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UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA

LUCAS R. *et al.*,

Plaintiffs,

v.

ALEX AZAR, Secretary of U.S. Dep't of Health and Human Services, *et al.*,

Defendants.

Case No.: 2-18-CV-05741 DMG (PLA)

DEFENDANTS' OPPOSITION TO PLAINTIFFS' EX PARTE APPLICATION FOR A TEMPORARY RESTRAINING ORDER [DKT. NO. 227]

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I. INTRODUCTION AND SUMMARY

This Court should deny Plaintiffs' extraordinary request for class-wide injunctive relief. Plaintiffs' claims lack merit, their motion rests on a mistaken view of the facts, and Plaintiffs fail to account for the many equitable and harm-related considerations that weigh strongly against the relief that Plaintiffs seek.

The COVID-19 pandemic has presented tremendous challenges for our Nation. But the Executive Branch is responding to those challenges for everyone in the country and for everyone who is entitled to its protection—including for the children at issue in this case. The U.S. Department of Health and Human Service (HHS) Office of Refugee Resettlement (ORR) is carefully, thoroughly, and expeditiously safeguarding the health and interests of the unaccompanied alien children (UACs) entrusted to its care under federal law. *See* 8 U.S.C. § 1232. Plaintiffs' claims in their TRO motion are not well taken and do not warrant a disruption of ORR's careful efforts to fulfill its statutory mandate. And their request for TRO relief is fundamentally improper: The purpose of a TRO is to maintain the status quo, yet the broad and hasty relief that Plaintiffs seek would be highly disruptive and would violate the TVPRA. Indeed, the rushed and sweeping relief that Plaintiffs seek threatens to increase the risk of harm to UACs in ORR custody. The Court should deny this motion for the multiple reasons.

Plaintiffs' arguments fail on the merits. To start, far from showing that ORR is violating the Trafficking Victims Protection Act of 2008 (TVPRA), the government is complying with the TVPRA, and the relief requested by Plaintiffs would violate that statute. The TVPRA imposes robust and thorough procedures that ORR must use, all to the end of safeguarding the welfare of children in its care, which includes both its obligation to safely and expeditiously release children to approved sponsors under 8 U.S.C. § 1232(c)(3)(A) and to maintain safe custody of those children under 8 U.S.C. § 1232(c)(2)(A). ORR's procedures are suited to safeguard these interests during the COVID-19 pandemic. In fulfilling its TVPRA obligations for safe custody, ORR maintains rigorous protocols for handling infectious diseases for children in care,

including mandatory staff training requirements, isolation capabilities across ORR's network of care providers that are suitable for housing children, hygiene education, and medical screenings. *See* ORR Guide § 3.4.6. ORR also issued extensive field guidance on the COVID-19 pandemic to its care provider network on March 2, March 13, March 19, March 20, and March 23, which implements important safety measures such as mandatory temperature checks for children and visitors; placement and travel restrictions to and from at-risk facilities; and heightened medical care. *See* Ex. R-W.

Against the backdrop of ORR's intensified efforts to protect the health and well-being of UACs in its care and custody during the COVID-19 pandemic, Plaintiffs' miscalculated assertions of injury have led them to ask that this Court impose a truncated and unlawful standard for release of those children (to un-vetted sponsors) and require administrative hearings for all denied sponsors where ORR would need to affirmatively prove that a sponsor would harm or neglect a child to avoid release. Br. 21; Pls. Proposed Order 41. That relief would upend the TVPRA's requirement of safe reunification, which requires that the sponsor be "capable of providing for the child's physical and mental well-being." 8 U.S.C. § 1232(c)(3)(A). The unsubstantiated claims of harm that Plaintiffs allege do not justify the far-sweeping relief they seek. Plaintiffs disregard that the COVID-19 response requires flexibility as the situation develops and given the varying circumstances in different parts of the country. Plaintiffs filed an emergency TRO motion without any real effort to understand the significant actions being taken by ORR in response to this fast-developing challenge. And Plaintiffs indiscriminately lump all congregate-care facilities together, irrespective of size, location, and set-up. These differing circumstances show that class-wide resolution would override the discretion ORR and care facilities need to manage this developing and changing crisis across the country to protect children and would disregard ORR's statutory obligations of safe and expeditious relief.

Plaintiffs' TRO request also conflicts with the *Flores* Settlement Agreement. *Flores* resolved due-process claims concerning the medical care of minors in custody

as well as release standards and procedures. Plaintiffs cannot bring claims here alleging that these policies and procedures violate the Due Process Clause; these claims are barred by res judicata. If there are concerns that *Flores* is now being violated, those claims must proceed in a *Flores* enforcement action. Plaintiffs cannot avoid that limitation by asserting that their claims have been brought exclusively under the TVPRA or that the TVPRA (or *Flores*) creates rights that they can enforce under the Due Process Clause. As this Court has held, the TVPRA is coextensive with *Flores* when it comes to release provisions. And the Agreement's care provisions are far more detailed than the TVPRA and ORR, under this Court's ruling, provides medical care that seeks compliance with applicable state laws. Plaintiffs should be precluded from arguing here that the medical care standards they negotiated for, and agreed to, in *Flores* are insufficient. If Plaintiffs are no longer satisfied with their negotiated and agreed-to rights under *Flores*, then they should seek to amend that agreement. Having not done so, their claims should fail because Plaintiffs cannot here claim that the medical care being provided does not comply with the *Flores* Settlement Agreement.

All of Plaintiffs' TRO merits arguments also fail because none of the facts relevant to their TRO request are pleaded in their operative (first amended) complaint ("complaint" or "Compl.," ECF No. 80), and thus none of the certified classes are appropriate to address their new allegations of injury. The complaint makes no allegations about any of the protocols that ORR has implemented to protect those in its care and custody from COVID-19, or the general conditions, cleanliness, or medical treatment inside any of ORR's grantee care facilities where UACs reside while awaiting unification with a safe sponsor. And notably, the operative complaint does not seek to address "extraordinary circumstances" like COVID-19—rather, it seeks an administrative appeal for minors denied unification to otherwise qualified sponsors under the TVPRA. Compl. ¶¶ 179-90. Plaintiffs are thus attempting to bring, by TRO motion, new claims based on new facts to seek new relief. Plaintiffs must file a new complaint and withstand the rigorous class-certification procedures before being

granted this relief. Given the widely varying circumstances presented by COVID-19, and the quickly changing crisis, class resolution very likely would not be appropriate if it were sought. But in any event, certification of a class for their original claims does not provide roving authority to obtain class-wide oversight on any issue of concern.

Even if *Flores* were disregarded and Plaintiffs could obtain TRO relief in this case on a due-process theory, Plaintiffs fail to show a due-process violation arising from either a lack of adequate medical care or unsafe conditions. The extensive measures that ORR has taken in coordination with the CDC and other components of HHS confirms the contrary. ORR has gone to extraordinary lengths to care for children in a profoundly challenging situation, while also fulfilling its statutory mandate under the TVPRA for expeditious release of children to custodians who will care for them, implementing measures both to prevent the spread of COVID-19 and provide appropriate medical care in the case of infection. ORR: (1) has stopped placements in New York, California, and Washington; (2) has limited air travel to local placements; (3) requires all care providers to conduct temperature checks for every UAC in care twice each day; (4) elevates all medical cases with flu-like symptoms; (5) maintains medically appropriate isolate capabilities at all of its shelters; and (6) restricts access to all visitors who display either an elevated temperature or flu-like symptoms. *See* Ex. Q-W. For medical care, ORR provides all UACs with testing at the recommendation of medical personnel, has full-time medical staff on-site, and isolates anyone who either tests positive or is suspected of exposure to the COVID-19 virus. *Id.* ORR is continuing to monitor the fast-developing situation, and will make further changes to policies as warranted. *See e.g.*, Ex. R at 1. These measures show neither a violation of the Due Process Clause's requirement for adequate medical care, nor deliberate indifference to protecting the safety and well-being of minors in its custody.

Plaintiffs also fail to show how their alleged injury would be redressed by the relief they seek. They provide no explanation of how the relevant actors could safely undertake Plaintiffs' proposed mass transit, within days, of hundreds of children across

the country at a time when public transportation is halted or severely restricted given the risks it poses to travelers and others. Nor have they shown why release to un-vetted sponsors who may have differing home situations would be safer than remaining in a facility with a medical staff on call 24 hours a day in conjunction with the normal TVPRA vetting process that Congress required. And Plaintiffs have not shown that their demand for administrative hearings during a time of strained resources for ORR would redress the harm that they allege. Plaintiffs' requested additional procedures are not required under the Due Process Clause, as explained in *Reno v. Flores*, 507 U.S. 292, 303 (1993), and would take crucial agency employees away from the vital task of releasing children to vetted sponsors and keeping them safe and healthy in the meantime.

The remaining injunctive factors weigh against the extraordinary remedy that Plaintiffs seek. As explained, Plaintiffs have not shown on a class-wide basis that every child in ORR care faces the same or a substantially similar risk of injury, given the significant differences in size, location, and capacity across ORR's network of care providers. Indeed, most of ORR's facilities are operating far below capacity, facilitating practices recommended by the CDC such as social distancing. Plaintiffs' claims of harm rely on guidance issued to prisons and jails, not congregate-care facilities housing children that often have to take account of many other factors such as whether the children, who are always in some form of custody, have a safe home in which to be placed. Even then, ORR's efforts to mitigate the risks of COVID-19 meet or exceed those that the CDC recommends for other types of congregate-care facilities. Ex. AA ¶ 20. Nor have Plaintiffs shown that the public interest weighs in their favor given the operational reality of what they seek would entail. Plaintiffs' dangerous proposal potentially involves transporting hundreds or thousands of children across the country, contrary to the CDC's shelter-in-place guidance, to un-vetted potential applicants, some of whom are strangers to the child, along with requiring ORR to implement potentially hundreds of administrative hearings for the remaining children during a pandemic.

II. BACKGROUND

A. ORR's Robust Actions

Defendants' official response to COVID-19 dates at least to January 31, 2020, when the Secretary of Health and Human Services declared COVID-19 a public health emergency. *See* Ex. AA ¶ 13. From the first appearance of COVID-19 in the United States, ORR has monitored the developing public health situation, including both federal and state mandates applicable to the jurisdictions in which ORR grantee care provider facilities—the locations where UAC in ORR custody and care reside—operate. *Id.* ¶ 17-18. ORR has provided the facilities with regular updates on infection prevention and control protocols, and has issued guidance on the screening and management of potential COVID-19 exposure among UACs, facility personnel, and visitors, consistent with official guidance from the Center for Disease Control (CDC), an agency of the Department of Health and Human Services. *Id.*

ORR is equipped to deal with viral and bacterial outbreaks. It has years of experience in identifying, containing, and treating contagious diseases, including seasonal influenza (flu), measles (rubella), mumps (parotitis), chicken pox (varicella), and tuberculosis. *See* Ex. Q ¶ 15. Even before the spread of COVID-19, ORR was ahead of the curve in developing protocols, policies, and experience relating to infectious disease containment. *See id.*

ORR's policies relating to managing communicable diseases are extensive, including policies requiring routine assessment of travel history when a child arrives at a care provider program, as well as medical screenings and vaccinations within 48 hours; ability to isolate or quarantine individuals for infectious disease control; hand hygiene and respiratory etiquette educational efforts; and established communicable disease reporting to the local health authority. Ex. Q ¶ 16 (citing ORR Policy Guide § 3.4.6 (Management of Communicable Diseases); § 3.4.7 (Maintaining Health Care Records and Confidentiality)).

Even accounting for its significant experience successfully managing communicable diseases, ORR's response to COVID-19 remains highly responsive and adaptable to the particular challenges of COVID-19. *See* Ex. Q ¶ 14, 17. To enhance its efforts to prevent the risk of exposure to COVID-19, ORR has mandated that all visitors and staff seeking to enter any grantee care provider facility must answer COVID-19 screening questions and submit to a mandatory temperature check. *Id.* ¶ 18. Except for UACs being processed for admission to the particular facility, grantee care-provider facilities are required to deny access to anyone who has a fever of 100°F or above; who exhibits symptoms of an acute respiratory infection; who has had contact with someone with a confirmed COVID-19 diagnosis in the previous 14 days; who has been tested for COVID-19 and is awaiting test results; or in the previous 14 days, has traveled to an area identified by the CDC as having widespread, sustained community transmission of COVID-19. *Id.* All UACs entering ORR care are screened for COVID-19 exposure or symptoms consistent with CDC COVID-19 guidelines. *Id.* ¶ 19. UACs at risk of COVID-19 exposure based on reported travel history, but without symptoms, are quarantined and monitored for 14 days. *Id.* ¶ 20. UACs who exhibit COVID-19 symptoms will be isolated and tested in consultation with the local health authority. *Id.*

Alongside measures to prevent exposure to COVID-19, ORR has instituted a rigorous monitoring regime to assure that any UAC who exhibits symptoms of COVID-19 is identified and appropriately isolated in consultation with the local health authority. Ex. Q ¶ 20-21. During this time in isolation, a child receives the same services as non-isolated peers in the same facility, which includes recreation and counseling, with adjustments—particularly to education services—to accommodate proper infection-control procedures. *Id.* ¶ 28. ORR has also required that each grantee care-provider facility monitor the temperature of every UAC in care. *Id.* ¶ 22. Children's temperatures are recorded twice daily. *Id.* If any UAC has a temperature above 100°F, the grantee care provider must immediately alert ORR, and must do so each day any child has a temperature over 100°F. *Id.* Further, any UAC who exhibit symptoms consistent with

COVID-19 will be immediately isolated and referred for evaluation by a licensed medical provider, in consultation with local health authorities, and tested for COVID-19, if that is the health provider's guidance. *Id.* ¶ 23.

The isolation procedures are the same for any UAC determined to be at risk for COVID-19 exposure or infection. Ex. Q ¶ 24. More specifically, the affected UAC will be provided a private room, with a closed door and bathroom access, preferably a private bathroom that is not used by others. *Id.* State and local health officials, along with ORR's health division, are notified and consulted for additional guidance on risk assessment, symptom monitoring, and isolation/quarantine. *Id.* Any facility personnel who enter an occupied isolation room are required to wear personal protective equipment, including an N95 respiratory mask and goggles or a face shield, per CDC guidelines. *Id.* ¶ 25. If a UAC in isolation needs to leave the isolation room for any reason (*e.g.*, to use the bathroom, to attend a medical appointment, etc.), the UAC must wear a surgical mask. *Id.* ¶ 26. If a UAC needs to be transported to a health clinic or other off-site location, the facility must notify the local health department for guidance on proper precautions during transport. *Id.* ¶ 27. The facility is also required to alert the intended destination in advance so proper infection control measures may be undertaken. *Id.* UACs are required to remain in isolation until cleared by appropriate health officials. *Id.* ¶ 28.

Besides extensive procedures to limit exposure to individual facilities and address and treat any affected UAC who may have COVID-19, ORR has also implemented further protocols to limit the overall risk of spreading COVID-19. ORR has stopped the placement of UAC at grantee care facilities in California, New York, and Washington due to COVID-19 outbreaks among the general public in those states. Ex. Q ¶ 32. ORR continues to monitor applicable state guidance to determine whether conditions warrant the suspension of placements in any particular locale, and will make changes as circumstances require. *Id.* Further, ORR prioritizes local facility placements for UACs in order to limit the need for travel on commercial airliners, but may use

commercial airliners to reunify a UAC with a sponsor, if it is safe to do so. *Id.* ¶ 33. Care providers must assess the safety of the UAC's ultimate destination, to anticipate logistical issues associated with COVID-19 disruptions. *Id.* Care providers also must consult with a Federal Field Specialist (who is an ORR employee) if a UAC will be traveling to a jurisdiction with widespread COVID-19 community transmission and resulting shelter-in-place order. *Id.* In such cases, release should be postponed until it is safe for the UAC to travel. *Id.*

Before the outbreak, ORR had been working on a telehealth initiative to increase UAC access to healthcare resources. Ex. Q ¶ 34. In light of orders restricting movement in New York and California, ORR rolled out its telehealth program in those locations ahead of schedule in order to ensure care provider facilities are able to provide UACs with access to medical care without leaving facilities. *Id.*

As of March 26, 2020, there were four confirmed cases among UACs in ORR care provider facilities. Ex. Q ¶ 35. All four cases were in a single facility in New York State, and the affected UACs are currently in isolation, per ORR and CDC guidelines, and are receiving appropriate monitoring and medical care. *Id.* Eighteen UACs in the care provider network had been tested, with at least eleven returning negative results. Ex. Q ¶ 36. While the tests were pending, pursuant to CDC Guidance, any UAC who had undergone COVID-19 testing was considered presumptively positive until results are available (usually, within three or four days after testing). Ex. Q ¶ 37. Eight program staff/contractors or foster parents at five care-provider programs located in New York, Washington, and Texas have self-reported testing positive for COVID-19. ORR's medical team and the affected programs have worked in close coordination with the local public-health departments on appropriate public-health measures, which typically involve self-quarantine at home, and the tracking and monitoring of the affected staff members' contacts within the care-provider facility, per CDC guidance. Ex. Q ¶ 38. The protocols discussed above are in place to prevent the further spread of

COVID-19, and ORR is providing medical care to those affected children. *See* Ex. Q ¶ 39.

CDC has issued guidance on COVID-19 containment in various congregate settings, including colleges, nursing homes, prisons, and homeless shelters. Ex. Q ¶ 36. ORR considered the CDC guidance when developing its own COVID-19 procedures, vetted its COVID-19 procedures with CDC, and understands that public health experts at CDC agree that the ORR procedures are consistent with CDC guidance. *Id.* Indeed, CDC has advised that "ORR's current COVID-19 procedures are consistent with CDC guidances for congregate settings; they direct grantee care-provider facilities to implement both containment and mitigation measures. In some respects, ORR's current COVID-19 procedures actually exceed those set forth in the CDC guidances to congregate care facilities." Ex. AA ¶ 20.

B. Plaintiffs' TRO Motion

Plaintiffs filed their TRO papers on March 25. Plaintiffs acknowledge that in light of the COVID-19 pandemic, ORR recently adopted safety measures for its congregate-care facilities and the unaccompanied minors in ORR care. Pl. Br. 7-8. They claim, however, that ORR guidelines fail to comply with safety measures from CDC and the medical community. Br. 8. Plaintiffs suggest that "ORR Guidance makes no mention of requiring or encouraging social or physical distancing between children or staff, nor of limiting the gathering of groups of children or staff within facilities." Br. 8-9 (citing Graves Decl.; Wang Decl.; Ex. K).[1] And they suggest that

[1] The materials submitted with Plaintiffs' TRO request should be given minimal weight. *See Orr v. Bank of America, NT & SA*, 285 F.3d 764, 773-74 (9th Cir. 2002); L.R. 7-6, 7-7 (mandating that the declarations "shall contain only factual, evidentiary matter and shall conform as far as possible to the requirements of Fed. R. Civ. P. 56(c)(4)."). Plaintiffs' declarations are replete with hearsay and speculation, improperly attempt to lay the foundation necessary for expert opinion, and are of tenuous relevance to litigation involving UACs in shelters. *E.g.*, Meyers Decl. (prisons and jails); Graves Decl. (populations other than ORR children). These and other exhibits present no factual evidence or expert opinion upon which the Court

ORR's COVID-19 guidelines "fall far below federal, state, and local mandates to reduce the spread of COVID-19," highlighting states' general "shelter in place" orders, as well as protocols for homeless shelters and prisons. Br. 10-12 (citations omitted). Plaintiffs do not cite any state guidance requiring congregate care facilities to release all children in care, nor could they. *See* Ex. X-Y (NY and CA guidance for children to remain in congregate care).

Plaintiffs allege that Defendants are in violation of the TVPRA by continuing to hold unaccompanied minors in shelters, specifically in instances where they have viable sponsors. Br. 13-16. They also claim that ORR is violating the terms of the *Flores* Settlement Agreement by not releasing UACs to remain in its care, alleging that said facilities are both unsafe and unsanitary. Br. 17. And they claim ORR violated UACs' procedural and substantive due-process rights by exposing them to dangerous conditions. Br. 18-22.

Finally, Plaintiffs claim that because of "the rapid spread of COVID-19 across the country and the impossibility of maintaining proper social distancing in ORR congregate care facilities, Class Members face an unacceptable risk of contracting COVID-19 in ORR custody." Br. 23. They ask the Court to enter a TRO ordering the immediate release of hundreds of UACs from congregate care.

III. ARGUMENT

The Court should deny Plaintiffs' TRO motion. "When 'a plaintiff has failed to show the likelihood of success on the merits, [the Court] need not consider the remaining three [elements]" for TRO relief. *See Garcia v. Google, Inc.*, 786 F.3d 733, 740 (9th Cir. 2015) (en banc) (internal quotations and formatting omitted). Plaintiffs

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should rely in finding facts. Finally, all of Plaintiffs' exhibits that focus on the nature and infectiousness of COVID-19 (*see, e.g.*, Ex. B; Ex. C; Ex. E) should be afforded minimal weight compared with evidence from HHS, which houses true authorities: the Centers for Disease Control and the Assistant Secretary for Preparedness and Response.

cannot make this showing. And considerations of harms and the equities strongly cut against a TRO, particularly where the sweeping and rushed relief that Plaintiffs seek threatens to increase harm to the UACs in ORR's care. Finally, Plaintiffs' request for relief is fundamentally improper. The purpose a TRO or preliminary injunction "is merely to preserve the relative positions of the parties until a trial on the merits can be held." *University of Texas v. Camenisch*, 451 U.S. 390, 395 (1981). Yet the relief that Plaintiffs seek would not maintain the status quo: it would disrupt the status quo and violate federal law.

A. Plaintiffs Fail to Show a Likelihood of Success on the Merits

1. Plaintiffs' TVPRA Claim Fails Because ORR is Fulfilling its Obligations Under the TVPRA by Implementing Careful Protocols in Response to COVID-19 and Plaintiffs' Proposed Relief Would Force ORR to Violate those Obligations

ORR is addressing the challenges presented by COVID-19 consistently with the TVPRA's requirements. The TVPRA imposes robust and thorough procedures on ORR, all to the end of safeguarding the welfare of children in its care, which includes both its obligation to safely and expeditiously release children to approved sponsors under 8 U.S.C. § 1232(c)(3)(A), *and* to maintain safe custody of those children under Section (c)(2)(A). ORR's procedures are particularly suited to safeguard these interests during the COVID-19 pandemic. In fulfilling its TVPRA obligations, ORR maintains rigorous protocols for handling infectious diseases for children in care, including mandatory staff training requirements, quarantine capabilities across ORR's network of care providers that are suitable for housing children, hygiene education, and medical screenings. *See* ORR Guide § 3.4.6. These procedures were formalized in 2015, but have been in place even longer. To further ensure the safety of children in care, ORR also issued extensive field guidance on the COVID-19 pandemic to its care provider network on March 2, March 13, March 19, March 20, and March 23, which implements important safety measures such as mandatory temperature checks for children and visitors; placement and travel restrictions to and from at-risk facilities; and heightened

medical care. *See* Ex. R-W. These guidelines are consistent with the approaches of state child welfare agencies who have children in congregate care, including New York and California, two epicenters of the COVID-19 pandemic. *See* Ex. X-Y.

Plaintiffs therefore misfire in contending that COVID-19 precautions are "all but impossible" for children in ORR congregate care. Nor have they explained why management of ORR grantee facilities should work differently from the many other types of congregate care facilities like nursing homes and long-term care facilities in the United States. They cite CDC Guidance used for jails and prisons, but the CDC has recognized that appropriate COVID-19 measures can be implemented at certain congregate care settings, including nursing homes and long-term care facilities. https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html; *see also* Ex. AA ¶ 17-18, 20 (CDC declaration).

In contending that ORR is violating the TRO (Br. 13-17), Plaintiffs fail to account for these significant measures that ORR has taken. And the arguments they do make lack merit. Plaintiffs principally contend that continuing to keeping the UACs at issue in custody for more than 30 days violates the TVPRA's prompt-placement mandate because those children "have family or other custodians available to receive them" and "[t]hirty days should be more than enough for ORR to assess post-release risk" to them. Br. 13-14, 16-17; *see also* Br. 13-17. The TVPRA erects no 30-day requirement, and Plaintiffs have provided no factual basis for grafting one into the statute when Congress has not spoken. Rather, Plaintiffs' claims are based on mere speculation and hypothesis, citing no evidence that a significant number of periods longer than 30 days are due to improper reasons.

Plaintiffs also suggest that ORR takes longer than 30 days to release the children at issue because of "discretionary investigatory measures" or "administrative inefficiency or indifference" and that such grounds are inadequate in the circumstances here. *See* Br. 15-16. But Plaintiffs cite no evidence to show that those reasons apply to the UACs here—let alone uniformly or on a class-wide basis. And the evidence shows

otherwise, as Plaintiffs are aware given their regular *Flores* updates on ORR's population in care.

Indeed, far from showing that ORR is violating the TVPRA, the relief that Plaintiffs request itself squarely conflicts with the TVPRA. Plaintiffs ask that the Court order ORR to release a child "[a]bsent good cause based on articulable facts that available custodian(s) would harm or neglect a class member, or that an individual class member presents an articulable danger to the public." Pls. Proposed Order 1. But this standard conflicts with the TVPRA. The standard states that ORR "may not" place a minor with a proposed custodian "unless" ORR determines that the "proposed custodian is *capable* of *providing for* the child's physical and mental well-being," which "at a minimum" "shall include verification of the custodian's identity and relationship to the child, if any, as well as an independent finding that the individual has not engaged in any activity that would indicate a potential risk to the child." 8 U.S.C. § 1232(c)(3)(A) (emphasis supplied). Plaintiffs ask ORR to release "*[a]bsent* good cause based on articulable facts that available custodian(s) *would harm or neglect* a class member, or that an individual class member presents an articulable danger to the public." Pls. Proposed Order at 1 (emphasis supplied). That is, instead of demonstrating the ability to *provide for* the child, Plaintiffs request there simply be no articulable evidence the applicant sponsor would *harm* the child.

Plaintiffs also ask the Court to direct ORR to provide an administrative hearing to all applicants for whom a determination has not yet been made. Pls. Proposed Order 1. Such a hearing would consist of the right to examine evidence, an opportunity to submit evidence, and a hearing. *Id.* at 1-2. But Congress did not provide these rights in the TVPRA. (And the Supreme Court has already said these are not required by the Due Process Clause, *see Reno v. Flores*, 507 U.S. 292, 303 (1993) (rejecting an asserted "right to an individual hearing on whether private placement would be in the child's 'best interests'" when "institutional custody (despite the availability of responsible

private custodians) is not unconstitutional in itself.").) There is no basis for engrafting such requirements onto the procedures here.

It is true that as of March 26, 2020, there have been four confirmed COVID-19 cases among UACs in one ORR care provider facility in New York. Ex. Q ¶ 35. But ORR has been addressing those cases with care and expedition, including providing immediate testing of every individual suspected of exposure, quarantine, and following CDC guidance. And importantly to the current motion seeking class-wide relief, there are no cases elsewhere in the network, and Plaintiffs have not shown that all UACs in ORR custody are at similar risk of injury. Indeed, children in ORR care are not located in just one uniform facility, and children are not all released to comparable homes.

2. The Relief Plaintiffs Seek is Barred by the *Flores* Agreement

Plaintiffs contend that ORR has violated the *Flores* Settlement Agreement (Br. 17-18), but the request for a TRO conflicts with the Agreement. As this Court knows, that Agreement remains in force and resolved due-process claims relating to the medical care of minors while in custody as well as standards and procedures for their release. *See Flores* Settlement Agreement ¶¶ 14, 15A, 17; *Flores v. Sessions*, 2018 WL 10162328 (C.D. Cal. July 30, 2018) (rejecting effort to impose additional release procedures under *Flores* Agreement or TVPRA). Plaintiffs are "members of the class protected under the settlement in *Flores*." Compl. ¶ 2; Order (Nov. 2, 2018). Accordingly, Plaintiffs cannot bring claims here alleging that the policies for providing medical care and policies and procedures for release of minors violate the Due Process Clause. *See SEC v. Randolph*, 736 F.2d 525, 528 (9th Cir. 1984) (consent decrees have the force of *res judicata*). Instead, if there are concerns that the *Flores* Agreement is now being violated, those claims must proceed in an enforcement action in the *Flores* litigation. *See* Order (Nov. 2, 2018) ("the interests of judicial economy counsel against permitting them to enforce the *Flores* Agreement in this action"); *id*. (citing cases laying out the "prohibition on duplicative actions").

Plaintiffs cannot avoid that limitation by asserting that their claims have been brought exclusively under the TVPRA or that the TVPRA (or *Flores* Agreement) creates rights that they can now enforce under the Due Process Clause. As this Court has held, the TVPRA is coextensive with the *Flores* Agreement when it comes to release provisions, as "[b]oth the TVPRA and the *Flores* Agreement allow ORR to determine a proposed sponsor's suitability" and in this respect "the Ninth Circuit noted that the TVPRA's suitability requirements mirror their counterparts in the Agreement." *Flores*, 2018 WL 10162328, at *2 (citing *Flores*, 862 F.3d at 878). The *Flores* Agreement resolved claims relating to the procedures for release, and Plaintiffs should not be re-litigating those procedures here. *See id*. And under the TVPRA, ORR "may not" release unless it determines that the potential custodian is capable of caring for the minor's physical and mental well-being. The evaluation "shall, at a minimum, include verification of the custodian's identity and relationship to the child, if any, as well as an independent finding that the individual has not engaged in any activity that would indicate a potential risk to the child." 8 U.S.C. § 1232(c)(3)(A). The statute thus both mandates an affirmative determination and vests the responsibility in ORR. Plaintiffs have no basis for departing from that.

And the care provisions of the *Flores* Settlement Agreement—in Exhibit 1 to that Agreement—are far more detailed than the TVPRA. *See* 2014 WL 7152078 (describing the medical care that must be provided to UAC). In its July 30, 2018 order, however, the *Flores* Court ruled that this Exhibit requires medical care that complies with applicable state laws. *See* Order 3 n.5. Plaintiffs should be precluded from arguing here that the standards of medical care they negotiated for, and agreed to, in *Flores* are insufficient. If Plaintiffs are no longer happy with their negotiated and agreed-to rights under *Flores*, then they should seek amendment of that agreement either through negotiations with the government or from the Court. *See Flores v. Sessions*, No. 85-4544, ECF No. 455, at 7 (C.D. Cal. July 9, 2018) (denying the government's motion to amend the agreement, but noting that "the parties are always free to meet and confer

regarding any contractual amendments on which they can mutually agree"). Further, as we explain, their claims that ORR has violated paragraph 9 of the *Flores* Agreement by failing to provide "suitable living accommodations" fails on the merits (Br. 17-18), as ORR's COVID-19 protocol and procedures fully comply with existing CDC and state and local guidance, *see supra* 12-13, *infra* 18-20 (¶ 12 does not apply, because it pertains to conditions following apprehension and not for ORR licensed facilities).

3. Plaintiffs Cannot Succeed on the Merits Because the TRO that they Seek is Beyond the Scope of the Complaint's Allegations and is Improper for Class-Wide Relief.

Plaintiffs TRO fails for a further independent reason. To qualify for injunctive relief, Plaintiffs must also show a sufficient nexus between the injury claimed in the motion and the conduct alleged in the underlying complaint. *See Pac. Radiation Oncology, LLC. v. Queen's Med. Ctr.*, 810 F.3d 631, 636 (9th Cir. 2015); *see also Garcia v. Google, inc.*, 786 F.3d 733, 744 (9th Cir. 2015) (because of a "mismatch" between the plaintiff's substantive copyright claim and the dangers she hoped to remedy through an injunction, the district court did not abuse its discretion in denying Garcia's request for a preliminary injunction). To that end, courts have denied motions for injunctive relief that are based on allegations and claims for relief that are beyond the scope of the complaint. In *Sekerke v. Leo*, No.: 3:19-cv-0034-GPC-RBB, 2020 WL 619581, at *9 (S.D. Cal. Feb. 10, 2020), for example, the court denied plaintiff's TRO request because it was premised on events that occurred after and outside of the events that gave rise to the complaint. The court ruled that if it were to grant plaintiffs' TRO request, it "would be required to engage in a factual analysis distinct from the analysis required by the claims," which would be improper. *Id.* (citations omitted); *see also*, *e.g.*, *Northern Arapaho Tribe v. LaCounte*, Nos. 60-11 & 16-60, 2017 WL 908547, at *3 (D. Mont. Mar. 7, 2017) (where TRO motion and complaint "present[ed] distinct facts and address distinct governing statutes and regulations," TRO motion fell "beyond the scope of either Complaint in this consolidated action."); *Clark v. Bank of Am. N.A.*,

No. 14-14-232, 2015 WL 1433834, at *8 (D. Idaho Mar. 27, 2015) (declining to consider TRO or preliminary injunction request raising "new arguments" that related broadly to the mortgage-centered conduct at the heart of complaint, but raised new, specific allegations).

The Court should reject the TRO request for the same reasons. Plaintiffs' TRO motion rests on events that occurred after and outside of events giving rise to the complaint. The complaint in this case has nothing to do with ORR's response to infectious disease or COVID-19. It does not assert that ORR's response to this crisis is inappropriate or inadequate under the TVPRA or the Constitution. And it does not lay out facts to establish that the response is improper or inadequate. And because of that, there was never any assessment of whether this Court could properly define or certify a class to address such concerns through class remedies. The complaint makes only general claims about the treatment and care of children, which cannot properly give rise to either a certification order or class-wide injunctive relief addressing COVID-19. *See* Compl. ¶ 189-90 ("As a matter of policy and practice, Defendants unreasonably and unnecessarily delay or refuse to release children to [proposed custodians]"). Similarly, the class was certified to address timing-based concerns about release; it was not certified to address requirements imposed by the TVPRA or the Due Process Clause on release relating to COVID-19 or concerns related to the spread of infectious diseases. *See* ECF No. 126 at 16-17 (certifying class where "ORR is refusing or will refuse to release to parents or other available custodians within thirty days of the proposed custodian's submitting a complete family reunification packet on the ground that the proposed custodian is or may be unfit").

Plaintiffs' TRO request bears no relationship to the ground for relief in the complaint or the basis for this Court's class-certification order. The complaint and the certified class challenge purported refusals to release minors to otherwise suitable sponsors within thirty days of receipt of a completed Family Reunification Packet, and the prayer for relief makes no mention of dramatically altering the standard governing

release under the TVPRA for sponsors due to a global pandemic. And there is no nexus to the purported lack of process in sponsor denial adjudication alleged in the complaint and the TRO's request for a mass release of hundreds of children to individuals who have not been properly vetted and have not shown they will be safe sponsors under the standards of the TVPRA. The newly alleged relief sought here must be sought, if at all, in a new complaint, not shoehorned into the existing one by requesting administrative hearings that are entirely inappropriate in a time of strained agency resources devoted to combatting the pandemic. And any class-wide relief would need to be sought based on such a complaint and only after Plaintiffs establish that they satisfy the rigorous requirements imposed by Rule 23.

For scope reasons alone, Plaintiffs lack a likelihood of success on the merits.

4. Plaintiffs Fail to Show a Due-Process Violation

As explained above, due-process claims relating to conditions and release for minors in ORR care were resolved in *Flores*, and any claim regarding enforcement of that Agreement would need to be raised in that matter under the terms set forth in the *Flores* Agreement. In any event, ORR's extensive and comprehensive response to COVID-19 satisfies the Due Process Clause. Plaintiffs' arguments to the contrary, Br. 18-22, lack merit.

Due process requires ORR to provide Plaintiffs with adequate medical care and safe conditions. *See Reno v. Flores*, 507 U.S. 292 (1993). And due process bars the government from acting with deliberate indifference to a known or obvious danger. *Patel v. Kent Sch. Dist.*, 648 F.3d at 971-72 (quoting *L.W. v. Grubbs*, 92 F.3d 894, 900 (9th Cir. 1996)). Deliberate indifference is a high bar and recognizes the discretion of caregivers to make appropriate treatment decisions—prior cases have explained that it could be met when a caregiver denies access to medical care, interferes with treatment, or fails to respond to a child's medical needs. *Estelle v. Gamble*, 429 U.S. 971, 104-05 (1976).

ORR has taken extensive measures to address the risks that COVID-19 could present to the UACs in its case. ORR has implemented a number of heightened safety precautions to ensure minors in its custody are not exposed to COVID-19 and that should those precautions not succeed, minors would receive the proper medical care. To prevent infection, ORR guidance to its network of care providers requires any UAC exhibiting symptoms consistent with COVID-19, such as coughing, fever, or difficulty breathing, at any point during their time in ORR care, to be immediately isolated and referred for evaluation by a licensed medical provider, in consultation with the local health authority. Ex. Q ¶ 22. Temperature checks are taken twice a day for UACs in care, with temperatures over 100 degrees requiring elevation to ORR, and visitors may not enter shelters who exhibit any of the above symptoms. Ex T. Further, if a UAC is recommended for testing by the health care provider or public health department, the UAC will receive testing. Ex. Q ¶ 23. ORR has also initiated telehealth capabilities in California and New York to ensure care provider facilities are able to provide UAC with access to medical care without having to leave their facilities. *Id.* ¶ 34. And for the rare cases where a UAC becomes infected with COVID-19, like the four children at the one NY shelter above, full medical quarantine is available for the other children in care, and the child is guaranteed to receive appropriate medical treatment. *Id.* ¶ 35; ORR Guide § 3.4.6.

Plaintiffs cite no evidence that ORR has acted with deliberate indifference to the impact of the COVID-19 pandemic on UACs in care. And the response shows that ORR has been extremely active and diligent. ORR provided initial COVID-19 guidance to the entire UAC care-provider network on March 2, 2020. Ex. R. It provided additional guidance on COVID-19 to the entire UAC care-provider network on March 19, 21, and 23. Ex. R-W. The mere fact that minors remain in congregate care while ORR attempts to safely and expeditiously reunify them with a qualified sponsor does not show that ORR has either failed to provide appropriate medical care required under the Due Process Clause, or that ORR is deliberately indifferent. Plaintiffs therefore

cannot prevail in the due process claims either as alleged in the complaint or as reiterated in the TRO and as applied to medical care and treatment.

Given these points, there is no basis to Plaintiffs' argument that ORR has failed to provide reasonable protections from the risks presented by the COVID-19 pandemic. Br. 18-19. Nor is there any merit to Plaintiffs' claim that ORR is subjecting the UACs at issue to "conditions that amount to punishment" or that are "excessive." Br. 19; *see also* Br. 19-20. As shown by the steady stream of guidance issued by ORR to address COVID-19 for its population in care, Ex. R-W, ORR's protocol for combatting the pandemic is calculated and calibrated to address the risk here—it is not excessive or unjustifiable as Plaintiffs claim.

Finally, Plaintiffs contend that ORR's failure to release the UACs at issue more rapidly violates procedural-due-process requirements for all UACs with an identified sponsor, even if the sponsor is distantly or unrelated to the child. *See* Br. 20-22. But Congress did not provide these rights under the TVPRA, and the Supreme Court has already held that such a hearing is not required by the Due Process Clause, when "institutional custody (despite the availability of responsible private custodians) is not unconstitutional in itself." *See Reno*, 507 U.S. at 303. For the reasons explained above, *supra* 18-19, ORR's medical care for its UAC population during this time of pandemic fully comports with the Due Process clause, and thus, Plaintiffs' procedural Due Process claims similarly fail.

5. Plaintiffs Fail to Show That Their Requested Relief Will Mitigate Risk of Harm from COVID-19

Plaintiffs' request for relief is barred for another independent reason: Plaintiffs' alleged injury—that they are subject to being exposed to COVID-19 due to their placement in congregate care—will not be redressed by ordering their release on an expedited basis to potential sponsors who have not yet been vetted. "Redressability requires an analysis of whether the court has the power to right or to prevent the claimed injury." *Gonzales v. Gorsuch*, 688 F.2d 1263, 1267 (9th Cir. 1982) (Kennedy, J.). For

standing purposes, a plaintiff's injury is redressable where there is "a 'substantial likelihood' that the requested relief will remedy the alleged injury." *Vermont Agency of Nat'l Res. v. United States ex rel. Stevens*, 529 U.S. 765, 771 (2000) (citation omitted). Plaintiffs have not carried their burden of showing that their desired relief—expedited release from ORR custody based on improperly overriding the TVPRA standard—will likely diminish their risk of exposure to COVID-19.

Notably, Plaintiffs do not articulate how release into communities or to sponsors who may already be exposed to COVID-19 will reduce the likelihood that the released minors will be exposed to or contract COVID-19. And in contrast to ORR's careful procedures for protecting against COVID-19 transmission, Plaintiffs do not explain how a massive number of expedited releases will safely occur. They offer no discussion of how to safely transport children from a facility that does not yet have a *single* case of COVID-19 into homes and communities that cannot make the same representation to justify class-wide relief. They have not addressed the reality that the situation is vastly different in different parts of the country, and to the contrary, ORR is taking that into account in managing its many grantees and placements with grantees. Ex. Q ¶ 32. Indeed, granting Plaintiffs' proposed TRO could even *increase* children's risk of exposure to COVID-19. ORR should be permitted to fulfill its statutory mandate of assessing whether releasing a child would be safe under all the circumstances, and a blanket order requiring releases on a set timeframe would be the opposite of helping to mitigate risks posed by the COVID-19 pandemic.

Moreover, ORR provides medical care at no cost of children in its custody, including Plaintiffs. Ex. Q ¶ 45. By reason of their placement in ORR facilities, Plaintiffs have greater access to robust medical care than does the general public. *See id.*; ORR Guide § 3.4.6. Aside from the increased risk of placing vulnerable children with un-vetted sponsors, ordering their release from ORR grantee care providers would leave these children without their present access to health care and could put Plaintiffs at greater risk should they contract COVID-19; at a minimum, ORR must be permitted

to assess whether proposed sponsors are able to provide adequate medical care. Additionally, transporting unexposed children via airlines to affect unification would *increase* their risk of exposure—the very harm Plaintiffs fear.

B. Considerations of Harm and the Equities Cut Against a TRO

Plaintiffs' TRO request fails on the remaining injunctive factors as well.

Plaintiffs fail to establish irreparable injury. An injunction is "unavailable absent a showing of irreparable injury, a requirement that cannot be met where there is no showing of any real or immediate threat that the plaintiff will be wronged []—a 'likelihood of substantial and immediate irreparable injury." *Los Angeles v. Lyons*, 41 U.S. 95, 111 (1983). Plaintiffs contend that detaining the children at issue "in congregate facilities that are inherently unsafe in the midst of the COVID-19 pandemic rather than releasing them to available custodians violates both substantive and procedural due process." Br. 18. But Plaintiffs' view fails to account for the measures that ORR has put into place (and will continue to put into place) to protect the children committed to its care. As discussed above, ORR has deployed extensive resources and efforts to address the harms that Plaintiffs claim. Given these measures in particular, Plaintiffs have not established that residing at an ORR grantee care provider facility increases risk to UACs of exposure to COVID-19 or presents a sufficient likelihood of irreparable harm. Moreover, many ORR grantee care provider facilities are currently far below capacity, which better enables social distancing. Ex. Q, ¶ 13-14. Notably, States continue to consider congregate care facilities essential.[2] Plaintiffs have not shown that Defendants are unprepared to respond to COVID-19 infections in specific grantee care facilities, let alone that they are unprepared to do so on a nationwide basis. Indeed, as shown above, ORR has robust procedures in place to protect children from the disease and provide any needed medical treatment. Further, the CDC indicates that "children do not appear to be at higher risk for COVID-19 than adults; . . . adults make

[2] *See, e.g.*, https://www.gnyha.org/news/executive-order-identifies-essential-health-care-operations/

up most of the known cases to date."[3] Plaintiffs are not entitled to immediate release to un-vetted applicant sponsors or to a transfer in facilities based on a conjectural injury that defies the known facts. As to the equities, the public interest favors not disturbing ORR's careful and adaptable response to this situation, especially where release threatens the public interest and increases health risks to the very children who Plaintiffs purport to help.

Finally, Plaintiffs have not satisfied the standard for a mandatory injunction. "Where a party seeks mandatory preliminary relief that goes well beyond maintaining the status quo pendent lite, courts should be extremely cautious about issuing a preliminary injunction." *Martin v. Int'l Olympic Comm.*, 740 F.2d 670, 675 (9th Cir. 1984); *see also Committee of Cent. Am. Refugee v. INS*, 795 F.2d 1434, 1442 (9th Cir. 1986). For mandatory preliminary relief to be granted, the plaintiff "must establish that the law and facts *clearly favor* [the plaintiff's] position." *Garcia v. Google, Inc.*, 786 F.3d 733, 740 (9th Cir. 2015) (emphasis in original). That is, the showing necessary to obtain an injunction that alters the status quo is higher than the showing necessary to merely preserve the status quo. *See, e.g., id.* Plaintiffs fall far short of making the necessary showing—their TRO motion is beyond the scope of the facts alleged in the complaint, it is unripe, it is not based on a class certified for the claims that Plaintiffs now make, it fails to show a likelihood of success on the merits, it fails to show irreparable injury, and it fails to show that the balance of the public interest factors favors them. Plaintiffs have failed to show that the facts and law "clearly favor" their position, so as to justify a mandatory injunction.

IV. CONCLUSION

In consultation with a host of federal, state, and local public health authorities, ORR is working day and night to reduce the risk to UACs posed by COVID-19, while complying with ORR's statutory mandate to release these children to safe sponsors as

[3] https://www.cdc.gov/coronavirus/2019-ncov/faq.html

soon as it is safe to do so. Plaintiffs' requested TRO would cause the agency to violate the TVPRA, undercut the agency's prodigious efforts, and *increase* the risk of harm to these children. The Court should deny the TRO motion.

DATED: March 27, 2020

Respectfully submitted,

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Exhibit Q

Sualog Declaration

UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA

LUCAS R., *et al.*, Plaintiffs, v. ALEX AZAR, Secretary of U.S. Dep't of Health and Human Services, *et al.*, Defendants.	Case No.: 2:18-CV-5741 DMG (PLAx) District Judge Dolly M. Gee

DECLARATION OF JALLYN SUALOG, DEPUTY DIRECTOR, OFFICE OF REFUGEE RESETTLEMENT

I, Jallyn Sualog, declare under penalty of perjury, pursuant to 28 U.S.C. § 1746, that my testimony below is true and correct:

1. I am the Deputy Director of the Office of Refugee Resettlement ("ORR"), an Office within the Administration for Children and Families ("ACF"), U.S. Department of Health and Human Services ("HHS").

2. I have held the position of Deputy Director since June 2018. I was previously the Director of Children's Services from September 2013 through June 2018. I have worked at ORR since February 2007. I have a Master's of Arts in Clinical Psychology. Before joining ORR, I worked as a mental health professional and managed the child welfare and social services programs for Hawaii's largest non-profit organization.

3. As the Deputy Director of ORR, I have responsibility for the oversight of the Unaccompanied Alien Children ("UAC") program, including all aspects of operations, planning and logistics, medical services, and monitoring. My job duties include the formulation and implementation of ORR's response to COVID-19 across its network of grantee care-provider facilities.

4. My testimony in this declaration is based upon my personal knowledge of ORR's response to COVID-19, information obtained from records and systems maintained by ORR in the regular course of performing my job duties, and CDC guidance documents regarding COVID-19, which I obtained from the CDC's official website and reviewed in connection with the performance of my duties.

5. I am testifying in this declaration to the best of my knowledge, and understand that this declaration is for use in the *Lucas R.* case.

Background

6. ORR is the agency charged with the care and custody of UAC pursuant to 8 U.S.C. § 1232(c) and other provisions. As such, ORR is committed to providing for the safety and well-being of all UAC in its care, as well as protecting the health and safety of the communities in which these children live—including from the risk of COVID-19.

7. To carry out its mission, ORR relies on a network of grantee care-provider facilities located across the country. There are a total of 107 facilities in the ORR grantee care-provider network that house UAC in a congregate setting: 98 shelters, 6 staff secure facilities, 1 secure facility, and 2 residential treatment centers ("RTCs").

8. Although each care-provider facility is unique in terms of its physical layout and capabilities, the ORR Guide generally defines a shelter as "a residential care provider facility in which all of the programmatic components are administered on-site, in the least restrictive environment."[1]

9. A staff secure facility is generally defined as "a facility that maintains stricter security measures, such as higher staff to unaccompanied alien children ratio for supervision, than a shelter in order to control disruptive behavior and to prevent escape. A staff secure facility is for unaccompanied alien children who may require close supervision but do not need placement in a secure facility. Service provision is tailored to address an unaccompanied alien child's individual needs and to manage the behaviors that necessitated the child's placement into this more restrictive setting. The staff secure atmosphere reflects a more shelter, home-like setting rather than secure detention. Unlike many secure care providers, a staff secure care provider is not equipped internally with multiple locked pods or cell units."[2]

10. A secure facility is generally defined as "a facility with a physically secure structure and staff able to control violent behavior. ORR uses a secure facility as the most restrictive placement option for an unaccompanied alien child who poses a danger to self or others or has been charged with having committed a criminal offense. A secure facility may be a licensed detention center or a highly structured therapeutic facility."[3]

11. An RTC is generally defined as "a sub-acute, time limited, interdisciplinary, psycho-educational, and therapeutic 24-hour-a-day structured program with community linkages, provided through

[1] ORR, Children Entering the United States Unaccompanied: Guide to Terms (Mar. 21, 2016), "Shelter care," available at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-guide-to-terms#Shelter Care.

[2] *Id.*, "Staff secure care," available at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-guide-to-terms#Staff Secure Care.

[3] *Id.*, "Secure care," available at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-guide-to-terms#Secure Care.

non-coercive, coordinated, individualized care, specialized services and interventions. Residential treatment centers provide highly customized care and services to individuals following either a community based placement or more intensive intervention, with the aim of moving individuals toward a stable, less intensive level of care or independence. ORR uses a RTC at the recommendation of a psychiatrist or psychologist or with ORR Treatment Authorization Request (TAR) approval for an unaccompanied alien child who poses a danger to self or others and does not require inpatient hospitalization."[4]

12. As of March 25, 2020, there are a total of 3,374 UAC in ORR care. This includes 439 UAC in long-term foster care and 374 UAC in transitional foster care, which are not congregate settings. For congregate settings only, there are 2,505 UAC in shelter facilities, 28 in staff secure facilities, 12 in secure facilities, and 16 in RTCs.

13. Currently, ORR's care-provider facilities are operating significantly below their maximum capacity and historical highs. For example, at this time last year (March of 2019), ORR was receiving approximately 8,000 monthly referrals and had almost 12,000 minors in care with an 87% occupancy rate (including influx and variance beds). In contrast, February referrals from 2020 were approximately 2,000 per month with approximately 3,600 minors in care, and a 28% occupancy rate (including influx and variance beds). As a result, ORR currently has additional capacity and more opportunity to ensure social distancing and isolation within the care provider network.

14. In addition, CDC recently issued an order under Public Health authorities suspending introduction of certain persons into the United States.[5] As a result, for the near-term, ORR is likely to have sufficient capacity to continue to implement necessary social distancing and/or isolation.

ORR Infection Control Measures in Care Provider Facilities

15. ORR has significant historical experience with the identification, mitigation, and treatment of contagious diseases affecting UAC, including seasonal influenza (flu), mumps (parotitis), chicken pox (varicella), and tuberculosis. Accordingly, ORR has policies pertaining to infectious disease control that predate the COVID-19 pandemic.

16. ORR's general, long-standing policies concerning the management of communicable disease require the routine assessment of travel history when a child arrives at a care-provider program; medical screenings and vaccinations within 48 hours of arriving at ORR shelters; ability to isolate or

[4] *Id.*, "Residential Treatment Center (RTC)," available at https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-guide-to-terms#Residential Treatment Center.

[5] CDC Order Under Sections 362 and 365 of the Public Health Service Act (42 U.S.C. §§ 265, 268), available at https://www.cdc.gov/quarantine/order-suspending-introduction-certain-persons.html.

quarantine individuals for the purpose of infectious disease control; hand hygiene and respiratory etiquette education efforts; and established communicable disease reporting to the local health authority.[6]

17. Since the first reports of COVID-19 in the U.S., ORR has monitored the public health reporting on COVID-19 in the jurisdictions in which grantee care-provider facilities operate. ORR has provided regular updates to grantee care-provider facilities on infection prevention and control, and issued guidance regarding the screening and management of UAC, facility personnel, and visitors who have potentially been exposed to COVID-19. All of these measures are rooted in CDC guidance.[7]

18. To prevent those who may have been exposed to, or who may be infected with COVID-19 from entering ORR facilities, ORR has mandated that all visitors and staff seeking to enter any grantee care-provider facility answer COVID-19 screening questions and submit to a mandatory temperature check. With the exception of UAC who are being processed for admission, grantee care-provider facilities are required to deny access to anyone with a fever of 100°F or above; or who exhibits signs of symptoms of an acute respiratory infection, such as a cough or shortness of breath; or who has had contact with someone with a confirmed diagnosis of COVID-19 in the previous 14 days; or who has been tested for COVID-19 and is awaiting test results; or who, in the previous 14 days, has traveled to a country identified by the CDC as having widespread, sustained community transmission of COVID-19.

19. In addition, UAC entering ORR care are screened for COVID-19 exposure or symptoms during their initial medical examination ("IME"), which has been expanded to include a COVID-19 health screening protocol consistent with CDC COVID-19 guidelines.

20. UAC at risk of COVID-19 exposure based on reported travel history, but without symptoms, are quarantined and monitored for 14 days. UAC who exhibit COVID-19 symptoms during their IME are isolated and tested in consultation with the local health authority.

21. ORR has also instituted a rigorous symptom-monitoring regime to ensure that any UAC in any facility who begins exhibiting potential symptoms of COVID-19 after their IME is immediately identified and appropriately isolated in consultation with the local health authority.

22. Since March 19, 2020, ORR has required each grantee care-provider facility to monitor the temperature of every UAC in care. UACs' temperatures are taken twice daily, once in the morning and again in the evening, and are recorded in a master census temperature report that each facility is required to maintain. If any UAC is found to have a temperature above 100°F, the grantee care-provider is required

[6] *See* ORR Policy Guide § 3.4.6 Management of Communicable Diseases, § 3.4.7 Maintaining Health Care Records and Confidentiality, https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-3.

[7] CDC, Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential Coronavirus Disease 2019 (COVID-19) Exposures: Geographic Risk and Contacts of Laboratory-confirmed Cases, https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html.

to immediately alert ORR. The grantee care-provider is required to alert ORR each day that any child has a temperature over 100°F. So for example, if a UAC has a 101°F fever for three days, ORR will be alerted of this fact every day for the duration of the child's fever. Early identification of potential COVID-19 cases allows for early introduction of appropriate public health measures.

23. Any UAC exhibiting symptoms consistent with COVID-19, such as coughing, fever, or difficulty breathing, at any point during their time in ORR care are to be immediately isolated and referred for evaluation by a licensed medical provider, in consultation with the local health authority. If a UAC is recommended for testing by the healthcare provider or public health department, the UAC will receive testing.

24. The same isolation procedures are used for any UAC determined to be at risk for COVID-19 exposure or infection, whether based on information collected during the IME, or through subsequent monitoring. The affected UAC will be provided with a private room, with a closed door and bathroom access, preferably a private bathroom that is not used by other staff or UAC. State and local health departments, along with ORR's Division of Health for Unaccompanied Children ("DHUC") are immediately notified and consulted for additional guidance on risk assessment, symptom monitoring, and isolation or quarantine.

25. Facility personnel who enter an occupied isolation room are required to wear personal protective equipment, including an N95 respirator and goggles or a face shield, per CDC guidelines.

26. If a UAC in isolation needs to leave the isolation room for any reason (e.g., to attend a medical appointment, etc.), the UAC must wear a surgical mask for the duration of their time outside the isolation room.

27. If a UAC must be transported to a health clinic or other off-site location, the facility must notify the local health department for guidance on proper precautions during transport. The facility is also required to alert the intended destination so that proper infection control measures may be implemented prior to the UAC's arrival.

28. UAC are required to remain in isolation until cleared by the local health department or DHUC. During this time in isolation, UAC receive the same services as their non-isolated peers in the same facility, although services—particularly education services—may be adjusted to accommodate proper infection-control procedures.

29. Any room, object, or vehicle used by a UAC in isolation is thoroughly sanitized afterwards.[8]

[8] *See* CDC, Disinfecting Your Facility if Someone is Sick, https://www.cdc.gov/coronavirus/2019-ncov/prepare/disinfecting-building-facility.html.

30. To assess whether each grantee care-provider facility has appropriate stores of personal protective equipment ("PPE") to safely respond in the event COVID-19 is detected within their facility, on March 13, 2020, ORR inventoried all care providers for their current levels of PPE (e.g., surgical masks and gowns, face shields, N95 respirators) and cleaning/disinfecting supplies, as well as the number of staff who are involved in cleaning and maintenance activities. Any facility that encounters difficulty maintaining adequate levels of COVID-19 related supplies may request additional stores from FEMA, and ORR may assist in facilitating any such requests.

31. Program staff will provide an affected UAC with notice of the isolation requirement and address questions or concerns the child may have about medical isolation, as well as potential delays to anticipated transfers or discharge plans. In order to protect the health of UAC and the local community, *UAC cannot be transferred either to another facility or released to a sponsor until cleared by local health authorities and DHUC.*

ORR Suspensions of Placements and Releases

32. Beginning on March 9, 2020, ORR stopped placements of UAC on a rolling basis in the states of California, New York, and Washington due to the ongoing outbreaks of COVID-19 among the general public in those states. ORR is continually monitoring the jurisdictions in which its grantee care-provider facilities operate to determine whether the conditions in the community surrounding the facility warrant the suspension of placements due to concerns related to COVID-19.

33. In addition, ORR is prioritizing local placements for all new referrals from DHS in order to limit the need for UAC to travel on commercial airliners, which poses a risk of exposing passengers (including UAC) to COVID-19. Care providers may still use air travel to reunify a UAC with their sponsor if it is safe to do so. However, care providers are required to assess the safety of the UAC's ultimate destination, in order to anticipate logistical issues associated with COVID-19 disruptions. Care-provider facilities are required to consult with their Federal Field Specialist ("FFS"), or delegee, if a UAC will be traveling to a jurisdiction with widespread community transmission of COVID-19 or that is subject to a community-wide "lock down," such as California. In such cases, release should be postponed until it is determined to be safe for the UAC to travel to their destination. This safety assessment includes consideration of the particular UAC's unique medical needs and vulnerabilities, and the UAC's respective medical specialists are consulted in the safety planning process.

34. Prior to the COVID-19 pandemic, ORR was working on a telehealth initiative to increase UAC's access to healthcare resources that may not be physically present in their locality. In light of the state orders restricting the movement of people generally in California, New York, and elsewhere, ORR has rolled out its telehealth capabilities ahead of schedule in numerous jurisdictions in order to ensure care-

provider facilities are able to provide UAC with access to medical care without having to leave their facilities. Those jurisdictions are: California, New York, Connecticut, Maryland, Massachusetts, New Jersey, Pennsylvania, Texas, and Virginia. Further, ORR is awaiting final approval from telehealth providers in Arizona, Florida, Illinois, Michigan, Washington, and Oregon, and anticipates the service will be available in these locations in the near future.

COVID-19 Cases in ORR Grantee Care Provider Facilities

35. As of March 26, 2020, there have been four confirmed COVID-19 cases among UAC across all ORR care-provider facilities. All four cases were in a single facility in New York state, and the affected UAC are currently in isolation, per ORR and CDC guidelines, and are receiving appropriate monitoring and medical care.

36. Currently, 18 UAC in the care-provider network have been tested. As noted, four tested positive for COVID-19, 11 tested negative for COVID-19, and three have test results pending.

37. Pursuant to CDC Guidance, any UAC who has undergone COVID-19 testing is considered presumptively positive until results are available (typically within 3-4 after testing) and are placed in isolation as a precautionary measure.

38. In addition, a total of eight program staff, contractors or foster parents at five care-provider programs across New York, Washington, and Texas have self-reported testing positive for COVID-19. ORR's medical team and the affected programs have worked in close coordination with the local public health departments on appropriate public health measures, which typically involve self-quarantine at home, and the tracking and monitoring of the affected staff members' contacts within the care-provider facility, per CDC guidance.[9]

39. In addition to the COVID-19 protocols described above, care-provider facilities are directed to follow any local requirements issued by the state licensing agency or other local public health authority related to the identification, reporting, and control of communicable diseases that are more stringent than ORR's protocols.

Assessment of Plaintiffs' Assertions

40. In their March 22, 2020 correspondence, Plaintiffs stated that they "are advised that *congregate care is inherently incongruent with the recommendations of the Centers for Disease Control and Prevention*, state health authorities, and epidemiologists, all of whom recommend (if not mandate) social distancing and related safety precautions that are difficult, if not impossible, to observe in facilities

[9] CDC, Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential Coronavirus Disease 2019 (COVID-19) Exposures: Geographic Risk and Contacts of Laboratory-confirmed Cases, https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html.

housing more than ten Class Members." *See* Ltr. from C. Holguin (Ctr. for Human Rights & Const. Law), to D. Shieh (DOJ), dated Mar. 22, 2020, at 2 (emphasis added), attached hereto as "Exhibit A."

41. CDC, however, has issued guidance on COVID-19 containment in various congregate settings, including colleges,[10] nursing homes,[11] prisons,[12] and homeless shelters.[13] ORR has implemented such guidance to the extent that it can be applied to its grantee care-provider facilities. Further, ORR has consulted with CDC regarding ORR's COVID-19 containment and mitigation strategies and has been told by CDC that they are consistent with CDC's recommendations.

42. I have serious concerns about the proposals in Plaintiffs' March 22 correspondence that call for the expedited release of UAC to potential sponsors. In particular, the immediate, blanket release of UAC to sponsors located in jurisdictions with widespread community transmission of COVID-19 would pose a risk to the health and welfare of the UAC. UAC are currently housed in settings where infection control protocols are rigorously enforced. In contrast, upon release, UAC may be exposed to COVID-19 in airports or transit systems, or through sponsors who have been exposed to COVID-19, or through circulation in communities with widespread community transmission of COVID-19.

43. Many sponsors are also located in states that are currently under "lock down" in which residents' freedom of movement has been significantly curtailed in an effort to control the spread of COVID-19, such as California, Washington, and New York. If anything, the current ORR approach is consistent with those "lock down" orders in that UAC are shielded from UAC community transmission.

44. ORR's efforts to safely release UAC to safe, approved sponsors remain ongoing. But Plaintiffs' proposal to release UAC to sponsors who are still undergoing vetting would materially increase the risk of release to a sponsor who potentially cannot or will not shelter in place with the UAC, or who may not adhere to appropriate infection control practices (e.g., social distancing), or who may circulate with the UAC in areas with widespread community transmission of COVID-19, all of which increase the health risks to the UAC. Plaintiffs' proposal would also increase the risk of release to a sponsor who, because vetting has not yet completed, is, or will become unable to financially support the UAC due to COVID-19-related business closures, layoffs, or furloughs.

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[10] CDC, Interim Guidance for Administrators of U.S. Higher Education, https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-ihe-response.html.

[11] CDC, Preventing the Spread of COVID-19 in Retirement Communities and Independent Living Facilities (Interim Guidance), https://www.cdc.gov/coronavirus/2019-ncov/community/retirement/guidance-retirement-response.html.

[12] CDC, Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities, https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html.

[13] CDC, Interim Guidance for Homeless Service Providers to Plan and Response to Coronavirus Disease 2019 (COVID-19), https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/plan-prepare-respond.html.

45. The immediate, blanket release of UAC to sponsors who are still undergoing vetting would also deprive these UAC of access to the significant medical resources of ORR (including testing for COVID-19). Once they leave ORR's care they are limited by the resources of their sponsor's household and local community, at a time when important medical resources may be in short supply.[14]

46. Plaintiffs propose that ORR can expedite the release of UAC to potential sponsors on Plaintiffs' terms while adequately vetting the sponsors for the new child welfare and public health concerns that have arisen in recent months and are continuing to evolve. Plaintiffs, however, do not identify the safeguards that ORR can jettison from the sponsor vetting process without putting UAC at risk.

47. Plaintiffs also overlook the fact that fingerprinting remains a key component for many sponsors in the sponsor vetting process, particularly sponsors who are not parents or close relatives. Such fingerprinting has been affected by the recent closures of some digital fingerprinting sites due to COVID-19.

48. Thirty-nine digital fingerprinting sites in 21 states[15] have, as of March 24, 2020, either closed, curtailed their hours of operation, or switched to an "appointment only" system in response the public health threat posed by COVID-19. Fingerprinting is a key component of the background check process that is needed to fulfill the requirements of the TVPRA and ensure UAC are not released into the custody of sponsors with disqualifying criminal histories, such as convicted human traffickers and pedophiles. Potential sponsors for whom ORR requires fingerprints (including those who are not Category 1 or 2A sponsors)[16] must be able to undergo fingerprinting in order for background checks to be performed.

49. To compensate for the reduced availability of digital fingerprinting, ORR's has directed care providers to automatically mail fingerprint cards to all individuals identified in family reunification applications, so that given limited hours at digital fingerprint locations, potential sponsors are aware of the ability to have fingerprints taken on fingerprint cards, including at a local law enforcement agency. While fingerprint cards are often used, this alternative to digital fingerprinting could take longer for potential sponsors to execute given the additional steps involved, and the reliance on the mail system to transmit the cards.

[14] ORR is aware of one instance in which 3 UAC who were recommended for COVID-19 testing were unable to immediately obtain a COVID-19 test due to the particular community's system for allocating tests among primary care providers. DHUC is monitoring this situation and will intervene as necessary to assure the UAC have prompt access to COVID-19 testing.

[15] Alabama, Arizona, California, Colorado, Florida, Georgia, Illinois, Louisiana, Massachusetts, Maryland, Missouri, North Carolina, Nebraska, New Jersey, New York, Oregon, Pennsylvania, Tennessee, Texas, Virginia, and Washington.

[16] ORR Policy Guide § 2.2.1, https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-2#2.2.1 (defining Category 2A sponsors; Category 1 sponsors are parents or legal guardians; Category 1 and 2A sponsors generally do not require fingerprinting, unless there is a special concern).

50. My opinion is that ORR cannot safely release UAC to sponsors absent vetting that includes the completion of fingerprint-based background checks where required, or other protective measures, such as home studies, which are required in certain instances by the TVPRA. This is especially true during the current public health emergency. The jettisoning of core safeguards in the sponsor vetting process in order to effectuate the immediate release of UAC would expose UAC to not only public health dangers but also material child welfare and safety risks.

51. Plaintiffs also request a full adversarial hearing in order for UAC to challenge failures to (yet) release to individuals applying to be sponsors (including individuals still undergoing vetting). In my opinion, the creation and operation of such an adversarial hearing process during the current public health emergency would require ORR to redeploy federal and grantee staff from program operations, and materially degrade the ability of ORR to conduct sponsor vetting and work with grantee care-provider facilities to maintain appropriate infection control measures and protect the health and safety of UAC at the facilities. My opinion is that to maximize child welfare during the current public health emergency, the federal and grantee staff need to focus on program operations with the goal of releasing UAC to sponsors only when it is safe to do so.

Executed on March 27, 2020.

Jallyn Sualog

Exhibit Q, Attachment A

March 22, 2020 Letter from Plaintiffs' Counsel

CENTER FOR HUMAN RIGHTS AND CONSTITUTIONAL LAW
256 S. OCCIDENTAL BOULEVARD
LOS ANGELES, CA 90057
Telephone: (213) 388-8693 Facsimile: (213) 386-9484
www.centerforhumanrights.org

March 22, 2020

Daniel Shieh
Benjamin Mark Moss
Marina C. Stevenson
Civil Division, Office of Immigration Litigation
United States Department of Justice
P.O. Box 878
Ben Franklin Station
Washington, DC 20044

Via email.

Re: *Lucas R. et al. v. Azar et al*, 2:18-cv-05741-DMG-PLA.

Dear Counsel:

Plaintiffs request that the parties meet and confer tomorrow, March 23, 2020, to explore ways in which the parties may cooperatively address the grave risk that Class Members[1] in the above-referenced action are now facing, or will shortly face, in ORR congregate care facilities as a result of the COVID-19 pandemic and public health national emergency. Absent a cooperative agreement, Plaintiffs will need to file a temporary restraining order ("TRO") immediately seeking relief from the Court, as described below.

Plaintiffs are advised that congregate care is inherently incongruent with the recommendations of the Centers for Disease Control and Prevention, state health authorities, and epidemiologists, all of whom recommend (if not mandate) social distancing and related safety precautions that are difficult, if not impossible, to observe in facilities housing more than ten Class Members.

We accordingly wish to discuss expediting the release of Class Members to available custodians. We, of course, appreciate the need to protect children against abuse or neglect following release, but believe that such risks need to be balanced against the substantial and immediate dangers that children would face as COVID-19 spreads through congregate care facilities. *See* TVPRA, 8 U.S.C. § 1232(c)(2)(A) (requiring ORR "promptly" place detained children "in the least restrictive setting that is *in the best interest of the child*" (emphasis added)).

We are already aware that Class Members have been exposed to COVID-19 at the MercyFirst and Abbott House programs in New York. We have also been informed that ORR has stopped

[1] Class Members include all youth within any of the five classes the Court certified in its order of November 2, 2018 (ECF No. 126), as modified by order entered December 27, 2018 (ECF No. 141).

placing Class Members at numerous other shelters in New York, as well as some in California, Washington, Oregon and Pennsylvania, though we do not know whether Class Members at shelters in these states have likewise been exposed to COVID-19.

As such, it is no longer in the best interest of many, if not all, Class Members to remain housed in congregate care, particularly where recommended and/or mandatory safety precautions are not observed and Class Members' exposure to COVID-19 is highly likely. *See* TVPRA, 8 U.S.C. § 1232(c)(2)(A). During this rapidly expanding and unprecedented public health crisis, Class Members' health and welfare must be paramount, as mandated by the TVPRA and state, local, and national authorities, among others.

We accordingly propose that the parties discuss the following:

1) The steps ORR has taken and is taking to ensure the safety of Class Members in light of the COVID-19 pandemic.

2) Whether, with respect to all members of the "unfit custodian class," as defined in the Court's order of December 27, 2018 (ECF No. 141) ("Unfit Custodian Class Members"), absent good cause based on articulable facts to believe that available custodian(s) would harm or neglect a class member, or that an individual class member presents a current danger to the public, ORR would be amenable to expediting release of all Unfit Custodian Class Members to available custodians who have been vetted and meet the safety threshold noted above, or else place such Unfit Custodian Class Members in non-congregate care.

3) Whether, with respect to Unfit Custodian Class Members whom it fails to release or place in non-congregate care, ORR would be amenable to amending Policy Guide § 2.7.8, *available at* www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-2#2.7 (last visited March 22, 2020), effective immediately, to provide as follows:

> a. All Unfit Custodian Class Members shall have the right of administrative appeal without regard to the degree of family affinity of their available custodians.
>
> b. The Assistant Secretary for Children and Families, or his or her designee, shall afford each administratively appealing Unfit Custodian Class Member —
>
> > i. a reasonable opportunity to examine ORR's evidence and reasons for the Unfit Custodian Class Member's continued detention in advance of any hearing;
> >
> > ii. the right to be represented by counsel;
> >
> > iii. a reasonable opportunity to submit documentary evidence and testimony in support of release;

iv. an opportunity to be heard via teleconference or video conference within five business days of filing an administrative appeal; and

v. a written decision issued no later than three business days following the administrative hearing directing the Unfit Custodian Class Member's immediate release, transfer to non-congregate care, or else setting out the reasons for continued custody and placement in congregate care.

Plaintiffs sincerely hope the parties can work jointly to protect the health and welfare of Class Members under increasingly difficult conditions, but are prepared to pursue all available legal remedies should such cooperation prove unsuccessful. Accordingly, Plaintiffs intend to apply for a TRO and order to show cause re: preliminary injunction by no later than the close of business on March 24, 2020, in the event the parties have not reached an agreement on the above. The requested relief will include all items discussed herein.

Should Defendants decline this invitation to confer, pursuant to Local Rule 7-19, Plaintiffs ask that Defendants advise whether they oppose the application for a TRO.

Thank you,

s/ Carlos Holguín

Carlos Holguín
One of the attorneys for Plaintiffs

Exhibit R

ORR March 2 Field Guidance

DRAFT COVID-19 INTERIM GUIDANCE FOR ORR PROGRAMS

Dear Colleagues –

We are providing interim preparedness and response guidance for coronavirus disease 2019 (COVID-19). This guidance is based on the Centers for Disease Control and Prevention (CDC) recommendations and is adapted for the UAC Program. This is a rapidly evolving situation, and updated guidance may be released in the future, as necessary.

Further guidance on UAC Portal documentation requirements regarding COVID-19 will be distributed in the near future.

Please carefully review the information below, and email DCSMedical@acf.hhs.gov with any questions.

CDC Situation Summary

See: https://www.cdc.gov/coronavirus/2019-ncov/summary.html

An outbreak of respiratory illness caused by a novel (new) coronavirus was first detected in Wuhan City, Hubei Province, China. Tens of thousands of corona virus disease 2019 (COVID-19) cases have been reported in China, with the virus reportedly spreading from person-to-person in parts of the country. Cases of COVID-19, are also being reported in other countries, including the United States. On January 30, 2020, the World Health Organization declared the outbreak a public health emergency of international concern.

Please refer to the CDC website for up-to-date information on COVID-19, including what is currently known about transmission, symptoms, and prevention efforts.
https://www.cdc.gov/coronavirus/2019-ncov/about/index.html

Symptoms of COVID-19
Reported illnesses have ranged from mild symptoms to severe illness. Symptoms may appear 2–14 days after exposure and can include:

- Fever
- Cough
- Shortness of breath

ORR's Division of Health for Unaccompanied Children (DHUC) Response

- DHUC is closely monitoring COVID-19 information and CDC-issued guidance.
- DHUC, in collaboration with the Department of Homeland Security/Customs and Border Protection (DHS/CBP) and the ORR Intakes Team, are monitoring when an unaccompanied alien child from a high-risk location as designated by CDC (see list below) is initially referred to ORR care. Subsequently, DHUC will notify and provide guidance to ORR care providers of those children referred for care and custody. Care providers will notify state and local health departments.

General communicable disease prevention and control measures that are already in place across ORR programs that will aid in COVID-19 response

- All ORR care providers document a child's travel history in the *Initial Intakes Assessment* and the *UAC Assessment*.
- The health of all UAC in care is routinely assessed by a licensed medical provider during the Initial Medical Exam (IME).
- All ORR care providers must have the ability to medically isolate or quarantine a child in a room to prevent contact with other children. Ideally, this room will be linked to a private bathroom.
- All ORR care providers must educate staff and children on hand-hygiene and respiratory etiquette.
- All ORR care providers must routinely have children with respiratory disease (e.g., influenza) wear a mask when not in an isolation room, such as when visiting a healthcare facility.
- All ORR care providers have a designated way to report potentially reportable diseases to their state or local health department. This same reporting structure is used for COVID-19.

COVID-19 Specific Guidance to ORR Care Providers

1. Identification of Risk

- Review jurisdiction-specific COVID-19 guidance from your state or local health department.
- Any child found to be at possible risk for COVID-19 based on travel history or contact with a known case must be flagged to DHUC via email within 4 hours to: DCSMedical@acf.hhs.gov.
- Information on the child's location of origin and travel history. The following UAC Portal data fields are used to help determine the child's epidemiologic risk:
    - *Initial Intakes Assessment*: 1) date of departure from home country; 2) date of arrival in the U.S.
    - *UAC Assessment*: 1) Additional UAC Info Tab - City of Origin, Neighborhood of Origin (be as specific as the child can provide); 2) Journey and Apprehension Tab- When did you leave your home country (month, day, year)? How long did the trip take? How did you get to the U.S.? Who did you travel with?
    - ORR/DHUC should be notified if any child is discovered to have been in one of the following countries in the 14 days prior to entering the United States:
        - China
        - Iran
        - Italy
        - Japan
        - South Korea
        - A current list can be found at this link under, "Affected Geographic Areas with Widespread or Sustained Community Transmission": https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html

2. Response

- If a child is found to be at risk for COVID-19 exposure and does NOT have symptoms of respiratory disease:
    - The child must be placed into a private room with a closed door and access to a bathroom (preferably a private bathroom not used by other staff or children).
    - Notify the state or local health department immediately for additional guidance on risk assessment, symptom monitoring, and quarantine.
    - Notify DHUC immediately via an email to DCSMedical@acf.hhs.gov for additional guidance on risk assessment, symptom monitoring, and quarantine.

- Quarantine must be maintained until the child is cleared by the health department and DHUC.
- The child CANNOT be transferred or discharged until cleared by the health department and DHUC.
- Program staff will provide the child notice of the quarantine requirement and address questions or concerns the child may have about medical isolation, as well as potential delays to anticipated transfers or discharge plans.

- If a child is found to be at risk for COVID-19 and HAS symptoms of respiratory disease:
  - Isolate the child in a negative pressure isolation room. If a negative pressure room is not available, place the child in a private room with a closed door access to a bathroom (preferably a private bathroom not used by other staff or children).
  - Notify the state or local health department immediately for additional guidance.
  - Notify DHUC immediately via an email to DCSMedical@acf.hhs.gov for additional guidance.
  - Personnel entering the room should use standard precautions, contact precautions, airborne precautions (e.g., N95 respirator), and eye protection (e.g., goggles or a face shield).
  - Ensure the child wears a plain surgical mask if he or she leaves the isolation room (e.g., to the bathroom or to go to a medical appointment).
  - If the child must be transported to a health clinic or facility, notify the local health department for guidance. Additionally, call ahead to the medical facility and notify them of the situation. This will ensure they can be ready with the necessary infection control measures.
  - Maintain isolation until cleared by the health department and DHUC.
  - The child CANNOT be transferred or discharged until cleared by the state or local health department and DHUC.
  - Program staff will provide the child notice of the quarantine requirement and address questions or concerns the child may have about medical isolation, as well as potential delays to anticipated transfers or discharge plans.

All CDC guidance can be found at:
https://www.cdc.gov/coronavirus/2019-ncov/index.html

Exhibit S

ORR March 13 Field Guidance

From:
To: ORR DUCO - All Staff
Subject: FW: DHUC Dispatch: Documenting Suspect/Confirmed COVID-19 Patients and Exposures in the UAC Portal
Date: Friday, March 13, 2020 12:31:57 PM
Attachments: COVID-19 Guidance_Initial Medical Exam Documentation_03132020.pdf
COVID-19 Guidance_ Contact Investigation Documentation_03132020.pdf
Importance: High

FYI - The message below was just sent to all programs.

POs – Please forward to your new programs that may not have made it onto the Distribution List yet. Thanks!

_____

From: (ACF)
Sent: Friday, March 13, 2020 12:26 PM
Subject: DHUC Dispatch: Documenting Suspect/Confirmed COVID-19 Patients and Exposures in the UAC Portal
Importance: High

Dear Colleagues,

In response to the COVID-19 pandemic, new fields have been added to the Initial Medical Exam, Medical Complaint and Update Visit forms in the Health tab of the UAC Portal. In addition, a new Contact Investigation form has been created to capture COVID-19 exposures. Please ensure that program staff follow this guidance as correct and complete data is critical in order for ORR to track disease transmission.

Please enter reports into the Health tab based on the following:

- If a minor is suspected of having COVID-19 at the IME because of symptom presentation (fever, cough, shortness of breath) AND an exposure (travel from a country with increased risk and/or contact with a COVID-19 patient), follow the guidance on UAC Portal documentation in the attached document titled ***COVID-19 Guidance: Initial Medical Exam Documentation.***

- If a minor is asymptomatic, but reports travel from or through a country with increased risk within the past 14 days OR a potential exposure to a confirmed COVID-19 patient, follow the guidance for UAC Portal documentation in the attached document titled ***COVID-19 Guidance: Contact Investigation Documentation.*** The document has two sections – Part A covers potential exposures through travel history and/or contact with a non-UAC COVID-19 patient and Part B covers potential exposures to a UAC diagnosed with COVID-19 at your program.

As the COVID-19 pandemic evolves, updated guidance on documentation will be sent to program staff.

Please contact DHUC with questions or concerns, DCSMedical@acf.hhs.gov.

Thank you!

, MPH

Epidemiologist

Office of Refugee Resettlement

Divison of Health for Unaccompanied Children

Mobile #: 2

COVID-19 Guidance: Initial Medical Exam Documentation

If a UAC in ORR custody is suspected of having COVID-19 at the IME due to symptom presentation (fever, cough, shortness of breath) and exposure (travel from a country with increased risk and/or contact with a COVID-19 patient):

1) Enter the UAC's travel history, as reported to the healthcare provider (HCP) performing the initial medical exam (IME), into the field labeled "Travel history (countries visited, date of arrival and departure for each)" in the **History and Physical Assessment** section. Enter each country, including country of origin, and the dates of arrival and departure for each. NOTE: If the minor reported travel history during a previous ORR assessment (e.g., UAC assessment), provide this information to the HCP before the IME begins.

History and Physical Assessment

Vital Signs

T (C°):	39.0	**BP (≥ 3 years):**	112/65	**Ht (cm):**	165
HR:	70	**RR:**	14	**Wt (kg):**	54

Allergies

Allergies reported: ○ No ○ Yes

Vision ≥ 5 years

	Right Eye	Left Eye	Both Eyes
Corrected	20/	20/	20/
Uncorrected	20/20	20/30	20/30

Medical History

Concerns expressed by child or caregiver: ○ No ◉ Yes

Specify concerns: Minor reports cough and feeling feverish for 2 days.

Travel history (countries visited, dates of arrival and departure for each): Minor departed Iran on 3/4/2020 and arrived in Italy on 3/5/2020; departed Italy on 3/7/2020 and arrived in Mexico on 3/7/2020. Traveled through Mexico and arrived in U.S. on 3/9/2020.

2) Document signs/symptoms reported by the UAC or as observed and reported by the ORR care provider or foster parents to the HCP during the exam in the **Review of Systems (ROS)** field. Ensure that the HCP addresses all signs/symptoms reported by the child or caregiver during the IME and obtains an accurate, or best estimate, onset date for each sign/symptom.

Review of Systems and Physical Examination

Review of Systems (ROS):

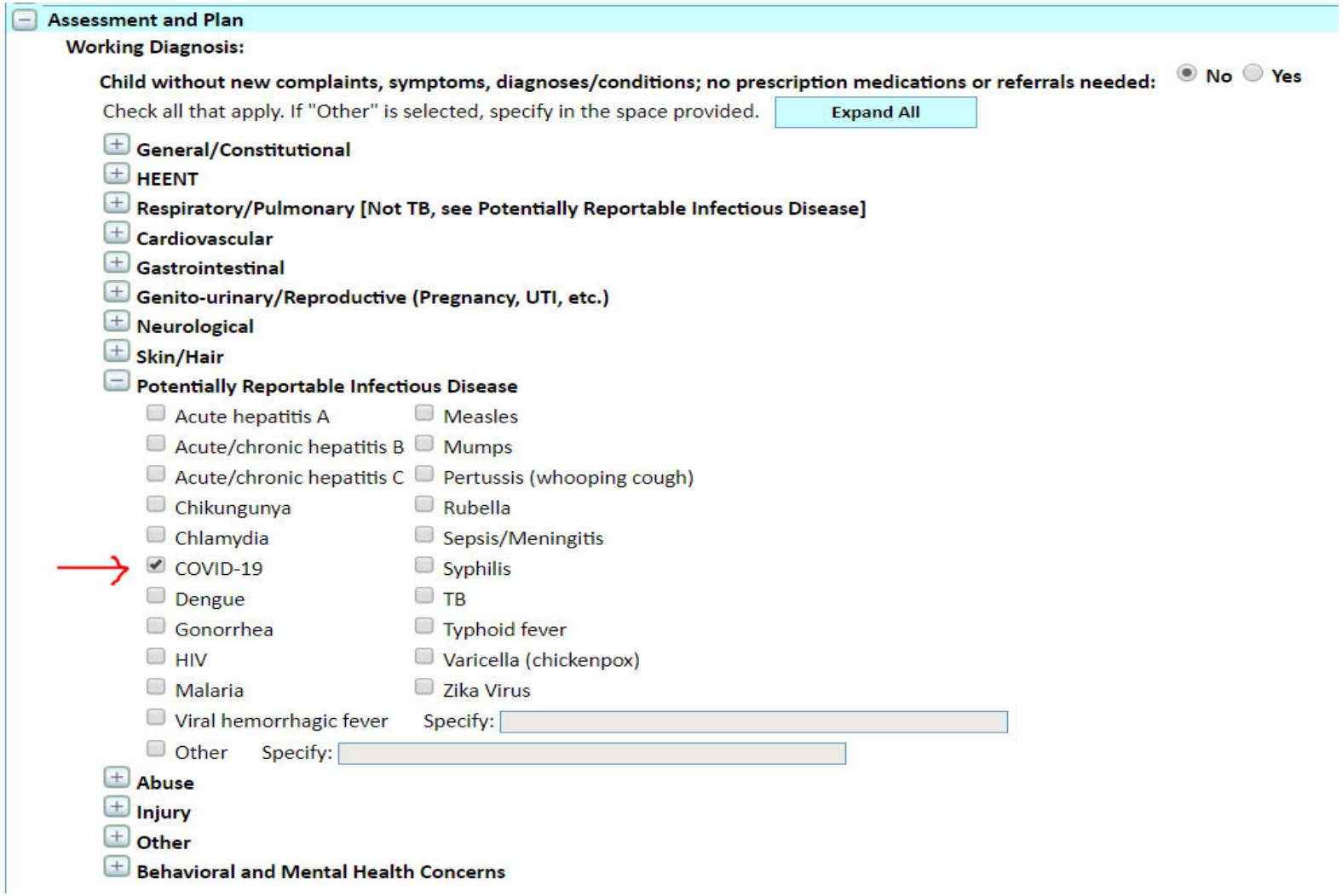
Abnormal findings: ○ No ◉ Yes

Check all applicable signs and symptoms and enter the date for each:

Sign/Symptom	Date	Date Unknown
☑ Fever (>37.8C°), measured temperature: 39.0	3/10/2020	☐
☑ Cough	3/10/2020	☐

3) Check the "COVID-19" option under the "Potentially Reportable Infectious Disease" category in the **Working Diagnosis** field. Do NOT check "Other" and write in different versions of the COVID-19 diagnosis (e.g., R/O Coronavirus, suspect COVID, COVID-19 exposure).

   Select "COVID-19" as a working diagnosis even if the HCP believes it is low on the differential. As with other conditions listed in the "Potentially Reportable Infectious Disease" category, an auto-notification will be sent to DHUC.

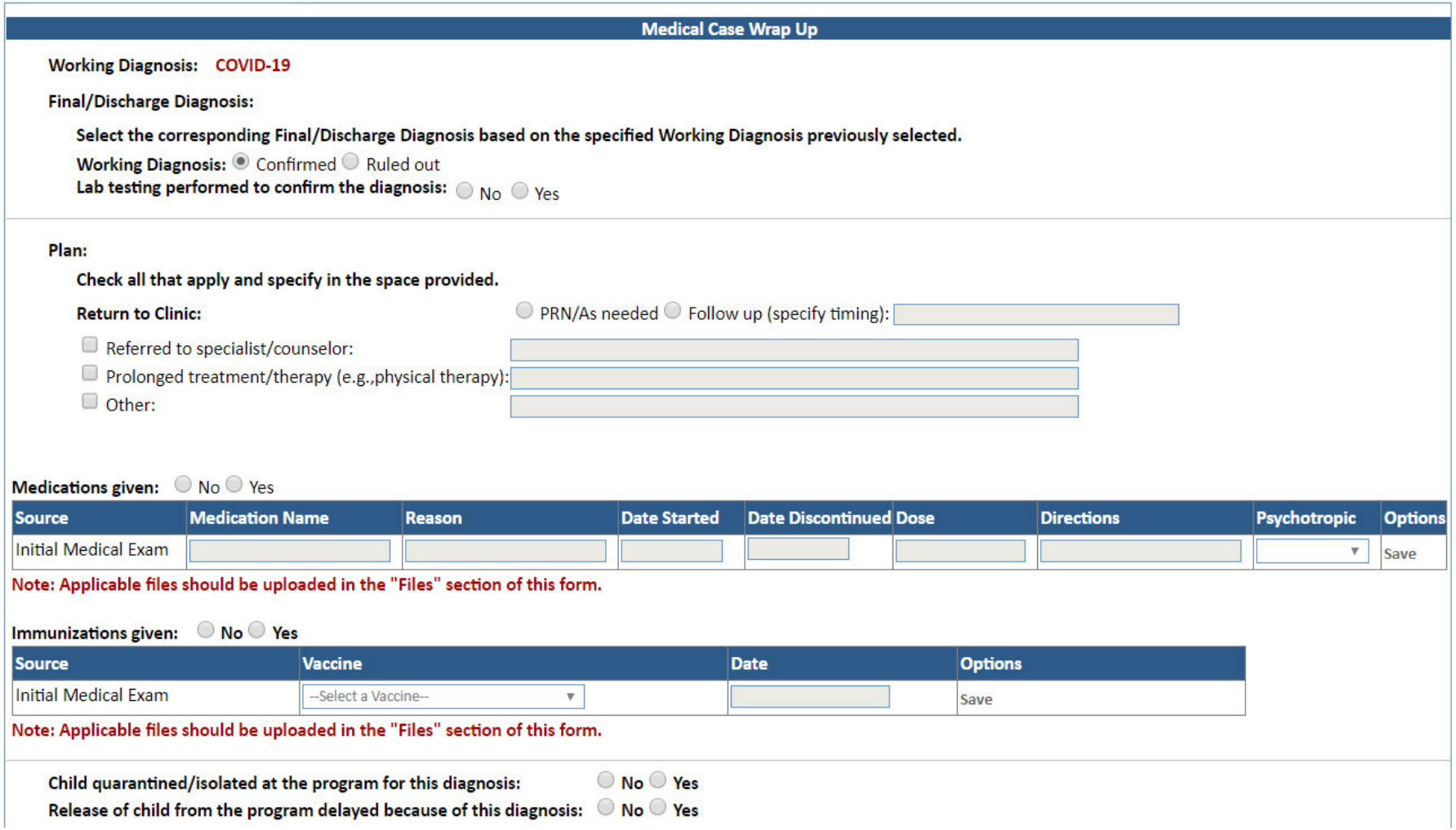


4) Enter all diagnostic testing related to the COVID-19 diagnosis into the **Potentially Reportable Infectious Disease (Non-TB) Lab Testing** section on the day the specimens were collected. Select "COVID-19" from the **Disease Tested** dropdown. Enter the date the specimen was collected and the source. Select "PCR" in the **Test** column. Update the **Result** field from "Pending" once the results come back from the lab. Contact DHUC for assistance with interpreting lab results.

Potentially Reportable Infectious Disease (Non-TB) Lab Testing

Disease Tested	Specimen Date	Specimen Source	Test	Result
COVID-19	3/10/2020	Sputum	PCR	Pending
COVID-19	3/10/2020	Nasopharyngeal (NP) or Throat	PCR	Pending

5) If DHUC concurs that the lab results validate the COVID-19 diagnosis, confirm the diagnosis in the **Case Wrap-Up** panel. Enter the plan details, medications, and public health interventions (e.g., quarantine/isolation, delayed discharge). Notify DHUC if a child's discharge is delayed for any health reason, including COVID-19. If the lab results are negative, contact DHUC for guidance on documentation requirements, DCSMedical@acf.hhs.gov.



Medical Case Wrap Up

Working Diagnosis: COVID-19

Final/Discharge Diagnosis:

Select the corresponding Final/Discharge Diagnosis based on the specified Working Diagnosis previously selected.

Working Diagnosis: ◉ Confirmed ○ Ruled out

Lab testing performed to confirm the diagnosis: ○ No ○ Yes

Plan:

Check all that apply and specify in the space provided.

Return to Clinic: ○ PRN/As needed ○ Follow up (specify timing):

☐ Referred to specialist/counselor:

☐ Prolonged treatment/therapy (e.g.,physical therapy):

☐ Other:

Medications given: ○ No ○ Yes

Source	Medication Name	Reason	Date Started	Date Discontinued	Dose	Directions	Psychotropic	Options
Initial Medical Exam								Save

Note: Applicable files should be uploaded in the "Files" section of this form.

Immunizations given: ○ No ○ Yes

Source	Vaccine	Date	Options
Initial Medical Exam	--Select a Vaccine--		Save

Note: Applicable files should be uploaded in the "Files" section of this form.

Child quarantined/isolated at the program for this diagnosis: ○ No ○ Yes

Release of child from the program delayed because of this diagnosis: ○ No ○ Yes

6) A confirmed COVID-19 diagnosis will generate an **Illness of Public Health Concern** panel in which public health interventions and potentially exposed UAC contacts should be entered. Click on the Edit icon in the **Options** column.

Illness of Public Health Concern

Disease	Health Department Notified	Number of Exposures	Options
COVID-19			

7) Complete the top three questions on "public health interventions" – Health department notification, number of staff exposed, and delayed/postponed discharge. If other UACs were exposed to the UAC patient, enter a Contact Investigation report for each. Refer to part B of the document titled, ***COVID-19 Guidance: Contact Investigation Documentation*** for detailed instructions. NOTE: Notify DHUC before intakes is stopped for a health-related reason.

Illness of Public Health Concern

Disease: COVID-19

Health department notified by program: No Yes

Number of staff members exposed to case:

Intakes delayed/postponed because of this diagnosis: No Yes

Exposures Add New

Click the 'Add New' button to add a Contact Investigation report for each UAC who was potentially exposed

A#	First Name	Last Name	Outcome of Contact Investigation	Contact Investigation

Clusters

Cluster ID	A#	First Name	Last Name
748	999888777	WarrenTest1	FAKE

>| Save >| Cancel

8) Upload all documentation (e.g., office notes, lab results) to the **Files** section of the report. Be specific in the "File Name" field, select the corresponding "File Type" and enter relevant details in the "File Description" field. NOTE: Remove commas from the document's name before uploading to the UAC Portal.

Files

Date Uploaded	File Name	File Type	File Description	Option
3/11/2020	COVID-19 Lab Results	Lab result	Specimens collected March 10th, 2020	View Delete

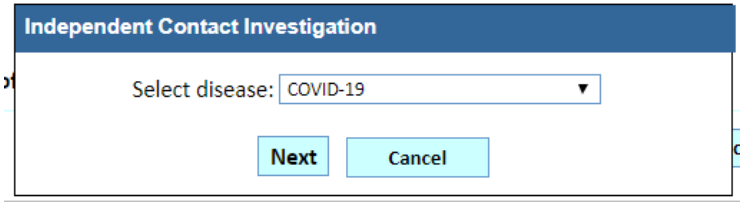
>| Upload File

COVID-19 Guidance: Contact Investigation Documentation

A. Asymptomatic UAC potentially exposed to COVID-19 through travel from or through a country with widespread or ongoing transmission of COVID-19 within the past 14 days or through contact with a non-UAC COVID-19 patient:

1) On the UAC Health screen, click on the "+" sign next to the **Contact Investigations** header to expand the section. Click on the "Add New" button.

2) Select "COVID-19" from the **Disease** dropdown and click on the "Next" button.



3) Complete all fields in the Contact Investigation form. Specify the source of exposure in the field "Relationship to case":
   - If the minor travelled from or through a country with widespread or ongoing transmission of COVID-19 within the past 14 days, type "Travel history includes a country at risk for COVID-19 exposure" exactly as written and enter the country name in parentheses. For example, "Travel history includes a country at risk for COVID-19 exposure (Italy)".
   - If the minor was potentially exposed to a confirmed COVID-19 patient who was not a UAC in your program, enter "Contact with a non-UAC COVID-19 patient" and enter the relationship in parentheses. For example, "Contact with a non-UAC COVID-19 patient (program staff member)".

- If the minor was potentially exposed through travel and contact with a non-UAC COVID-19 patient, write both of the above statements and separate with a semi-colon. For example, "Travel history includes a country at risk for COVID-19 exposure (China, Iran); Contact with a non-UAC COVID-19 patient (foster parent)".

In the field "Date of first exposure to case", enter the **LAST** date of exposure to the country with widespread or ongoing transmission/COVID-19 patient. For quarantine purposes, it is important to capture the day of last exposure. Enter medications, immunizations, lab testing, and public health interventions (e.g., quarantine, delayed discharge).

The field, "Outcome of ORR contact investigation" has four options – *Pending, Cleared, Incomplete evaluation*, and *Diagnosed with illness*. Select based on the following:

- *Pending*: Minor is in quarantine.
- *Incomplete evaluation*: Minor is lost to follow-up prior to the end of the quarantine period (e.g., runaway, picked up by ICE).
- *Cleared*: Minor remained asymptomatic for the entirety of the quarantine period and has been medically cleared by the health department and DHUC.
- *Diagnosed with illness*: Minor developed related signs/symptoms and was diagnosed with COVID-19. A Medical Complaint must also be entered to capture the COVID-19 diagnosis and potential exposures. Refer to steps 2 through 7 in the document, ***COVID-19 Guidance: Initial Medical Exam Documentation*** for detailed instructions. NOTE: An auto-notification will be sent to DHUC.

Remember to update the "Outcome of ORR contact investigation" with the final outcome (i.e., the Outcome should not be left as *Pending*).

COVID-19 Contact Investigation

Relationship to case: Travel history includes a country at risk for COVID-19 exposure (Italy)

Date of first exposure to case: 03/11/2020

Medications given: ○ No ○ Yes

Source	Medication Name	Reason	Date Started	Date Discontinued	Dose	Directions	Psychotropic	Options
Initial Medical Exam								Save

Note: Applicable files should be uploaded in the "Files" section of this form.

Immunization given: ○ No ○ Yes

Source	Vaccine	Date	Options
Contact Investigation	--Select a Vaccine--		Save

Note: Applicable files should be uploaded in the "Files" section of this form.

Lab testing performed? ○ No ○ Yes

Disease Tested	Specimen Date	Test Name	Result	Options
--Select a Disease--		--Select a Test--	--Select a Result--	Add

Note: Applicable files should be uploaded in the "Files" section of this form.

Actions Taken

Was child quarantined? ○ No ● Yes

If quarantined, was discharge delayed? ○ No ○ Yes

Outcome of ORR contact investigation: Pending

(Note: If this child was diagnosed with the illness or developed related symptoms, a Medical Complaint must be entered.)

>| Save >| Cancel

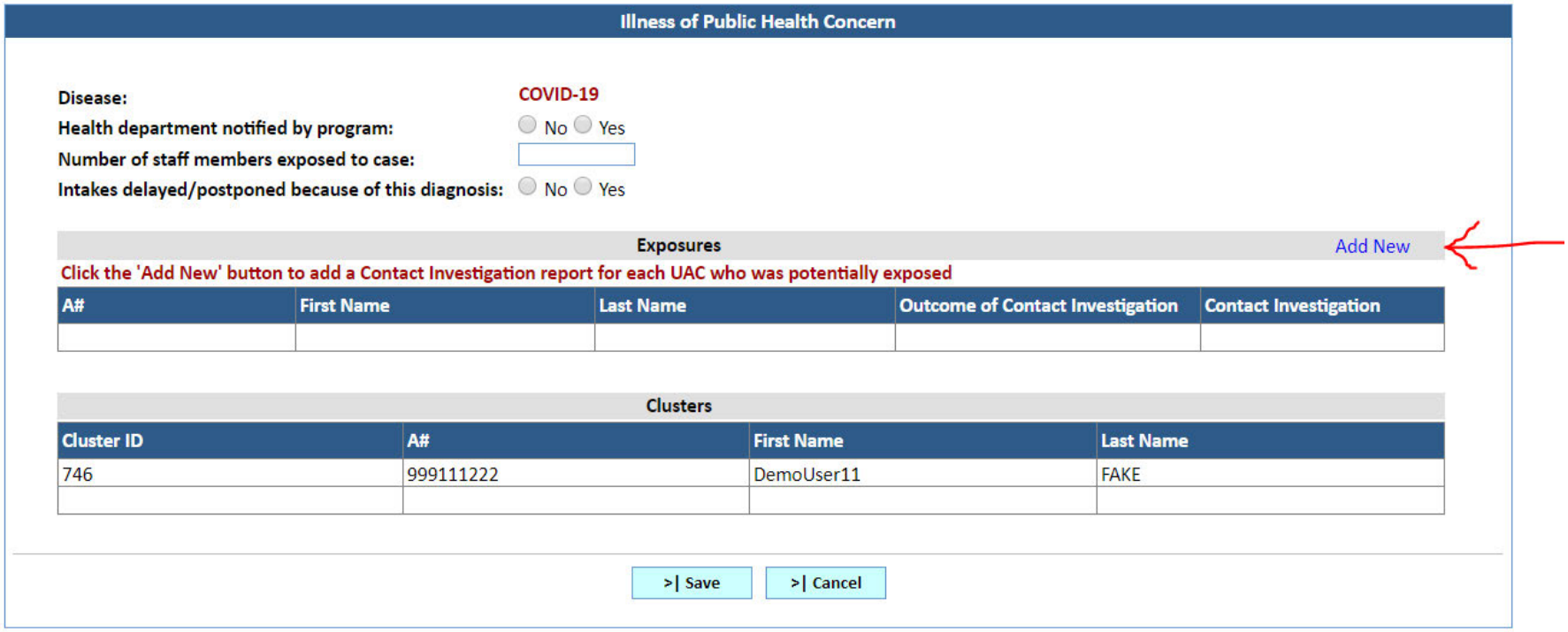
B. Asymptomatic UAC potentially exposed to a UAC with COVID-19 in your program:

1) If other UACs were potentially exposed to a UAC-patient with confirmed COVID-19, enter the contacts through the COVID-19 patient's **Illness of Public Health Concern** panel in the IME. Click on the Edit icon in the **Options** column to open the panel.

Illness of Public Health Concern

Disease	Health Department Notified	Number of Exposures	Options
COVID-19			

2) Add a contact by clicking the "Add New" link in the **Exposures** header. NOTE: Discharged UAC who are identified as potentially exposed can be entered up to 45 days after release/transfer.



Illness of Public Health Concern

Disease: COVID-19

Health department notified by program: No Yes

Number of staff members exposed to case:

Intakes delayed/postponed because of this diagnosis: No Yes

Exposures Add New

Click the 'Add New' button to add a Contact Investigation report for each UAC who was potentially exposed

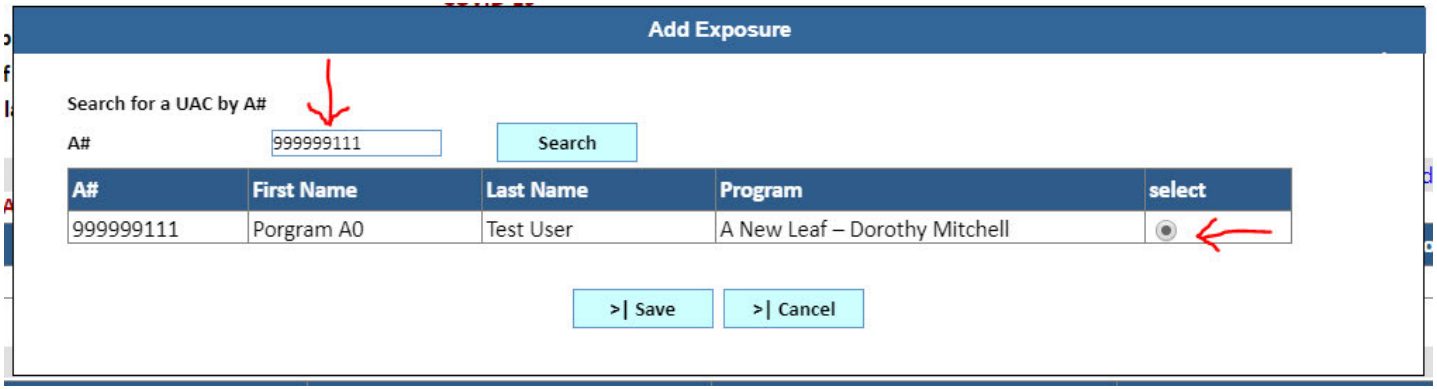
A#	First Name	Last Name	Outcome of Contact Investigation	Contact Investigation

Clusters

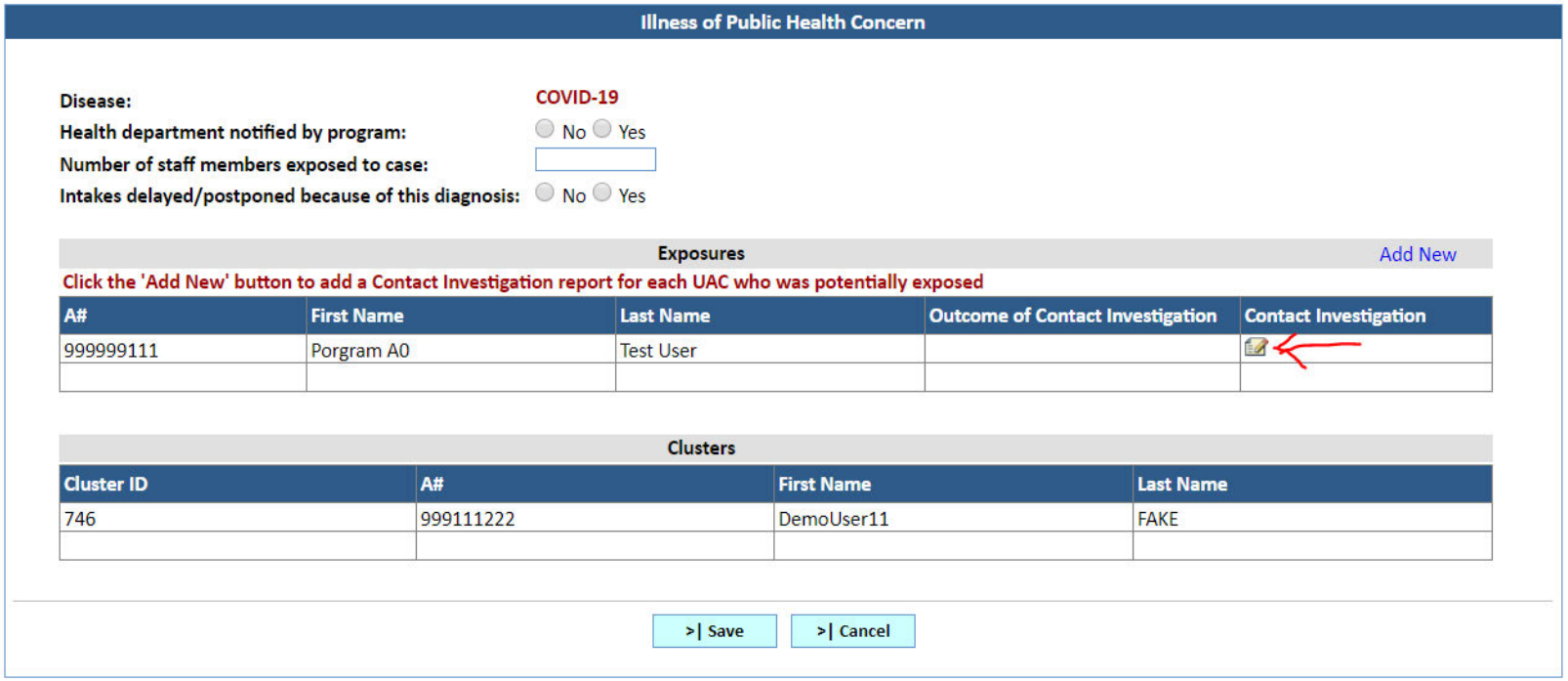
Cluster ID	A#	First Name	Last Name
746	999111222	DemoUser11	FAKE

>| Save >| Cancel

3) Enter the minor's A# and click on the "Search" button. When the correct minor displays, click on the circle in the **Select** column and click the "Save" button. Repeat this step for every contact.



4) After all contacts have been added, click on the Edit icon in the **Contact Investigation** column of the first contact to display the Contact Investigation form.



5) Complete the entire form. Enter the "Relationship to the case" while at your program. In the field "Date of first exposure to case", enter the **LAST** date of exposure to the country with widespread or ongoing transmission/COVID-19 patient. For quarantine purposes, it is important to capture the day of last exposure. Enter medications, immunizations, lab testing, and public health interventions (e.g., quarantine, delayed discharge).

   The field, "Outcome of ORR contact investigation" has four options – *Pending, Cleared, Incomplete evaluation*, and *Diagnosed with illness*. Select based on the following:

   - *Pending*: Minor is in quarantine.
   - *Incomplete evaluation*: Minor is lost to follow-up prior to the end of the quarantine period (e.g., runaway, picked up by ICE).
   - *Cleared*: Minor remained asymptomatic for the entirety of the quarantine period and has been medically cleared by the health department and DHUC.
   - *Diagnosed with illness*: Minor developed related signs/symptoms and was diagnosed with COVID-19. A Medical Complaint must also be entered to capture the COVID-19 diagnosis and potential exposures. Refer to steps 2 through 7 in the document, ***COVID-19 Guidance: Initial Medical Exam Documentation*** for detailed instructions. NOTE: An auto-notification will be sent to DHUC.

   Remember to update the "Outcome of ORR contact investigation" with the final outcome (i.e., the Outcome should not be left as *Pending*). NOTE: The Contact Investigation report can be accessed through the contact's UAC Health screen and the COVID-19 patient's Illness of Public Health Concern panel.

COVID-19 Contact Investigation

ID of cluster child could potentially become part of: 746
Relationship to case: Roommate
Date of first exposure to case: 3/11/2020
View index case's report: View

Medications given: ○ No ○ Yes

Source	Medication Name	Reason	Date Started	Date Discontinued	Dose	Directions	Psychotropic	Options
Initial Medical Exam								Save

Note: Applicable files should be uploaded in the "Files" section of this form.

Immunization given: ○ No ○ Yes

Source	Vaccine	Date	Options
Contact Investigation	--Select a Vaccine--		Save

Note: Applicable files should be uploaded in the "Files" section of this form.

Lab testing performed? ○ No ○ Yes

Disease Tested	Specimen Date	Test Name	Result	Options
--Select a Disease--		--Select a Test--	--Select a Result--	Add

Note: Applicable files should be uploaded in the "Files" section of this form.

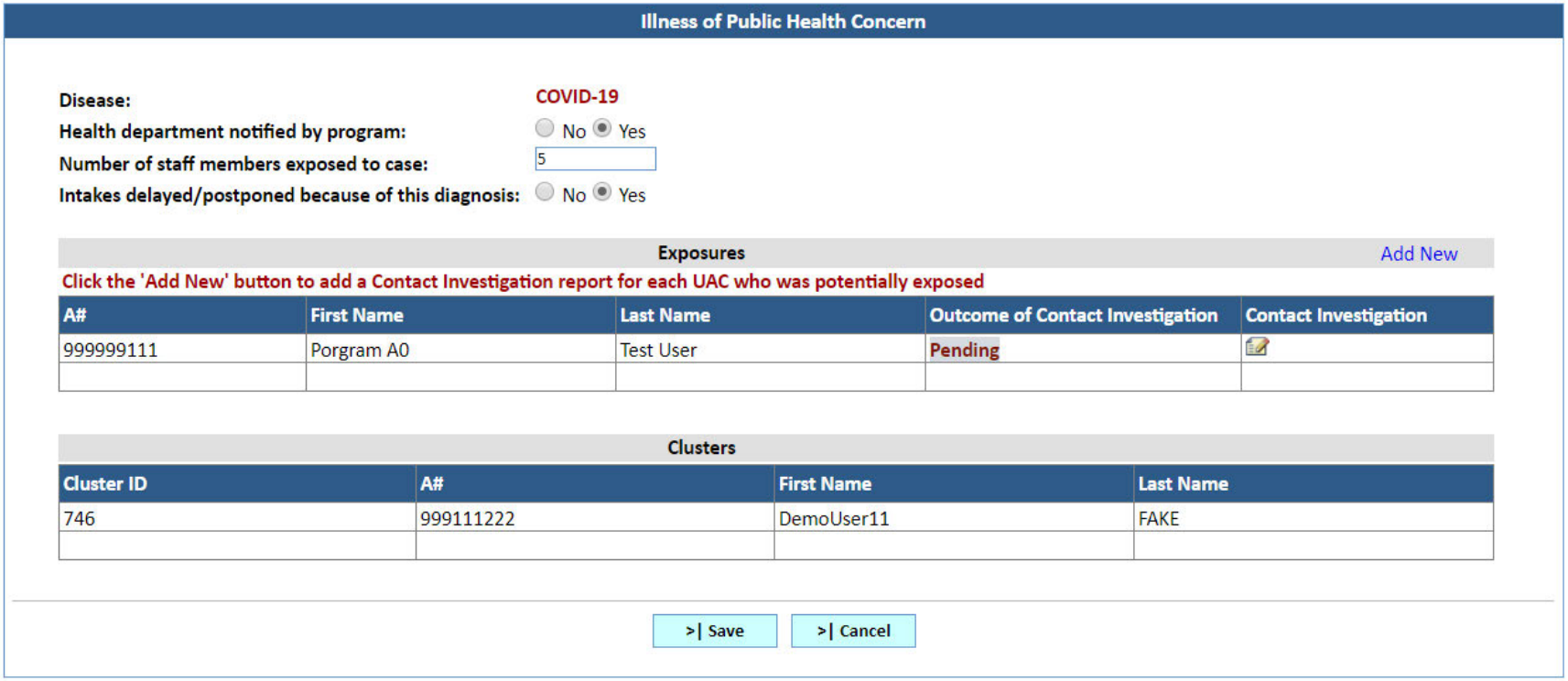
Actions Taken

Was child quarantined? ○ No ◉ Yes
If quarantined, was discharge delayed? ○ No ○ Yes

Outcome of ORR contact investigation: Pending
(Note: If this child was diagnosed with the illness or developed related symptoms, a Medical Complaint must be entered.)

>| Save >| Cancel

6) After saving the Contact Investigation report, the system will automatically return to the COVID-19 patient's **Illness of Public Health Concern** panel. Complete the Contact Investigation form for each contact, answer the Health Department notification, number of exposed staff (if known), and delayed/postponed intakes fields at the top of the panel and click the "Save" button. NOTE: Notify DHUC before intakes is stopped for a health-related reason.



Illness of Public Health Concern

Disease: COVID-19
Health department notified by program: ○ No ◉ Yes
Number of staff members exposed to case: 5
Intakes delayed/postponed because of this diagnosis: ○ No ◉ Yes

Exposures Add New

Click the 'Add New' button to add a Contact Investigation report for each UAC who was potentially exposed

A#	First Name	Last Name	Outcome of Contact Investigation	Contact Investigation
999999111	Porgram A0	Test User	Pending	

Clusters

Cluster ID	A#	First Name	Last Name
746	999111222	DemoUser11	FAKE

>| Save >| Cancel

Exhibit T

ORR March 13 Guidance on PPE Capacity

From: UAC_COVID-19 (ACF)
Subject: RESPONSE REQUIRED: Personal protective equipment capacity for COVID-19 preparedness
Date: Friday, March 13, 2020 7:22:42 PM
Attachments: PPE_Capacity_v20200313_Final.xlsx
Importance: High

Dear Colleague –

As one step in the continued preparation and response to the COVID-19 pandemic, please take the time to evaluate your program's supply of personal protective equipment, sanitation supplies, and the number of staff who might be required to use them. Please use the attached spreadsheet (columns A through Z) to return this information about your program to ORR **by close of business on TUESDAY, March 17th.**

We know that many programs might have their own method of tracking this information, but we aim to use this information to better support programs.

Thank you for your continued efforts in protecting unaccompanied children and yourselves from COVID-19.

Unaccompanied Children Programs
Office of Refugee Resettlement
Administration for Children and Families
U.S. Department of Health and Human Services

Exhibit U

ORR March 19 Field Guidance

From: UAC Policy (ACF)
Subject: ORR FIELD GUIDANCE: COVID-19
Date: Thursday, March 19, 2020 4:19:03 PM
Attachments: UAC Temperature Tracker.xlsx

The below message was just sent to the UAC Care Provider Network.

Dear ORR Care Provider:

ORR is issuing additional field guidance to all programs to take proactive measures and limit the spread of COVID-19. Effective immediately and until further notice ORR requires care providers to:

- **Take two (2) temperature checks of each child in their care daily (once in the morning and once in the evening), following appropriate thermometer disinfection and infection control procedures between each use.** Care providers must document children's temperatures in a master census temperature report to be updated twice daily. ORR recommends you maintain a spreadsheet or hard copy document with UAC's name, A# and dates which captures the child's temperature twice daily.

  Separately care providers report fevers to ORR Intakes at **Orrducs_Intakes@acf.hhs.gov**, **only** if a child has a temperature of 100° or above, and daily there after until no child(ren) have a temperature of 100° or above using the attached *UAC Temperature Tracker* spreadsheet. Care providers must password protect the *UAC Temperature Tracker* using the standard password when submitting the spreadsheet to ORR Intakes.

  If a child has a temperature above 100°, please also follow guidelines provided in the March 13th *COVID-19 Interim Guidance for ORR Programs* by submitting the "INTERIM COVID-10 Acute Respiratory Disease Transfer and Discharge Tracker".

- **Require any staff member or visitor to the care provide facility to undergo mandatory temperature checks prior to entering the facility.**

- **Further, ORR care providers are prohibited from allowing entry of any individual (except UAC in the process of admission) who meet any of the following criteria:**
  - A fever of above 100° or above;
  - Signs of symptoms of an acute respiratory infection, such as a cough, shortness of breath;
  - In the previous 14 days has had contact with someone with a confirmed diagnosis of COVID-19; is under investigation for COVID-19; or
  - In the previous 14 days has travelled internationally to countries with widespread, sustained community transmission. For updated information on affected countries, visit: https://www.cdc.gov/coronavirus/2019-nCoV/travelers/index.html

  If your state licensing agency or other health authority has more restrictive requirements please follow the state or locality requirements. However, please report those restrictions to your ORR Project Officer as soon as possible.

Your first master census temperature report must be created today. If you anticipate any problems please immediately contact your ORR Project Officer. Remember you are only required to submit the *UAC Temperature Tracker* if a UAC in your care has a fever of 100° or above.

Thank you for your cooperation during this rapidly evolving time. Your assistance is vital to containing COVID-19 and protecting children, staff, and their families.

Exhibit V

ORR March 20 Field Guidance

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of Refugee Resettlement | 330 C Street, S.W., Washington, DC 20201
www.acf.hhs.gov/programs/orr

Frequently Asked Questions for Office of Refugee Resettlement (ORR) Programs Related to COVID-19

Updated: March 20, 2020

Personnel:

Q1: May grant funds be used to pay for unscheduled leave taken by grantee care provider (or sub-recipient) staff?

A1: Yes, if the grantee's (or sub-recipient's) written internal policies and procedures allow for such unscheduled leave, when paid from all funding sources (both Federal and non-Federal). If a formal policy is not in place, then the grantee should adopt one as soon as possible. The policy(ies) should be in compliance generally with 45 CFR Part 75, but more specifically with 45 CFR 75.402-404 (reasonable and allowable costs); 45 CFR 75.432 Compensation – fringe benefits, and 45 CFR 75.437 Employee health and welfare costs.

Q2: Should care provider staff be asked to use their personal leave if they have contracted or been exposed to COVID-19?

A2: If the employee reasonably believes they have contracted or been exposed to COVID-19, ORR strongly recommends that they should NOT be required to use personal leave, but may qualify under your policies for sick or other leave and continue to be paid as normal, consistent with those policies, in order to avoid exposure to the virus. Leave policies should be in compliance generally with 45 CFR Part 75, but more specifically with 45 CFR 75.402-404 (reasonable and allowable costs); 45 CFR 75.432 Compensation – fringe benefits, and 45 CFR 75.437 Employee health and welfare costs.

Q3: Will care providers pay the employee if their illness is COVID-19 associated (diagnosed or exposed)?

A3: Yes, if the individual tests positive or remains quarantined due to COVID-19 exposure. If they are tested and are sick from another illness, appropriate sick or other leave must be used. Again, leave policies should be in compliance generally with 45 CFR Part 75, but more specifically with 45 CFR 75.402-404 (reasonable and allowable costs); 45 CFR 75.432 Compensation – fringe benefits, and 45 CFR 75.437 Employee health and welfare costs.

Q4: How long may grantee staff be paid if quarantined?

A4: Currently, ORR recommends paying quarantined staff for the CDC recommendations or for as long as a doctor recommends.

Q5: May care providers pay their staff overtime during this period?

A5: Yes, the care provider must contact their ORR Project Officer and Grants Management Specialist if they need to move funds in order to compensate staff for overtime.

Unification:

Q6: Are care providers able to fly unaccompanied alien children (UAC) for reunification, or should ground transportation be utilized?

A6: At this time, care providers may still use air travel for the purpose of unifying a child with their sponsor. Before traveling, please assess the safety of the locations the minors will be traveling to. If there is a known exposure risk or a community lockdown, please work with your Federal Field Specialist (FFS) to postpone release until it is safe for the minor to travel[1]. At the time of this writing, the White House and the Centers for Disease Control and Prevention (CDC) have not issued domestic travel restrictions within the United States. Please review the latest recommendations and guidance on the CDC's website: https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html.

Q7: May care providers reduce the number of staff who escort UACs who are unifying with their sponsors?

A7: Yes, programs may reduce the number of staff who escort children on flights, as long as the ratio is reasonable. Per ORR Policy Guide 3.3.14, to the greatest extent possible under the circumstances, when transporting UAC, care providers will assign transport staff of the same gender as the child or youth. Additionally, the CDC is not recommending individuals to self-quarantine unless exposed directly to COVID-19 per the following guidance: https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html. Care providers may also use the CDC's risk assessment guidance as a resource when arranging travel for UACs who are unifying with their sponsors: https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html and https://www.cdc.gov/coronavirus/2019-ncov/community/index.html

Q8: Is there any flexibility on the requirement to physically transfer custody of a UAC to a sponsor within 3 days of an approved release?

A8: To the greatest extent possible, care providers should secure transportation for the child within 3 days after ORR approves release. However, if care providers are having issues securing transportation or finding an escort for the reunification, care providers must make a concerted effort to release the child as close to the required time frames as possible, and also note the reasons for the delay in relevant documentation. Alternatively, sponsors can also make arrangements to pick a UAC up directly from the care provider. Please assess the safety of the locations the minor will be traveling to before releasing the minor to their sponsor. If there is a known exposure risk or a community lockdown, please work with your FFS to postpone release until it is safe for the minor to travel.

Services:

Q9: Will care providers still be held to the mandated timeline for certain services (i.e., an initial medical exam within 48 hours), or will there be flexibility given the strain of resources in some communities and programs during this crisis?

A9: To the greatest extent possible, care providers should meet service requirements within ORR's required time frames. However, if constraints on resources and staffing prevent care providers from meeting the timelines for all services, care providers must make a concerted effort to meet the

[1] As outlined in 45 CFR Part **410.301**(a) "ORR releases a UAC to an approved sponsor without unnecessary delay, but may continue to retain custody of a UAC if ORR determines that continued custody is necessary to ensure the UAC's safety or the safety of others, or that continued custody is required to secure the UAC's timely appearance before DHS or the immigration courts."

requirements as close to the required time frames as possible, and also note the reasons for the delay in relevant documentation.

Q10: Can Transitional Foster Care programs provide gift cards to compensate Foster Parents for the cost of the meals and snacks that children would normally eat during school hours?

A10: It is ORR's responsibility to bear the cost of care for UAC. Keeping this in mind, care providers should renegotiate the rate at which they pay the foster parents to include the additional meals. Because the duration of these events is unknown at this time, an alternative approach is for care providers to set up a system by which foster parents can request reimbursement from the care provider for the additional meals, and the care provider can subsequently request reimbursement from ORR for these amounts.

In addition, for awareness, USDA is helping school districts across the country set up meal distribution sites where children can pick up meals and take them home. Grantees may encourage foster parents to call their local school district office or social services agency to find out about options available in their area.

Q11: If necessary, can care providers provide remote case management and clinical services through telephone or video conferencing?

A11: Yes, case managers and clinicians may provide remote case management and clinical services, as long as the care provider has that functionality in place. If a minor is in a crisis/emergency situation, the program is expected to provide face to face intervention.

Q12: Can Legal Service Providers (LSPs) provide legal services through telephone or video conferencing?

A12: Yes, LSPs may use telephone or video conferencing to provide services to UACs. Care providers should work in coordination with the LSPs to assure the continuity of legal services as a mission critical requirement to UAC.

Q13: Can care providers still take UACs on community outings at this time?

A13: At this time, care providers should generally avoid taking children to public spaces and should review current guidance and recommendations of "social distancing" by the White House, CDC, and state/local governments. Note: Providers must ensure minors are still going outside for exercise and fresh air as long as shelters are able to maintain social distancing. See CDC's recommended guidance: https://www.cdc.gov/coronavirus/2019-ncov/community/index.html and the White House's recommended guidance: https://www.whitehouse.gov/wp-content/uploads/2020/03/03.16.20_coronavirus-guidance_8.5x11_315PM.pdf

Q14: How long can UACs in TFC and LTFC programs remain out of school? If programs are not prepared for virtual learning are any budget modifications allowed to allow programs to obtain the necessary equipment?

A14: Care providers should follow the educational guidance of their local communities (following recommendations provided by state/local governments, or the local board of education). At this time, if care providers require modification of their budgets to add provisions for interim educational services, they must contact their ORR Project Officer as soon as possible.

Medical:

Q15: Will assistance be available for maintaining inventory of Personal Protective Equipment (PPE), if necessary?

A15: Programs should use all commercial resources available to them to maintain an appropriate inventory of PPE, while keeping in mind the nationwide shortage for these materials. If all other efforts have been exhausted, programs should contact the following email, UAC_COVID-19@acf.hhs.gov and the response team will attempt to assist with PPE shortfalls.

Q16: If a UAC is hospitalized, should the program still visit the child in the hospital?

A16: Staff should follow the hospital's visitation protocols and their state licensing requirements. If the hospital prohibits visitors, the care provider should be checking in with the UAC by telephone every day and connecting with supervising medical staff on a regular basis.

Staffing and Supervision:

Q17: If many staff are absent due to illness, quarantine, or issues with their own childcare, to the point where they do not meet ORR minimum staffing ratios, what should the program do?

A17: If a care provider is at risk of not maintaining required staff supervision ratios, please contact your assigned ORR Project Officer immediately to discuss next steps.

Q18: To ease any staffing or supervision shortfalls, if a care provider has multiple programs in one concentrated area, can they consolidate children in one shelter, as long as it meets licensing requirements?

A18: Yes, as long as the care provider still meets state licensing requirements. The care provider should contact their ORR Project Officer, FFS, and the Intakes team to discuss.

Q19: Will ORR consider paying for grantee employees' personal child care while they are working?

A19: No, ORR cannot compensate grantee employees for their personal child care expenses.

Exhibit W

ORR March 20 Stop Placement

From: @Vera.org>
Sent: Friday, March 20, 2020 3:27 PM
To:

Subject: RE: COVID-19 Stop Placements

Dear
Thank you for sharing. We will share with our subcontractors.
On the call we were told there was a stop placement for Washington, New York and California. I see a number of other sites outside of those states on the list below but I assume that is a safeguard given the social distancing best practice and the conditions at the program (not because of suspected infection at those sites). Is that correct?
We see Canaan New York on the list. Is that operational? We had not yet been informed they were up and running.
Thank you,

From: @acf.hhs.gov>
Sent: Friday, March 20, 2020 11:08 AM
To: @Vera.org>; Vera.org>; @Vera.org>; @Vera.org>; @vera.org>
Cc:

Subject: COVID-19 Stop Placements

*** PLEASE NOTE: EXTERNAL EMAIL ***

Good Afternoon All:
Hope all is well. Please see the below stop placements in place as discussed in the earlier email correspondence related to COVID-19:

Regards,

Program Name	Location	Bed Type	Date of Stop Placement
Alba Care Services	El Centro CA	TFC	3/9/2020
Alba Care Services	Moreno Valley	TFC	3/9/2020
BCS Modesto	Modesto, CA	TFC	3/9/2020
BCFS Fairfield (Staff Secure)	Fairfield CA	Staff Secure	3/9/2020
Crittenton	Fullerton, CA	LTFC	3/9/2020
Crittenton	Fullerton, CA	Shelter	3/9/2020
David & Margaret	La Verne, CA	LTFC	3/9/2020
David & Margaret	La Verne, CA	Shelter	3/9/2020
Friends of Youth	Renton, WA	Staff Secure	3/9/2020
Friends of Youth	Renton, WA	LTFC	3/9/2020
SWK Pleasant Hill	Pleasant Hill, CA	Shelter	3/9/2020
Urban Strategies Paz Naz	Pasadena, CA	TFC	3/9/2020
Morrison Shelter	Portland, OR	Shelter	3/13/2020
Rites of Passage Sycamore	Oracle, AZ	Shelter	3/16/2020
LSS NY	Bronx, NY	TFC	3/16/2020
LSS NY Safe Haven 2	Bronx, NY	TFC	3/16/2020
LSS of New York - Shelter	Bronx, NY	Shelter	3/16/2020
Bethany Helping Hands	Womeldorf, PA	Shelter	3/18/2020
Urban Strategies Maranata	Waco, TX	TFC	3/18/2020
Mercy First	Syossett, NY	Shelter	3/19/2020
Mercy First	Syossett, NY	RTC	3/19/2020
Abbott House - LTFC	Bronx, NY	LTFC	3/20/2020
Abbott House - Shelter	Irvington,NY	Shelter	3/20/2020
Abbott House - TFC	Bronx, NY	TFC	3/20/2020
Berkshire Farm and Youth Center	Canaan, NY	Shelter	3/20/2020
Berkshire Farm and Youth Center **(NEW PROG.)**	Canaan,NY	TFC	3/20/2020
Catholic Guardian Services	Bronx, NY	Shelter	3/20/2020
Catholic Guardian Services LTFC	Bronx, NY	LTFC	3/20/2020
Catholic Guardian Services Shelter	Bronx, NY	Shelter	3/20/2020
Catholic Guardian Services Shelter	Bronx, NY	Shelter	3/20/2020
Catholic Guardian Services TFC **(NEW CAP.)**	Bronx, NY	TFC	3/20/2020
Cayuga Home for Children DBA Cayuga Centers	Bronx, NY	TFC	3/20/2020
Cayuga Home for Children DBA Cayuga Centers	New York	LTFC	3/20/2020
Children's Home of Kingston	Kingston ,NY	Shelter	3/20/2020
Children's Home of Poughkeepsie NY	Poughkeepsie ,NY	Shelter	3/20/2020
Children's Village - Shelter	Dobbs Ferry ,NY	Shelter	3/20/2020
Children's Village - Staff Secure	Dobbs Ferry ,NY	Staff Secure	3/20/2020
Children's Village - Therapeutic	Dobbs Ferry ,NY	Therapeutic	3/20/2020
JCCA	Bronx ,NY	LTFC	3/20/2020
Lincoln Hall	Lincolndale ,NY	Shelter	3/20/2020
Rising Ground - Shelter	Yonkers ,NY	Shelter	3/20/2020
Rising Ground - TFC	Yonkers ,NY	TFC	3/20/2020
Rising Ground (f.k.a. Leake & Watts) LTFC	Yonkers ,NY	LTFC	3/20/2020
Rising Ground Shelter	Yonkers ,NY	Shelter	3/20/2020
Rising Ground TFC **(NEW CAP.)**	Yonkers ,NY	TFC	3/20/2020

Division of Unaccompanied Children Operations
Office of Refugee Resettlement
Mary E. Switzer Building, 5th Floor
330 C Street SW, Washington, D.C. 20201
(

acf.hhs.gov

Exhibit X

ORR March 23 Field Guidance

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of Refugee Resettlement | 330 C Street, S.W., Washington, DC 20201
www.acf.hhs.gov/programs/orr

March 23, 2020

Dear ORR Care Provider:

The Office of Refugee Resettlement (ORR) is issuing additional field guidance to all programs to take proactive measures and limit the spread of COVID-19. Effective immediately and until further notice ORR requires care providers to:

- **Take two (2) temperature checks of each child in their care daily (once in the morning and once in the evening) using a no-touch thermometer, or following appropriate thermometer disinfection and infection control procedures between each use until such time as no-touch thermometers can be acquired.** ORR authorizes the use of grant funds to purchase no-touch thermometers. The care provider may use the thermometer(s) they currently have on hand, following appropriate thermometer disinfection and infection control procedures between each use, until no-touch thermometers are procured**.** ORR providers are required to undertake all reasonable efforts to acquire a sufficient number of no-touch thermometers for their population as expeditiously as possible.

  Care providers must document children's temperatures in a master census temperature report to be updated twice daily. ORR recommends you maintain a spreadsheet or hard copy document with UAC's name, A# and dates which captures the child's temperature twice daily.

  Separately care providers report fevers to ORR Intakes at Orrducs_Intakes@acf.hhs.gov, **only** if a child has a temperature of 100° or above, and daily there after until no child(ren) have a temperature of 100° or above using the attached *UAC Temperature Tracker* spreadsheet. Care providers will password protect the *UAC Temperature Tracker* using the standard password when submitting the spreadsheet to ORR Intakes.

  If a child has a temperature above 100°, please also follow guidelines provided in the March 13th *COVID-19 Interim Guidance for ORR Programs* by submitting the "INTERIM COVID-10 Acute Respiratory Disease Transfer and Discharge Tracker".

- **Require any staff member or visitor to the care provide facility to undergo mandatory temperature checks prior to entering the facility.** Use no-touch thermometers for staff and visitor temperature checks. ORR authorizes the use of grant funds to purchase no-touch thermometers. The care provider may use the thermometer(s) they currently have on hand until no-touch thermometers are procured.

- **Further, ORR care providers must prohibit entry of any individual (except UAC in the process of admission) who meet any of the following criteria:**

- A fever of above 100° or above;
- Signs of symptoms of an acute respiratory infection, such as a cough, shortness of breath;
- In the previous 14 days has had contact with someone with a confirmed diagnosis of COVID-19;
- is under investigation for COVID-19; or
- In the previous 14 days has travelled internationally to countries with widespread, sustained community transmission. For updated information on affected countries, visit: https://www.cdc.gov/coronavirus/2019-nCoV/travelers/index.html.

If your state licensing agency or other health authority has more restrictive requirements please follow the state or locality requirements. However, please report those restrictions to your ORR Project Officer as soon as possible.

Your first master census temperature report must be created today. If you anticipate any problems please immediately contact your ORR Project Officer. Remember you are only required to submit the Tracker if a UAC in your care has a fever of 100° or above;

Thank you for your cooperation during this rapidly evolving time. Your assistance is vital to containing COVID-19 and protecting children, staff, and their families.

Exhibit Y

NY Guidance

NEW YORK STATE | Office of Children and Family Services

ANDREW M. CUOMO
Governor

SHEILA J. POOLE
Commissioner

Dear Provider:

The Governor's most recent Executive Order, EO 202.7, as well as the associated Guidance issued by the Empire State Development Corporation, sets forth in-person work restrictions, effective as of March 21, 2020 at 8 pm, and until further notice.

These restrictions require all businesses and nonprofit entities to utilize telecommuting and work from home procedures to the extent possible.

Please remember that an **essential business is exempt from the restrictions mentioned above.**

Essential business includes congregate care facilities operated, licensed or certified by the Office of Children and Family Services (OCFS) including programs for youth in foster care and detention, run away and homeless youth programs, domestic violence programs. child care programs and adult care facilities. The order also identified the following entities as essential businesses: food banks; human services providers whose function includes the direct care of patients in state-licensed or funded voluntary programs; the care, protection, custody and oversight of individuals both in the community and in state-licensed residential facilities; those operating community shelters and other critical human services agencies providing direct care or support. **All these entities are exempt from the restrictions mentioned above.**

We are writing to confirm that your agency, which provide services to youth and/or adults in programs as described above and are operated, licensed or certified by OCFS, qualify for this exemption and should remain in operation to the extent necessary to provide those services. This includes your administrative offices and those employees necessary to support the essential functions of your agency's mission.

Please remember to continue to maintain good hygiene and precautionary measures, as COVID-19 can be spread from infected individuals to others through close personal contact. Providers must encourage good hygiene and social distancing within the workplace and must keep staff home if they are sick.

Providers should regularly check the NYS DOH and OCFS websites for the latest guidance on COVID-19 as the outbreak evolves.
https://www.health.ny.gov/diseases/communicable/coronavirus/providers.htm

https://ocfs.ny.gov/main/news/COVID-19/

NEW YORK STATE | Office of Children and Family Services

ANDREW M. CUOMO
Governor

SHEILA J. POOLE
Commissioner

Guidance for NYS Office of Children and Family Services Programs

(funded, operated, licensed, regulated, or designated providers)

Department of Health 24/7 Hotline: 1-888-364-3065

Dear Staff/Providers:

The following guidance is based on the most current Centers for Disease Control and Prevention (CDC) and NYS Department of Health (DOH) recommendations for prevention of the spread the novel coronavirus of 2019 disease (COVID-19) and the management of Persons Under Investigation (PUI). Specific additional guidance for residential programs is documented below. Please review this information, including the links below, with your program's leadership and staff and make any necessary adjustments to your program policies and protocols. This guidance is not intended to address every potential scenario that may arise as this event evolves. OCFS encourages you to also monitor your Local Health Department guidance and keep in close contact with your OCFS regional office staff who have been instructed to immediately elevate priority issues of concern.

A. Guidance for programs funded, licensed or regulated by OCFS when making home visits (including foster boarding homes oversight):

When preparing or scheduling appointments for home-based visits, be sure to ask all clients or applicable family members the following 3 questions:

1. Have you traveled to a country for which the CDC has issued a Level 2 or 3 travel designation within the last 14 days?;
2. Have you had contact with any Persons Under Investigation (PUIs) for COVID-19 within the last 14 days, OR with anyone with known COVID-19?; and
3. Do you have any symptoms of a respiratory infection (e.g., cough, sore throat, fever, or shortness of breath)?

- If the client or family members respond "Yes" to questions 1 OR 2, but "No" to question 3 (i.e., reports no symptoms of a respiratory infection) immediately consult the provider supervisor/ treatment team to assess whether there are any potentially urgent safety risks or behavioral health needs (e.g., medications, suicide or violence risk, etc.).

- If there are urgent needs, the provider supervisor/treatment team should assess whether those needs can be safely met remotely (e.g., e-prescribing, telephone assessment, telehealth visit, etc.). If the client must be seen to meet urgent needs, including behavioral health needs, the provider supervisor/treatment team should instruct the client to remain at home and contact their medical professional immediately. Instruct the impacted client or family member to use a mask, if available, place themselves in a separate room with the door closed if possible, and get assessed by a medical professional immediately before any visitation arrangements are made. Please contact your Regional Office to discuss urgent scenarios so they can provide guidance on a case by case basis.
- If the client does not have urgent needs or those needs can be met remotely, please instruct the family/client to stay home and to contact the NYS DOH for further guidance, which may include a recommendation for a self-imposed quarantine for 14 days. The provider supervisor/caseworker supervisor/treatment team should also contact NYS DOH directly to relay the information from question 1 and 2.

- If the client or family members responds "Yes" to questions 1 OR 2, AND 3, (i.e., reports having symptoms):
  - Instruct the client to remain at home and contact their medical professional immediately.
  - Alternatively, the client may be referred to the nearest emergency room for immediate attention.
  - In all circumstances above, please instruct the client or family member to notify the receiving medical provider and transporter in advance of potential concern for COVID-19.
  - Please contact your Regional Office to discuss any urgent service needs so they can provide guidance on a case by case basis.

B. Guidance for screening visitors/members of the public to OCFS facilities, residential and non-residential programs funded, licensed or regulated by OCFS:

The below protocol is applicable to any facility or program that receives visitors or members of the public as a part of its daily operations. This includes members of the public who attend in-person administrative hearings in OCFS regional offices.

- All facilities, programs and offices receiving regular in-person contact with members of the public should immediately develop policies to schedule and pre-screen over the telephone all visits by non-client/residents-or-staff entities, including families, attorneys, case managers and social workers, using the three questions above.
  - Upon screening, if a potential visitor answers "Yes" to any of the three questions above, please politely instruct them not to visit the facility, program or office until the specific scenario can be further assessed. If a member of the public is scheduled to appear before an administrative law judge for an administrative hearing, the hearing will be adjourned until further notice.

- For those potential visitors who answer "Yes" to questions 1 OR 2, but "No" to question 3 (i.e., reports no symptoms of a respiratory infection), please also instruct them to contact the NYS DOH for further direction.
- For those potential visitors who answer "Yes" to questions 1 OR 2, AND also "Yes" to question 3, (i.e., reports having symptoms) please also instruct them to immediately contact their medical provider and Local Health Department, and to call 911 if they are experiencing serious symptoms (e.g., shortness of breath).
- Please also instruct the screened individual to notify the receiving medical provider and transporter in advance of potential concern for COVID-19.

- If facilities/program providers receive unscheduled visitors, either politely instruct them to leave and call to schedule a visit, or screen them appropriately before allowing entrance into the facility/program.
  - If upon screening, the unscheduled visitor answers "Yes" to any of the questions above, provide them a mask, if available, place them in a separate room with the door closed if possible, and have them assessed by a program medical provider using appropriate Personal Protective Equipment (PPE) if possible. If no qualified program medical provider is available, ask that they contact their own medical professional immediately.
  - Alternatively, they may be referred to the nearest emergency room for immediate attention.
  - In all circumstances above, please also instruct the screened individual to notify the receiving medical provider and transporter in advance of potential concern for COVID-19.

*** PLEASE NOTE – Screening for current residents at OCFS facilities or residential programs funded, licensed or regulated by OCFS (include Runaway and Homeless Youth, Domestic Violence shelters, and Residential Vision Rehabilitation Centers):**

All OCFS facilities and residential facilities funded, licensed or regulated by OCFS should be certain to also screen any incoming residents using the guidance above, and should respond accordingly if a resident is experiencing symptoms and responds "Yes" to questions 1 AND 2 above. If a current or incoming resident can answer "Yes" to questions 1, 2, AND 3:

- Provide a mask for the recipient of services/resident;
- Isolate the recipient of services/resident in a private room with the door closed if possible and ensure that they are kept separate from other tenants.
- A program medical provider should then immediately assess the individual using appropriate PPE if possible, or if no qualified program medical provider is available, the person should be asked to contact their own medical professional immediately. The programs should also contact the NYS DOH (**1-888-364-3065**) for further recommendations including transport to their recommended medical facility if

necessary. Please also instruct the program to notify the receiving medical provider and transporter in advance of potential concern for COVID-19.

All OCFS facilities and residential facilities funded, licensed or regulated by OCFS should continue to review their own emergency preparedness plans and assess for continued operation in case of an emergency.

- All facilities and programs should assess both their facility and workforce capacity to accommodate the potential need for an increased number of isolations rooms and the potential decrease in staffing availability.
- As a result of the above assessment, programs may need to prioritize service provision and planning.
- If the needs or the facility/program exceed current capacity or ability, please contact the relevant OCFS program lead/Regional Office for further assistance.

C. Guidance for visitors to any childcare setting, including licensors/registrars:

- When preparing to visit or inspect a childcare setting, all childcare licensors/registrars should immediately implement policies to schedule and pre-screen over the telephone all visits using the three questions above.
  - If licensors/registrars receive "Yes" answer to any of the questions, they should not visit the program until the specific scenario can be further assessed. If a health and safety issue necessitated the need to visit the provider, please contact your Regional Office to discuss so they can provide guidance on a case by case basis.
  - If licensors/registrars receive "Yes" to questions 1 OR 2, but "No" to question 3 (i.e., reports no symptoms of a respiratory infection), they should additionally instruct the provider to contact the NYS DOH for further direction.
  - If licensors/registrars receive "Yes" answers to questions 1 or 2, AND also "Yes" to question 3, (i.e., reports having symptoms), the licensors/registrars should instruct the provider to immediately contact their medical provider and Local Health Department, and to call 911 if they are experiencing serious symptoms (e.g., shortness of breath). Please instruct the provider to notify the medical provider and transporter in advance and inform them of potential concern for COVID-19
- In the event there is a serious health and safety need that requires an unannounced visit, licensors/registrars should screen the provider before entering the program and instruct the provider as above if answering "Yes" to any questions.
- The above protocol should be used when parents or family members request to visit a childcare program, and childcare providers should review with program leadership and staff to make any necessary adjustments to program policies and protocols.

Additionally, all the above facilities/programs/providers should contact any entities that have staff regularly visiting their programs (e.g., contracted/per diem staffing agencies, pharmacy delivery organizations, itinerant provider staff, cleaning agencies, etc.) to review and approve their screening protocols. If the protocols of outside entities do not meet these standards, providers should take responsibility for screening these visitors.

Finally, as a reminder, all Staff/Providers should follow the CDC's guidelines for infection control basics including hand hygiene:

- Infection Control Basics
- Hand Hygiene in Health Care Settings
- Handwashing: Clean Hands Save Lives

NEW YORK STATE | Office of Children and Family Services

ANDREW M. CUOMO
Governor

SHEILA J. POOLE
Commissioner

Information for Child Care Programs

In an effort to support child care programs and be responsive to the needs of the community during this time, Governor Cuomo has granted OCFS the authority to temporarily waive selective regulatory requirements. The Division of Child Care Services encourages programs who are either experiencing hardship due to COVID-19 or are in a position to assist those experiencing hardship due to COVID-19 to submit a waiver request to your licensor/registrar. Each request will be evaluated on a case-by-case basis and approval will be time limited. For example, in light of school closings, a current FDC who is at capacity (8) might be willing and able to accept two additional school-aged children for the 14 days their school is closed. The program must submit a waiver request for consideration by OCFS which indicates how the health and safety of the children in the program will be maintained. OCFS is committed to reviewing these as expediently as possible. If approval is granted, the waiver would be limited to the duration of the school closure. This program could submit another waiver request in the event the school closure is extended, or other if the program has a new circumstance requiring a waiver. This is just one example of a potential waiver request. Child care programs are encouraged to consider what scenarios (if any) are applicable to them specifically and apply as necessary throughout the duration of this health crisis. OCFS encourages innovative and entrepreneurial thinking to work together to get through this current crisis.

Below are several Frequently Asked Questions compiled to provide guidance to the child care community. OCFS will continue to add to this list as applicable. Please reach out to your regulator with questions.

Frequently Asked Questions for Child Care Programs

Updated 3/23/2020

Q. Are child care programs being ordered to close?

A. Child care programs are NOT being ordered to close. In fact, quite the opposite is true. Governor Cuomo and his administration consider child care to be an essential function critical to enabling parents to go to work.

Q. Who can order an child care program to close due to COVID-19?

A. In certain circumstances, local authorities, mainly local Departments of Health, have the authority to direct programs to close under quarantine or other emergency orders. In addition, child care programs are business entities and can voluntarily close the program.

Q. Have the requirements regarding staff/child ratios been lifted?

A. OCFS has been granted the authority to waive select regulatory requirements in order to meet the need for child care services. Staff/child ratio is one such requirement. You may contact your regulator and submit a waiver request. For the duration of this emergency, there may be flexibility regarding certain regulatory requirements.

Q. Have the regulations regarding comprehensive background clearance checks been lifted?

A. OCFS has been granted the authority to waive select regulatory requirements in order to meet the need for child care services. Comprehensive background clearance checks are one such requirement. You may contact your regulator and submit a waiver request. For the duration of this emergency, there may be flexibility regarding certain regulatory requirements.

Q. How do child care programs maintain a perimeter of 6 feet while caring for them?

A. Adults must be in close proximity to young children in order to provide proper care. It is important to take universal precautions. Ensure handwashing strategies are being followed including washing with soap and water for at least 20 seconds. When soap and water are not available individual wipes may be used in combination with hand sanitizer. Also, be sure to perform routine substantial cleaning of the childcare program.

Q. Are child care programs required to maintain a group size of 10 or less?

A. The Centers for Disease Control, in its guidance on events and mass gatherings recommends group size to ten or fewer and therefore we ask providers to reconfigure space to limit overall density of rooms to ten or fewer children. See https://www.cdc.gov/coronavirus/2019-ncov/community/large-events/index.html.
Your licensed/registered capacity, however, remains in effect unless you've been approved for a waiver by OCFS as there may be ways for you to serve a greater number of children while continuing to prioritize their health and safety and that of your employees**.**

Q. Why haven't child care programs been closed?

A. Child care is considered an essential service. In a time of crisis, other essential professionals must be able to go to work and have safe and suitable child care available to their children. If you have openings in your program, please use those openings to serve the children of employees who are unable to work from home and must continue to report to their work location. Please reach out to your local Child Care Resource and Referral agency and make them aware of any slots you have available.

Q. How do programs limit access to the program and try to reduce exposure to COVID-19?

A. Programs are encouraged to utilize these screening questions:

1. Within the last 14 days, have you traveled to a country that the federal Centers for Disease Control and Prevention should be avoided for nonessential travel or where travelers should practice enhanced precautions?
(China, Iran, Italy, South Korea, Japan)

2. Have you had contact with any person with known COVID-19 or person under investigation for COVID-19?

3. Do you have any symptoms of a respiratory infection (e.g., cough, sore throat, fever, shortness of breath)?

4. Are you or anyone in your home in active quarantine status?

If an individual responds “yes” to any of the above, do not allow that individual to enter the program. Where staffing allows, programs can implement strategies to reduce traffic in the program including meeting children at the door.

3/16/2020

Q. Is OCFS going to close my child care program because of COVID-19?

A. No. NYS Department of Health and local health departments will instruct a child care programs regarding how to respond to COVID-19.

Q. What if my child care program is located in New York City?

A. For child care programs located in NYC, including those regulated by OCFS, additional information can be obtained by going to the NYC Department of Health and Mental Hygiene website at https://www1.nyc.gov/site/doh/index.page. The New York City Health Department will let you know if you are required to close your program. For information about COVID-19 in New York City, including when to call your health care provider if you feel sick, visit: http://nyc.gov/health.

Q. If my neighborhood school closes, is my child care program required to close?

A. No, unless the program is told to by a public health official, or if it is located in the school facility.

Q. What if my program is located in the containment bubble? What if there are new containment areas?

A. If a program is in the containment area and is directed to close, you will be contacted by local DOH. At this time, group family and family day care homes are not considered places of mass gatherings. Day Care Centers and School Aged Child Care may or may not be considered places of mass gathering as it is based on their capacity. Your local department of health will direct you.

Q. What if I am directed to close, or choose to close?

A. In either case, you must inform your regulator.

Q. Families are contacting me who are needing child care, especially for school-aged children, but my program is full.

A. If you want to take the additional children, and believe your program can handle the additional children, contact your regulator and submit a waiver request. During the duration of this emergency, there may be flexibility regarding certain regulatory requirements.

Q. What if I want to expand my license/registration to serve more children temporarily?

A. Contact your regulator and submit a waiver request. During the duration of this emergency, there may be flexibility regarding certain regulatory requirements.

Q. What If I want to bring on new assistant/staff during emergency?

A. Contact your regulator and submit a waiver request. During the duration of this emergency, there may be flexibility regarding certain regulatory requirements.

Q. What if hospitals, schools, etc. contact me about taking on additional children?

A. Contact your regulator and submit a waiver request. During the duration of this emergency, there may be flexibility regarding certain regulatory requirements.

Q. What if my program has too many staff absent to continue care?

A. Contact your regulator. There may be possibilities to bring substitutes on board quickly and explore other possibilities in collaboration with other local programs.

Q. What if my program is closed for a period of time? How will I get by?

A. We are receiving ongoing guidance from the federal Office of Child Care and considerations are being made to support programs.

Q. What if a program staff /volunteer is mandated to be quarantined?

A. If the person tests positive for the virus, the program will be contacted by the local Department of Health (DOH) and will be directed on what steps are needed. It is likely the program will be directed to close and self-quarantine the remaining staff and children.

Q. What if a staff person at a child care program is precautionarily quarantined?

A. If a staff member has been exposed to the virus and has self-quarantined but has not tested positive, the individual must not report to work during the quarantine period. The center may continue to operate unless notified otherwise by local DOH.

Q. What if a parent of a child is quarantined?

A. In the event a parent of a child in your program must be quarantined, advise the parent they cannot enter the child care program for any reason, including picking up their child. If the parent is exhibiting signs of illness or has been tested and is positive for the virus, they must utilize an emergency contact authorized by the parent to come pick up the child. If the parent is being quarantined as a precautionary measure, without symptoms or a positive test, child care staff should walk out or deliver the child to the parent outside the child care building. The child must not return to the child care program for the duration of the quarantine.

Q. What if a household member of a home-based provider is quarantined?

A. The program must not operate and must contact local DOH.

Q. What if a child is quarantined?

A. Children who have been quarantined either through exposure to the virus or a positive test must not attend programs for the duration of the quarantine period. If a child has been diagnosed as positive and has attended the program within the past week, the program must contact local DOH.

Q. What if a family seeks child care for school-aged children whose school has closed?

A. When bringing on additional children, for school-aged children, please confirm what school the child attends. OCFS will distribute lists of schools that have been mandatorily closed for quarantine to the regional offices. No children with any symptoms of illness, or children from schools under mandatory quarantine should attend programs.

Q. My program serves families who receive child care subsidy, what will happen when children are absent, or my program is forced to close?

A. We are receiving ongoing guidance from the federal Office of Child Care and considerations are being made to support programs. This includes allowing counties to pay for absence and closure days.

Exhibit Z

CA Guidance

CDSS
KIM JOHNSON
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • *www.cdss.ca.gov*

GAVIN NEWSOM
GOVERNOR

March 4, 2020 PIN 20-02-CRP

TO: ALL LICENSED CHILDREN'S RESIDENTIAL FACILITIES

Original signed by Pamela Dickfoss
FROM: PAMELA DICKFOSS
Deputy Director
Community Care Licensing Division

SUBJECT: **CORONAVIRUS INFORMATION AND GUIDELINES FOR CHILDREN'S RESIDENTIAL FACILITIES**

Provider Information Notice (PIN) Summary

PIN 20-02-CRP provides information and guidance from the California Department of Public Health (CDPH) and Center for Disease Control and Prevention (CDC), for all children's residential facilities regarding the Coronavirus Disease 2019 (COVID-19).

The California Department of Public Health (CDPH), Center for Disease Control (CDC), and World Health Organization (WHO) have released information on the recent identification of the COVID-19. The coronavirus itself is a large family of viruses that, while not new, have different strains. The COVID-19 strain is a newly identified strain that causes respiratory illness similar to influenza. The purpose of this PIN is to provide you with information relevant to residential settings.

To stop transmission of this virus, recommendations include to:

- avoid close contact with people who are sick,
- avoid touching your eyes, nose, and mouth,
- stay home when you are sick,
- cover your cough or sneeze with a tissue, then throw the tissue in the trash,

- clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipes.

Should you have reason to suspect an outbreak of COVID-19 in your facility, please contact your local health department **immediately**. Licensees are encouraged to have a plan in place, and ample supplies, to respond to a COVID-19 outbreak in their area. Follow plans for sheltering in place in circumstances where you may need to quarantine.

Children's Residential Program licensees are also required to report outbreaks to your Children's Residential Regional Office within the next working day during its normal business hours along with a written report within seven days of the occurrence per Title 22 of the California Code of Regulations, 80061(a)(H), 86561(a)(5), and 89361 (a)(5).

There are several resources available regarding COVID-19:

- General guidance on the COVID-19 can be found on the CDPH web page
- Interim guidance for preventing the spread of COVID-19 in homes and residential communities can be found on the CDC web page.
- More information and new updates regarding COVID-19 can be found on the WHO web page.

If you have any questions, please contact your local Children's Residential Regional Office.

Exhibit AA

Cohn Declaration

UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA

LUCAS R., *et al.*, Plaintiffs, v. ALEX AZAR, Secretary of U.S. Dep't of Health and Human Services, *et al.*, Defendants.	Case No.: 2:18-CV-5741 DMG (PLAx) District Judge Dolly M. Gee

DECLARATION OF DR. AMANDA COHN, CHIEF MEDICAL OFFICER, NATIONAL CENTER FOR IMMUNIZATIONS AND RESPIRATORY DISEASES, CENTERS FOR DISEASE CONTROL AND PREVENTION

I, Amanda Cohn, declare under penalty of perjury, pursuant to 28 U.S.C. § 1746, that my testimony below is true and correct:

1. I am currently on detail serving as the Acting Director, National Center for Birth Defects and Developmental Disabilities. My permanent position is the Chief Medical Officer, National Center for Immunizations and Respiratory Diseases (NCIRD). I also serve as the Executive Secretary, Advisory Committee on Immunization Practices (ACIP), which sets U.S. immunization policy. Since January 3, 2020, I have served as a Deputy Incident Manager for the CDC COVID-19 response, which became a full Emergency Operations Activation the week of January 19, 2020.

2. I have held the position of Chief Medical Officer, NCIRD since early 2019. Prior to 2019, I was a Senior Advisor for Vaccines and Executive Secretary, ACIP, and served as the Deputy Director for Immunization Services Division, NCIRD. I have been a medical officer focused on vaccine-preventable diseases and respiratory diseases at CDC since 2004.

3. I received my medical degree from Emory School of Medicine in 2001. From 2001-2004, I completed an internship and residency in Pediatrics at Boston Children's Hospital and Boston Medical Center. From 2004-2006, I was an Epidemic Intelligence Service Officer at CDC, where I received specialized training in epidemiology, outbreak control, and vaccine-preventable diseases.

4. In my current role, I am responsible for the Influenza Coordination Unit and Vaccine Policy in NCIRD. In addition to my role as the Executive Secretary, ACIP, I am an internal CDC subject matter resource for cross-cutting immunization issues, including immunization in shelter settings. Additionally,

I have led and overseen planning and preparedness for pandemic influenza and other respiratory disease threats. I have been the NCIRD lead for border health issues, including supporting government agencies in prevention and control of vaccine-preventable diseases among staff and persons in custody of the U.S. government. As the Deputy Incident Manager of the CDC COVID-19 response, I am responsible for guidance related to healthcare settings, worker safety, community mitigation, and at-risk populations. I have also provided oversight on movement and monitoring guidance for persons exposed to COVID-19, as well as the guidance for mass gatherings.

5. In the course of performing my job duties, I have reviewed and am familiar with CDC's guidance regarding COVID-19, including the CDC guidance applicable to various congregate settings including institutes of higher education, detention facilities, nursing homes, and homeless shelters, all of which is available on CDC's website.

6. In addition, in the course of performing my job duties, I have consulted with the Office of Refugee Resettlement ("ORR") on multiple clinical issues over the years. As a result of those consultations, I have general familiarity with the structure and operations of ORR, the population of unaccompanied alien children ("UAC") in ORR care, and the ORR network of grantee care provider facilities.

7. In 2014, I was the Vaccines Task Force lead for the CDC's effort to support ORR's response to the influx of UAC at the Southwestern Border. I was a co-author on a report "Multistate Outbreak of Respiratory Infections Among Unaccompanied Children, June 2014-July 2014" published in the journal Clinical Infectious Diseases. I have provided technical comments on many ORR guidance documents over the years and consulted with ORR on multiple issues around immunization, vaccine-preventable disease outbreaks, and influenza prevention and control.

8. More recently, I reviewed ORR's guidance to care provider facilities on COVID-19 to confirm that it aligned with CDC's guidelines and recommendations, and the best practices for preventing and controlling the spread of COVID-19 within residential facilities. This includes guidance related to symptom and temperature monitoring of staff and children, cleaning and hygiene guidance, and ensuring the ability to isolate ill UAC and quarantine potentially exposed UAC. As part of my review, I conferred with ORR's Director of the Division of Health for Unaccompanied Children ("DHUC"), Dr. Michael Bartholomew, on how to best ensure the health and safety of UAC and staff. Over the last two weeks, I have received and responded to multiple requests from ORR for consultation to ensure their guidance is consistent with the most up to date and rapidly evolving CDC guidance.

9. My testimony in this declaration is based upon my personal knowledge; information about ORR's response to COVID-19 that I received in emails from and phone calls with the relevant ORR

personnel in the regular course of performing my job duties; and CDC guidance documents regarding COVID-19, which I obtained from the CDC's official website and reviewed in connection with the performance of my job duties. In preparing this declaration, I also reviewed the declaration of ORR Deputy Director Jallyn Sualog, and the memorandum of law and declarations submitted by the Plaintiffs in support of their request for a temporary restraining order in the *Lucas R.* case.

10. I am testifying in this declaration to the best of my knowledge, and understand that this declaration is for use in the *Lucas R.* case.

Background Regarding COVID-19

11. COVID-19 is a novel coronavirus that originally caused an outbreak of respiratory illness in Wuhan, China. COVID-19 is spread primarily by person-to-person contact through droplets produced when an infected person coughs or sneezes. COVID-19 may also spread through contact with contaminated surfaces or objects, and there is emerging evidence that there may be asymptomatic or pre-symptomatic transmission.

12. Since the initial outbreak in Wuhan, China, COVID-19 has spread across the globe. On January 30, 2020, the Director-General of the World Health Organization declared that COVID-19 constitutes a Public Health Emergency of International Concern. On March 11, 2020, the World Health Organization classified COVID-19 as a pandemic.

13. COVID-19 now presents a significant public health risk in the United States. On January 31, 2020, the Secretary of HHS declared that a public health emergency exists under section 319 of the Public Health Service Act. On March 13, 2020, the President issued a Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak. As of March 16, 2020, all 50 states and several local and territorial jurisdictions declared states of emergency.

14. There are currently confirmed COVID-19 infections in every state and the number of confirmed infections is increasing on a daily basis. Globally and in the United States, the groups at risk for severe disease, and a majority of the morbidity and mortality, is older adults and persons with multiple co-morbidities.

15. CDC believes that there is currently community-based transmission of COVID-19 ongoing in many communities across the United States. Several cities and states have widespread transmission where the healthcare systems and public health are overwhelmed.

CDC Guidances to the Public and Institutions

16. To protect the public health, CDC has issued guidance to the general public advising individuals to limit non-essential travel and social contacts, and to practice social-distancing when outside their homes (i.e., maintain a distance of at least six feet from others while in public). Essentially, this

guidance encourages all Americans to practice the shelter-in-place strategy now mandated in certain states. CDC, however, does not recommend that individuals within the same domicile, or living unit, attempt to practice social distancing unless there is a known exposure to COVID-19.

17. CDC's guidance to the general public related to limiting the size of gatherings is intended to complement, not supersede, the more detailed guidance intended for specific congregate settings such as institutions of higher education, nursing homes, prisons, and homeless shelters. In all of these guidance documents related to congregate living settings, CDC recommends institutions implement practices tailored to their particular circumstances.

18. In general, the various CDC guidance documents for specific congregate settings adopt a two-pronged approach of reducing the potential for a case to occur in a facility (prevention) and limiting the spread of cases in a facility if a case occurs (containment). Prevention refers to precautions facilities can take to prevent individuals infected with, or possibly exposed to COVID-19, from entering in the first place—thus, reducing the risk of exposure to those inside. Effective prevention measures for congregate settings include screening visitors for COVID-19 risk factors, such as travel to a heavily infected area, contact with a confirmed case of COVID-19, or exhibiting symptoms of the disease (i.e., fever, cough, shortness of breath). Prevention also entails the adoption of rigorous hygiene practices within facilities, including more frequent cleaning, particularly of high-traffic surfaces and shared spaces.

19. Containment focuses on limiting spread from any potential infections that may emerge within a facility, by regularly monitoring the population within the facility for signs of COVID-19 infection. In the event any individual exhibits possible symptoms of COVID-19 infection, the individual is to be immediately isolated and tested. In addition, any contacts that individual may have had with others should be traced, and those individuals should be monitored, and possibly isolated depending on the nature of the contact. Like any contagious disease, the risk of acquiring COVID-19 from contact with a confirmed case depends on the nature and extent of the contact.

20. ORR's current COVID-19 procedures are consistent with CDC guidances for congregate settings; they direct grantee care-provider facilities to implement both prevention and containment measures. In some respects, ORR's current COVID-19 procedures actually exceed those set forth in the CDC guidances to congregate care facilities. For example, ORR's twice-daily temperature monitoring regime goes beyond what CDC has recommended for other congregate settings. Additionally, ORR facilities have preparedness plans that ensure immediate care is provided to ill children.

21. Further, ORR's stop-placement orders in California, New York, and Washington are consistent with CDC and other public guidance recommending that non-essential travel and public movements be avoided, especially to areas in the U.S. with widespread transmission. For example, the

White House recently issued guidance that all persons who recently travelled to New York should be under home quarantine for 14 days. These three states are currently in the acceleration phase of the epidemic; the expectation is that in the next several days to weeks these areas will be in a deceleration phase and other states may be in the acceleration phase.

22. My understanding is that the Plaintiffs in this case have requested the expedited release of UAC in ORR custody to sponsors located throughout the United States. Moving UAC children outside of custody likely increases risk of exposing UAC to COVID-19 relative to remaining in custody, given that they are currently housed in well-controlled environments and may be transferred to areas where there is widespread community transmission, or to homes where there may be persons who have been exposed.

23. In addition to the prevention and containment practices ORR has already implemented, it is my understanding that ORR has adequate space within its facilities to isolate any UAC suspected of or confirmed to be infected with COVID-19, given that the ORR network of grantee care-provider facilities is currently operating at approximately 30% capacity. Moreover, the CDC's recent order prohibiting the introduction of certain aliens into the U.S. is anticipated to reduce the number of new UAC entering ORR's care. Given the amount of space within the ORR network and the relatively static nature of its current population, maintaining their current living situation and not releasing UAC to communities with widespread transmission is the most prudent measure to reduce the risk of infection among the current population of UAC. Although there is a risk of cases of COVID-19 in a UAC facility among UAC or staff, with all of the protective measures ORR has implemented and the current space available in facilities to manage ill UAC, based on currently available information the overall risk to UAC is lower in the facilities than traveling and placing children in home environments in some locations in the U.S. at this time.

24. Requiring UAC to travel significant distances (presumably, via plane, train, or bus) and enter new living environments poses a significant risk of exposing UAC to COVID-19 both in transit, and upon arrival into their sponsor's household, where it is uncertain how vigorously the occupants have avoided exposure to COVID-19 themselves. Given the high prevalence of COVID-19 in the general community, removing UAC from their current living environments presents a serious risk of exposing them to COVID-19.

25. Fortunately, the vast majority of individuals who become infected with COVID-19 will experience only mild symptoms, and there have been very few reports of serious illness among children and adolescents globally. The general advice to those with mild cases of COVID-19 is the same advice that would be given to an individual with a bad cold or flu: stay at home and avoid contact with others; rest; drink plenty of fluids; manage symptoms with over-the-counter-medications, and seek medical attention if symptoms worsen.

26. The population of UAC in ORR care are not at any significantly increased risk from COVID-19, and have access to strong medical care that is equal to or greater than what they would have in the community should they need it. UAC are primarily healthy adolescents, which currently available information indicates are not at an increased risk of experiencing serious or severe cases of COVID-19 that would require hospitalization or mechanical respiratory support.

27. CDC is committed to continuing to work with ORR to ensure that its COVID-19 procedures are informed by the latest CDC guidance, which in turn is shaped by the latest epidemiological information available about the ongoing pandemic.

Executed on March 27, 2020.

Amanda Cohn, MD