and requirements.

We also developed protocols for observing the facilities' layout and for evaluating the procedures the facilities had in place for testing for COVID-19 and protecting against its spread. However, our protocol did not include a walkthrough of the COVID-19-positive areas, so we do not have any observations specific to procedures for children placed in quarantine or isolation at most facilities. We tested our protocols at one EIS and refined them before visiting the other facilities.

After we completed our visits to the ICF and EISs, we met with ACF and ORR officials on July 19, 2021, to alert them of our preliminary findings and observations. During that briefing, we indicated to ACF and ORR officials that, based on these findings and observations, we

¹⁶ Serial testing involves testing the same individual multiple times within a few days. In the March 30 guidance, CDC recommended serial testing every 3 days.

concluded that outreach and technical assistance to facilities to reiterate ORR policy and program requirements for COVID-19 protocol were warranted. On July 23, 2021, we provided ORR with a schedule that showed our preliminary findings and observations by facility so that ORR could take actions, as warranted.

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 A contains the details of our audit scope and methodology.

FINDINGS

Most facilities could have done more to meet CDC and HHS recommendations and requirements designed to keep children safe and protect against the spread of COVID-19. We found that these facilities lacked: (1) procedures for COVID-19 testing of children, employees, and volunteers; (2) measures to protect against the spread of COVID-19; and (3) procedures to report required testing and results to ORR and State and local health entities. Specifically, we determined that the facilities:

- did not perform COVID-19 testing as recommended by CDC,
- failed to implement some of the CDC-recommended and required measures to protect against the spread of COVID-19, and
- failed to report COVID-19 testing and results to ORR and State and local health entities.

These issues occurred because the influx required ORR to rapidly expand capacity and set up new facilities, including developing COVID-19 protocols for EISs and guidance for their use. However, ORR did not have a process for widely disseminating the guidance and frequent updates to appropriate staff. According to EIS officials, this contributed to the difficulty in knowing what COVID-19 protocols and guidance needed to be implemented within the facility. In addition, ORR contracted with several organizations that had little or no experience in providing shelter and services to children, and the contracts did not contain adequate details about COVID-19 protocols. Facility officials had to quickly hire and train large numbers of staff, many of whom had no prior relevant experience, without the benefit of standardized training materials, so COVID-19 and child care training varied among facilities. Moreover, ORR did not effectively monitor facilities to ensure that CDC and ACF guidance on COVID-19 testing, mitigation strategies, and reporting requirements was implemented as recommended. As a result, facilities did not fully implement procedures related to COVID-19, thereby potentially placing the health and safety of children, employees, and volunteers at risk.

MANY FACILITIES DID NOT PERFORM COVID-19 TESTING AS RECOMMENDED BY HHS AND CDC GUIDANCE

Testing procedures to quickly identify COVID-19 cases among children, employees, and volunteers at the ICF and EISs are critical to managing COVID-19 and its spread at these facilities. All facilities completed some COVID-19 testing as recommended by HHS and CDC guidance; however, five facilities did not ensure that testing of children complied with the recommendations, and nine facilities did not ensure that testing of employees and volunteers complied with the recommendations. See Appendix C for a summary of facilities that had one or more issues of noncompliance related to COVID-19 testing.

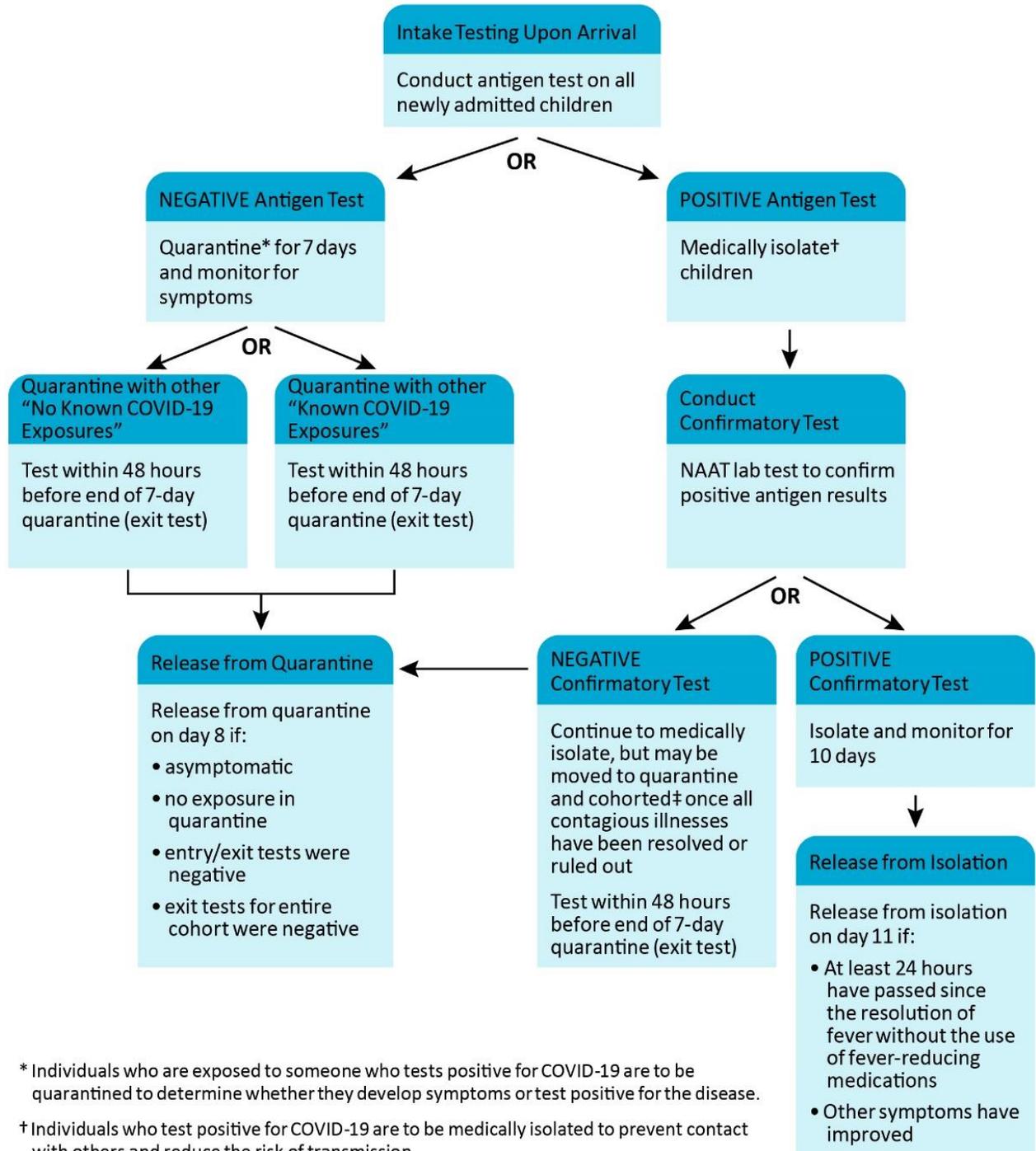
Five Facilities Did Not Always Perform COVID-19 Testing of Children as Recommended by HHS and CDC Guidance¹⁷

The March 30 guidance specifically referred EISs to the March 22 guidance for the quarantine of children. The March 22 guidance recommended that ORR facilities that implement a reduced quarantine duration (7 days) test newly admitted children without symptoms for COVID-19 both on admission and again within 48 hours before the end of the quarantine period (e.g., day 5, 6, or 7) with confirmation of a negative test before release from quarantine.

In its March 30 guidance, CDC recommended that ICF and EISs test all children who arrive with signs and symptoms of COVID-19 with an antigen test as soon as possible. The guidance stated that, depending on the results of the antigen test, confirmation with a nucleic acid amplification test could be needed (e.g., when a person with symptoms tests negative or a person without symptoms tests positive). CDC recommended that ORR use the Antigen Testing Algorithm (see Appendix D) to determine when confirmatory testing is needed. Confirmatory testing is recommended anytime the criteria is met for a confirmatory test, and not just upon intake. The March 30 guidance also recommended that the ICF and EISs perform rapid antigen tests on all children every 3 days (serial testing). Figure 1 (next page) outlines the recommended intake testing process and potential outcomes.

¹⁷ A facility may have more than one identified issue.

Figure 1: Recommended Intake Testing Process and Potential Outcomes



* Individuals who are exposed to someone who tests positive for COVID-19 are to be quarantined to determine whether they develop symptoms or test positive for the disease.

† Individuals who test positive for COVID-19 are to be medically isolated to prevent contact with others and reduce the risk of transmission.

‡ “Cohorting” refers to the practice of isolating multiple children together with confirmed COVID-19 or quarantining potentially exposed children or asymptomatic children together as a group (due to a limited number of individual rooms). Cohorts are also referred to as “pods.”

As described below, five facilities did not perform COVID-19 testing of children in accordance with HHS and CDC guidance:

Intake Testing Not Performed

Two EISs did not test children upon intake:

- One EIS, for the first 2 weeks it was open, did not test any children for COVID-19 upon intake because it did not have adequate space or staffing available to test the children. The facility subsequently erected a tent and hired a new contractor devoted to testing the children.
- One EIS did not test children upon intake if, based on the results of testing performed by DHS or other facilities, the child had tested positive for COVID-19. Instead, it placed the child in isolation for 10 days, which may have resulted in isolating children when not needed (or for longer than recommended).¹⁸

Confirmatory Testing Not Performed

One EIS did not perform confirmatory testing, even when the criteria for performing a confirmatory test was met. Instead, it isolated children with positive COVID-19 rapid antigen test results together without conducting a confirmatory test as recommended in the CDC guidance.

Serial Testing Not Performed

Four facilities did not perform serial testing of children in accordance with CDC guidance:

- The ICF had a policy to serial test 20 percent of children who had not previously tested positive, were not currently positive, or were not in quarantine. However, this policy did not follow CDC recommendations to test all children every 3 days. Additionally, the ICF did not perform any serial testing.
- One EIS had a procedure in place to serial test all children every 3 days. However, it did not test all children every 3 days.
- Two EISs completed serial testing on children every 4 days. One EIS did not count the day of the test, counted the next 3 days, and required the next test on the following day, resulting in testing every 4 days, instead of every 3 days as recommended. At the second EIS, 50 percent of the children were tested each Tuesday and Saturday; the

¹⁸ The isolation period began on the date of the child's arrival at the facility rather than on the date of the positive COVID-19 test because DHS did not provide the facility with the date of the positive test.

other 50 percent were tested each Wednesday and Saturday. As a result, all children were tested either 4 or 3 days apart, respectively.

Nine Facilities Did Not Always Follow CDC Guidance for COVID-19 Testing of Employees and Volunteers

In its March 30 guidance, CDC recommended that facilities implement serial testing to quickly identify COVID-19 cases among children, employees, and volunteers and help prevent further transmission. The March 30 guidance also recommended universally testing staff every 3 days, regardless of vaccination status. Nine facilities did not follow CDC recommendations for COVID-19 testing of employees and volunteers as follows:

- The ICF did not require a COVID-19 test for employees who provided proof of vaccination; unvaccinated employees were serial tested once a week. The ICF did not have any volunteers.
- One EIS serial tested employees and volunteers every 7 days regardless of their vaccination status.
- Four EISs serial tested vaccinated employees and volunteers every 7 days; unvaccinated employees were tested every 3 days.
- One EIS serial tested vaccinated employees and volunteers once a week; unvaccinated and partially vaccinated employees were tested twice a week.
- One EIS assigned testing days to the employees and used an Excel spreadsheet to track testing, but it tracked only the tests administered and the EIS did not monitor the testing to ensure compliance with CDC-recommended serial testing. In addition, vaccinated employees and volunteers at this EIS were tested only once a week. Unvaccinated employees and volunteers were tested twice a week.
- One EIS completed serial testing on employees and volunteers every 4 days and used stickers that testing staff placed on employee and volunteer badges to track the next required test. Security officers were to observe the stickers on individuals' badges as they stopped at the facility's main gate and direct them for a COVID-19 test, if required, before entering the facility. However, based on our experience while visiting the EIS, the security officers did not always check badges.

FACILITIES DID NOT ALWAYS PROTECT AGAINST THE SPREAD OF COVID-19

Implementing measures to protect against the spread of COVID-19 in the ICF and EISs is critical to protecting the health and safety of children, employees, and volunteers in these facilities. All facilities had some measures in place, as recommended by HHS and CDC, to protect against the

spread of COVID-19; however, most lacked some key measures designed to help mitigate the spread of COVID-19. See Appendix C for a summary of facilities' noncompliance with guidance for protecting against the spread of COVID-19.

Eight Facilities Did Not Conduct Contact Tracing

In its March 30 guidance, CDC recommended that ORR facilities, including ICFs and EISs, quarantine staff, volunteers, and contractors who have been in close contact with someone who has COVID-19. The March 30 guidance specifically referred facilities to the March 22 guidance for the quarantine of children. The guidance required facilities to begin contact tracing immediately after an individual tests positive for COVID-19, and the infected person's close contacts should be identified, quarantined, and tested for COVID-19.¹⁹ Additionally, the March 30 guidance stated that when maintaining distance is a challenge, the use of cohorting (identifying a group and keeping them distanced from other groups) is recommended, and mixing cohorts should be prevented as much as possible.

Eight facilities did not conduct contact tracing:

- Five EISs did not conduct contact tracing for children and did not institute quarantine cohorts if a child tested positive for COVID-19.
- One EIS did not conduct contact tracing for children. Additionally, with respect to the use of quarantine cohorts, the EIS waited for three children to test positive for COVID-19 before it quarantined the cohort.
- Five EISs did not conduct contact tracing for employees; however, two of the EISs, while not conducting contact tracing in the facility, reported positive COVID-19 test results to the local health department and relied on it to conduct contact tracing in the community.

Five Facilities Did Not Always Comply With Mask Wearing

In its March 30 guidance, CDC mandated that facilities ensure mask wearing for all children, employees, and volunteers unless actively eating, drinking, taking medications, or sleeping. Six facilities generally complied with mask wearing; when children were not wearing masks or not wearing masks correctly, we observed employees reminding the children to comply. However, five facilities did not always ensure compliance with mask wearing:

¹⁹ According to CDC, contact tracing is used to help slow the spread of COVID-19 by: (1) letting people know they may have been exposed to COVID-19 and should monitor their health for signs and symptoms of COVID-19, (2) helping people who may have been exposed to COVID-19 get tested, and (3) asking people to self-isolate if they have COVID-19 or self-quarantine if they are a close contact of someone with COVID-19.

- At the ICF, we observed children not wearing a mask while in their living quarters. According to facility officials, children were required to wear masks only when they went to recreation, made weekly phone calls, or went for medical treatment.
- At one EIS, we observed several children not wearing a mask, or not wearing it correctly (i.e., not covering both their mouths and noses), and a few employees or volunteers not wearing masks.
- At one EIS, we observed children involved in outdoor recreational activities not wearing masks.
- At one EIS, we observed several children not wearing a mask, or not wearing it correctly, while playing games or watching television with other children.
- At one EIS, we observed children not wearing a mask while awake and sitting on their bunk beds.

The children observed not complying with mask wearing were not actively eating, drinking, taking medications, or sleeping. Additionally, we did not observe anyone reminding the children or employees at these facilities to wear their masks.

Four Facilities Did Not Quarantine Children Upon Intake

The March 30 guidance specifically referred facilities to the March 22 guidance for the quarantine of children. The March 22 guidance advised ORR facilities to concurrently implement diagnostic testing regimes and shorten quarantine periods from 14 days to 7 days only if children are tested within 48 hours before the end of quarantine and the test is negative. The guidance also stated that facilities should continue with their Unaccompanied Children Prevention and Control Activities. These activities include, among other things, testing newly admitted children without symptoms both on admission and again within 48 hours before the end of quarantine (e.g., day 5, 6, or 7) with confirmation of a negative test before release from quarantine. Most facilities followed the shortened 7-day quarantine guidance, but one facility quarantined children for 10 days. Four facilities did not quarantine children upon intake:

- Two EISs assigned children to the general population once intake was completed if they had a negative COVID-19 rapid test. Officials at one facility stated that the 3-day serial testing mitigated the risk of not quarantining newly referred children who tested negative upon intake.
- Two EISs did not quarantine children upon intake unless they had COVID-19, had a positive COVID-19 test, or had known exposure. However, the facilities attempted to cohort children to prevent additional potential exposures.

Four Facilities Did Not Practice Adequate Physical Distancing

In its March 30 guidance, CDC recommended that physical distancing be practiced in combination with other preventive actions to reduce the spread of COVID-19. In addition, the March 30 CDC guidance recommended that children, employees, and volunteers maintain a safe space of at least 6 feet from other people who are not from their household or cohort in both indoor and outdoor settings. Seven facilities met CDC's physical distancing requirements. However, four facilities did not adequately physical distance as follows:

- Two EISs did not practice physical distancing. At one EIS, children slept in cot bunk beds that were spaced so close together that employees and volunteers were unable to see the children in the lower cots. At the second one, children's beds were set up so that no cots were head to head, but they were not 6 feet apart. These EISs did not practice physical distancing in other settings either (i.e., recreation, dining, and living areas).
- One EIS did not physically distance children in the general housing. The layout of the site and available housing space were not conducive for physical distancing because rooms were joined and set up with multiple bunk beds in each room. However, we observed physical distancing in the cafeteria and intake tent.
- Staff at one EIS did not practice physical distancing. In addition, staff at the facility did not maintain physical distancing from children during activities.

Three Facilities Did Not Conduct Symptom Screening and Temperature Checks for Employees and Volunteers

In its March 30 guidance, CDC recommended that ORR facilities, including ICFs and EISs, ensure that symptom screening and temperature checks are conducted daily for all employees and volunteers. According to the guidance, employees and volunteers should not be permitted to enter the site if they are experiencing any symptoms of COVID-19 (or other communicable diseases), are waiting for COVID-19 test results, or have tested positive for COVID-19 in the last 10 days. Eight facilities followed CDC's recommendations for symptom screening and temperature checks. However, three facilities did not adequately conduct symptom screening and temperature checks on employees and volunteers:

- One EIS did not conduct daily symptom screening and temperature checks for anyone other than the contracted staff who were bussed to the EIS, which was roughly half of all staff. An official at the facility stated that the contracted staff were screened and their temperatures were checked on the bus before they departed from their hotel.
- One EIS conducted daily symptom screening of employees. However, it did not conduct daily temperature checks. An official there stated that there was no evidence that daily temperature checks were a useful practice.

- One EIS did not conduct daily symptom screening and temperature checks for employees. Instead, it relied on its employees to conduct their own symptom screening and temperature checks but did not verify the self-screening was completed.

One Facility Did Not Isolate Individuals Who Tested Positive for COVID-19 for the Recommended Amount of Time

In its March 30 guidance, CDC recommended that facilities isolate children, employees, or volunteers for 10 days if they test positive for COVID-19. All facilities isolated individuals who tested positive; however, one EIS isolated individuals for only 7 days although 10 days were recommended.

SOME FACILITIES DID NOT REPORT COVID-19 TESTING AND RESULTS

Reporting COVID-19 test results to ORR and State and local health entities is critical to managing COVID-19 and its spread. Most facilities completed some COVID-19 reporting as required; however, five facilities did not report COVID-19 test results to ORR, and three facilities did not report test results to their State and local health entities. See Appendix C for a summary of facilities' noncompliance with guidance related to reporting COVID-19 testing and results.

Five Facilities Did Not Report Required Testing and Results to ORR

In its March 22 guidance, HHS required that each COVID-19 test be recorded in the child's Unaccompanied Children Portal (UC Portal) medical records, regardless of the result.^{20, 21} Each positive COVID-19 test result was to be reported in the appropriate health report in the UC Portal, which generates a notification to the ORR Division of Health for Unaccompanied Children (DHUC).

In its March 30 guidance, CDC recommended that facilities' medical teams report positive COVID-19 test results for children to DHUC via secure email or a password-protected file.

Five facilities did not report required testing results to ORR:

- One EIS did not document all COVID-19 tests. According to facility officials, most children's medical records in the UC Portal contained the result of the COVID-19 test performed when a child arrived at the facility but rarely included the results of any serial testing. Additionally, the facility did not consistently report COVID-19 test results to

²⁰ Although the March 30 guidance does not address or specifically refer to the March 22 guidance, ACF's comments on our draft report indicate that reporting of test results in the UC Portal is still a requirement.

²¹ According to ORR, the Unaccompanied Children Portal is a secure, web-based system that allows personnel from ACF and programs that house unaccompanied children to enter and retrieve information about the children.

ORR and reported them in varying formats (e.g., daily situation reports, lists of hospitalized children, significant incident reports).

- Two EISs reported only positive COVID-19 test results in the UC Portal.
- Two EISs submitted only the confirmed COVID-19 diagnosis test records in the UC Portal; however, the facilities did not email DHUC when the facility received positive test results.

Three Facilities Did Not Report Required Test Results to Their State or Local Health Entities

In its March 30 guidance, CDC recommended that facilities follow local requirements for reporting COVID-19 test results. Texas required facilities to submit to the Texas Department of State Health Services, as well as to the local health department, daily reports of all test results, both positive and negative.²² California required all laboratories operating and testing specimens to report through the State's system all positive and non-positive test results within 8 hours of the time the laboratory notifies the health care provider or other person authorized to receive the report.²³ California also required employers to report workplace outbreaks of COVID-19 (3 or more cases within 14 days) to their local health department within 48 hours.²⁴

Eight facilities reported COVID-19 testing to their State and local health entities. Some of the eight facilities relied on contractors to conduct COVID-19 testing and report results to the State and local health entities, but other sites directly reported results to their local health entity, which in turn reported the results to the State. However, three facilities did not report test results:

- The ICF, located in Texas, did not report any COVID-19 test results to the State. The medical staff stated that they were working on setting up the proper reporting format requested by the State.
- One EIS, located in Texas, did not report COVID-19 test results to the State. Instead, it reported only positive COVID-19 test results to the City Department of Health. It is unclear whether the City Health Department submitted the results to the State.

²² Texas Exec. Order No. GA-10, *Relating to daily reporting during the COVID-19 disaster*. Effective Mar. 24, 2020.

²³ California considered as laboratories all places of employment that conduct COVID-19 tests. California Code of Regulations, Title 17, §§ 2500 and 2505; California Department of Public Health, *COVID-19 for Laboratories: Frequently Asked Questions (FAQ's)*, available online at <https://cdph.ca.gov/Programs/OSPHLD/LFS/Pages/COVID-19FAQ.aspx>. Accessed on June 24, 2021.

²⁴ California Assembly Bill 685 (Chapter 84, Statutes of 2020) (Sept. 17, 2020); California Department of Public Health, *AB 685 COVID-19 Workplace Outbreak Reporting Requirements*, available online at <https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/ab685.aspx>. Accessed on Nov. 19, 2021.

- One EIS, located in California, did not report COVID-19 test results to the State. Instead, it reported COVID-19 test results to the Mayor's office and county health department upon request; it reported positive staff cases to the county health department. It is unclear whether the Mayor's office or county health department submitted the results to the State.

CONCLUSION

ORR must address the shortcomings we identified to ensure that similar issues do not recur with future influxes and any future communicable diseases. ORR must do more to ensure that the ICF and EISs currently in operation, as well as any facilities opened in the future, have adequate procedures in place to test for and protect against the spread of COVID-19 (and any future communicable diseases) and report COVID-19 testing and results to ORR and State and local health entities as required. Effective oversight of facility operations is critical to ensure compliance with all requirements and CDC-recommended practices related to COVID-19. Clear communication of COVID-19 guidance by ORR to facilities will also assist facilities' efforts to control the spread of COVID-19 and protect the health and safety of children, employees, and volunteers.

Most facilities could have done more to follow CDC recommendations and comply with requirements designed to keep children safe and protect against the spread of COVID-19. We found that these facilities lacked: (1) procedures for COVID-19 testing of children, employees, and volunteers; (2) measures to protect against the spread of COVID-19; and (3) procedures to report required test results to ORR and State and local health entities.

Although the scale of the surge was unprecedented, ORR has faced several surges in the past and should have been better prepared to manage the sustained surge. We found that ORR was rapidly expanding capacity, setting up EISs, and developing COVID-19 protocols and guidance for their use. However, ORR did not have a process in place for widely disseminating the guidance, and frequent updates, to appropriate staff at the EISs. According to EIS officials, this contributed to the difficulty in knowing what COVID-19 protocols and guidance needed to be implemented within the facility. In addition, ORR contracted with several organizations that had little or no experience in providing shelter and services to children, and the contracts did not contain adequate details about COVID-19 protocols. Facility officials had to quickly hire and train large numbers of staff, many of whom had no prior relevant experience, without the benefit of standardized training materials, so COVID-19 and child care training varied among facilities. Moreover, ORR did not effectively monitor facilities to ensure that guidance on COVID-19 testing and mitigation strategies was implemented as recommended and that reporting requirements were met. As a result, facilities did not fully implement procedures related to COVID-19, thereby potentially placing the health and safety of children, employees, and volunteers at risk.

RECOMMENDATIONS

We recommend that the Office of Refugee Resettlement:

- develop a process to clearly communicate COVID-19 guidance and updates to the appropriate staff at the EISs so that staff have a full understanding of what is required of them to help protect against the spread of COVID-19;
- reiterate to facilities that they must comply with ORR's COVID-19 testing and reporting requirements and with State reporting requirements;
- improve and increase training provided to facilities regarding COVID-19 mitigation strategies; and
- perform routine oversight of facilities to reinforce implementation and compliance with all requirements related to COVID-19.

ADMINISTRATION FOR CHILDREN AND FAMILIES COMMENTS

In written comments on our draft report, ACF, commenting on behalf of ORR, concurred with our recommendations and described the actions it has taken to address the findings. ACF stated that ORR will review and define the relevant ICF and EIS stakeholders that should be updated when there are changes to COVID-19 guidance and outlined the process that will be used to communicate with these stakeholders to help minimize confusion and maximize successful implementation of any new or updated guidance. ACF also stated that ORR, in collaboration with CDC, has taken steps to standardize and automate the COVID-19 testing and reporting process for the two EISs that were still in operation at the time of ACF's comments. ACF stated that ORR is committed to improving training on the COVID-19 mitigation strategies and will continue to perform routine oversight of adherence to COVID-19-related requirements, including remote monitoring and site visits, as needed.

ACF also provided technical comments on our draft report which we addressed as appropriate.

ACF's comments, excluding the technical comments, are included as Appendix E.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We conducted site visits at 1 ICF and 10 of the 14 EISs in 3 States in May and June 2021. In total, we visited 11 sites that were fully operational at the time of our audit start. The remaining four sites were either closed or closing at the time of our audit start.

We conducted our site visits when ORR was experiencing a surge of children into custody and trying to control the spread of COVID-19 within the ICF and EISs. Our goal was to identify vulnerabilities and opportunities for improvement within the UC Program that could help ORR prepare for future surges or public health emergencies and respond to the COVID-19 pandemic.

We limited our assessment of ORR's and the ICF's and EISs' internal controls to those related to minimizing the spread of COVID-19 and to COVID-19 testing and reporting.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed CDC and ACF guidance related to COVID-19 protocols at the ICF and EISs;
- developed interview questions that focused on the following five areas:
 - general overview of the facility,
 - intake and initial COVID-19 testing of children,
 - serial COVID-19 testing of children and employees,
 - reporting of COVID-19 testing and results, and
 - challenges the facilities faced related to COVID-19;
- developed protocols for observing the facilities' layout and for evaluating the procedures the facilities had in place for testing for COVID-19 and protecting against its spread;
- reviewed documentation at the ICF and EISs related to their COVID-19 testing, measures to protect against the spread of COVID-19, and reporting of COVID-19 testing and results;
- conducted walkthroughs of the ICF and EISs to observe the sites' layouts and COVID-19 protocols in use; and

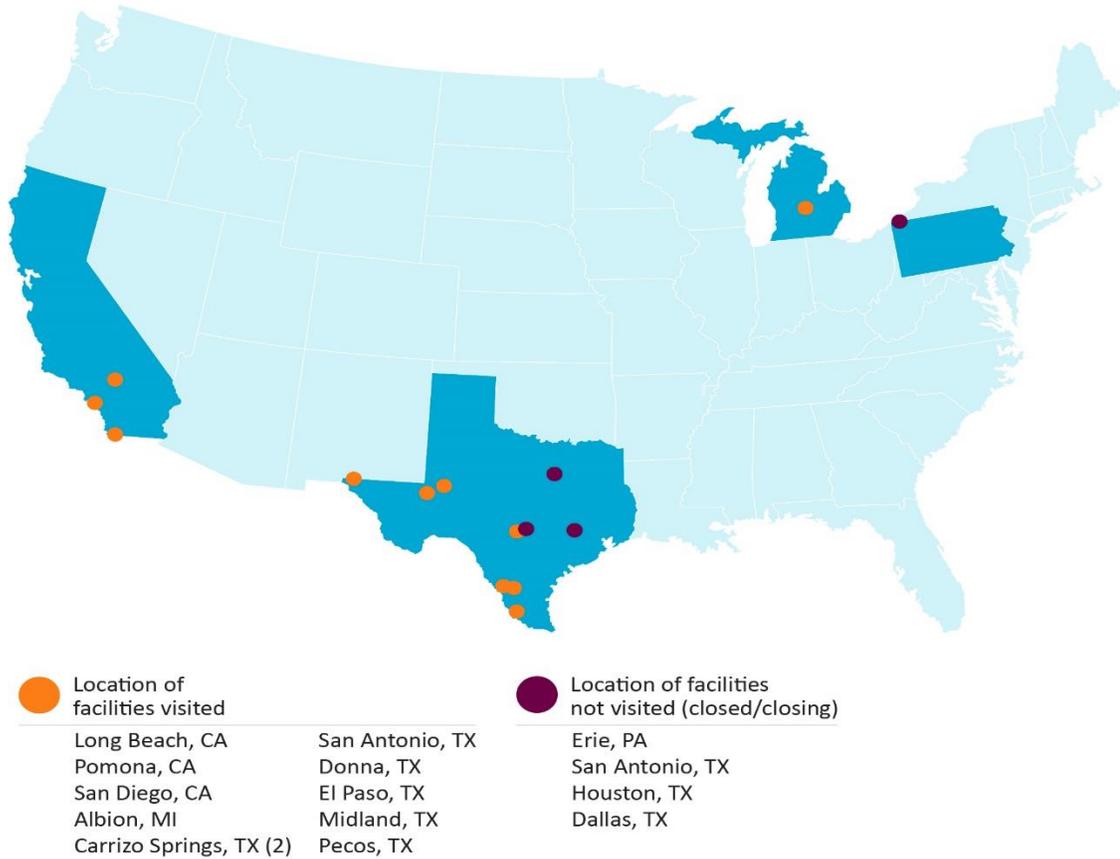
- interviewed ORR and CDC officials, contracting officer representatives, Federal field specialists, contract staff, including the prime contractor and medical contractors, and other knowledgeable officials.

After we completed our visits to the ICF and EISs, we met with ACF and ORR officials on July 19, 2021, to alert them of our preliminary findings and observations. During that briefing, we indicated to ACF and ORR officials that, based on these findings and observations, we concluded that outreach and technical assistance to facilities to reiterate ORR policy and program requirements for COVID-19 protocol were warranted. On July 23, 2021, we provided ORR with a schedule that showed our preliminary findings and observations by facility so that ORR could take actions, as warranted. We conducted an exit conference with ACF and ORR officials on September 27, 2021.

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: CARE PROVIDER FACILITIES VISITED BY OIG

During May and June 2021, OIG staff conducted site visits at 11 facilities across 3 States.



Number and Type of Facilities

14	Emergency Intake Sites	Provide potentially lifesaving services for unaccompanied children that are consistent with best practices and standards in an emergency response during disasters or other humanitarian situations; they provide clean and comfortable sleeping quarters, meals, toiletries, laundry, and access to medical services.
1	Influx Care Facility	Provides children with temporary emergency shelter and services; used when ORR experiences an influx of children.

Facilities Visited

The table below lists the 11 facilities that OIG visited.

Facility Name	Facility Type	Number of Children in Care*	Age Range of Children Provided Services
California (3)			
Long Beach Convention Center	EIS	547	0–17
Pomona Fairplex	EIS	691	0–17
San Diego Convention Center	EIS	565	6–17
Michigan (1)			
Starr Commonwealth	EIS	92	5–17
Texas (7)			
Carrizo Springs	ICF	584	3–17
Delphi (Donna)	EIS	665	13–17
Dimmit (Carrizo Springs)	EIS	396	13–17
Fort Bliss (El Paso)	EIS	4,326	13–17
Joint Base Lackland (San Antonio)	EIS	113	13–17
Midland	EIS	258	5–17
Pecos	EIS	1,556	13–17

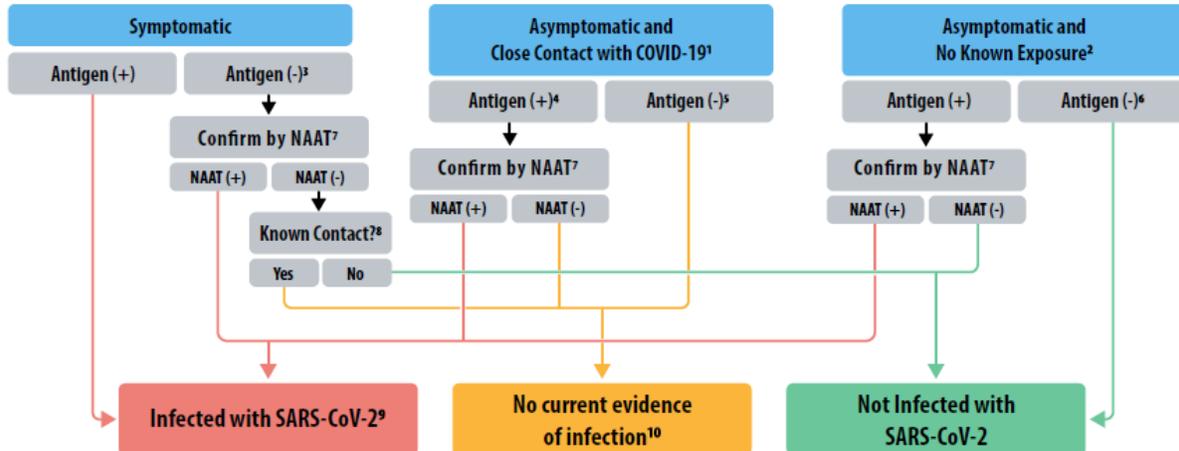
*These figures reflect the number of children in care at the time of the site visit.

APPENDIX C: SUMMARY OF FACILITIES' NONCOMPLIANCE WITH COVID-19 GUIDANCE

Issues	Facility											Total
	1	2	3	4	5	6	7	8	9	10	11	
Facility Lacked Procedures for COVID-19 Testing of Children	X	X		X	X	X						5
Facility Lacked Procedures for COVID-19 Testing for Employees and Volunteers	X	X		X	X	X	X	X		X	X	9
Facility Did Not Conduct Contact Tracing for Children or Employees		X	X	X	X	X	X		X	X		8
Facility Did Not Always Comply With Mask Wearing	X	X	X			X				X		5
Facility Did Not Always Quarantine Children Upon Intake		X			X			X	X			4
Facility Did Not Always Practice Adequate Physical Distancing		X	X	X					X			4
Facility Did Not Conduct Symptom Screening and Temperature Checks for Employees and Volunteers				X	X				X			3
Facility Did Not Follow CDC Guidance for Isolating Children Who Test Positive for COVID-19				X								1
Facility Did Not Report Required Testing and Results to ORR for Children		X	X	X						X	X	5
Facility Did Not Always Report Required Testing Results to Its State or Local Health Entities for Children or Employees	X		X							X		3

APPENDIX D: CDC ANTIGEN TESTING ALGORITHM

Antigen Test Algorithm



¹ Single, multiple, or continuous known exposure to a person with COVID-19 within the last 14 days; perform NAAT first if short turnaround time is available, if person cannot be effectively and safely quarantined, or if there are barriers to possible confirmatory testing.

² No known exposure to a person with COVID-19 within the last 14 days.

³ If a symptomatic person has a low likelihood of SARS-CoV-2 infection, clinical discretion should determine if this negative antigen test result requires confirmatory testing.

⁴ In instances of higher pretest probability, such as high incidence of incidence of infection in the community, clinical discretion should determine if this positive antigen result requires confirmation.

⁵ In certain settings, serial antigen testing could be considered for those with a negative antigen test result; serial testing may not require confirmation of negative results. The role of a negative antigen test result in ending quarantine depends upon when it is performed in the quarantine period. See CDC's [Options to Reduce Quarantine](#) for guidance on use of antigen testing for this purpose and when a negative antigen test result indicates not infected with SARS-CoV-2.

⁶ If prevalence of infection is not low in the community, clinical discretion should consider whether this negative antigen result requires confirmation.

⁷ Nucleic acid amplification test; confirm within 48 hours using a NAAT, such as RT-PCR, that has been evaluated against FDA's reference panel for analytical sensitivity.

⁸ Known exposure to a person with COVID-19 within the last 14 days; if unsure, clinical discretion should determine whether isolation is necessary.

⁹ Isolation is necessary. See CDC's guidance for [Isolation](#).

¹⁰ Quarantine is necessary. See CDC's guidance for [Quarantine](#); clinical discretion should determine if and when additional testing is necessary.



cdc.gov/coronavirus

APPENDIX E: ADMINISTRATION FOR CHILDREN AND FAMILIES COMMENTS



ADMINISTRATION FOR **CHILDREN & FAMILIES**

Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, D.C. 20201 | www.acf.hhs.gov

April 29, 2022

Ms. Christi A. Grimm
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 (OIG) draft report titled, *Office of Refugee Resettlement's Influx Care Facility and Emergency Intake Sites Did Not Adequately Safeguard Unaccompanied Children From COVID-19, (A-06-21-07002)*.

The following are ACF's responses to the OIG's four recommendations to the ACF Office of Refugee Resettlement (ORR):

Recommendation 1:

Develop a process to clearly communicate COVID-19 guidance and updates to the appropriate staff at the Emergency Intake Sites (EISs) so that staff have a full understanding of what is required of them to help protect against the spread of COVID-19.

Response:

ACF concurs with this recommendation. Since January 2021, ORR and the Centers for Disease Control and Prevention (CDC) have been in close, frequent contact at both the leadership and staff level regarding the health and safety of unaccompanied children (UC) in the care and custody of ORR during the coronavirus disease (COVID-19) pandemic. Coordination and communication between ORR and CDC have been critical in ensuring ORR has information and resources available to effectively implement safeguards to protect unaccompanied children, staff at ORR-funded programs, and their respective communities from the risk of COVID-19.

Beginning in March 2021, the ORR/Division of Health for Unaccompanied Children (DHUC) has held or participated in routine calls with key medical stakeholders at the EISs. These calls include discussion of COVID-19 prevention and control activities at EIS. Scheduled calls include(d):

- Site-specific introductory calls with EIS prime and medical sub-contractor leadership, in conjunction with ACF contracting officials, ORR/DHUC, and ORR Federal Field Specialists (FFS). This began in March 2021 as each EIS was activated and opened.
- Regular "Medical Check-in" calls during the initial phase of an EIS opening, to include ORR/DHUC Medical Services Team, the EIS site lead, ORR Federal Field Specialists, and EIS medical leadership (e.g., Chief Medical Officer (CMO), medical coordinator, and/or clinic manager).

ORR COVID-19 Protocol and Reporting (A-06-21-07002)

- Routine “DHUC-EIS CMO” calls, to include EIS contractor CMO, EIS Federal CMO, CDC EIS site representative, CDC Southwest Border Migrant Health Task Force representative, contractor safety team representative, federal safety officer lead, EIS site leadership, and ORR/DHUC representatives (these calls were held daily through Fall 2021, before moving to a Monday-Wednesday-Friday schedule, and then to the current weekly meeting schedule).
- Ad hoc calls with EIS medical stakeholders, as needed to address any immediate health and safety concerns.
- Dedicated call for safety officers at EIS (initially held daily, currently held twice weekly).

More specifically, calls have addressed:

- Review of critical public health, environmental health, and medical/mental health safety issues and on-site challenges.
- Review of ORR requirements and site-specific Situation Reports to ensure EIS are performing UC health assessments and vaccinations, as required.
- Sharing updates on and changes to COVID-19 and other communicable disease guidance.
- Monitoring for compliance and safety concerns.
- Assessing for training needs (to include COVID-19-related training needs).
- Addressing UC Portal documentation issues, including documentation on the COVID-19 disease and COVID-19 vaccinations.
- Planning and coordination for mass COVID-19 vaccination events.
- Best practices sharing between EIS sites.

All written COVID-19 guidance documents pertaining to EIS are included in the introductory packet that is distributed to EIS medical leadership, and routinely shared to account for EIS staff rotations. Updated COVID-19 guidance documents are also distributed by email to established EIS points of contact as they are reissued.

To strengthen the existing processes, ORR will review and define the relevant Influx Care Facilities (ICF) and EIS stakeholders that should be updated when there are changes in COVID-19 guidance. When new public health guidance is issued for ICF or EIS facilities, these key stakeholders will be notified in writing, as required per current protocol. Within one week of written notification of new public health guidance, a meeting will be scheduled to offer opportunities to clarify guidance and respond to questions about its implementation. These meetings will be open to all key stakeholders. To the greatest extent possible, changes to public health guidance will be batched into weekly digests to minimize confusion and maximize successful implementation.

Recommendation 2:

Reiterate to facilities the COVID-19 testing and reporting required by ORR and that facilities must comply with state reporting requirements.

Response:

ACF concurs with this recommendation. ORR prioritizes the health, safety, and well-being of children in ORR care and continues the unwavering commitment to detect COVID-19 and mitigate further transmission in the UC population. As of the writing of this response, CDC and ORR continue to recommend the routine testing of asymptomatic UC and staff—also known as “surveillance testing”—as an important COVID-19 mitigation strategy in EIS facilities. ORR

Page 2

will reiterate the importance of adhering to current recommendations when carrying out surveillance testing, including the use of recommended spacing intervals between testing episodes and the use of appropriate diagnostic algorithms. ORR will reiterate to contract leadership the importance of ensuring that COVID-19 test results are reported in accordance with ORR and state reporting requirements, which may change over time.

ORR, in collaboration with CDC, has also taken steps to standardize and automate the COVID-19 testing and reporting process for the two EIS facilities that remain open as of March 2022. COVID-19 testing for UC and staff at both sites is now conducted by the same testing contractor to maximize adherence to the recommended testing intervals and algorithms. Because manual data entry of hundreds of COVID-19 test results per day requires substantial staff resources and time, ORR has also worked with the testing contractor to automate and batch data entry of UC COVID-19 test results to the UC Portal, thereby improving reporting completeness and timeliness.

Recommendation 3:

Improve and increase training provided to facilities regarding COVID-19 mitigation strategies.

Response:

ACF concurs with this recommendation. As detailed in ORR's response to Recommendation 1, ORR/DHUC has coordinated regularly scheduled calls that address training related to COVID-19 mitigation strategies. Additionally, substantial efforts have been made to address training needs related to UC Portal COVID-19 reporting and documentation, including:

- ORR/DHUC hosted 17 web-based UC Portal trainings for EIS staff which all included direction on documenting COVID-19 testing in the UC Portal. Some trainings were offered to multiple EISs at one time while others were targeted to specific EISs. Many of these trainings were recorded and distributed to EIS staff for internal training purposes.
- In-person trainings that covered COVID-19 documentation were delivered on the below dates:
 - ORR EIS at Fort Bliss, May 2021 (eight trainings) and February 2022 (four trainings),
 - Pecos EIS, July 2021 (two trainings), November 2021 (one training) and February 2022 (three trainings),
 - Pomona EIS, August 2021 (one training)
 - Starr EIS, November 2021 (one training), and
- An EIS UC Portal User Guide containing COVID-19 lab testing documentation guidance was sent to EISs in April 2021.

Implementing multiple, simultaneous COVID-19 mitigation strategies within congregate settings can be complex. As such, ORR is committed to improve training on the COVID-19 mitigation strategies that are currently employed. This may include but is not limited to the following strategies: masking, immunization, cleaning/disinfecting, surveillance testing, symptom monitoring, UC quarantine upon intake, quarantine of COVID-exposed persons, and isolation of COVID-infected persons.

Recommendation 4:

Perform routine oversight of facilities to reinforce implementation and compliance with all requirements related to COVID-19.

Response:

ACF concurs with this recommendation. The OIG report findings are based on site visits conducted in May and June 2021. During and since that time, ACF/ORR has provided in-person and remote oversight to EIS. This oversight includes:

- ORR/DHUC in-person details and site visits to EIS, including, but not limited to, review of COVID-19 prevention and control activities:
 - ORR's EIS at Fort Bliss, May-June 2021 (Two extended details, 60 days total)
 - Pecos EIS, July, and November 2021 (Two site visits)
 - Pomona EIS, August 2021 (One site visit)
 - Starr EIS, November 2021 (One site visit)
 - Dallas EIS, March 2021 (One extended detail, 21 days),
- UC Monitoring Team site visits gathering and reviewing information and documentation about EIS program operations, including COVID-19 checks,
- Remote monitoring of COVID-19 vaccination coverage at EIS using UC Portal data, and technical assistance to correct any identified compliance issues,
- Remote monitoring of COVID-19 disease and vaccination metrics on EIS Daily Situation Reports, and technical assistance to correct any identified compliance issues, and
- Refer to responses to Recommendation 1 for information on regularly scheduled calls that address EIS adherence to COVID-19 prevention and control requirements.

ORR will continue to perform routine oversight of adherence to COVID-19-related requirements, including remote monitoring (e.g., running regular reports on data entered in the UC Portal) and site visits, as needed. When concerns are identified, they will be communicated to stakeholders in a timely fashion and corrective actions will be recommended, as appropriate.

Summary

In closing, ACF is working diligently with our stakeholders, including the CDC, to ensure EIS have the most up-to-date information related to COVID-19 to keep children in ORR care safe and healthy.

Again, thank you for the opportunity to review this draft report. Please direct any follow-up inquires to Benita Turner, Office of Administration, Administration for Children and Families, (202) 401-9379.

Sincerely,

/ January Contreras /

January Contreras
Assistant Secretary
Administration for Children and Families
U.S. Department of Health and Human Services