APRIL 9, 2021
ORR JUVENILE
COORDINATOR REPORT

ORR JUVENILE COORDINATOR INTERIM REPORT

April 9, 2021

Aurora Miranda-Maese, ORR Juvenile Coordinator

Introduction

In accordance with the April 24, 2020 Order, issued by The Honorable Dolly M. Gee of The United States District Court for the Central District of California, the undersigned ORR Juvenile Coordinator, Aurora Miranda-Maese, has filed monthly reports during the pendency of the national health emergency related to the COVID-19 pandemic. The reports addressed the six Court ordered topics and additional requirements as directed by the Court. At the March 19, 2021 status hearing, the Court issued a new order, which modified ORR Juvenile Coordinator's report to include topics detailed by the Court and information agreed upon by the parties as detailed in the Joint Status Report filed March 26, 2021. Therefore, the current report covers the topics agreed upon by the parties as well as the items listed below. Where the topics agreed upon by the parties and the Court's Order overlap, the Juvenile Coordinator provides a consolidated response.

- Reasons for delays in transferring Class Members from CBP to ORR custody;
- The names and locations of ORR facilities where any Class Member has contracted COVID-19 while already housed at the facility, rather than being diagnosed with COVID-19 at intake;
- Updates on ORR's plans, if any, to expand capacity;
- Updates on ORR's plans, if any, to expedite intake and/or release of Class Members; and;
- Descriptions of ORR's collaboration with other agencies, including CBP and the Federal Emergency Management Agency ("FEMA"); and
- Descriptions of ORR's COVID-19 plans in light of any recent updates to CDC guidelines and the start of vaccine distribution, including any steps to ensure prompt vaccination of personnel and residents;
- Summary of updates to any publicly-available relevant policies (policies related to COVID protections in ORR custody) during the reporting period, as well as ORR's COVID-19 plans in light of any recent updates to CDC guidelines as well as developments regarding vaccine distribution in line with the Court's order modifying ORR's reports.

This report covers the period from March 1, 2021 to April 7, 2021 and commences immediately after the end date of the previous report. Information for this report is derived from a cross-section of personnel in the ORR Unaccompanied Children Program. The Juvenile Coordinator consulted with and participated in daily coordination meetings with several ORR teams including: Division for Planning and Logistics, Division of Health for Unaccompanied Children, Division for Unaccompanied Children Operations, Division

of Policy and Procedures, Compliance and Monitoring Team, and the Data and Systems Team. During the daily meetings, the Juvenile Coordinator received reports from members of the Federal Field Staff and various points of contacts overseeing operations at licensed shelters, influx care facilities, and Emergency Intake Sites.

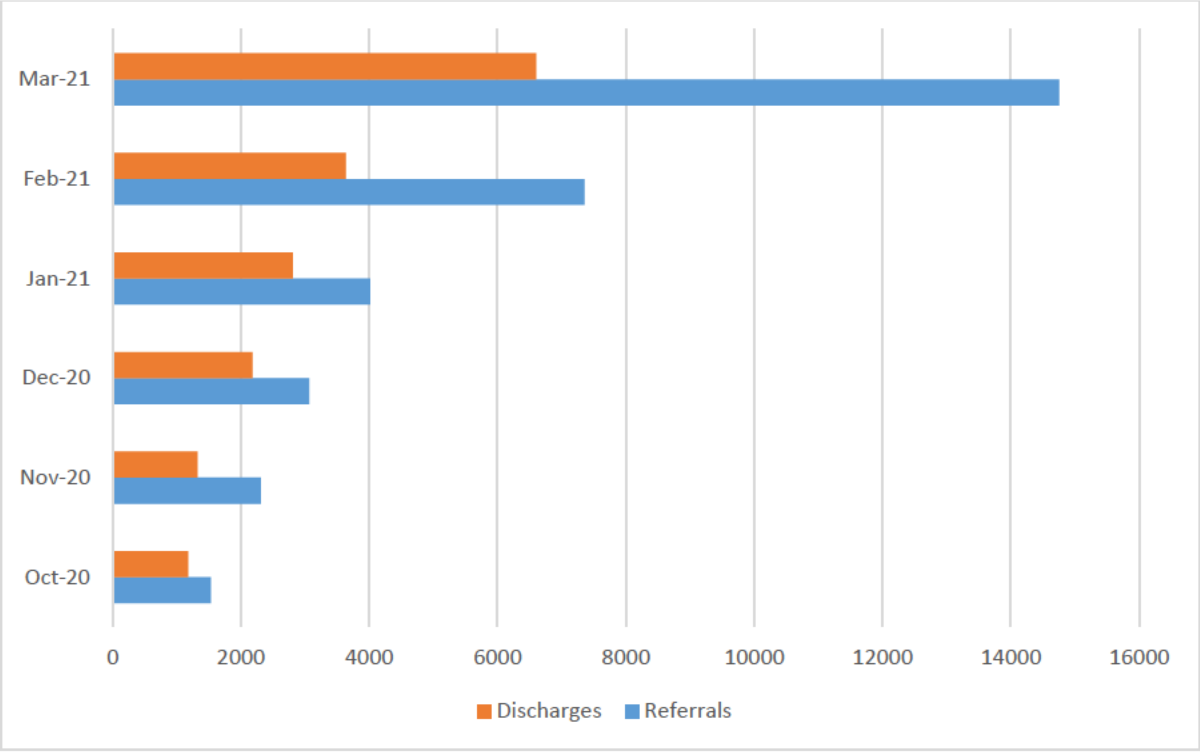
ORR Capacity

Overview

As of April 7, 2021, ORR has 18,445 minors in custody, which represents a significant increase from the February 28, 2021 census of 7,774 minors. During the current reporting period, ORR received referrals for approximately 20,359 minors and discharged approximately 8,890 minors.

Figure 1 below provides information regarding the increase in ORR referrals and discharges for the last six months, beginning October 1, 2020 to March 31, 2021. As the chart below depicts totals for each month, April is omitted because only seven days have passed. The chart in the next report will include the monthly total for April. From April 1 to April 7, 2021, ORR received approximately 5,063 referrals and discharged approximately 2,048 minors.

Figure 1: ORR Referrals and Discharges from October 1, 2020 to March 31, 2021[1]



[1] The information in Figure 1 reflects the number of ORR's discharges and referrals from October 1, 2020 – March 31, 2021.

Figure 2 below summarizes ORR's bed capacity as of April 8, 2021. This information is dynamic as ORR is aggressively pursuing efforts to increase bed capacity. Therefore, it is likely that the information depicted in the figure below changed very soon after it was produced.

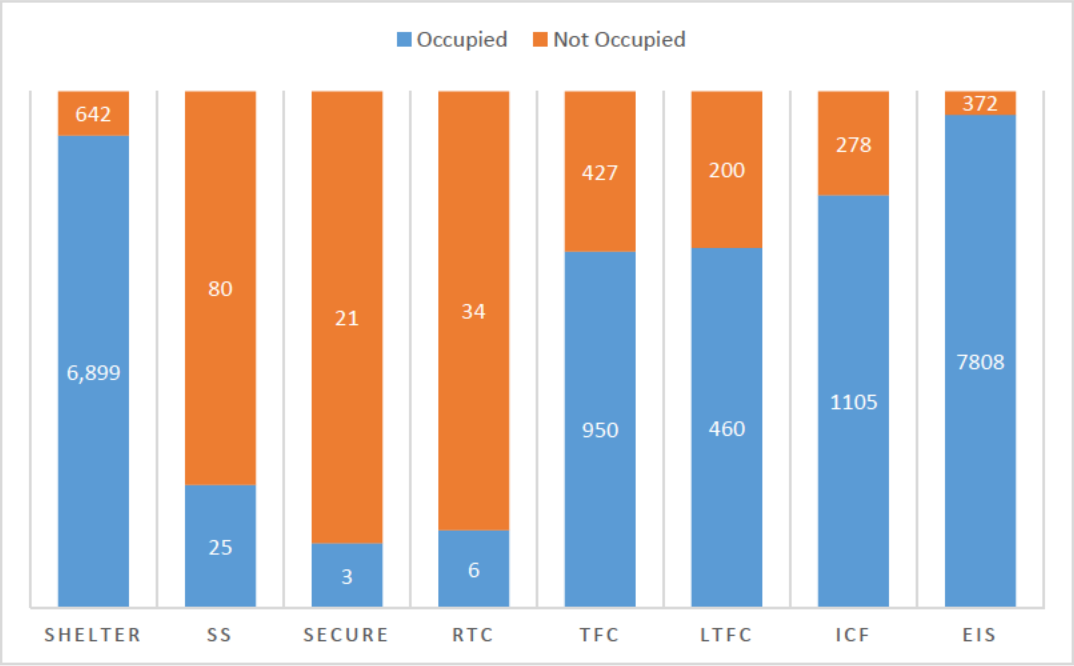
Figure 2: ORR Bed Occupancy by Residence Type as of April 8, 2021[2]

ORR Program Type	Total Beds	# of Beds Occupied	# of Beds Not Occupied
Shelter	7,541	6,899 91%	642 9%
Staff Secure	105	25 24%	80 76%
Secure	24	3 12%	21 88%
RTC	40	6 15%	34 85%
TFC	1,377	950 69%	427 31%
LTFC	460	260 57%	200 43%
Influx Care Facilities (ICF)	1,383	1,105 80%	278 20%
Emergency Intake Sites (EIS)	8,180	7,808 95%	372 5%
TOTAL	*18,714*	*17,090* 91%	*1,624* *9%*

[2]The census for minors in ORR custody constantly fluctuate as children are admitted, transferred, and discharged at all times of each day. Therefore, the census reflected in Figure 2 and Figure 3 is a snapshot of the capacity at the exact time that the review was conducted. Furthermore, ORR is constantly reassessing bed capacity as circumstances regarding the COVID-19 pandemic and increasing number of minors requiring quarantine or medical isolation are referred to ORR. This chart reflects ORR's reassessed capacity on the morning of April 8, 2021.

Figure 3 below provides a depiction of capacity by facility type. A larger proportion of more restrictive facilities (i.e. secure, staff secure, and RTC) are not occupied as most minors do not meet the criteria for placement at those facilities. Regarding TFC and LTFC, ORR strives to place minors with families that are willing to accept them from the border. Where families and/or foster care programs have declined to accept minors directly from the border, ORR attempts to free border placement beds by transferring longer residing minors to those foster care placements as appropriate. In some cases, a foster care home may have specifications for the demographics able to reside with them (i.e. parenting teens, tender aged children, and special needs).

Figure 3: ORR Bed Occupancy by Residence Type as of April 8, 2021[2]



Reasons for delays in transferring Class Members from CBP to ORR custody

As depicted in Figures 1 to 3 above, ORR has experienced an insurmountable number of minors arriving at the border. Their arrival in historically high numbers coincide with the nation's efforts to control the spread of COVID-19, which is also a priority for ORR facilities. From March 2020 until March 2021, ORR and its care provider network operated with a reduced bed capacity in accordance with social distancing guidelines from the CDC, and public health officials. On March 5, 2021, ORR issued new guidelines in consultation with CDC, which urged facilities to expand bed capacity as much as possible and provided additional instructions for safeguarding against COVID-19. However, increasing bed capacity at a sufficient speed to match the extremely high numbers of minors arriving at the border is a challenge. ORR received over 7,000 referrals in February, over 14,000 referrals in March, and over 5,000 referrals from April 1 to April 7, 2021. Despite ORR's aggressive efforts to timely place the minors in ORR facilities, the number of children arriving at the border is outpacing the speed at which ORR can secure additional beds and staff.

Plans to Expand Capacity

ORR's current permanent licensed capacity is constrained by the unprecedented increase of minors referred to ORR. Recognizing that most of these licensed facilities are near full capacity, ORR is reviewing new proposals offering additional licensed programs. In addition, current programs are exploring additional licensed facilities within their companies. Despite these assertive and ongoing efforts to increase licensed bed capacity, the current influx levels have necessitated the need for ORR to open non-state licensed Influx Care Facilities (ICF) and implement the newly established Emergency Intake Site (EIS) facilities.

EIS facilities are designed for mass care and offer basic standards of care for minors such as providing clean and comfortable sleeping quarters, meals, toiletries, laundry, and access to medical services. A COVID-19 health screening protocol for all minors is implemented to follow CDC guidelines for preventing and controlling communicable diseases. For minors diagnosed with COVID-19, EIS either have established medical isolation areas or are designated for only minors that test negative for COVID-19. In addition to medical services, case management and legal services are available for all sites that were opened in March and are either implemented or in the process of being implemented for the sites that opened from April 1 to 7.

The EIS facilities are part of a multi-pronged approach to absorb the current surge. EIS facilities are intended to be short-term/temporary facilities (generally, under a 6-month period). In addition, ORR is working to safely increase capacity in its permanent/licensed network by implementing CDC COVID-19 guidance and using ICF with the same standards of care as ORR's permanent/licensed network. Simultaneously, ORR is continuing to aggressively move toward the long-term goal of acquiring enough state-licensed beds in our care provider network to reduce the need in the future for Influx Care Facilities or Emergency Intake Sites.

Figure 4 and Figure 5 below provide information regarding EIS and ICF that are operational as of April 8, 2021.

Figure 4: ORR Emergency Intake Sites as of April 8, 2021[3]

Emergency Intake Sites			
Facility Name	**Total Beds**	**Beds Occupied**	**Beds Not Occupied**
El Paso (Ft. Bliss)	2000	1943	57
San Antonio (Freeman)	1823	1816	7
Dallas (Kay Bailey Hutchinson)	2300	2125	175
Midland	607	509	98
San Diego	1450	1415	35
Houston	500	484	16
Delphi	375	357	18
Dimmit	506	429	77
Totals	**8180**	**7808**	**372**

[3] The information reflected in Figure 4 represents ORR's EIS facilities that are operational as of April 8, 2021.

Figure 5: ORR Influx Care Facilities as of April 8, 2021[4]

Influx Care Facilities			
Facility	**Total Beds**	**Beds Occupied**	**Beds Not Occupied**
Carrizo (Carrizo Springs I)	1008	879	129
Pecos Lodge	375	369	6
Totals	**1383**	**1105**	**278**

Care provider programs continue implementing prudent staffing models in adherence with guidance from the CDC, state and local authorities and their own organizational policies in order to limit exposure risk for their employees. As a result, programs are not able to meet ORR and state-licensing mandated staffing supervision, which further reduces the maximum capacity each program can accommodate.

Some of ORR facilities are struggling with staffing shortages and are having a hard time filling positions. Programs are reporting difficulties with hiring staff due to a decreased response to job postings and in finding qualified applicants for positions posted. Also, some potential candidates are not continuing with the hiring process, citing fears of contracting COVID-19.

In addition, ORR facilities are experiencing difficulties with staff retention. Programs have reported challenges with an inability to hire and retain employees who are often faced with caretaker responsibilities within their own homes and concerns that potential employees may have working in a congregate setting, which may put them at risk for exposure. Other reasons cited include: low morale, the inability to telework, working additional hours due to coverage needs, delays with State licensing to complete the clearance process, and concerns regarding travel during the pandemic. ORR has been working with programs to identify strategies to mitigate staffing challenges where possible.

To offset staffing shortages, several federal staff from diverse areas of the federal government have volunteered to assist in ORR's effort to serve minors. Currently, volunteers include personnel from U.S. Public Health Service, various programs in Health and Human Services, and the Department of Homeland Security. A solicitation for volunteers was also recently sent to the Department of Justice.

ORR's collaboration with other agencies, including CBP and FEMA

ORR is working with other agencies, establishing collaborative relationships with Customs and Border Patrol (CBP) and the Federal Emergency Management Agency (FEMA) to ensure that unaccompanied migrant minors are safe and unified with family members or other suitable sponsors as quickly and safely as possible. ORR is working closely with FEMA and other federal partners to establish EIS facilities and engage service providers. Services will be provided by a combination of the American Red Cross, Federal staff, including teams from the HHS Office of the Assistant Secretary for Preparedness and Response and the U.S. Public Health Service Commissioned Corps, and various contractors.

[4] The information reflected in Figure 5 reflects ORR's ICF that are operational as of April 8, 2021.

Release Efforts

Plans to Expedite Intake and/or Release of Class Members

On March 22, 2021, ORR issued guidance for the expedited release of eligible Category 1 cases (see attached ORR Field Guidance #10, Expedited Release for Eligible Category One Cases). ORR has prepared this field guidance to best serve minors in ORR custody who have parents or other potential Category 1 sponsors in the United States. Based on this guidance, a minor may be released on an expedited basis to their sponsor provided that the following conditions are met:

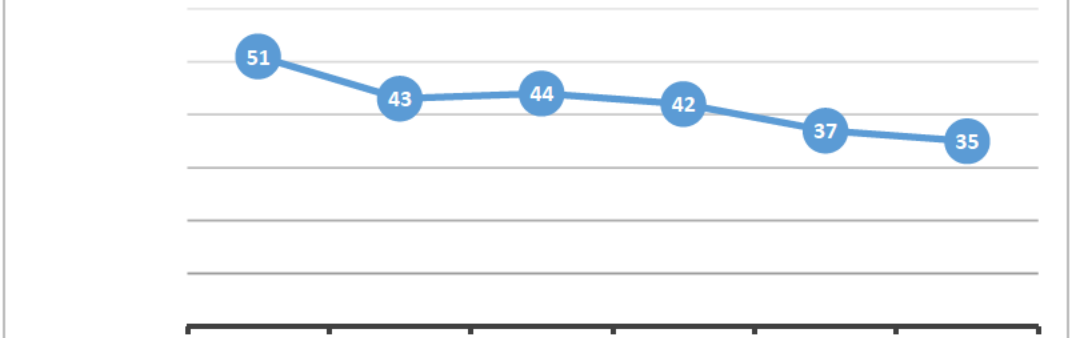
- If the child is screened and determined not to be especially vulnerable;
- If the child is not subject to a mandatory TVPRA home study; and
- If there are no other red flags present in the case (i.e. abuse or neglect)

In cases where expedited release is appropriate, ORR authorizes care providers to pay for the sponsor's travel to the ORR care provider facility to pick up the minor and complete paperwork at the facility (if allowed). Travel arrangements should be made as soon as it appears that the minor's release is viable.

Average Length of Care

Over the past six months (October 2020 to March 2021), ORR's assertive efforts to release minors has resulted in a steady decline in the average amount of time that minors remain in ORR custody. This measure of time that a minor remains in ORR custody is known as the length of care. As detailed in Figure 6 below, ORR's efforts have maintained the steady decline in average length of care despite the significant increase in the number of minors in ORR custody.

Figure 6: Average Length of Care for Minors in ORR Custody



	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Length of Care	51	43	44	42	37	35

COVID-19 in ORR Facilities

ORR Facilities with Class Members diagnosed with COVID-19 with source tracing

The Juvenile Coordinator consulted with the Division of Health for Unaccompanied Children (DHUC) to address the status of those infected to determine the minors who are in medical isolation. Figure 7 below provides the census data for the minors diagnosed with COVID-19 as of March 31, 2021.

Figure 7: Positive COVID-19 Minors Census Data as of March 31, 2021[5]

Program Name (Location)	Bed Capacity	Beds Occupied	Positive Minors Upon ORR Admission	Positive Minors Acquired in ORR care	Positive Minors Source Under Investigation
[redacted] (AZ)	20	20	1		
[redacted] (NY)	51	50	2	1	
[redacted] (TX)	192	189		1	
[redacted] (TX)	94	94	4		
[redacted] (TX)	53	49	1		
[redacted] (CA)	16	11	1		
[redacted] (TX)	374	374	30	3	1
[redacted] (TX)	80	77	8	4	
[redacted] (MD)	28	22	2		
[redacted] (WV)	20	19	2		
[redacted] (PA)	20	14	1		
[redacted] (TX)	86	75	1		
[redacted] (TX)	1008	879	70	15	1
[redacted] (NY)	4	4		1	
[redacted] (NY)	382	356	2		1
[redacted] (AZ)	28	25	2		1
[redacted] (NY)	24	23	1		
[redacted] (NY)	45	42	1		2
[redacted] (TX)	288	288	5	1	
[redacted] (TX)	46	46	2		
[redacted] (TX)	202	186	7		
[redacted] (TX)	85	85	4		

[5]Figure 7 is a result of the data gathered by the ORR Juvenile Coordinator in consultation with DHUC as it pertains to positive COVID-19 cases of minors throughout the shelter network. This information reflects the status as of March 31, 2021. In addition, the bed capacity and census for each shelter is a snapshot in time as this information is constantly changing as developments arise.

Program Name (Location)	Bed Capacity	Beds Occupied	Positive Minors Upon ORR Admission	Positive Minors Acquired in ORR care	Positive Minors Source Under Investigation
[redacted] (TX)	103	102	7		
[redacted] (TX)	61	53	3		
[redacted] (CA)	41	38	1		
[redacted] (TX)	72	66	1	2	
[redacted] (FL)	39	39	3	1	
[redacted] (IL)	42	40	2		
[redacted] (IL)	55	53	3		
[redacted] (IL)	185	181	10	2	
[redacted] (FL)	93	90	2		
[redacted] (TX)	2300	2245	67		
[redacted] (PA)	39	33	1		
[redacted] (TN)	62	62	4		
[redacted] (NY)	64	63	3		
[redacted] (NY)	63	59	5		
[redacted] (NY)	12	11	1		
[redacted] (TX)	608	592	14		
[redacted] (AZ)	45	45	2	1	
[redacted] (AZ)	25	18	1		
[redacted] (MI)	19	19	2	1	
[redacted] (CA)	1250	1175	1		
[redacted] (NY)	30	29	1		
[redacted] (TX)	48	48	3		
[redacted] (TX)	335	312	49		
[redacted] (AZ)	96	74	4	2	
[redacted] (AZ)	122	113	10		
[redacted] (TX)	30	30	10		
[redacted] (TX)	68	68	5		
[redacted] (AZ)	160	144	10	5	
[redacted] (AZ)	68	68	3	1	
[redacted] (TX)	159	158	6		
[redacted] (TX)	60	53	1		
[redacted] (TX)	600	554	17		
[redacted] (TX)	191	191	8		
[redacted] (TX)	184	175	10		
[redacted] (TX)	43	43	3		
[redacted] (TX)	293	292	19		
[redacted] (AZ)	164	161	10		
[redacted] (AZ)	41	41	4	1	
[redacted] (AZ)	90	82	2		

Program Name (Location)	Bed Capacity	Beds Occupied	Positive Minors Upon ORR Admission	Positive Minors Acquired in ORR care	Positive Minors Source Under Investigation
[redacted] (TX)	43	34	2		
[redacted] (TX)	103	103	9		
[redacted] (TX)	55	39	2		
[redacted] (TX)	116	113	17		
[redacted] (CA)	1250	1175	4		
[redacted] (TX)	28	26	1		
[redacted] (KS)	51	51	2		
[redacted] (TX)	20	20	1		
[redacted] (FL)	108	101	3		
[redacted] (AZ)	20	19	8		
[redacted] (VA)	84	84	5		

As of March 31, 2021, there are a total of 558 minors in ORR custody who have been diagnosed with COVID-19 who are currently in medical isolation. Five hundred nine (509) of these minors were diagnosed with COVID-19 prior to placement in ORR facilities, and forty-three (43) acquired COVID-19 while in ORR facilities.

As previously mentioned, ORR places minors newly referred along the Southwest Border into shelters local to the site of referral. On March 13, 2021, ORR issued guidance (COVID-19: Interim Guidance for Shortening Quarantine Duration and Increasing Testing for ORR Facilities) that now recommends minors be quarantined for seven days if they are tested within 48 hours before the end of their quarantine period and the test is negative. To decrease overcrowding at CBP facilities, shortening the quarantine period to seven days with a negative test result is advised based on CDC recommendations at all ORR facilities.

Minors in such quarantine are tested at least twice for COVID-19, once shortly after admission and again prior to release from quarantine. In the last year, approximately 52,000 COVID-19 viral tests have been completed for the unaccompanied minors in ORR's program.

According to the revised ORR guidance issued on March 25, 2021, contact tracing should begin immediately if anyone tests positive for COVID-19. Minors who test positive for COVID-19 will be isolated until they meet the criteria to discontinue isolation. Minors exposed to COVID-19 shall be quarantined for seven days and tested by the 5th, 6th or 7th day of their quarantine. Minors will be released from quarantine upon receiving a negative test result.

ORR does not require that staff disclose their private medical information as it relates to COVID-19; however, some staff voluntarily reported this information. Since collecting information, ORR has been notified of 1,496 (cumulative) personnel with positive COVID-19 test results as of March 31, 2021. Staff with suspected exposure to or positive COVID-19 test results are required to quarantine for at least 14 days. Furthermore, the exposed or infected staff are not permitted to have any contact with minors or other staff at the shelters until their quarantine has ended.

As a reminder, DHUC does not collect information about individual staff member's quarantine or isolation status to avoid obtaining or asking for any protected health information that DHUC does not have the legal authority to collect. Additionally, DHUC does not have public health jurisdiction over adult staff members; this falls to state and local health agencies.

At this time, care provider program staff who are eligible for the COVID-19 vaccine based on the CDC's Advisory Committee on Immunization Practices (ACIP) recommendations and the recommendations of their state and local jurisdictions may opt to receive the vaccine.

Description of ORR's COVID-19 plans in light of any recent updates to CDC guidelines and the start of vaccine distribution, including any steps to ensure prompt vaccination of personnel and residents.

On March 2, 2021, the President announced that he is directing all states to prioritize school staff and childcare workers for COVID-19 vaccination, and is challenging them to get teachers, school staff, and workers in childcare programs their first shot by the end of March. The Department of Health and Human Services has determined that staff in organizations caring for minors through the Unaccompanied Refugee Minors (URM) Program and Unaccompanied Children (UC) Care Provider Organizations are eligible for vaccination through this directive as childcare workers.

The CDC is working with states that have not yet included teachers, school staff, and childcare workers in their prioritization to ensure they have the support needed to make this change. CDC is identifying best practices for vaccinating these essential workers, as well as addressing barriers that immunization programs have experienced in order to share best practices and increase the efficiency of this effort.

States have been directed to make these workers eligible at all available vaccination locations. Teachers, school staff and childcare workers will also be offered the opportunity to be vaccinated at these sites if they wish to be. Additionally, the Federal Retail Pharmacy Program prioritized vaccinations for teachers, school staff and childcare workers during the month of March. Starting on March 8, 2021, teachers and school staff in pre-K-12 schools and childcare programs, including URM and UC care providers, were able to sign up for an appointment at over 9,000 pharmacy locations participating in the federal program nationwide.

ORR follows ACIP vaccine recommendations and guidelines for minors in ORR care, and this includes phased recommendations for the COVID-19 vaccine distribution. While supply is limited, allocation of COVID-19 vaccines is determined by the care provider's state and local jurisdictions.

As of December 20, 2020, ACIP recommends persons aged 16–17 years with high-risk medical conditions be included in Phase 1c of COVID-19 vaccination distribution (after Phases 1a and 1b, which include health care personnel, long-term care facility residents, frontline essential workers, and persons aged ≥75 years). Persons aged 16–17 years without high-risk medical conditions are recommended to receive the COVID-19 vaccine during Phase 2, along with all persons ≥16 years not previously recommended for vaccination. As of December 18, 2020, only the Pfizer-BioNTech COVID-19 vaccine is authorized for use in persons aged 16–17 years.

ORR works with care provider programs who might have the COVID-19 vaccine available through their jurisdiction, based on local distribution plans, to determine if any child currently in care is eligible to receive the vaccine. This includes a review of age criteria (16–17 years), expected unification timeline to ensure both doses could be provided without delaying a minor's release, and recent receipt of other vaccinations (given the lack of data on the safety and efficacy of COVID-19 vaccines administered simultaneously with other vaccines, CDC currently recommends that the vaccine be administered alone, with a minimum interval of 14 days before or after administration with any other vaccine).

ORR continues to closely monitor the development of ACIP recommendations and vaccine prioritization for COVID-19 vaccines, and to develop guidance specific to the COVID-19 epidemiology and operational complexities of the UC Program.

Summary

The undersigned respectfully submits this report to the Court pursuant to the Court Order dated March 19, 2021. The undersigned will continue to work independently and with the Special Master and will continue to file interim reports per the Court's directive to monitor facilities to assure compliance with CDC guidance and adherence to ORR guidelines.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary for Public Affairs

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of Refugee Resettlement

COVID-19: Interim Guidance for Shortening Quarantine Duration and Increasing Testing for Office of Refugee Resettlement Facilities

This document provides information on the impact of shortening quarantine duration and expanding screening testing regimes for all Office of Refugee Resettlement (ORR) facilities that serve unaccompanied children (UC). The document reflects current CDC guidelines and recommendations. Reducing the quarantine period and increasing testing measures will facilitate the movement of UC from U.S. Customs and Border Protection (CBP) to ORR border and interior facilities designed to house children and provide them with needed services.

There is a compelling need to minimize UC presence at U.S. Customs and Border Protection (CBP) facilities, and a much more suitable environment and improved conditions are afforded by ORR facilities relative to CBP facilities. CBP facilities are meant for short-term (72 hours or less) stays. At this time, CBP does not have adequate space for physical distancing, quarantine of persons exposed to COVID-19, or isolation of ill or infected persons. Because of the identified risks associated with overcrowding in CBP facilities, ORR shelters are advised to concurrently implement diagnostic testing regimes and shorten quarantine periods to seven days only if UC are tested within 48 hours before the end of quarantine and the test is negative.

To decrease overcrowding at CBP facilities, shortening the quarantine period to 7 days with a negative test result at all ORR facilities is advised based on CDC recommendations.

To decrease overcrowding at CBP facilities, shortening the quarantine period to 7 days with a negative test result is advised based on CDC recommendations at all ORR facilities.

In addition, CDC advises ORR facilities ensure:

1. All mitigation recommendations should be continued;
2. All facilities should consider screening staff and children with antigen test;
3. All new cases should be properly isolated and full contact investigation implemented; and
4. Staff are strongly encouraged to be vaccinated when eligible and available.

Risk considerations for COVID-19 among children and adolescents

Although children can be infected with SARS-CoV-2, can get sick from COVID-19, and can spread the virus to others, less than 10% of diagnosed COVID-19 cases in the United States have been among children and adolescents aged 5–17 years. Compared with adults, children and adolescents who have COVID-19 are more commonly asymptomatic (never develop symptoms) or have mild,

non-specific symptoms. Children are less likely to develop severe illness or die from COVID-19. Similar to adults with SARS-CoV-2 infections, children can spread SARS-CoV-2 to others, including when they don't have symptoms or have mild, non-specific symptoms. Because of limited space available in ORR facilities, some children may remain in CBP facilities awaiting placement and transfer. As a result of this delay, UC are at risk of delays in being referred to ORR facilities for care and of remaining in conditions that could elevate their risk of exposure to and infection with SARS-CoV-2. While expanding capacity, ORR facilities should strengthen mitigation to reduce risk of transmission and avoid outbreaks in facilities.

Risk considerations for congregate settings

Characteristics of congregate settings, including ORR facilities, affect exposure to and transmission of COVID-19. These factors may influence the potential benefits and risks of various option for length of quarantines. An ORR shelter would encounter challenges with complying with the recommendation in CDC's guidance for reduced quarantine, to continue monitoring children for symptoms of illness and continue mask-wearing through what would have been quarantine day 14 in instances where a child is transferred to another shelter or discharged to a sponsor after the 7-day quarantine period. Whenever possible, facilities are encouraged to carefully implement efforts for symptom monitoring through the quarantine period even with shorter quarantine implementation, which can include a mechanism for a secondary ORR shelter or a child's sponsor to report onset of symptoms after the 7-day period to identify potential exposures at the original facility. If a child remains in the same shelter where the quarantine occurred, monitoring for symptoms of COVID-19 and mask-wearing should continue. Failure to detect post-quarantine transmission rapidly could result in repeated cycles of having to medically isolate infected people and quarantine their close contacts.

Facility management that implements a reduced quarantine duration for children in ORR facilities should continue with their UC Prevention and Control Activities. These activities include testing newly admitted children without symptoms both on admission and again within 48 hours before the end of quarantine (e.g., day 5, 6, or 7) with confirmation of a negative test before release from quarantine; checking all children's temperature once a day; testing and isolating any child with signs or symptoms of COVID-19; and additional testing as recommended by the local health department. CDC recommends routine screening testing of staff for early detection of a possible outbreak (see below for details on routine screening testing). ORR should also continue to cohort children. Children with COVID-19, regardless of symptoms, must be isolated until they meet CDC criteria for release from isolation.

In addition, staff and visitors entering ORR facilities should adhere to all recommended mitigation strategies (e.g., mask wearing, physical distancing, hand hygiene, cleaning and disinfection, and proper ventilation). Staff and visitors who are symptomatic, or who have tested positive for SARS-CoV-2 regardless of symptoms, should not enter the facility until they have been determined not to have COVID-19 through negative nucleic acid amplification test (NAAT, for those who never tested positive) or they have completed the required 10-day isolation period. Additionally, staff and visitors who are not yet fully vaccinated who have been exposed in the past 14 days should also not enter the facility until they have completed quarantine; depending on the policies of local health authorities, this quarantine period could be 14 days, or a shorter period of 10 days without testing or 7 days with a negative test result on day 5 or later. Staff movement across the facility should also be limited as much as possible without disrupting facility operations. ORR contract staff working in facilities serving UC should also be encouraged to receive the COVID-19 vaccine, when eligible. ORR staff who have been fully vaccinated will no longer be required to quarantine following an exposure to

someone with COVID-19. As increasing numbers of staff become vaccinated, the risk for transmission within a facility is reduced.

Screening Testing: Repeat testing and/or expanded testing of children and staff

In ORR facilities with high to moderate transmission risk, ORR facility management should work collaboratively with local public health officials and the ORR Division of Health for Unaccompanied Children (DHUC) to develop a strategy for screening testing or of repeat testing of randomly selected asymptomatic staff and children at the facility, as feasible, to identify cases and prevent secondary transmission. Screening testing involves using SARS-CoV-2 viral tests (diagnostic tests used for screening purposes) to identify asymptomatically infected people without known exposure who may be contagious so that measures can be taken to prevent further transmission, namely, isolation of the infected persons and quarantine of exposed persons. Examples of screening testing include weekly testing of employees in a workplace and plans to test children and staff. Achieving substantial reductions in transmission with screening testing requires frequent testing and rapid reporting of results that may not be possible for every facility.

In any sampling strategy, testing of staff should be prioritized over testing of children, and older children prioritized over younger children, given the differing risks previously noted. ORR facilities should consider sampling staff from different parts of the facility to assess for possible SARS-CoV-2 spread. In facilities where three or more people test positive for COVID-19, ORR facility management should consider using NAAT to confirm as many rapid antigen tests as possible.

The frequency of screening testing can be determined based on the level of spread in a facility and/or in a community. Examples of testing frequency for a screening testing program include:

- Test non-vaccinated staff at least once per week. In areas with substantial and high community transmission, twice weekly screening testing may be preferable to more quickly detect infections among staff.
- Test children aged 5-18 once per week.
- Test a random sample of at least 10% of children each week. For example, an ORR facility might randomly select and test 20% of a facility's children each week. Alternatively, a facility might select to test one cohort or pod of children from different parts of the facility each week. Strategies to randomly select children may need to be adapted to the context of the ORR facility.

If a positive test result is returned from any of the strategies described above, the infected staff member or child should be isolated. If antigen testing was used, the positive result should be confirmed by NAAT. The infected person's close contacts should be identified, quarantined and tested. Due to challenges in tracing individual contacts in congregate settings such as ORR facilities, using quarantine cohorts where quarantine within units (such as a dormitory) may be the most feasible option for quarantine. All children residing in the same unit as the child who tested positive (or the unit where the staff member worked) should be considered exposed. The entire unit should be considered a quarantine cohort and thus children that have not been residing in this "unit" should not be added, and children from this quarantine cohort should likewise not be moved to another unit until the end of the quarantine period.

Before implementing any screening testing strategy, ORR facilities should work with the local health department and ORR DHUC to develop a confirmation and referral plan.

When considering which tests to use for screening testing, ORR facilities or their testing partners should select tests that can be reliably supplied and that provide results within 24 hours.

- NAATs are high-sensitivity tests for detecting SARS-CoV-2 nucleic acid. Most NAATs need to be processed in a laboratory with variable time to results (may be 1-3 days), but some NAATs are point-of-care tests with results available in about 15 minutes. Pooled NAAT testing — in which samples from multiple people are initially combined — may reduce costs and turn-around times. These may be considered for weekly screening testing in facilities or communities with moderate community transmission.
- Antigen tests are generally less sensitive than NAATs for clinical diagnosis. Most can be processed at the point-of-care with results available in about 15 minutes. In circumstances with low to medium pre-test probabilities, antigen test results may need confirmation with a NAAT, such as a negative test in persons with symptoms and a positive test in persons without symptoms.

For antigen tests, the immediacy of results (results in 15-30 minutes), their modest cost, and the feasibility of their implementation make them a reasonable option for ORR facility-based screening testing. The feasibility and acceptability of tests that use nasal (anterior nares) swabs make these types of tests more readily implemented in ORR facility settings. Tests that use saliva specimens may also be acceptable alternatives for younger children, if test results are available and results are returned within 24 hours. See Interim Guidance for Antigen Testing for SARS-CoV-2 for more information.

People who have recovered from COVID-19 in the past 3 months should be excluded from the random selection for screening testing. CDC guidance recommends including fully vaccinated persons in routine screening testing programs.

Contact tracing should begin immediately if anyone tests positive for COVID-19. Close contacts of persons with confirmed or probable COVID-19 should be tested and either isolated until they meet criteria to discontinue isolation (for persons diagnosed with SARS-CoV-2 infection) or quarantined for 7 days with testing on days 5, 6, or 7 and a negative test result (for persons exposed to a person diagnosed with SARS-CoV-2 infection). Fully vaccinated personnel who are considered close contacts do not need to quarantine but should be tested according to related guidance.

COVID-19 Reporting Requirements to ORR DHUC

ORR DHUC will continue to monitor COVID-19 test data across the UC Program network to assess the effectiveness of mitigation strategies. Therefore, all interventions undertaken to prevent transmission of COVID-19 at the care provider program must be documented in the UC Portal, including quarantine upon admission into ORR care, after transfer to a new ORR program, and as a result of a known exposure. Each COVID-19 test must be entered in the UC Portal regardless of the result. When a child tests positive for COVID-19, document the confirmed COVID-19 diagnosis in the appropriate health report in the UC Portal which will generate a notification to DHUC. In addition, notify DHUC via email at DCSMedical@acf.hhs.gov within 4 hours of receipt of the positive lab result. If other children were potentially exposed to the lab-confirmed child during the infectious period, document each potential exposure in the UC Portal and update the outcome of the public health investigation when the quarantine period is complete.

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

FIELD GUIDANCE – March 22, 2021

RE: ORR Field Guidance #10, Expedited Release for Eligible Category 1 Cases

GUIDANCE

The Office of Refugee Resettlement (ORR) prioritizes the placement of unaccompanied children (UC) with parents and legal guardians available to provide custody in the United States. To that end, ORR is instituting a revised policy of Expedited Release for Eligible Category 1 Cases. Under this revised policy, certain children will be released to their parents or legal guardians using specialized procedures that modify standard release requirements under ORR Policy Guide, section 2 and accompanying instruments. Due to the novel nature of this policy, and in recognition of operational flexibilities that may require additional follow up, these instructions may be further modified by ORR.

Expedited Release

As a preliminary step, a child may only be released to their parental or legal guardian sponsor under processes for Expedited Release for Eligible Category 1 Cases if the following three conditions for Expedited Release for Eligible Category 1 Cases are met:

- If the child is screened and determined to not be especially vulnerable;
- If the child is not be otherwise subject to a mandatory TVPRA home study; and
- If there are no other red flags present in the case, including red flags relating to abuse or neglect.

In the event any of these conditions apply, the case will follow standard sponsor assessment and release procedures, including completion of the Initial Medical Exam (IME).

Once the basic conditions listed above are met, care providers can release a Category 1 case provided the following steps are taken (further details on these processes are provided in the "INSTRUCTIONS" section below):

(1) Completion of a Modified *UC Assessment* for Expedited Release Cases

(2) Completion of Interviews with the Child and the Parent

(3) Completion of a Modified *Family Reunification Application*

(4) Establishment of Proof of Relationship and Identity

(5) Completion of Sponsor Background Check (no household member checks) with a valid *Authorization for Release of Information*.

(6) Completion of a Modified *Sponsor Assessment*

After completion of these requirements the Case Manager makes a release recommendation that is transmitted directly to the ORR Federal Field Specialist. No third-party Case Coordinator review of the case is required for Expedited Release for Eligible Category 1 Cases.

Transfer of Custody

After completion of the requirements above, and so long as no concerns relating to abuse or neglect exist, the child may be released directly to the sponsor's care.

In cases where Expedited Release for Eligible Category 1 Cases is appropriate, ORR authorizes care providers to pay for the sponsor's travel to the ORR care provider facility to pick up their child and complete paperwork at the facility (if allowed). ORR also authorizes care providers to pay other transport fees for return travel or allow for the child's transport to the sponsor's location following traditional transfer of physical custody policies under ORR Policy Guide 2.8.2, including ORR paying for such travel (including for escorts). Travel arrangements should be made as soon as it appears that the child's release is viable.

INSTRUCTIONS

The following section provides the care providers with instructions regarding the steps listed above that must be followed any time the Expedited Release for Eligible Category 1 Cases process is used.

In all Expedited Release for Eligible Category 1 Cases, the care provider is responsible for the following:

(1) Completion of a Modified *UC Assessment* for Expedited Release Cases

(a) Care provider staff completes a modified *UC Assessment* for Category 1 cases. If the case is later determined to require completion of a standard release, the care provider will make efforts to update the standard *UC Assessment* for the child.

(b) The Case Manager will upload the modified *UC Assessment* into the ORR database.

(2) Completion of Interviews with the Child and the Parent

The Case Manager interviews the child and parent separately to determine if there are any concerns related to trafficking or abuse. See ORR Policy Guide 2.2.1 and UC MAP 2.2.1.

(3) Completion of a Modified *Family Reunification Application*

(a) ORR plans to create a modified *Family Reunification Application* in the near future. Until a new form is created Case Managers working on the sponsors behalf will fill out the

standard *Family Reunification Application* (FRP-3 or FRP-3S), questions 1-11, and 15. The responses to the application questions are made during the sponsor interview.

(b) The Case Manager will read the contents of the *Sponsor Care Agreement* to the sponsor and ensure the sponsor agrees to those conditions of release.

(c) The Case Manager will read the attestation regarding perjury to the sponsor on page 7 of the *Family Reunification Application*. Additionally, the Case Manager will attest in the Release Request that they had the interview with the sponsor and obtained the sponsor's attestation.

(d) The Case Manager will upload the application into the ORR database.

(e) The Case Manager will then mail the *Family Reunification Packet* documents to the sponsor after the child's release, including the partially completed *Family Reunification Application* completed on the sponsor's behalf. Any discrepancies can be reconciled after the release. See ORR Policy Guide 2.2.3

(f) Importantly, Know Your Rights (KYRs) are not a requirement for release, but if a child has not received a KYR, release information may be shared with a Legal Service Provider (LSP) to facilitate legal services after the child's release.

(4) Establishment of Proof of Relationship and Identity

(a) The care provider will establish proof of the child's identity.

(b) The care provider will establish proof of the sponsor's identity and relationship to the child. This will be accomplished using supporting documentation such as birth certificates for the child and the sponsor, or other documents used to verify the sponsor's identity and prove the parent-child relationship (or legal adoption). Copies or photos of documents are allowed, including those taken on phones and texted or emailed to the care provider.

(c) **ALTERNATE PROCESS:** *DNA Collection and Results*

Alternatively, and where available, sponsors and children can prove biological parentage through DNA. Use of DNA is only used for purposes of establishing biological relationships for purposes of sponsorship and is not submitted to law enforcement personnel or run against law enforcement databases.

Submission of DNA by the parent is voluntary. Competent unaccompanied children aged 14 or over must voluntarily consent to DNA submissions. ORR will presume consent for children under the age of 14 for purposes of DNA submissions to establish relationship. In any event, ORR will provide advanced notice to a child's attorney of record that a DNA test will be conducted.

ORR will ensure that DNA results are destroyed within 15 business days following confirmation of the results by ORR or ORR contractors or grantees. Following confirmation of results, ORR will share results with the potential sponsor and may share results with the child after making a determination that sharing the results is in the child's best interest.

References to results of DNA tests are maintained in the ORR database but are considered confidential information and may only be disclosed as required by law.

DNA may be collected at a care provider site using rapid test results or through the use of an external laboratory.

(5) Completion of Sponsor Background Check using *Authorization for Release of Information*.

(a) The Case Manager will conduct a sponsor background check according to the following requirements:

(i) A parental sponsor undergoes a public records check following standard procedures. Please mail or have the sponsor fill out and submit any authorization forms (*Authorization for Release of Information*) required by the public records check vendor. The care provider may accept a photograph of a signed form for purposes of the public records check. Additionally, for purposes of Expedited Release for Eligible Category 1 Cases, no other background checks are required for other household members (alternate care givers need not be identified).

(ii) If the results of the sponsor's public records check come back with derogatory information that may lead to a denial of release under ORR Policy Guide 2.7.4, the case is no longer eligible for Expedited Release for Eligible Category 1 Cases and instead follows standard procedures. Please note only case review results that may lead to denial under section 2.7.4 are cases that are no longer eligible for release (e.g. DUIs are not an example of criminal history that would lead to a denial of sponsorship to a parent).

(6) Completion of a Modified *Sponsor Assessment*

The Case Manager completes a modified *Sponsor Assessment* and uploads the results to the ORR Database.

Recommendation and Decision Making

In all cases involving Expedited Release for Eligible Category 1 Cases, the Case Manager makes a release recommendation using only the information described in the preceding sections following procedures for straight release, without sending the case for a third party review by a Case Coordinator. The recommendation is then sent directly to the ORR Federal Field Specialist who makes a final release decision.