Learning from COVID-19: An Early Analysis of "Pain Points" in Congregate Care for Unaccompanied Children in Pandemic

By Mario Bruzzone

Readers will be well aware that the COVID-19 pandemic is ongoing. While many scientific questions about COVID-19 remain, scientists and public-health officials are reasonably certain about a number of aspects of the virus. Transmission is primarily airborne. Individuals have several days between contracting the virus and becoming symptomatic. A large proportion of people afflicted with COVID-19 will remain asymptomatic. Asymptomatic individuals can transmit the virus. And so on. With this knowledge, individuals have largely learned to live with COVID-19—working from home, social distancing, and wearing masks while in the proximity of others. So too have organizations.

COVID-19 presented challenges to congregate-care facilities, famously at nursing homes but also for facilities that care for unaccompanied children (UCs). The Office of Refugee Resettlement (ORR) operates a network of grantee facilities that provide care for UCs in the United States. UC care providers were put under tremendous strain by COVID-19, especially in the early period when knowledge was much less certain than it is now. Today, UC care providers have established policies and procedures for keeping UCs in their care safe, controlling subsequent infection when a child is diagnosed positive, and preventing onward spread of disease. USCRI regularly talks with several care providers and organizes an affinity group that meets quarterly, and this brief is based on those ongoing conversations.

Learning from COVID-19 is crucial, both to being prepared for the next outbreak and as a stress event that shows problems that persist even apart from crisis situations. This brief identifies five "pain points" around the response to COVID-19 for the care of unaccompanied children. Rather than being comprehensive, the brief is meant to mark a moment in time, while the procedures are well-known and their successes and limitations are front-of-mind. The brief is meant to memorialize a moment when the initial chaos of the pandemic has abated, but while the pandemic-safety procedures are ongoing—a first pass, and material that should inform any comprehensive later account. If some issues raised here are moot—for example, a lack of focus on utilization rate (pain point #4)—they might still identify faults in communication rather than procedure. By capturing information now, this brief means to help inform future response without looking to assign blame. We are all learning from COVID-19 as we go.

COVID-19 Pain Point #1:
Delegation of Responsibility between ORR and State Licensing Agencies

The ORR shelter system requires that facilities be licensed by their individual states to provide care. In other words, and in normal circumstances, ORR relies on state licensing agencies to guarantee that facilities are safe, suitable, and up to code. Partly this is for legal reasons, as the *Flores* Settlement Agreement requires that facilities be state-licensed. ORR provides additional requirements and guidelines for shelters and other facilities (e.g., group homes), which pertain to the special needs of unaccompanied children as a population—for example, abuse reporting guidelines that are appropriate to children who come from a variety of cultural backgrounds, speak a variety of languages,

are alone, and may have suffered severe trauma. ORR rules are also very specific for placements out of the ORR system, whether to families or into other facilities, such as those run by states.

In the COVID-19 pandemic, ORR issued four field guidances to care providers. The first ORR field guidance required temperature checks. The second set standards for verbal screenings for staff and visitors. The third again required temperature checks, essentially updating the first guidance. The fourth provided procedures to medically clear unaccompanied children before they could be released either to homes or providers outside of the ORR network. For some ORR providers, state child-welfare agencies had already issued or soon thereafter issued stricter guidance. For others, state agencies provided guidances that covered different areas of care. Integration and synthesis were done provider-by-provider. Likewise, some providers have reported that, during the height of the pandemic, their staff was unsure whether unaccompanied children had specific needs or risks that differed from the general population that they serve.

COVID-19 Pain Point #2:
Coordination Problems around PPE, Medical Screenings, and Testing

At the outset of the pandemic, providers faced significant uncertainty in how best to keep UCs safe within facilities. Uncertainty is normal for emerging infectious diseases. ORR provided advice to UC care providers for safe procedures as well as input for safe transfers, but advice was sporadic and not comprehensive. Consequently, care providers and individual facilities designed individually appropriate practices based on the best available information at the time and state guidelines. The variability in approach created challenges within the network of ORR care providers, particularly when UCs are transferred between facilities. Over time, providers have learned to manage the specific issues related to COVID-19, as described below. A future health emergency is likely to run into similar but non-identical situations.

Generally, care providers trusted that other care providers performed their due-diligence in screening UCs for COVID-19 and made good-faith efforts to restrict the transmission of the disease. For transfers between programs, most (but not all) receiving programs required a negative COVID-19 test. However, shelters knew that a negative test does not ensure that an individual is free of COVID-19; rather, it is the conjunction of reliable testing and safety protocols within care facilities—the use of personal protective equipment (PPE), physical distancing, air filtration, and so forth—that keep COVID-19 from spreading. In this context, care providers identify ORR's lack of additional funding for PPE, increased medical screenings, and testing as a source of uncertainty in the height of the pandemic. COVID-19 put many organizations under financial strain, including some care providers. Care providers did not know what procedures other care providers had taken, in part because many of these measures were difficult to convey with precision, but also because they did not know if financial exigencies had forced other providers to use a cheaper but riskier approach to preventing COVID-19 spread than their own. As above, differing state guidelines for congregate-care facilities also played a role in uncertainty. Learning from this, we should note that the situation presented is largely a coordination problem—each provider believed that each other provider to be working in good faith, but nonetheless could not trust that a new arrival would be free of COVID-19.

COVID-19 Pain Point #3:
Communication Between Providers, and from Providers to ORR

At several points in the COVID-19 pandemic, ORR asked or required care providers to submit information on facilities' procedures and health protocols. Information requested included intake processes, testing of transfers within the ORR network, safety measures for support staff, quarantine protocols, and isolation protocols. ORR data-gathering was important in the moment and will likely be important in formulating improvements. After providing this information to ORR, providers

began to feel an absence of collaboration and information-sharing. Some facilities recognized that they had struggled on how to take in new UCs and facilitate transfers while keeping current shelter residents and staff safe. Others felt that they had been successful or had innovated, and wanted to share best-practices. Retrospectively, many providers felt that the lack of communication between providers was a missed opportunity to support other programs, learn, increase standardization, effectively increase trust between facilities, and increase efficiency. Facilities vary in physical layout, and so even changes to internal physical layout might have been helpful. A few programs also felt that, although they had strong relationships with ORR staff, they lacked a collective venue for information-sharing upward as well as the validation that their experiences were typical and thus their ideas appropriate to share. Moving forward, USCRI will use our Affinity Group to better connect providers on best practices, filling this gap to some degree.

COVID-19 Pain Point #4:
Lack of Systemic Focus on Utilization Rate

ORR commonly reports its "census": the number of beds currently occupied and the average length-of-stay in care. Intuitively the metrics make sense, because they are easy to understand and because they answer the questions of *How many children does ORR have?* and *How long have they been in ORR custody?* In the months immediately prior to the pandemic's onset in the United States, the census typically showed 3000-5000 UCs in care, with an average length of stay around 40 days. It's tempting to think of the ORR "census" on the model of a census—a static measure of one point in time—or a hospital—where UCs are in care until they are "well" enough to depart. However, ORR's primary goal as dictated in *Flores* is safe reunification. A better mental model than "census" or "hospital" is "subway station": each station has a maximum number of people who can stand on the platform, but if more trains run, then the capacity of the station goes up. The maximum capacity is figured as utilization rate. Utilization rate is better than a static count because maximum capacity is not the same as static capacity: A shelter with 10 beds has a static capacity of 10 children, but if the shelter reunified each child each day, then the monthly maximum capacity would be 300 (10 children x 30 days) and utilization rate is 100%. Other measures, such as length-of-stay, can be helpful but less so in a public-health crisis. For example, many UCs who are classified as Category 4 cases—the hardest to place—never left care during the pandemic. Their presence does not strongly impact utilization rate, but it does impact length-of-stay, which is an average across all children in the ORR system.

In response to the COVID-19 pandemic, many shelters took measures to reunify UC with families more rapidly. Swifter reunifications decrease utilization rate, freeing beds and space for social distancing in shelters. Care providers took measures that included speeding outreach and vetting of sponsors, as well as accelerating the placement of individual youth into facilities other than congregate care. In some cases, ORR made post-release services more widely available, which also speeds release. At the same time, care providers and ORR needed to ensure that COVID-19 safety protocols were in place in the home to which the child would be released, sometimes slowing down the release process. Moving forward, ORR and care providers should work together to balance the specific needs during the pandemic for safe and timely releases.

COVID-19 Pain Point #5:
Planning for Scale in Utilization

ORR planning correctly identified intakes at care-provider facilities as a potential bottleneck. Because individuals who contract COVID-19 can transmit the virus while asymptomatic, and because it can take several days between contracting the disease and a positive test, shelters are required to quarantine incoming transfers into facilities. Guidance so far has focused on low numbers of transfers into shelters each day. With low numbers, individual quarantine is possible and reasonable. However, providers

recognize that there are possible scenarios in which safe quarantine procedures exist but not on an individual-isolation model for larger numbers of transfers. For example, a public-health measure within care-provider facilities to separate UCs into pods and then doing group-testing would be appropriate in situations where multiple children arrive at a provider each day. This concern can be understood as related to utilization rate: if rates are below a certain number, individual quarantine is appropriate. If utilization goes higher than that number, intake procedures switch over to a different model for quarantine and COVID-19 safety. Currently care providers are unsure what the utilization rate is that would trigger adjusted intake procedures. An ongoing assessment by ORR would be beneficial to the network. releases.

COVID-19 Pain Point #5:
Planning for Scale in Utilization

Uniformly, ORR and UC care providers have taken COVID-19 seriously. Most of the pain points presented here have an implicit fix, but the method of achieving that fix is open. For example, ORR might take steps to increase communication between providers regionally, since COVID-19 outbreaks seem to occur in regional clusters. Alternatively, ORR might organize calls between providers based on facility size, since best practices in larger shelters will systematically vary from best practices in smaller shelters. ORR has collected data from shelters during the pandemic, and that data can inform immediate and after-the-fact improvements. Moreover, comparison with pandemic responses and needs in other types of congregate-care facilities might reveal unmet needs that are particular to UC care. Multiple companies are said to be close to having a vaccine for COVID-19. But even with immediate release of a vaccine, or several, it will be some time before the population in the U.S. is fully vaccinated, much less the world's population of 7.5 billion.