

ANNUAL REPORT 2020

OFFICE OF THE IMMIGRATION DETENTION OMBUDSMAN

January 19, 2021





**Homeland
Security**

January 19, 2021

The Honorable Ron Johnson
Chairman
Committee on Homeland Security &
Governmental Affairs
United States Senate
Washington, DC 20510

The Honorable Lindsey Graham
Chairman
Committee on the Judiciary
United States Senate
Washington, DC 20510

The Honorable Gary Peters
Ranking Member
Committee on Homeland Security &
Governmental Affairs
United States Senate
Washington, DC 20510

The Honorable Dianne Feinstein
Ranking Member
Committee on the Judiciary
United States Senate
Washington, DC 20510

The Honorable Bennie Thompson
Chairman
Committee on Homeland Security
United States House of Representatives
Washington, DC 20515

The Honorable Jerrold Nadler
Chair
Committee on the Judiciary
United States House of Representatives
Washington, DC 20515

The Honorable John Katko
Ranking Member
Committee on Homeland Security
United States House of Representatives
Washington, DC 20515

The Honorable Jim Jordan
Ranking Member
Committee on the Judiciary
United States House of Representatives
Washington, DC 20515

Dear Chairmen and Ranking Members:

The newly formed Office of the Immigration Detention Ombudsman is pleased to submit its 2020 Annual Report pursuant to 6 U.S.C. § 205. I am available to provide additional information upon request.

Sincerely,

A handwritten signature in blue ink that reads "Luke Bellocchi".

Luke Bellocchi
Ombudsman for Immigration Detention

Message from the Ombudsman



I am pleased to present the first Office of the Immigration Detention Ombudsman’s Annual Report to Congress. The Office of the Immigration Detention Ombudsman (OIDO) is a new and independent office within the Department of Homeland Security (DHS). The mandate of the office is to: assist individuals with complaints about the potential violation of immigration detention standards or misconduct by DHS (or contract) personnel; provide oversight of immigration detention facilities, including conducting unannounced inspections and reviewing contract terms for immigration detention facilities and services; and serve as an independent office to review and resolve problems stemming from the same. The Ombudsman’s Office was established by Congress ([Sec. 106 of the Consolidated Appropriations Act, 2020, Public Law 116-93](#)) and is

not a part of U.S. Immigration and Customs Enforcement (ICE) or U.S. Customs and Border Protection (CBP).

As an independent office that answers directly to the DHS Secretary, OIDO will objectively evaluate whether DHS components are in compliance with detention laws, regulations, and standards by issuing findings and recommendations that are viewed as impartial and without bias. As noted in this report, there are various other government offices that have oversight responsibility for issues related to immigration detention. As its statutory mandate requires, OIDO must “[e]nsure that the functions performed by the Ombudsman are complementary to existing functions within the Department of Homeland Security.” As a direct result of its discussions with these various entities, OIDO plans to take an active role in deconflicting immigration detention-related complaints and investigations to ensure that multiple offices are not unknowingly investigating the same complaint at the same time, thereby improving the efficiency and effectiveness of handling detention-related complaints at DHS.

The following report serves as the inaugural annual report of this office, as required by statute, and serves to provide a basic understanding of various aspects of immigration detention from the point of apprehension to release or removal. Although the report serves to describe the situation in very broad and general terms, it may occasionally make reference to legal cases, statutes, and regulation; however, this document is not intended to serve as a legal document for use in litigation or other legal forums. I want to thank the OIDO staff for their contributions to this important report, including especially Maryellen Meymarian, Allison Posner, Capt. Chiara Rodriguez (PHSO), and George Sterling.

My hope is that this report serves as an informative resource on immigration detention issues and as a basis for this office to examine these issues in more detail.

Submitted with sincere wishes to improve the conditions of immigration detention under current law,



Luke Bellocchi

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I. A New Component within DHS: The Office of the Immigration Detention Ombudsman

On December 20, 2019, through the enactment of the Consolidated Appropriations Act, 2020 (Sec. 106 of [Pub. L. 116-93](#); 6 U.S.C. 205), Congress created the position of the Immigration Detention Ombudsman within the Department of Homeland Security. The key legislative language reads as follows:

“SEC. 405. OMBUDSMAN FOR IMMIGRATION DETENTION.

“(a) IN GENERAL.—Within the Department, there shall be a position of Immigration Detention Ombudsman (in this section referred to as the ‘Ombudsman’). The Ombudsman shall be independent of Department agencies and officers and shall report directly to the Secretary. The Ombudsman shall be a senior official with a background in civil rights enforcement, civil detention care and custody, and immigration law.

“(b) FUNCTIONS.—The functions of the Ombudsman shall be to—

“(1) Establish and administer an independent, neutral, and confidential process to receive, investigate, resolve, and provide redress, including referral for investigation to the Office of the Inspector General, referral to U.S. Citizenship and Immigration Services for immigration relief, or any other action determined appropriate, for cases in which Department officers or other personnel, or contracted, subcontracted, or cooperating entity personnel, are found to have engaged in misconduct or violated the rights of individuals in immigration detention;

“(2) Establish an accessible and standardized process regarding complaints against any officer or employee of U.S. Customs and Border Protection or U.S. Immigration and Customs Enforcement, or any contracted, subcontracted, or cooperating entity personnel, for violations of law, standards of professional conduct, contract terms, or policy related to immigration detention;

“(3) Conduct unannounced inspections of detention facilities holding individuals in federal immigration custody, including those owned or operated by units of State or local government and privately-owned or operated facilities;

“(4) Review, examine, and make recommendations to address concerns or violations of contract terms identified in reviews, audits, investigations, or detainee interviews regarding immigration detention facilities and services;

“(5) Provide assistance to individuals affected by potential misconduct, excessive force, or violations of law or detention standards by Department of Homeland Security officers or other personnel, or contracted, subcontracted, or cooperating entity personnel; and

“(6) Ensure that the functions performed by the Ombudsman are complementary to existing functions within the Department of Homeland Security.

The Department of Homeland Security quickly took steps to implement this new law. On January 28, 2020, the Senior Official Performing the Duties of the Deputy Secretary selected two senior DHS officials and charged them with setting up the new office.

A. Formation of the New Office

DHS leadership assembled a cross-component working group of senior-level staff members to identify existing lines of effort within DHS involved in detention oversight, examine statutory authorities and mission requirements, and solicit recommendations for the OIDO organizational structure. While all components were invited to participate, the most active participants were officials from agencies with significant equities in the OIDO: U.S. Customs and Border Protection (CBP), U.S. Immigration and Customs Enforcement (ICE), the Office for Civil Rights and Civil Liberties (CRCL), U.S. Citizenship and Immigration Services (USCIS), DHS Policy (PLCY), Office of General Counsel (OGC), and the Office of the Chief Financial Officer (OCFO). The working group held several meetings. In these meetings, senior DHS professionals were able to highlight the core programs they currently manage that provide detention oversight.

As noted below, ICE currently has a multi-faceted audit program, which includes contracted, external audits and internal audits performed by ICE’s Office of Detention Oversight within the Office of Professional Responsibility. In addition, ICE maintains several ways to receive complaints from detainees, including the Detainee Reporting and Information Line (DRIL), managed by ICE’s Custody and Management Division, and the Joint Intake Center, which is managed by ICE’s Office of Professional Responsibility. CBP also receives detainee complaints through the Joint Intake Center, overseen by CBP’s Office of Professional Responsibility, and manages an internal audit program, the Self-Inspection Program, through CBP’s Office of Accountability. Finally, both CBP and ICE have processes to review compliance with the Prison Rape Elimination Act (PREA).

In addition to these CBP and ICE programs, CRCL and the Office of the Inspector General (OIG) have established programs and processes for taking in detainee complaints and conducting audits and investigations of immigration detention facilities.

Based on information derived from the working group and the requirements of OIDO’s enacting legislation, several steps were developed to establish the OIDO.

Among these, the priorities identified were:

1. Develop two core program areas:
 - (a) the provision of individual assistance to detainees, and
 - (b) detention oversight.
2. Create a case management system to manage detainee complaints.
3. Begin staffing by bringing in knowledgeable and experienced detailees from other DHS components, while simultaneously working to hire permanent staff.

During the first half of 2020, OIDO also drafted a plan to establish the Office of the Immigration Detention Ombudsman within the Department of Homeland Security and articulate authorities as granted to the Immigration Detention Ombudsman through the enacting legislation.

OIDO began to execute its plan to stand up the Office, initially through a DHS senior official detailed to the Office, and then through the appointment of the first Ombudsman. First, OIDO acquired three detailees to develop the core program areas: individual assistance and detention oversight. Two of the detailees were professionals from ICE who have significant operational and legal experience related to immigration detention. The third was the lead case management expert from the Office of the Citizenship and Immigration Services Ombudsman. OIDO also hired a human resources specialist to help manage hiring activity and the onboarding of new employees. Simultaneously, OIDO began working with the Office of the Chief Human Capital Officer (OCHCO) -- the human resources office within DHS headquarters -- to develop position descriptions for the first tier of managers and subject matter experts. It also set up weekly meetings with senior staff at the Office of the Chief Financial Officer (OCFO) to monitor spending and manage other financial obligations. OIDO has also secured initial office space and equipment at St. Elizabeth's (DHS headquarters) and is exploring the possibilities of procuring space within the National Capital Region (NCR) and establishing regional offices.

As OIDO moves into 2021, it now has on the payroll the following personnel: an Ombudsman, a Deputy Ombudsman, a Director of Detention Oversight Investigations (DOI), an Acting Director of Case Management, a Director of Operations, a Data and Systems Analyst, two human resource specialists, an Assets and Logistics manager, a detailee advising on ICE detention facilities and one advising on medical investigations. Over the next month, the following personnel will join the office: a Director of Detention Oversight Policy (DOP), a Deputy Director of DOI, an Assistant Director of DOI, a Director of External Affairs, a Director of Case Management, two Program Management Analysts for DOI, and four subject matter experts covering medical issues, contracts, immigration detention standards, and agency procedures to work with DOI and DOP. Finally, OIDO has made significant progress on the development of a case management system, which will not only support the intake and resolution of individual complaints but will also support the detention oversight team as it executes inspections and investigations.

B. Mission and Vision

Leadership formulated the following statements to set the tone for OIDO business as the office expands and gains its footing.

Leadership Statement

The Office of the Immigration Detention Ombudsman (OIDO) acts as an independent office within the Department of Homeland Security (DHS) to resolve problems related to the detention of individuals and families, as mandated under current immigration law. The Office respects the difficult and often dangerous work of those enforcing the nation's immigration laws, while also working to ensure humane conditions for foreign nationals held in detention. Our focus will be to research individual and policy-level conditions of immigration detention and provide well-supported and well-reasoned recommendations to improve the conditions of immigration detention. In all times, the Ombudsman's Office shall serve its mission to provide an independent, credible, and even-handed approach to addressing these issues and provide fair resolution to aggrieved parties.

Mission Statement

OIDO is committed to actively contributing to DHS' mission by addressing individual and systemic concerns related to the detention of individuals under current immigration law. These concerns include noncompliance with immigration detention standards as articulated in Customs and Border Protection's (CBP) National Standards on Transport, Escort, Detention, and Search (TEDS) and Immigration and Customs Enforcement's (ICE) various detention standards including the Performance-Based National Detention Standards (PBNDS), the National Detention Standards (NDS), and the Family Residential Standards (FRS). To achieve these goals, the office will:

- administer an independent, neutral, and confidential process to receive, investigate, resolve, and provide redress related to allegations of misconduct or violations of individual rights in the immigration detention setting;
- establish and maintain a process to accept complaints against any government employees, contracted, subcontracted, or cooperating entity personnel or their proxies related to immigration detention;
- conduct announced and unannounced inspections of immigration detention facilities;
- examine and make official recommendations to address concerns identified in investigations related to immigration detention facilities and services; and
- work with other components as a complimentary function of the Department.

OIDO will accomplish its mission by always maintaining its core values of:

- Integrity;
- Credibility;
- Objectivity;
- Independence;
- Treating all individuals with respect and dignity;

- Recommending reasonable and realistic solutions; and
- Ensuring humane conditions exist for those in detention.

Vision

OIDO will be seen by the Department, Congress, the general public, and detained individuals as a credible and effective force in: (1) stemming medical, familial, and civil rights problems at individual detention centers from becoming systemic problems; (2) working with the Department to ensure that conditions are humane for detainees; (3) managing the intake of complaints regarding detainee conditions, including those involving misconduct, providing triage for those complaints, and resolving adverse conditions in detention through engagement with relevant offices within DHS; (4) maintaining or improving the integrity of the immigration detention system, while accurately documenting agency compliance with articulated detention standards; and (5) engaging in detailed evaluation of detention conditions and providing well-supported and well-reasoned recommendations for their improvement.

C. Development of a Case Management Process

In May 2020, OIDO brought on an Acting Director of Case Management on detail from the Office of the Citizenship and Immigration Services Ombudsman (CISOMB). The Director began communication with the Department's Office of the Chief Information Officer (OCIO) to take steps to develop a case management system, website, and other technology for the office. After getting through the procurement process to fund the technology project and get a signed Memorandum of Agreement (MOA), OCIO and OIDO brought together a team of contract developers, including a Project Manager who had previously worked on CISOMB's case management system and an expert with many years of experience working in ICE's Enforcement and Removal (ERO) programs. As a first technology step, an internal site was set up for document storage and sharing among the OIDO team.

On August 26, 2020, OIDO held a kickoff meeting with the OCIO staff and contract team to establish a timeline and map out the steps to get a basic product, known as ID-CMS, operational by February 2021. Additional releases will be rolled out over the three years of the contract. The team meets daily to elicit requirements for the case management system using lessons learned from CISOMB's nine-year-old case management system. In October, the office welcomed to the staff a Data and Systems Analyst who brings broad experience with various ICE and USCIS databases. Through daily meetings, OIDO staff have initiated conversations about other, similar systems within the department and viewed demonstrations of several of these existing programs to learn more about options and make further determinations about system requirements. The OIDO staff has also worked with OCIO to compile reference documents including user guides, standards, process flows, and sample reporting from other systems and groups. The OCIO team continued to gather requirements for the very specific needs of the system -- from intake, documentation gathering, case review, assignment, and analysis to resolution of each complaint, as well as how the system will be used for maintaining records about individual detention facilities and standards, and documentation gathered through facility audits.

Staff also discussed ways the public will access the office, including a website, a portal for online filing of the Ombudsman's complaint form, and a call center. To achieve its statutory mandate of

providing an independent, neutral, and confidential process to receive complaints from detainees in immigration custody, the office has been investigating a variety of ways detainees may submit complaints, while using the existing infrastructure resources available. At present, ICE uses a computer tablet in over half of its facilities to allow detainees to access a variety of services and communication options. The main vendor of the tablets is Talton Communications, Inc. OIDO investigated the use of the ICE Talton tablet and its potential to allow detainees to file complaints directly with OIDO using this technology. At present, detained aliens in certain ICE facilities can use the tablets to communicate with ICE officers and detention staff, including to file internal complaints. In September of 2020, OIDO engaged in discussions with Talton staff to review the functions and limitations of its tablet. On October 1, 2020, an OIDO staff member traveled to the Elizabeth Detention Facility in New Jersey and conducted a live video demonstration with OIDO and its development team to demonstrate the functions of the tablet. OIDO determined that this technology, and the potential to expand to other detention-related tablets, would be an effective way for certain detained aliens to file complaints with OIDO.

After months of gathering and understanding the full requirements and needs of every user of the system (e.g., detainees who will file a complaint from within a facility, their representatives, OIDO case analysts, team managers, auditors, and oversight staff) the development team set out its plan with each requirement as a separate step, including the approval and acceptance criteria the Ombudsman will use to know when each phase is complete. The development, begun on December 7, 2020, will be done in Agile style – in two-week sprints of work that will allow the Ombudsman to see progress and test parts of the system throughout. The initial “minimally viable product” is expected to be available in early February 2021.

The Office of the Immigration Detention Ombudsman page has been set up on DHS’ website, linked to the Department’s pages on Immigration and Customs Enforcement and Border Security: <https://www.dhs.gov/office-immigration-detention-ombudsman>. As decisions are made about the case management system and office processes are established, the office continues to work closely with Department experts on privacy, as well as records management and retention. Each phase requires the Privacy Office’s approval, including the intake form, the case management system that will store complainant and detainee information, and the site visit and audit processes. Privacy Threshold Agreements for each step of the process are in review by the various offices within the Department. Next steps include drafting and approval of Privacy Impact Assessments and review and approval of the Office’s intake form by the Office of Management and Budget.

A flow chart of OIDO’s anticipated process for handling complaints can be found in the appendix.

D. Detention Oversight Investigation and Policy

OIDO has established two separate roles for Detention Oversight -- investigation and policy. The offices will be known as Detention Oversight Investigation (DOI) and Detention Oversight Policy (DOP). These offices will work jointly on the oversight role.

The investigation team will conduct announced and unannounced visits to Immigration and Customs Enforcement (ICE) and Customs and Border Protection (CBP) facilities throughout the United States. Visits may be initiated as a result of trends identified through casework, inconsistent

results of audits conducted by other agencies, current events, or other factors. Inspections will focus on reported or suspected violations of applicable detention standards. Reports outlining findings and proposing operational, contractual, or other changes will be issued at the conclusion of each investigation.

OIDO staff had the opportunity to observe a virtual investigation conducted in September by the DHS Office of Civil Rights and Civil Liberties and determined that, despite the risk to government staff, in-person travel is essential to observe conditions in detention centers firsthand. OIDO staff began visits to facilities in October, as described below. OIDO will continue to travel for informational sessions and investigations unless conditions related to the Coronavirus Disease 2019 (COVID-19) significantly impact travel, or it is deemed unsafe due to active virus conditions at designated locations.

To succeed in its oversight role and establish credibility with members of Congress, DHS, and the public, OIDO will seek to gradually implement the standards found in the December 2020 Council of the Inspectors General on Integrity and Efficiency’s “Quality Standards for Inspection and Evaluation” (Blue Book) and also incorporate other best practices in government performance auditing as applicable. The best way to improve DHS operations is for OIDO to provide timely, credible reports that are based on high ethical principles and professional competency.

The policy team will support the investigative team through subject matter experts (SME) and overseeing contracted experts. Staff will focus on identifying large policy or procedural changes that can be made in the immigration detention context. OIDO’s initial plans are to focus on getting in-house experts with the following experience: medical (a physician and an investigative nurse), contracts, family and unaccompanied alien children (UACs), detention standards, and civil rights.

E. Training

OIDO has investigated training options for its staff to rapidly develop skills necessary to conduct investigations. OIDO is entering into a contract with the GAO Center for Audit Excellence (CAE)¹ to offer technical assistance to the office in evaluating program and training needs. OIDO has also identified training classes through Graduate School USA on standards for government performance audits that can be immediately accessed.² OIDO is also engaging with Federal Law Enforcement Training Center (FLETC) certified instructors to provide the office with a customized version of FLETC’s Internal Affairs Investigative Training Class to be provided virtually.

To gain a greater understanding of medical issues, ICE’s Health Service Corps (IHSC) has been providing regular informational sessions on a variety of topics to OIDO staff, including the behavioral health, dental, and pharmacy programs. These topics have included a review of IHSC’s organization, structure, duties, and a review of its first annual report.³ These sessions have allowed OIDO staff to gain valuable insight into the complexities of providing medical care and services in a detained setting, as well as to understand the additional COVID-19 concerns.

¹ CAE <https://www.gao.gov/about/what-gao-does/audit-role/cae>.

² The Graduate School, <https://www.graduateschool.edu/training/curriculum-offerings/auditing>.

³ US ICE Health Services Corps Fiscal Year 2020, <https://www.ice.gov/doclib/about/offices/ihsc/pdf/IHSCFY20AnnualReport.pdf>.

II. DHS Detention Authority

The Immigration and Nationality Act (INA) provides DHS the authority to detain certain non-U.S. nationals (“aliens”). The INA defines the term “alien” as “any person not a citizen or national of the United States” (8 U.S.C. § 1101(a)(3)); to avoid confusion, this report will use this legal term throughout. Sometimes immigration detention is mandatory, and sometimes it is discretionary. The purpose of detention is to ensure that detainees appear in immigration court when there appears to be a high likelihood that they will not; mandatory detention is set in statute for these situations.

In many ways, detention for alleged immigration violations is similar to detention that is required when the U.S. Marshals take custody of individuals who are indicted (but not convicted) of a federal criminal violation and place them into pre-trial custody until a court hearing determines their innocence or guilt (at which point, they are released or sent to prison to serve their criminal sentence). In many of those cases, there is an opportunity to establish release based on a bond; in most immigration detention cases, there is also an opportunity to establish release on conditions set by DHS.

Detention authority is complex. Whether an alien is subject to discretionary or mandatory detention depends on various legal and factual issues.⁴ Factors taken into consideration may include whether an alien: is seeking admission at an authorized port-of-entry (but is found to be legally inadmissible by CBP); has entered the U.S. without authorization and inspection (often at an unauthorized border crossing); has been lawfully admitted, but either violated the terms of admission or overstayed the authorized term of stay; has been issued a final order of removal by an immigration judge after a hearing; and/or has engaged in unlawful activity or other immigration violations. At present, detention authority is subject to numerous ongoing litigation challenges, and legal authority even varies among the federal court circuits.

The main statutory provisions of the current immigration detention framework are as follows:

- INA § 235(b) Inspection of Applicants for Admission
- INA § 236 Apprehension and Detention of Aliens
 - (a) Discretionary Detention
 - (c) Mandatory Detention
- INA § 238 Expedited Removal of Aliens Convicted of Committing Aggravated Felonies
- INA § 241 Detention and Removal of Aliens Ordered Removed

In general, detention is mandatory when an alien: has been convicted of a crime that makes him/her deportable, is at a port of entry and appears to be inadmissible (and is held in custody until return transportation is arranged), or is under a final order of removal by an immigration judge. The list of crimes referred to above includes the following general descriptions – crimes involving moral turpitude, possession of controlled substances, drug trafficking, human trafficking, money

⁴ See e.g. *Matter of R-A-V-P-*, 27 I&N Dec. 803 (BIA 2020); *Matter of M-S-*, 27 I&N Dec. 509 (A.G. 2019); *Matter of Guerra*, 24 I&N 37 (BIA 2006) (relevant factors considered for bond determination).

laundering, aggravated felonies, unlawful possession of a firearm, and terrorism (not an exhaustive list).

Detention is discretionary for the majority of aliens in removal proceedings. Depending on a variety of factors, detainees may be released or paroled. Individuals may be released on their own recognizance, or they may be required to post a bond and/or may be placed on “alternatives to detention” (ATD), which may include wearing an electronic ankle bracelet or checking in with ICE through the use of a location-tracking phone application. The conditions of release are designed to ensure appearance at immigration court hearings and to carry out a final removal, if ordered by a court. Those who do not appear for their court date are called “absconders.” Factors considered when assessing an individual for discretionary release include the possibility of immigration relief options, including asylum. A brief overview of U.S. asylum processing is available in the Citizenship and Immigration Services Ombudsman (CISOMB) Annual Report for 2020.⁵

⁵ CISOMB Annual Report 2020, June 30, 2020 starting at 41, https://www.dhs.gov/sites/default/files/publications/20_0630_cisomb-2020-annual-report-to-congress.pdf.

III. Immigration Detention Facilities and Standards

The two main DHS agencies responsible for the detention of aliens are U.S. Customs and Border Protection (CBP) and U.S. Immigration and Customs Enforcement (ICE). As law enforcement agencies responsible for civil and criminal enforcement of the INA, CBP and ICE routinely detain aliens subject to removal proceedings for the purposes of ensuring appearances at immigration court hearings and effectuating removal.

Within CBP, three separate operational components work to enforce current customs and immigration laws and confront security threats (e.g., illegal munitions, explosives, illegal drugs, and people intending harm). The Office of Field Operations (OFO) facilitates lawful trade and travel at official designated U.S. ports of entry (including ship ports, airports, and land border crossing points). In other words, OFO includes mainly the officers seen at airports or land ports of entry who examine passports or other immigration documents and ask questions of applicants for admission to determine whether they meet the legal requirements for admission (whether or not they obtained a visa from a U.S. consular facility abroad). In some cases, an applicant for admission at a port of entry may have a legitimate U.S. visa that is incompatible with their intended activity in the U.S., and OFO must detain them and often return them to their home country because they are legally inadmissible. For example, if a German national who obtained a tourist visa from the U.S. Embassy in Berlin flies to the U.S. and applies for entry at JFK International Airport, but after questioning by an OFO officer, admits that she intends to work in the U.S., that applicant will likely be found inadmissible and be detained at OFO detention facilities at the airport until she returns to Germany. OFO is also required to process individuals who appear at the border seeking asylum or other forms of protection, even if the alien does not have any identity or travel documents. OFO has 20 major field offices, 328 ports of entry, and various international locations with a staff of more than 28,000 employees.⁶

The U.S. Border Patrol (USBP) operates between official (mostly land) ports of entry to detect, interdict, and apprehend individuals who attempt to illegally enter or smuggle people or contraband across U.S. borders. USBP operations are coordinated by 20 sector offices with a workforce of over 20,000 agents who are assigned to patrol the more than 6,000 miles of U.S. land borders.⁷

Once apprehended, an alien found attempting to cross the border outside an official port of entry is deemed subject to a ground of inadmissibility and temporarily detained for preliminary immigration vetting and processing. Usually, USBP will handle this processing after the apprehended individual is brought to a USBP facility nearby. Processing includes preparing a charging document, opening a file (called an “A-file”), and collecting biometric information on each individual. These individuals are placed into a holding cell and given necessities and a cursory medical examination by contract medical professionals, until they are moved to a longer-term detention facility run by Immigration and Customs Enforcement (see below) or returned to the border for removal. Presently, USBP is not supposed to hold these individuals more than 72 hours from the time of apprehension, including the time to transport them to an ICE facility for

⁶ CBP’s Executive Assistant Commissioners’ Offices, <https://www.cbp.gov/about/leadership-organization/executive-assistant-commissioners-offices>.

⁷ *Id.*

longer-term detention.⁸ Under the current Title 42 authority,⁹ USBP may send individuals (excluding families and unaccompanied minors) entering the U.S. from Mexico immediately back to Mexico.

All individuals detained by any CBP component are subject to CBP's National Standards on Transport, Escort, Detention, and Search (TEDS).¹⁰ These standards govern all transportation and hold room operations. All OFO and USBP locations may legally maintain temporary custody of inadmissible and removable aliens while processing immigration paperwork. Under normal conditions, detainees can leave detention if they opt to return to their place of recent origin, or they may make a request for protection to establish a legal basis to remain in the U.S. Individuals who assert a fear of returning to their country of origin by seeking asylum may be transferred to an ICE facility for a credible fear assessment or further immigration proceedings.

ICE's Enforcement and Removal Operations (ERO) is primarily responsible for apprehending, detaining, and removing unlawful aliens from the U.S. ERO manages detained aliens in a variety of immigration detention facilities and provides transportation (often through a contractor) for aliens as necessary.¹¹ These detention facilities may be ICE-run facilities, privately-run facilities contracted through ICE, or may include local, state, and federal facilities that contract with ICE. ERO is also responsible for aliens who may be placed in an alternative to detention (ATD) program. ICE maintains a variety of detention standards, including:

- 2020 Family Residential Standards¹²
- 2019 National Detention Standards¹³
- 2011 Performance-Based National Detention Standards (Updated in 2016)¹⁴
- 2008 Performance-Based National Detention Standards¹⁵
- 2000 National Detention Standards¹⁶

The National Detention Standards (NDS), promulgated in 2000, have been primarily utilized at smaller, non-dedicated detention facilities. These non-ICE facilities include approximately 45 facilities with Intergovernmental Service Agreements (IGSA), approximately 35 United States Marshals Service (USMS) facilities, and approximately 60 facilities (both IGSA and USMS) with

⁸ CBP National Standards on Transport, Escort, Detention, and Search (TEDS), October 2015.

<https://www.cbp.gov/document/directives/cbp-national-standards-transport-escort-detention-and-search>.

⁹ Control of Communicable Diseases; Foreign Quarantine: Suspension of the Right To Introduce and Prohibition of Introduction of Persons Into United States From Designated Foreign Countries or Places for Public Health Purposes, 42 U.S.C. §71.40 (Suspension of the right to introduce and prohibition of the introduction of persons into the United States from designated foreign countries or places for public health purposes.) Final Rule, 85 FR 56,448 (September 11, 2020).

¹⁰ CBP TEDS, *supra* note 8.

¹¹ See Appendix 3, ICE Transportation Charts.

¹² 2020 FRS, <https://www.ice.gov/detention-standards/family-residential>. These standards were updated from the original 2007 Family Residential Standards.

¹³ 2019 NDS, <https://www.ice.gov/detention-standards/2019>.

¹⁴ 2011 PBNDS, <https://www.ice.gov/detention-standards/2011>.

¹⁵ 2008 PNNDS, <https://www.ice.gov/detention-standards/2008>.

¹⁶ 2000 NDS, <https://icegov.sharepoint.com/sites/insight/ero/custody> (last visited January 18, 2021 and a direct link to the 2000 NDS standards was not currently available).

ICE detainee populations of less than 10.¹⁷ Presently, ICE is attempting to transition all NDS facilities to the newer 2019 National Detention Standards (NDS 2019) for non-dedicated facilities. The updated version simplifies the original NDS, while incorporating legal and policy changes such as incorporation of the DHS Prison Rape Elimination Act (PREA) standards.

ICE originally developed the Performance-Based National Detention Standards (PBNDS 2008) to articulate detention standards designed to improve the safety, security, and conditions of confinement for detainees. The PBNDS 2011 was a further attempt to improve a variety of known issues including: medical and mental health services, access to legal services, religious opportunities, communication for detainees with limited English proficiency, reporting and responding to complaints, recreation, and visitation. PBNDS 2011 was modified in 2016 to be consistent with various legal and regulatory requirements, in addition to ICE policies. The large majority of immigration detention facilities operating under PBNDS 2011 accepted the 2016 revisions. Finally, ICE maintains the Family Residential Standards (FRS) from 2020, exclusively utilized at ICE's family residential facilities.

ICE broadly categorizes detention facilities in three ways based on the authorized period of use, type of contract or agreement, and applicable detention standard. The most basic classification is based on authorized period of use. ICE facilities are generally approved for use for either under 72 hours or over 72 hours. The under 72-hour facilities are local detention facilities used to house aliens for short periods of time or over weekends until detainees can be transported to a facility approved for use 72 hours and longer. Facilities approved for use 72 hours and longer are also referred to as "full-use" facilities. During fiscal year 2020, ICE utilized 277 facilities; approximately 1/3 of these facilities were approved for use under 72 hours. These facilities, however, held only 1% of the daily population on average. ICE's full-use facilities house 99% of the adult detained population.

ICE contracts with facilities in five primary ways. First, ICE owns Service Processing Centers (SPCs), although many security functions in these SPCs are contracted to a third party. Second, ICE contracts directly with private vendors who own and operate detention facilities, commonly referred to as Contract Detention Facilities (CDFs). Third, ICE enters into agreements with local governments for detention capacity under Intergovernmental Service Agreements (IGSAs). The local government may, in turn, contract with a private vendor to operate the facility on its behalf, or the government may operate the facility itself. A subset of ICE IGSAs are facilities dedicated to ICE's use, Dedicated IGSAs (DIGSAs). Fourth, ICE may ride on a United States Marshals Service (USMS) agreement.¹⁸ USMS maintains its own CDFs on which ICE may be a rider (USMS CDF). The most common form of agreement that ICE utilizes is the USMS intergovernmental agreement with local governments (USMS IGA). Finally, in limited areas where no detention capacity is available, ICE utilizes a Bureau of Prisons (BOP) Metropolitan Detention Center (MDC) or Federal Detention Center (FDC).

¹⁷ 2019 National Detention Standards for Non-Dedicated Facilities, <https://www.ice.gov/detain/detention-management/2019>.

¹⁸ U.S. Marshals Service, Defendant and Prisoner Custody and Detention, <https://www.usmarshals.gov/prisoner/detention.htm>.

ICE Owned	Service Processing Centers (SPCs)
ICE Contract with Detention Vendor	Contract Detention Facilities (CDFs)
ICE Agreement with Local Government	Intergovernmental Service Agreement (IGSAs)
ICE Agreement with Local Government with ICE detainees only	Dedicated IGSAs (DIGSAs)
U.S. Marshals Contract with Detention Vendor	U.S. Marshals Service Contract Detention Facilities (USMS CDF)
U.S. Marshals Agreement with Local Government	United States Marshals Service Intergovernmental Agreement (USMS IGA)
Department of Justice Bureau of Prisons	Examples include: Metropolitan Detention Center (MDC) or Federal Detention Center (FDC)

Each type of agreement has both advantages and disadvantages. As ICE directly owns the SPCs and maintains the security contract, ICE maintains the most control over these facilities. The largest disadvantage to this arrangement is the operational cost, as these facilities are the most expensive for ICE to operate. ICE maintains contractual control over CDFs and DIGSAs, but, because ICE does not own these facilities, any change in services requires a modification to the contract or agreement. For example, a change in the detention standards requires the contract or agreement to be modified, and a change in the standard that requires the vendor or government to construct additional space, for example, may be costly. ICE has less control over USMS CDFs, as USMS must consent to and complete any contractual change required by ICE. ICE has limited control over USMS IGAs for similar reasons. Although these facilities are plentiful, ICE primarily utilizes these facilities for under 72-hour detention. However, due to the nature of these agreements, ICE's recourse for non-compliance is to reduce or discontinue use. Finally, BOP facilities are bound by BOP policy.

IV. Extreme Challenges in Immigration Detention FY 2019-2020

Variations in types and flows of immigration numbers have always presented challenges to the existing immigration detention infrastructure. However, the past two years have highlighted the shifting of priorities and resources to adequately and humanely address immigration detention. These range from a surge of vulnerable populations along the southwest border to protecting from a novel deadly disease. Going forward, disease prevention and detection will need to be an integral part of immigration detention practices, for the safety of both officers and aliens.

A. Surge of Vulnerable Populations

FY 2019 brought a humanitarian crisis that overwhelmed the federal government's ability to address a significant migrant population surge. At its highest peak in May of 2019, more than 4,800 undocumented aliens attempted to cross the U.S. border daily. For 2019 alone, CBP's total enforcement numbers were over 1.1 million,¹⁹ with apprehensions along the U.S.-Mexico border at their highest annual level in 12 years. Of those apprehended, 473,682 were family unit members and 76,020 were unaccompanied alien children (UAC).²⁰ This represented a 342 percent increase of family unit members from the previous year's record of 107,212.²¹ These vulnerable populations accounted for 64.5 percent of all individuals apprehended at the southwest border by the USBP. The U.S. government did not have the resources or infrastructure to adequately address the crisis volume of migrants attempting entry.

Existing immigration detention facilities were built and designed primarily to handle single adults, with more limited options for vulnerable populations. As a result, existing detention infrastructure and government resources were not equipped to adequately process large numbers of unauthorized family units and UAC. The crisis flow of migrants was not limited to the border; it also placed undue pressure on internal detention management. As border apprehensions grew substantially, so did the overall number of detained aliens in immigration custody. ICE's ERO average daily population (ADP) reached 50,165 – an increase of 19 percent compared to the prior year, with CBP apprehensions accounting for 60 percent of ICE's detained population.²² ICE also released approximately 200,000 family unit members, while processing 37,906 at its three Family Residential Centers.²³ On the non-detained side, ERO's immigration court docket grew to more than 3.2 million cases, including aliens with cases in all stages of the immigration process throughout the U.S.²⁴

¹⁹ FY 2019, 1,148,024. CBP Enforcement Statistics Fiscal Year 2021, <https://www.cbp.gov/newsroom/stats/cbp-enforcement-statistics>.

²⁰ U.S. Border Patrol Southwest Border Apprehensions FY 2019, <https://www.cbp.gov/newsroom/stats/sw-border-migration/fy-2019>.

²¹ U.S. Border Patrol Southwest Border Apprehensions FY 2018, <https://www.cbp.gov/newsroom/stats/sw-border-migration/fy-2018>.

²² U.S. Immigration and Customs Enforcement Fiscal Year 2019 Enforcement and Removal Operations Report, p. 5, <https://www.ice.gov/sites/default/files/documents/Document/2019/eroReportFY2019.pdf>.

²³ *Id.*

²⁴ *Id.*

One policy change designed to deter unauthorized entries was the implementation of the Migrant Protection Protocols (MPP) that went into effect on January 28, 2019. Pursuant to Section 235(b)(2)(C) of the Immigration and Nationality Act (INA), MPP permits the expedited processing and return to Mexico of citizens and nationals of countries other than Mexico who are seeking asylum in the U.S.²⁵ For the duration of their immigration proceedings, MPP aliens reside in Mexico while being permitted to enter the U.S. for the limited purpose of attending court on appointed days. The program was started at the San Ysidro Port of Entry in California and was eventually expanded to cover the entire southwest border.²⁶ Legal challenges to MPP are currently pending before the Supreme Court.²⁷ As of October 1, 2020, 65,409 individuals have been enrolled in MPP, with 67 percent of cases completed at the immigration court level. Of the cases processed, only 523 individuals have been granted relief.²⁸ Individuals who assert a fear of persecution or torture in or upon returning to Mexico are referred to USCIS for a Non-Refoulement Assessment.²⁹ At present, MPP court hearings are temporarily postponed due to COVID-19.³⁰

B. COVID-19 and Travel Restrictions

As a result of travel restrictions due to COVID-19 and various immigration policy changes implemented in 2019, the number of detained aliens in custody dwindled in 2020 to a fraction of previous years' numbers. To slow the spread of the disease, the federal government ordered agencies to prioritize resources while also ensuring critical government functions continued. The impact of these unexpected changes resulted in substantial operational changes not only to the federal workforce but, more substantially, to how aliens are processed for immigration violations and detained for immigration court proceedings.

This year, the most substantial impact to immigration operations has come as a result of the COVID-19 pandemic. Immigration limitations found in sections 212(f) and 215(a) of the Immigration and Nationality Act, 8 U.S.C. 1182(f) and 1185(a), and section 301 of title 3, United States Code were initially used to limit travel and prevent entry of individuals who may have been exposed to COVID-19. Starting on January 31, 2020, Presidential Proclamation 9984 suspended the entry of individuals physically present in the People's Republic of China during the 14-day period preceding their entry or attempted entry into the United States.³¹ Further

²⁵ Migrant Protection Protocols, January 24, 2019, <https://www.dhs.gov/news/2019/01/24/migrant-protection-protocols>.

²⁶ Memorandum from Todd A. Hoffman, Customs and Border Protection, "Guidance on Migrant Protection Protocols," <https://www.cbp.gov/sites/default/files/assets/documents/2019-Jan/MPP%20OFO%20Memo%201-28-19.pdf>.

²⁷ See *Wolf v. Innovation Law Lab*, 951 F. 3d 1073 (9th Cir. 2020); *cert. granted.*, No. 19-1212, — U.S. —, — S.Ct. —, — L.Ed.2d —, 2020 WL 6121563 (Oct. 19, 2020).

²⁸ Migrant Protection Protocols Metrics and Measures, https://www.dhs.gov/sites/default/files/publications/migrant_protection_protocols_metrics_and_measures_1.pdf

²⁹ *Id.*

³⁰ Department of Homeland Security and Department of Justice Announce Plan to Restart MPP Hearings, <https://www.dhs.gov/news/2020/07/17/department-homeland-security-and-department-justice-announce-plan-restart-mpp>. See also, Migrant Protection Protocols, <https://www.dhs.gov/migrant-protection-protocols>.

³¹ 85 Fed. Reg. 6,044, (Feb. 4, 2020); 85 Fed. Reg. 7214 amended (February 7, 2020).

Presidential Proclamations also limited travel from Iran;³² the Schengen countries³³ including Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, and Sweden, Switzerland; the United Kingdom and the Republic of Ireland;³⁴ Canada;³⁵ Mexico;³⁶ and Brazil.³⁷ Proclamation 1001411 further suspended the entry of immigrants to the United States expected to impact the U.S. labor market during an economic recovery following COVID-19.³⁸

Starting on March 20, 2020, the U.S. Department of Health and Human Services' (HHS) Centers for Disease Control and Prevention (CDC) issued an interim final rule to amend its Foreign Quarantine Regulations which suspended admissions of certain persons into the U.S. in the interest of public health.³⁹ The present CDC order suspends the right of individuals from foreign countries where there is a quarantinable communicable disease to enter and remain in the United States.⁴⁰ As applied, Title 42 of the United States Code Section 265 prohibits the entry of certain persons who pose a potential health risk due to possible exposure to COVID-19 in certain countries. These travel restrictions are designed to limit the potential spread and transmission of COVID-19 from individuals seeking to enter the U.S. Pursuant to Title 42, CBP may immediately remove qualifying individuals to their country of last transit when possible.⁴¹ Effective October 13, 2020,⁴² HHS' final rule provides a procedure for the CDC Director to suspend admission of foreign

³² Presidential Proclamation 9992 of February 29, 2020, 85 FR 12855 (March 4, 2020). Amended Proclamation 9984 of January 31, 85 FR 6699 (February 5, 2020).

³³ Presidential Proclamation 9993 of March 11, 2020; 85 FR 15045 (March 16, 2020).

³⁴ Presidential Proclamation 9996 of March 14, 2020; 85 FR 15341 (March 14, 2020).

³⁵ 85 Fed. Reg. 16,548 (March 24, 2020); 85 Fed. Reg. 22,352 (April 22, 2020); 85 Fed. Reg. 31,059 (May 22, 2020); 85 Fed. Reg. 44185 (July 22, 2020).

³⁶ 85 Fed. Reg. 16,547 (March 24, 2020); 85 Fed. Reg. 22353 (April 22, 2020); 85 Fed. Reg. 31,057 (May 22, 2020); 85 Fed. Reg. 44,183 (July 22, 2020).

³⁷ Presidential Proclamations 10041 of May 25, 2020, 85 FR 31933 (May 28, 2020); 10042 of May 25, 2020 85 Fed. Reg. 31,957 (May 28, 2020).

³⁸ Presidential Proclamation 10014, April 22, 2020; 85 FR 23441 (April 27, 2020). This proclamation has been updated numerous times. Most recently, it was extended to March 31, 2021. *See* Presidential Proclamation 10131, December 31, 2020; 86 FR 417 (January 6, 2021), <https://www.whitehouse.gov/presidential-actions/proclamation-suspension-entry-immigrants-nonimmigrants-continue-present-risk-united-states-labor-market/>.

³⁹ Control of Communicable Diseases; Foreign Quarantine: Suspension of Introduction of Persons Into United States From Designated Foreign Countries or Places for Public Health Purposes, 85 Fed. Reg. 16,559 (March 24, 2020); Originally issued on March 20, 2020, extended on April 20, 2020, and amended on May 19, 2020.

⁴⁰ Order Suspending the Right to Introduce Certain Persons From Countries Where a Quarantinable Communicable Disease Exists, 42 U.S.C. 265, 268; <https://www.cdc.gov/coronavirus/downloads/10.13.2020-CDC-Order-Prohibiting-Introduction-of-Persons-FINAL-ALL-CLEAR-encrypted.pdf>; Notice of Order Under Sections 362 and 365 of the Public Health Service Act Suspending Introduction of Certain Persons from Countries Where a Communicable Disease Exists, 85 Fed. Reg. 17,060 (Mar. 26, 2020).

⁴¹ CBP Nationwide Enforcement Encounters: Title 8 Enforcement Actions and Title 42 Expulsions, https://www.cbp.gov/newsroom/stats/cbp-enforcement-statistics/title-8-and-title-42-statistics?_ga=2.162658300.1755296360.1607548024-1435792048.1600955293; U.S. Border Patrol Monthly Enforcement Encounters 2020: Title 42 Expulsions and Title 8 Apprehensions, <https://www.cbp.gov/newsroom/stats/cbp-enforcement-statistics/title-8-and-title-42-statistics-fy2020>.

⁴² U.S. Border Patrol Monthly Enforcement Encounters 2020: Title 42 Expulsions and Title 8 Apprehensions, https://www.cbp.gov/newsroom/stats/cbp-enforcement-statistics/title-8-and-title-42-statistics?_ga=2.162658300.1755296360.1607548024-1435792048.1600955293.

persons to limit the introduction of quarantinable communicable diseases.⁴³ Despite the issuance of the final rule, a recent court decision exempts juveniles from the order.⁴⁴

While DHS took dramatic steps to reduce the danger of viral infection from individuals entering crowded immigration custody facilities, ICE ERO implemented mitigation measures to address the uncertain nature of this public health crisis in the detention setting. ICE's existing 2008 and 2011 Performance-Based National Detention Standards (PBNDS) require detention facilities to "comply with current and future plans implemented by federal, state, or local authorities addressing specific public health issues including communicable disease reporting requirements."⁴⁵ The 2019 National Detention Standards (NDS) require "collaboration with local or state health departments in accordance with state and local laws and recommendations."⁴⁶

Within the ICE detention framework, beginning in January 2020, ICE ERO and ICE Health Service Corps (IHSC) issued various protocols and guidance addressing the global pandemic and contributed to CDC's *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*,⁴⁷ which was first published on March 23, 2020. On March 27, 2020, ICE ERO issued a memorandum to all detention wardens and superintendents entitled *Memorandum on Coronavirus Action Plan, Revision 1*.⁴⁸ The measures specified in this memorandum applied to IHSC and non-IHSC staffed ICE dedicated facilities. ICE encouraged intergovernmental partners and non-dedicated facilities to adhere to local and statewide guidance, including public health policies, authorities, and reporting requirements, and recommended the measures as "best practices" for risk mitigation of infection and transmission in a highly transient detained population. It further referenced the CDC as the authoritative source.

On April 10, 2020, ICE ERO released the *COVID-19 Pandemic Response Requirements (PRR)*, for all facilities housing ICE detainees.⁴⁹ The document includes best practices for such facilities to ensure that detainees are appropriately housed and that available mitigation measures are implemented. The ICE ERO COVID-19 PRR has been updated five times in response to evolving guidance from medical professionals, epidemiologists, and detention experts, and in response to legal actions, such as the *Fraihat v. ICE*⁵⁰ court order. *Fraihat v. ICE* defined certain high risk

⁴³ Control of Communicable Diseases; Foreign Quarantine: Suspension of the Right To Introduce and Prohibition of Introduction of Persons Into United States From Designated Foreign Countries or Places for Public Health Purposes, 42 U.S.C. §71.40 (Suspension of the right to introduce and prohibition of the introduction of persons into the United States from designated foreign countries or places for public health purposes.) Final Rule, 85 FR 56,448 (September 11, 2020).

⁴⁴ *P.J.E.S. by and through Escobar Francisco v. Wolf*, - F. Supp.3d. -, (D.D.C. Nov. 18, 2020) 2020WL 67770508.

⁴⁵ Performance-Based National Detention Standards (PBNDS) 2008 and 2011, Medical Care 4.3, (C.) Communicable Disease and Infection Control, p. 261-262.

⁴⁶ The 2019 National Detention Standards, p. 114.

⁴⁷ CDC's *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> (last accessed January 13, 2021).

⁴⁸ Memorandum from Executive Associate Director Enrique Lucero, Enforcement and Removal Operations, *Memorandum on Coronavirus 2019 (COVID-19) Action Plan, Revision 1* (March 27, 2020).

⁴⁹ *Pandemic Response Requirements (PRR)*, <https://www.ice.gov/coronavirus/prr>; PRR Version 1, April 10, 2020, <https://www.ice.gov/doclib/coronavirus/eroCOVID19responseReqsCleanFacilities-v1.pdf>.

⁵⁰ See *Fraihat v ICE*, 445 F. Supp.3d 709106 (C.D. Cal. 2020), *appeal pending* (9th Cir. 20-55634 filed June 19, 2020); 2020 Slip Copy WL 6541994 (October 7, 2020), *appeal pending* (9th Cir. 20-56297 filed December 4, 2020).

(vulnerable) populations that are at increased risk of severe illness from COVID-19 beyond the CDC’s recommendations. The National Commission on Correctional Health Care (NCCHC) reported, in general, “incarcerated individuals should be considered at risk for serious disease at an earlier age than the general population due to premature aging and higher rates of mortality from COVID-19 in this population.”⁵¹

In compliance with the *Fraihat v. ICE* court order, effective December 14, 2020, ICE was required to perform twice daily temperature and COVID-19 symptom screening for *Fraihat* subclass members. In turn, IHSC developed a monitoring tool, the *IHSC Fraihat Compliance System* (IFCS), to facilitate documentation and reporting in IHSC and non-IHSC-staffed facilities.⁵² These twice daily symptom screenings and temperature checks augmented additional guidance within ICE ERO’s COVID-19 PRR. As more information becomes available, facilities are encouraged to contact the CDC or their state, local, and/or territorial public health departments if they need further guidance specific to their site, while also complying with ICE’s mandates. Until COVID-19 vaccinations are rolled out and are available to a broad range of staff, general population, and detainees, OIDO intends to examine whether there should be a comprehensive review of the COVID-19 protocols for DHS. As a result of litigation challenges and additional information about disease transmission and prevention, ICE has updated the PRR multiple times.⁵³ The current version was issued in October 2020.⁵⁴

As a result of the pandemic and its consequential economic impact, as well as measures such as Title 42 (discussed above), the number of individuals trying to cross the border dropped dramatically in mid to late 2020. As of December 4, 2020, the number of ICE detainees had dropped to 16,377,⁵⁵ with 1,633 individuals having been ordered released by the courts.⁵⁶ Despite efforts to prevent the spread of the disease, as of December 10, 2020, 7,851 detainees in ICE custody have tested positive, and eight have died.⁵⁷ Over 70,000 ICE detainees have been tested since February 2020.⁵⁸

⁵¹ NCCHC *Clinical Care of the COVID-19 Patient*, https://www.ncchc.org/blog/clinical-care-of-the-covid-19-patient?MessageRunDetailID=4135868452&PostID=24244636&utm_medium=email&utm_source=rasa_io (last visited January 14, 2021).

⁵² IHSC AD Smith Memorandum, *Fraihat v. ICE Court Order: Performing Twice Daily Temperature and COVID-19 Symptom Screening for High-Risk Detainees*, dated December 14, 2020.

⁵³ See *Fraihat v. ICE*, 445 F. Supp.3d 709106 (C.D. Cal. 2020), *appeal pending* (9th Cir. 20-55634 filed June 19, 2020); 2020 Slip Copy WL 6541994 (October 7, 2020), *appeal pending* (9th Cir. 20-56297 filed December 4, 2020).

⁵⁴ PRR Version 5, October 27, 2020, <https://www.ice.gov/coronavirus/prr>.

⁵⁵ ICE Detainee Statistics Tab at <https://www.ice.gov/coronavirus> (last accessed December 9, 2020).

⁵⁶ ICE Judicial Releases Tab at <https://www.ice.gov/coronavirus> (last accessed December 9, 2020), Number of Detainees ICE Released After Court-Order (as of December 7, 2020).

⁵⁷ ICE Detainee Statistics Tab at <https://www.ice.gov/coronavirus> (last accessed December 10, 2020).

⁵⁸ *Id.*

V. Existing Oversight Challenges with Compliance – Oversight

The Office of the Immigration Detention Ombudsman (OIDO) is an independent and neutral authority authorized to receive confidential complaints, investigate allegations, and resolve and provide redress when appropriate to individuals in the immigration detention setting. In this oversight capacity, OIDO shares responsibility with various other federal government entities. To develop an operational framework for OIDO, it is important to fully understand the nature and scope of existing detention oversight, compliance, and inspection mechanisms within DHS. Section 106 grants significant authorities to OIDO, many of which overlap with the detention oversight and compliance authorities of existing entities within CBP and ICE, as well as offices within DHS, including the Office for Civil Rights and Civil Liberties (CRCL) and the Office of the Inspector General (OIG).

The following offices have overlapping or related oversight authority to OIDO.

A. U.S. Customs and Border Protection (CBP)

1. Individual Complaints

CBP's Office of Professional Responsibility (OPR) takes in complaints from the public, detained aliens, non-governmental organizations (NGOs), attorneys, etc., via the Joint Intake Center. The Joint Intake Center (JIC), operated jointly by CBP and ICE, serves as the central "clearinghouse" for receiving, processing, and tracking allegations of misconduct involving CBP and ICE employees and contractors. CBP OPR and ICE OPR staff the JIC with six personnel, who enter all incoming information into the Joint Integrity Case Management System (JICMS). The JICMS is not only an intake system for CBP and ICE; it provides a centralized and uniform system for accessing, managing, and processing reports of alleged misconduct between CBP, ICE, and the DHS Office of Inspector General (OIG). CBP's Use of Force Reporting System (UFRS) is a separate database for reporting any use of deadly and intermediate force.⁵⁹

Pursuant to DHS Management Directive 0810.1, *Office of the Inspector General (2004)*, CBP refers all serious allegations regarding employee or contractor misconduct to OIG, which has the right of first refusal to accept and investigate such cases. OIG has discretion to select which cases it chooses to investigate and usually refers cases it declines (the large majority) back to CBP OPR. Once the case is returned to CBP OPR, it either opens its own investigation or sends the case to local CBP management for investigation and disposition. Substantiated cases of serious misconduct against CBP employees are handled by the Discipline Review Board (DRB). The DRB is a three-member board comprised of rotating senior management officials, established to promote consistency in disciplinary measures. The primary function of the DRB is to review the most serious reports of administrative misconduct and propose sanctions as appropriate. Where an adverse action is warranted, local management typically imposes sanctions ranging from a 15-day suspension to removal. For disciplinary actions of 14-day suspensions or less, local management has the responsibility to review, propose, and impose disciplinary action.

⁵⁹ CBP Use of Force Policy, Guidelines and Procedures Handbook, May 2014 at page 18, <https://www.cbp.gov/sites/default/files/documents/UseofForcePolicyHandbook.pdf>.

2. Detention Oversight/Review

The CBP Office of Accountability conducts self-inspections of CBP facilities, assesses program health, and measures organizational performance. Within the Office of Accountability, the CBP Management Inspection Division (MID) conducts periodic audits of CBP detention facilities and manages the Self-Inspection Program (SIP), CBP's core method for providing oversight of its detention facilities. SIP annually audits for compliance with certain standards, including the National Standards for Transport, Escort, Detention, and Search (TEDS). In addition to the Self-Inspection Program, CBP engages external, independent auditors who review facility operations every three to five years to ensure compliance with the Prison Rape Elimination Act (PREA). The CBP Privacy and Diversity Office, which is under the Office of the Commissioner, facilitates PREA audits.

3. Contract Audit/Review

CBP does not manage contracted facilities and thus, unlike ICE, has no established process for contract audit or review.

B. U.S. Immigration and Customs Enforcement (ICE)

1. Individual Complaints

ICE has two main methods for taking in and resolving individual complaints: the Joint Intake Center (JIC), operated jointly by the ICE Office of Professional Responsibility (ICE OPR) and CBP OPR, and the Detention Reporting and Information Line (DRIL), operated by ICE Enforcement and Removal Operations (ERO).

a. Joint Intake Center

The JIC and the Joint Integrity Case Management System (JICMS) are used by ICE OPR and CBP OPR to receive and document allegations and complaints related to ICE and CBP employees, contractors, and operations. The JIC receives complaints through several modes of communication: email, a toll-free reporting number, mail, and fax. The majority (80-90%) of complaints are received via the JIC email address (jointintake@cbp.dhs.gov).

The JIC has six analysts on staff, who review and document complaints in JICMS. Once in JICMS, all allegations of misconduct by ICE employees or contractors are sent to OIG, which, pursuant to Management Directive 0810.1, *Office of the Inspector General (2004)*, has right of first refusal to review and investigate. If OIG declines to investigate the allegations, it will refer the case back to ICE OPR.

At that point, ICE OPR will review, assess, and assign the allegation for investigation. ICE OPR will retain and investigate allegations involving criminal or serious misconduct by ICE employees and contractors. ICE OPR will assign less serious misconduct allegations to ICE Program offices. Detention-related complaints that do not rise to the level of an ICE OPR investigation will be sent

to ERO's Administrative Inquiry Unit (AIU), for review. ERO AIU can assign the case to an OPR-trained fact finder or a management official for an administrative inquiry, or the case can be assigned to the appropriate ERO field office for action.

It should be noted that detention-related allegations that do not involve an ICE employee or contractor (e.g. detainee-on-detainee abuse) are not forwarded to OIG but are reviewed by ICE OPR. ICE OPR can also retain these cases for investigation or assign them to ERO AIU for an administrative inquiry.

b. Detention Reporting and Information Line

The Detention Reporting and Information Line (DRIL) is a toll-free service managed by ICE ERO that allows detainees and members of the public to communicate and lodge complaints directly with ERO. The Custody Management Division (CMD) within ERO manages the call center. CMD receives and resolves concerns, questions, and complaints regarding a variety of issues, including alleged sexual or physical assault or abuse, serious or unresolved problems in detention, serious mental disorders or conditions, and reasonable accommodations related to disabilities. The DRIL also takes inquiries from the public, law enforcement, and others, as well as requests for basic case information. Complaints regarding serious misconduct involving ICE employees or contractors are forwarded to the JIC, triggering review by OIG or ICE OPR, as described above.

c. Other Procedures

Finally, while not described here in detail, it is worth noting that ICE has specific processes dedicated to other important aspects of detention, including reasonable accommodations due to disability, segregation review, transgender detention, holding room assessment, and allegations of sexual abuse/assault.

2. Detention Oversight/Review

ICE performs layered oversight of its detention facilities through contract inspections managed by ICE ERO and internal inspections conducted by ICE OPR.

a. ICE Enforcement and Removal (ERO)

i. Contract Inspections

ERO contracts with an independent contractor (The Nakamoto Group) to conduct annual and bi-annual inspections of ICE detention facilities, assess compliance with ICE's standards, and ensure that deficiencies are resolved by facility management. The inspection teams typically include an environmental health and safety subject matter expert, a health professional (i.e., physician, physician's assistant, registered nurse, or nurse practitioner), and a detainee rights subject matter expert.

During these three-day audits, inspectors measure current conditions by utilizing ICE-developed, standardized checklists that are tailored to the applicable detention standards for the facility being

inspected. These checklists help the inspection teams focus on the most critical elements of the ICE detention standards, about 700 key areas, to ensure conditions are appropriate for detainee health and safety. Post-inspection, the teams are required to issue a written report to ICE. When the audit identifies deficiencies, ERO works with the field offices and facilities to ensure timely corrective action.

ICE also maintains a specialized process for reviewing juvenile and family detention contracts. Contract inspectors for the ICE Juvenile and Family Residential Management Unit (JFRMU) conduct monthly inspections (typically every four to six weeks) of the three Family Residential Centers (FRCs). In addition, JFRMU's contract inspectors annually visit the FRCs with a team of subject matter experts to perform an extended review of conditions.

ii. Detention Service Managers (DSM)/Detention Standards Compliance Officers (DSCO)

In addition to ICE's contract inspection program, ERO operates an on-site monitoring program utilizing 46 federal DSMs and DSCOs (Full-time Equivalent, or FTE positions), who monitor detention conditions and day-to-day operations at 55 key detention facilities. These facilities hold approximately 80% of ICE's average daily population (ADP). DSMs and DSCOs review facilities daily to ensure compliance with ICE detention standards, resolve detainee issues "on the spot" when possible, work with local ICE field offices to address concerns, and report significant issues to ICE headquarters. On-site monitoring is designed to increase transparency, reduce the length of time required to implement corrective actions, and provide senior leadership regular reporting on facility issues.

3. Operational Review Self-Assessment (ORSA) Program for Under 72-Hour Facilities

Facilities that house detainees for 72 hours or less, and facilities that house detainees for more than 72 hours with an ADP of less than 10 are inspected under the ORSA program. The ORSA program is a modified version of the annual inspections used for the National Detention Standards (NDS), which focuses on key elements of the standards. These self-assessments are conducted annually by detention facility staff in conjunction with field office personnel to assess whether a given facility is adequately prepared to house ICE detainees, even with a low ADP.

4. Family Residential Center (FRC) Compliance Officers

FRCs employ Compliance Officers who daily oversee compliance with the Family Residential Standards and troubleshoot issues as they arise. The on-site compliance officers work closely with contract inspectors to identify emerging issues and ensure that identified issues are resolved in a timely manner.

5. Technical Assessment Review (TAR)

TARs are additional technical assessment reviews that take place 120 days after an inspection that results in an initial deficient rating. They are designed to help facilities pass the 180-day inspection

required after receiving a deficient rating. If the facility does not pass the 180-day inspection, it can no longer maintain an ICE population.

6. Quality Assurance Teams (QATs)

QATs are designed to provide quality assurance management of ICE's contract inspections. The QATs accompany contract inspectors on selected inspections to evaluate the contractors' performance. QAT members also interview detainees, review complaints, evaluate incidents involving use of force, review segregation practices, and review classification determinations.

7. ICE Detention Monitoring Council (DMC)

The ICE DMC was created in 2010 to provide a formal setting to ensure that senior leadership from all programs with detention responsibility jointly examine serious issues related to detention conditions. The DMC meets and supplements program-specific investigatory and oversight functions.

8. ICE ERO Contracting Officer's Representative (COR)

ERO's COR is responsible for monitoring all aspects of the day-to-day administration of each detention facility contract. Tasked with observing, documenting, and reporting contractor performance to both the Contracting Officer (CO) and contractor, the COR is the first line of defense in ensuring that detention contracts comply with detention standards and federal laws. CORs' duties include monitoring contractor performance, assisting with performance evaluations, inspecting and accepting completed work, processing invoices, exercising technical direction, and evaluating work in progress.

9. ICE Office of Professional Responsibility (OPR)

i. Inspections

ICE OPR's Office of Detention Oversight (ODO), a unit within the Inspections and Detention Oversight Division (IDOD), provides oversight of ICE detention operations by assessing compliance with federal law, policies, and procedures, and the agency's own detention standards. ODO has historically conducted oversight inspections of ICE detention facilities that hold more than ten detainees for over 72 hours. These inspections assess compliance with the ICE National Detention Standards (NDS) 2000, the Performance-Based National Detention Standards (PBNDS) 2008 or 2011, and the Family Residential Standards (FRS), as applicable. ODO focuses its reviews on 18 to 19 core standards that have a significant impact on detainees' life, health, and safety. Historically, given available staffing, ODO has completed approximately 30-35 inspections per year. Through the Consolidated Appropriations Act of 2020, however, Congress appropriated additional funds to increase ODO's inspections. With the recent enhancements, ODO will transition to bi-annual inspections of ICE detention facilities, increasing inspections from 30 to 35 per year to approximately 280 per year, to cover every over 72-hour ICE detention facility. When fully implemented in 2021, this effort will represent an eight-fold increase in the current inspection rate.

ii. ICE OPR External Review and Analysis Unit (ERAU)

Finally, the External Review and Analysis Unit (ERAU) within ICE OPR oversees contract audits of detention facilities for compliance with the DHS PREA Standards and conducts reviews of the facts and circumstances surrounding the death of any detainee in ICE custody.

C. DHS Office for Civil Rights and Civil Liberties (CRCL)

1. Individual Complaints

Pursuant to 6 USC § 345, CRCL's Compliance Branch investigates complaints from the public alleging violations of civil rights or civil liberties by DHS personnel, programs, or activities. CRCL receives allegations and information from a variety of sources, including the general public, NGOs, Members of Congress, DHS components, OIG, and other governmental agencies. OIG has the right of first refusal for all complaints opened by CRCL. The OIG typically retains a small percentage of CRCL matters for investigation and refers the rest back to CRCL.

Because CRCL receives all kinds of information from outside sources—including material that is not actionable, not within CRCL's jurisdiction, or insufficiently detailed to act upon—CRCL only considers an incoming allegation a formal complaint once CRCL determines that it meets office guidelines. Those guidelines generally provide that the Compliance Branch may open a complaint and conduct an investigation when civil rights or civil liberties issues are raised. CRCL generally does not open complaints on issues being addressed through other avenues in the Department unless one of the following factors is met:

- An issue or fact pattern appears to be systemic or widespread;
- An issue or fact pattern is egregious, raising serious concerns that warrant a civil rights or civil liberties investigation by a DHS Headquarters office;
- An issue or fact pattern is novel, and existing avenues may not be suited to address the civil rights or civil liberties issues presented; or
- Despite the issue having been received directly and investigated by another DHS complaint avenue, the civil rights issues raised are not being adequately addressed.

CRCL considers all allegations not opened as complaints to be part of its "information layer." This refers to a subset of the Compliance Branch system of record, used to track issues and identify potential patterns of civil rights or civil liberties allegations that may result in CRCL review. CRCL may ultimately investigate matters recorded in its information layer and open them as complaints if they are subsequently identified as relevant to a pattern or to an emerging civil rights or civil liberties issue.

CRCL's Compliance Branch investigates both ICE and CBP detention-related allegations. Detention investigations may include issues such as access to medical and mental health care,

religious accommodation, use of force, segregation, environmental health and safety, and sexual abuse. Allegations involving ICE comprise a substantial proportion of the Compliance Branch's investigations. For instance, in FY 2019, nearly half of the allegations received by CRCL involved ICE. Of that number, CRCL opened a portion as complaints for investigation. CRCL conducted nine on-site investigations at ICE facilities in FY 2019, focusing primarily on ICE's adherence to relevant detention standards, the provision of medical and mental health care, and various aspects of the conditions of detention.

It is important to note that, with certain exceptions, CRCL's Compliance Branch *generally does not resolve individual complaints by requesting DHS components to take specific action* – such as altering an individual's detention conditions, releasing an alien from detention, or providing an immigration benefit. Instead, the Compliance Branch uses the complaints to develop broad, policy-based recommendations to components regarding civil rights and civil liberties issues.

The notable exceptions to this rule are decisions issued in response to disability-related complaints pursuant to Section 504 of the Rehabilitation Act of 1973 and complaints alleging inadequate medical treatment in ICE custody. As part of its effort to address these complaints, CRCL has developed, in coordination with ICE, a medical referral program. Through this program, CRCL works to quickly notify ICE of a detainee's medical or mental health issue that requires immediate attention. The ICE Health Service Corps (IHSC) takes the referral and then reports back to CRCL the results of its review. In the last three years, CRCL sent over 1,100 medical referrals (327 in FY 2017, 416 in FY 2018, and 410 in FY 2019) to ICE.

Finally, CRCL also manages a process through which immigration detainees, their families, attorneys, or other advocates can make complaints against ICE and CBP employees and contractors. CRCL may initiate investigations based on allegations of violations of law and detention policy. However, CRCL does not have jurisdiction to address misconduct directly. If an allegation involves both civil rights allegations and specific allegations of employee misconduct, CRCL will coordinate with the component's Office of Professional Responsibility on how best to proceed. In addition, as part of a larger civil rights investigation, CRCL may uncover potential employee or contractor misconduct.

2. Detention Oversight/Review

CRCL's Compliance Branch conducts on-site investigations of CBP, ICE, and ICE-contracted detention facilities. CRCL often enlists the assistance of subject matter experts in the areas of medical care, mental health care, correctional security and operations, use of force, suicide prevention, and environmental health and safety for these visits. These on-site investigations are coordinated in advance with the component, rather than conducted through unannounced visits. In FY 2019, CRCL conducted on-site investigations at nine ICE facilities, six CBP facilities, and three U.S. Coast Guard cutters.

As a result of its investigations, CRCL makes recommendations to address civil rights- or civil liberties-related concerns identified. The goal of these recommendations is to improve conditions of detention for aliens in DHS custody, to enhance compliance with detention standards,

constitutional requirements, or other relevant policies, procedures, or guiding principles at the relevant facilities.

D. DHS Office of the Inspector General (OIG)

1. Individual Complaints

In a typical fiscal year, OIG receives approximately 24,000 complaints from a variety of sources, including the public, government employees, NGOs, and government agencies. OIG receives these complaints via multiple modes of communication. Complaints that come in from the public are reviewed and entered into OIG's case management system, called the Electronic Data System (EDS).

Referrals from DHS component agencies reach OIG electronically. For instance, CBP and ICE send referrals to OIG through JICMS, which connects with EDS. The connectivity allows EDS to receive the information directly from ICE or CBP and automatically generates an OIG complaint number. All other DHS component agencies, including CRCL, use a web portal to submit referrals to OIG. Like the JICMS, the information submitted via the web portal is imported into EDS, so when an agency submits a referral, EDS data fields are automatically populated with the information transmitted, generating a new complaint at OIG.

Complaints are assessed as appropriate and either opened for investigation, closed because no further action is warranted, or referred to the relevant OIG field office within five business days of receipt. The field office then reviews the complaint to determine whether an investigation is warranted. Notably, OIG has right of first refusal to conduct criminal investigations of allegations of fraud, waste, abuse, or mismanagement of detention facilities.⁶⁰ If the field office declines to initiate an investigation, the closed complaint is electronically sent back to OIG's intake group where it may be, based on certain criteria (such as permission from the complainant), referred to another DHS OIG Program Office, a DHS component, or the originating agency. If sent back to the originating agency, that agency will then process the complaint according to its own standard operating procedures. OIG reports that it refers most complaints to programs or other agencies and opens investigations on a small percentage of the total complaints it receives.

2. Detention Oversight/Review

OIG conducts inspections of ICE and CBP detention facilities--*including unannounced visits*--and periodically reviews and evaluates detention operations and related activities, as it does for all Department component programs.

A. Detention Inspections

In the past three years, OIG has published multiple reports summarizing its findings of inspections of detention facilities. Some of these have garnered significant attention from Congress and the public. For example, in June 2019, OIG released an inspection report detailing its concern about conditions at detention facilities in four locations: (1) Adelanto ICE Processing Center, Adelanto,

⁶⁰ DHS Directive 0810.1 was issued on June 10, 2004, prior to the establishment of OIG's statutory authority.

CA; (2) Essex County Correctional Facility, Essex County, NJ; (3) LaSalle ICE Processing Center, LaSalle, LA; and (4) Aurora ICE Processing Center, Aurora, CO.⁶¹ In June 2018, OIG released a report concluding that ICE inspections and monitoring of detention facilities did not lead to sustained compliance with detention standards or systemic improvements.⁶² In December 2017, OIG released an inspection report stemming from inspections at detention facilities in six locations: (1) Hudson County Jail, Kearny, NJ; (2) Laredo Processing Center, Laredo, TX; (3) Otero County Processing Center, Chaparral, NM; (4) Santa Ana City Jail, Santa Ana, CA; (5) Stewart Detention Center, Lumpkin, GA; and (6) Theo Lacy Facility, Orange, CA.⁶³ The latter, Theo Lacy Facility, was also the subject of an OIG management alert in March 2017.⁶⁴

OIG has also published several inspection reports on CBP facilities in recent years. In July 2019, OIG issued a management alert concluding that CBP needed to do more to address “dangerous overcrowding and prolonged detention” of children and adults in the Rio Grande Valley facility.⁶⁵ It issued another management alert in May 2019 regarding “dangerous overcrowding and prolonged detention” of single adults at the El Paso Del Norte Processing Center.⁶⁶ In September 2018, OIG issued a report stemming from inspections of detention conditions for Unaccompanied Alien Children (UACs) in CBP custody.⁶⁷

B. Detention-Related Program Reviews and Evaluations

In addition to detention facility inspections, OIG also reviews and evaluates detention facilities and operations. For example, OIG has investigated ICE detention contracting practices (CBP does not have contract facilities). In February 2018, OIG released a report concluding that ICE did not follow federal procurement guidelines when contracting for detention services.⁶⁸ In January 2019,

⁶¹ DHS OIG Report, Concerns about ICE Detainee Treatment and Care at Four Detention Facilities, OIG-19-47, June 3, 2020, <https://www.oig.dhs.gov/sites/default/files/assets/2019-06/OIG-19-47-Jun19.pdf>.

⁶² DHS OIG Report, ICE’s Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements, OIG-18-67, June 26, 2018, <https://www.oig.dhs.gov/sites/default/files/assets/2018-06/OIG-18-67-Jun18.pdf>.

⁶³ DHS OIG Report, Concerns About ICE Detainee Treatment and Care at Detention Facilities, OIG-18-32, December 11, 2017, <https://www.oig.dhs.gov/sites/default/files/assets/2017-12/OIG-18-32-Dec17.pdf>.

⁶⁴ DHS OIG Report, Management Alert on Issues Requiring Immediate Action at the Theo Lacy Facility in Orange, California, OIG-17-43-MA, March 6, 2017. <https://www.oig.dhs.gov/sites/default/files/assets/2017/OIG-17-43-MA-030617.pdf>.

⁶⁵ DHS OIG Report, Management Alert – DHS Needs to Address Dangerous Overcrowding Among Single Adults at El Paso Del Norte Processing Center, OIG-19-46, <https://www.oig.dhs.gov/sites/default/files/assets/2019-05/OIG-19-46-May19.pdf>.

⁶⁶ DHS OIG Report, Management Alert – DHS Needs to Address Dangerous and Prolonged Detention of Children and Adults in the Rio Grande Valley, OIG-19-51, <https://www.oig.dhs.gov/sites/default/files/assets/2019-07/OIG-19-51-Jul19.pdf>.

⁶⁷ DHS OIG Report, Results of Unannounced Inspections of Conditions for Unaccompanied Alien Children in CBP Custody, OIG-18-87, September 28, 2018, <https://www.oig.dhs.gov/sites/default/files/assets/2018-10/OIG-18-87-Sep18.pdf>.

⁶⁸ DHS OIG Report, ICE’s Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements, OIG-18-67, June 26, 2018, <https://www.oig.dhs.gov/sites/default/files/assets/2018-06/OIG-18-67-Jun18.pdf>.

OIG published a report regarding ICE's ability to hold contractors accountable for failure to meet performance standards.⁶⁹

E. Challenges with Compliance

Each office has its own mission and interpretation of the relevant detention standards and conditions of confinement. However, with multiple entities performing oversight of detention, no central oversight authority currently exists. A side effect of this oversight structure is that the sheer number of inspections per year, as opposed to industry standard American Correctional Association (ACA) accreditation every three years, proves too burdensome for some local jails and limits options for detention capacity. As part of its mission, OIDO will review the reports and recommendations generated from all oversight entities, identify trends, and make systemic recommendations to improve the immigration detention system.

⁶⁹ DHS OIG Report, ICE Does Not Fully Use Contracting Tools to Hold Detention Facility Contractors Accountable for Failing to Meet Performance Standards, OIG-19-18, January 29, 2019, <https://www.oig.dhs.gov/sites/default/files/assets/2019-02/OIG-19-18-Jan19.pdf>.

VI. Site Visits and Medical Findings

As a learning exercise, OIDO staff members were able to observe a portion of the DHS Civil Rights and Civil Liberties (CRCL) Prairieland virtual investigation held September 8-11, 2020. OIDO staff did not comment or interact with the investigation, other than to provide introduction and answer minor administrative questions. Due to significant telecommunication problems, CRCL limited OIDO staff involvement in the full investigation. The opportunity to observe this virtual investigation allowed OIDO staff to gain valuable insight into the advantages and disadvantages of conducting a virtual audit.

The virtual audit encountered various video connection problems, including significant loss of connection or inability to establish a connection; connection delays, loss of audio while using the video platform; sound distortion problems during interviews; and sound clarity issues with the interpreters. As a result of this experience, OIDO is taking steps to ensure that any future use of video teleconferencing is adequately supported in advance of an investigation through training and equipment testing, adequate WIFI or cellular connections, and use of supporting technology.

After COVID-19 conditions abate, in-person investigations will resume. However, this virtual visit demonstrated that it may be possible to save costs and have some government staff and outside experts continue with a combination of remote inspections and on-site staff. This remote working environment may also allow OIDO to contract with new experts who may have the type of experience needed, but who would generally not have the time and ability to travel. Another benefit of remote video teleconferencing would allow OIDO staff to gain experience faster, without having to travel constantly. DHS components have generally lacked facility expertise, which necessitates hiring contracted experts. However, with remote capabilities, OIDO staff could gain valuable experience working with outside experts, without having to travel and incur additional costs.

A. U.S. Customs and Border Protection (CBP)

1. Border Tour from San Diego, CA to Yuma, AZ

From October 19, 2020 to October 23, 2020, CBP provided OIDO staff a coordinated in-person border tour of multiple locations along the southwest border in the San Diego, CA, El Centro, CA, and Yuma, AZ areas. The purpose of this visit was to gain a greater understanding of the challenges faced by CBP along the southwest border, with an emphasis on operational capabilities and limitations facing the agency as a result of COVID-19 and the difficulties of addressing populations consisting of family units and UAC.

OIDO staff observed significant operational disruptions due to COVID-19. To limit virus transmission to federal workers and other detained aliens, and to comply with segregation requirements to accommodate different



types of migrant populations, CBP has very limited detention space to process even the few aliens not immediately subject to expulsion. COVID-19 isolation procedures further complicate the detention of different populations. For aliens who remain detained even for limited periods of time, additional limitations surround how detainees are transported and whether ERO has bed space to accommodate aliens. At the time of this visit, CBP did not have the ability to test aliens for COVID-19 unless an individual was taken to a local hospital for medical treatment. Every alien encounter must be treated as if the detainee is infected. At present, Title 42 expulsions and the MPP program have drastically reduced impacts on custody. It is unclear how CBP would be able to handle a large influx of migrant crossings during a pandemic.

While present at the Calexico Port of Entry Title 42 Rally Point, OIDO staff observed USBP officers process cases for expulsion. Title 42 expulsions are administered by only taking basic information and immediately returning the alien. Immediately after apprehension, aliens are directly processed in a covered outdoor area adjacent to the port of entry. After an opportunity to wash their hands, aliens are asked basic biographic information, fingerprinted, and photographed. Once the process is completed, aliens are immediately escorted to the Mexican border. The entire process takes only a few minutes and serves to significantly limit agency personnel's exposure to disease transmission. To date, over 4,000 CBP employees have tested positive for the virus, with 15 having died as a result.⁷⁰

Even prior to COVID-19, CBP discussed the challenges of housing large numbers of aliens during the 2019 border surge. As the numbers greatly exceeded the agency's capacity, the recent surge documented the need for the agency to obtain resources that are quickly scalable and flexible to address any future border influx. USBP discussed temporary measures to cope with the crisis, including conversion of a port area to temporary holding; the installation of tents in a parking lot; the installation of showers; and the conversion of a garage into a holding area. This prior housing crisis was addressed with a multi-million-dollar temporary structure and contract security staff. It was noted that funds obligated to the project were delayed, resulting in significant burdens on the existing staff and unreasonable conditions for aliens in detention. One significant improvement has been USBP's ability to contract for a medical provider to provide basic medical screening and care upon intake. Discussions were also held concerning the coordination with Health and Human Services', Office of Refugee Resettlement (ORR), for placement of unaccompanied children.



⁷⁰ CBP COVID-19 Updates and Announcements, <https://www.cbp.gov/newsroom/coronavirus>. (last visited December 12, 2020).

As part of this trip, OIDO staff evaluated existing DHS cellular technology to determine if video conferencing can be used to facilitate future OIDO visits. The resulting tests determined that local Verizon cellular coverage would not support video conferencing. The locations visited along the south west border varied with coverage provided by both Verizon and AT&T. In some locations, the Verizon service would not even support an audio call. However, in conducting the testing, it



was determined that CBP has dedicated WIFI in all buildings which automatically connects to CBP-approved devices. When tested, this signal was strong enough to support video conferencing without additional equipment. OIDO is engaged in discussions with CBP to make CBP WIFI access available for future OIDO visits and investigations.

2. Weslaco Border Patrol Station

On January 5, 2021, staff visited the Weslaco Border Patrol Station located in the Rio Grande Valley in Weslaco, Texas. The Weslaco facility is primarily used to process family units and unaccompanied alien children who will be placed in one of ERO's family detention facilities or in ORR custody. ERO's Juvenile and Family Domestic Transportation Unit has one supervisor and two officers embedded in the station to facilitate transportation needs. The general average processing time is 72 hours, however, due to lower numbers, the average is presently 48 hours. Medical screening is provided onsite through a fixed rate medical contract.

Title 42 limitations have significantly reduced detainees by 75%. During the surge in 2019, arrests in the area were approximately 1,500 per day, with 800 being family units. The facility was inadequately prepared to handle an influx of family and children, even prior to COVID-19. During this time, the Border Patrol had also leveraged National Guard and Federal Emergency Management Agency (FEMA) resources. The National Guard was used in a very limited fashion, such as in the control center for observation and for escorting detainees to the bathroom.

During the prior surge, this location utilized a sally port and a temporary tent to address the processing of the influx. However, a tent is labor intensive, as it requires two agents per pod. Portable showers were added in a structure adjacent to the sally port. The location also has a 12-hour coverage caregiver contract to care for and shower unaccompanied children of tender age. During the crisis, ERO had embedded officers at the location to process families into the alternatives to detention (ATD) program. At present, Border Patrol officers complete the process due to the lower numbers.

CBP indicated that if the Title 42 provisions were lifted, current projections estimate that a new surge would surpass the numbers that existed in 2019. Per CBP, catch and release would also not be a viable option. When that program was implemented in 2019, there was a 300% increase in border crossers in 30 days. If a similar surge were to occur during the pandemic, CBP estimates that it would have to cease functioning within 72 hours.

B. U.S. Immigration and Customs Enforcement (ICE)

OIDO has been engaging with ICE to seek informational in person visits and virtual presentations. ICE-controlled and contracted detention facilities have continued to operate while addressing active COVID-19 cases.⁷¹ Due to increasing COVID-19 cases within the U.S., there is concern that anyone who enters a facility could be a carrier of the virus. OIDO staff worked with ICE to limit staff visitation into the facilities and wore protective gear appropriate given the conditions.

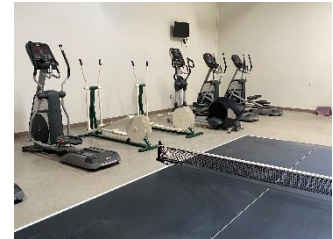
1. Farmville

On December 18, 2020, OIDO staff toured the Farmville Detention Center (Farmville) located approximately one hour southwest of Richmond, VA. Farmville is an ICE-dedicated contract facility that has been operational since August of 2010. The facility was built to house ICE detainees and has a large medical unit, a day room, an indoor exercise room, and a large multi-purpose room with video screens. The multi-purpose room is available for legal presentations. The facility is equipped with a law library and has incorporated library access computers within the housing units.



The facility was originally designed with open bay dorms primarily for low security detainees. At present, changes in the risk classification of the population, primarily related to housing gang members, have led to operational difficulties. The facility has only seven segregation cells to separate gang members or handle disciplinary issues. These rooms are double bunked for a maximum capacity of 14. The facility has direct supervision of detainees with an officer directly within each of the housing units.

Farmville has a guaranteed minimum population of 550, with a maximum population of 736. At the time of the visit, the population was down to 101 as a result of ongoing litigation related to COVID-19 that has halted all new transfers to the facility since June of 2020. Social distancing procedures are in place, temperature checks are conducted twice per day, and all visitors entering the facility are also questioned for possible exposure and temperature checked.



2. Richmond Holding Cells

OIDO viewed ERO's Richmond Holding Cells on December 18, 2020, in Richmond, Virginia. The cells are designed to hold detainees for less than 12 hours. This location allows ICE to process initial intakes and arrange for transportation to a designated facility. ERO staff in Richmond is augmented by contractors from Farmville to assist with transportation needs. The total holding capacity is approximately 120, but only 4 detainees were present during the visit, as there has been a significant reduction in intake due to COVID-19.

⁷¹ ICE Guidance on COVID-19, <https://www.ice.gov/coronavirus>.

ERO's COVID-19 procedures include: ensuring that detainees wear masks during transportation to and from the facility; performing a COVID-19 screening questionnaire about potential virus exposure and sickness; and assessing local conditions when detainees are transferred from local law enforcement. Holding cells in Richmond are equipped with ICE-standard Talton pro-bono phones and permit detainee communication with consulates and other potential mandatorily posted phone numbers to report complaints. Often, such short-term facilities may not provide direct access to phones in the holding cells.

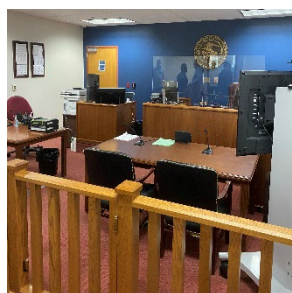
3. Port Isabel Service Processing Center

The Port Isabel Service Processing Center is located in Los Fresnos, TX. OIDO staff visited this facility on January 6, 2021. This location is one of only five Service Processing Centers within ERO. Originally built in the 1940s as a U.S. Army artillery base, ICE (formerly the Immigration and Nationality Service) assumed control of the property in the 1970s. Although ICE owns the property, the agency contracts for the operation of the facility. There have been extensive modifications over the years, with the last major construction completed in 2007. At the time of the visit, a new food service building was under construction.

ERO Staff at the facility manages the caseload at Port Isabel and a satellite facility, El Valle Detention Facility located in Raymondville, TX. The total population under management from this site is approximately 800, with 500 in Port Isabel and 300 in El Valle. Maximum capacity is 1,175 at Port Isabel and 1,000 at El Valle. Port Isabel is male-only, while El Valle holds the female population. All housing units are open dormitory style.



At the time of the visit, there were only eight high classification detainees present. The Talton phone system is operational and tablets are installed for detainees to file grievances, make requests, and conduct video calls. The location also has on-site courtrooms and immigration judges, a barber shop, a large multi-purpose room for legal presentations, and a large law library in the detainee services building.



The ICE Health Service Corps (IHSC) staffs the large and well-equipped medical area with a mixture of IHSC and medical contract staff, including medical, behavioral health, pharmacy, and dental staff. Approximately 50,000 prescriptions are filled per year, with a pill line located in a trailer outside the medical unit. Notably, the medical observation unit has several negative pressure rooms, important to prevent the spread of COVID-19. Construction is underway to bring the total number of negative pressure rooms to 14. There is a large outside field for recreation.

Contact visitation is permitted. Since April, there have been only 200 COVID-19 cases, 100 each in Port Isabel and El Valle. Aggressive measures have been implemented to limit intermingling of detainees and staff.

OIDO met with ERO's Juvenile and Family Domestic Transportation Unit on January 5, 2021, to discuss transportation of families and unaccompanied minor children. ERO transported over

68,000 individuals during fiscal year 2019 during the height of the border crisis; 3,000 were family units. Transportation fell to approximately 28,500 during fiscal year 2020, as the Title 42 limitation and the Migrant Protection Protocols were implemented. Although there was a significant drop-off in numbers in April, the workload has continued to increase ever since. ERO utilizes a contractor for transportation of unaccompanied alien children to ORR and family units to ERO family detention facilities.

C. Health and Human Services' Office of Refugee Resettlement (ORR)

In cooperation with the Office of Refugee Resettlement (ORR), OIDO staff was able to visit the Comprehensive Health Services (CHS) Los Fresnos, Texas location on January 6, 2021. OIDO staff greatly appreciated the opportunity to understand and observe care and custody issues related to the special needs of sheltering children. This shelter has been in operation over 30 years and has a 144-bed capacity; eight children were present at the time of the visit. It is licensed by the State



of Texas. The facility is divided into cottages, and children are separated by gender and age, with a two-year age span per cottage. This location does care for infants. There is an eight to one child to staff ratio.

Children are screened in the intake area and have a medical exam within 48 hours. The facility utilizes community health resources with a primary care physician who visits the facility. If needed, children are transported to a pediatrician for additional care. The present length of stay is 14-21 days; the average stay pre- COVID-19 was seven days. When possible, the shelter performs reunification interviews with a sponsor in conjunction with an ORR Federal Field Specialist (FFS). Sponsors must demonstrate a relationship and undergo background checks. FFS has final approval for placement with a sponsor. Sponsors are responsible for transportation. Children are primarily transported to California, New York, Georgia, North Carolina, South Carolina, and within Texas. The population consists primarily of children from the Northern Triangle countries -- El Salvador, Honduras, and Guatemala.

Legal service providers are available to assist children with their immigration cases. Legal rights presentations are provided; OIDO had the opportunity to see one during the visit. Children have access to free telephone calls to consult with their consulates. Consulate staff sometimes come to visit.

Education is provided to all students, and an entrance test is administered to assess a student's educational level. Many age groups may be in the same level class depending on prior education. Individualized plans for students are available when needed. The school is not accredited but attempts to follow Texas state curriculum. The facility has a gym and pool for physical exercise. Food is prepared on site.



D. DHS Detainee Health Systems

On November 20, 2020, OIDO staff benefited from a presentation on information technology (IT) systems currently used or under development within the Department to document detainee health care. This was an overview of CBP and ICE’s electronic health records. Ultimately, these systems will communicate in a DHS-wide medical system. Slides from the IT presentation and related to other IHSC processes and programs are available in the appendix.

1. U.S. Customs and Border Protection (CBP)

CBP’s plan is to continue to use its Web-based Emergency Operations Center (WebEOC) platform. Health intake and evaluation forms have been designed within the system, and each detention facility can capture data. Detainees are assessed at intake, as needed/ordered, and upon exiting the facility. At the time of discharge, the operator will generate a medical summary to the Unified Immigration Portal (UIP). A limitation within WebEOC is that it is a proprietary product owned by Juvare, designed for emergency preparedness and response⁷² and was not designed for interoperability, ultimately making it difficult to exchange information.

The UIP is a platform that connects several federal agencies with data across the immigration lifecycle. The program is located within CBP but will ultimately connect to HHS, ICE, USCIS, and the Department of Justice (DOJ). The project has direct Congressional funding and support. The UIP is built on the Salesforce CRM platform.⁷³ Although Salesforce is a proprietary system, and its technology is complex, it is much easier to integrate with than WebEOC. Deployment is ongoing; initial access was granted to an HHS user in summer 2019.

2. U.S. Immigration and Customs Enforcement IHSC eClinical Works

IHSC uses eClinicalWorks (eCW) commercial electronic health record (EHR) system at all 20 IHSC-staffed facilities. Managed by a small data analytics team, eCW functionality is continuously being reconfigured to meet the needs of a detention EHR and the reporting requirements of internal and external stakeholders. A benefit within the IHSC-staffed facilities is its ability to communicate across facilities in real-time. Once a detainee is transferred to a non-IHSC staffed facility, records must be printed or provided through other electronic means to the receiving facility to ensure continuity of care. IHSC recently renewed the eCW contract for five years.

In December 2020, Congress mandated that the DHS Chief Medical Officer (CMO): 1) develop and establish interim and long-term electronic systems for recording and maintaining information related to the health of individuals in the Department's custody; 2) facilitate automated reporting requirements for electronic health records; 3) conduct disease surveillance and outbreak response

⁷² Juvare, “Battle-Tested Software for Emergency Preparedness and Response, <https://www.juvare.com/> (last visited January 17, 2021).

⁷³ Salesforce, “Bring your CRM to the future, <https://www.salesforce.com/crm/> (last visited January 17, 2021).

across detention facilities and related partner systems; 4) and monitor performance, support peer review processes, and conduct other health system administration functions.⁷⁴

In response, the Medical and Public Health Information Sharing Environment (MPHISE) was developed to support the CMO's response to the national and public health emergencies. MPHISE is an existing platform designed to coordinate and support CMO COVID-19 response activities. MPHISE will eventually be transitioned to the Medical Information eXchange (MIX) to fulfill the Congressional mandate for a DHS-wide EHR. An added benefit of the MIX is that it is exceptionally cost effective as an EHR system for DHS, specifically built to operate within the distinct mission of DHS. Projections for completion of the MIX are that it will be fully operational within 18-24 months, dependent on adequate funding.

3. Vaccine Limitations

Vaccine access is currently limited and delivery is complicated.⁷⁵ HHS' Operation Warp Speed controls the distribution of vaccines, and the process for delivery varies based on the manufacture.⁷⁶ Presently available vaccines have storage and handling requirements that may limit their ability to be widely available in non-medically equipped locations or to be administered with only one dose. Currently authorized vaccines require two shots for adequate protection based on the following time frame:

- [Pfizer-BioNTech](#) doses should be given 3 weeks (21 days) apart, and
- [Moderna](#) doses should be given 1 month (28 days) apart.

The CDC strongly recommends that individuals receive the “second shot as close to the recommended 3-week or 1-month interval as possible.”⁷⁷

The Pfizer vaccine must be shipped in specially designed, temperature-controlled thermal shippers. During storage, conditions must be kept around -70 degrees Celsius (-94 degrees Fahrenheit), per Pfizer's storage and handling requirements.⁷⁸ The vaccine can be stored in those conditions for up to 10 days. From there, it can be stored in "ultra-low temperature freezers" for up to six months. The Pfizer vaccine can also be stored in refrigeration units that are "commonly available in hospitals" at temperatures between 36- and 46-degrees Fahrenheit for five days.⁷⁹

⁷⁴ Department of Homeland Security Appropriates Bill 2021, H. Rept. 116-458, July 20, 2020, referencing Explanatory Statement accompanying Public Law 116-93, <https://www.congress.gov/congressional-report/116th-congress/house-report/458>.

⁷⁵ CDC, “COVID-19 Vaccine Distribution”, <https://www.hhs.gov/coronavirus/covid-19-vaccines/distribution/index.html>, (last visited January 17, 2020).

⁷⁶ Operation Warp Speed “Vaccine Distribution Process,” <https://www.hhs.gov/sites/default/files/ows-vaccine-distribution-process.pdf> (last visited January 17, 2021).

⁷⁷ CDC, “Frequently Asked Questions about COVID-19 Vaccinations,” <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html>.

⁷⁸ Pfizer-BioNTech COVID-19 Vaccine, “Storage and Handling Summary,” <https://www.cdc.gov/vaccines/covid-19/info-by-product/pfizer/downloads/storage-summary.pdf> (last visited January 16, 2021).

⁷⁹ Pfizer-BioNTech COVID-19 Vaccine, “Vaccine Preparation and Administration Summary,” <https://www.cdc.gov/vaccines/covid-19/info-by-product/pfizer/downloads/prep-and-admin-summary.pdf> (last visited January 16, 2021).

The Moderna vaccine has different requirements. This vaccine should be shipped at -20 degrees Celsius (-4 degrees Fahrenheit) and can stay stable in refrigeration units between 2 and 8 degrees Celsius (36 to 46 degrees Fahrenheit) for 30 days.⁸⁰ The vaccine will stay stable at -20 degrees Celsius for up to six months and at room temperature for up to 12 hours.

Planning for a vaccination program for detained individuals may be highly dependent on many factors. For instance, the storage and refrigeration capabilities of the detention facility, access to medical personnel and services, length in detention, and consideration for continuity of care when a detained alien is released or removed. For these reasons and when vaccines become available, CDC⁸¹ encourages facilities to coordinate with their state/local health departments. States have discretion to determine vaccine priority categories for individuals, and these may differ from the CDC guidelines.⁸²

Currently, it is unknown if and when DHS may be able to vaccinate detained aliens. Presently, “DHS does not have internal capabilities to receive or distribute the vaccine given their handling requirements. We have established a partnership with the Veterans Health Administration to offer the vaccine to eligible DHS employees...DHS federal employees who are first responder healthcare workers with a greater likelihood for COVID-19 exposure are eligible to receive the vaccination. DHS continues to work with CDC ACIP to offer vaccinations to our other frontline mission critical occupations as soon as possible after they are prioritized.”⁸³

At such time when a vaccine becomes widely available and DHS facilities have the capability to distribute the vaccine, numerous factors will need to be addressed. Any mass vaccine process will need to be created across DHS to document which aliens were vaccinated and when, so that appropriate follow up vaccines can be given. A detained vaccine program may also be complicated if individuals are released shortly after getting their first vaccine, as DHS does not have the resources or logistics to track aliens to make sure that they received the second and correct dose of the vaccine as recommended by CDC guidance. There is also no guarantee that DHS will be able to get the same type of manufactured vaccine if an alien is transferred from one facility to another, which frequently happens when an alien is initially encountered. As noted by this report, medical records transfer across DHS and even within ICE are not fully electronic or automatic. Medical records transfers require significant time and resources. Another significant factor is how many detainees will even take the vaccine, as vaccines are voluntary.

⁸⁰ Moderna, “Storage & Handling,” <https://www.modernatx.com/covid19vaccine-eua/providers/storage-handling>. (last visited January 16, 2021).

⁸¹ CDC’s *COVID-19 Vaccine FAQs in Correctional and Detention Centers*, <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/vaccine-faqs.html>, (last visited January 17, 2021).

⁸² CDC, “How CDC is Making COVID-19 Vaccine Recommendations,” <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations-process.html> (last visited January 17, 2021).

⁸³ Bailey, Angela, DHS Chief Human Capital Officer, “COVID-19 Update 17 (Limited COVID-19 Employee Vaccination Program) from the Chief Human Capital Officer, December 17, 2020.

VII. Recognized Challenges with Detention Standards Compliance

A. Infrastructure

ICE's entire system is heavily contracted. The agency rents, and does not own, most of its detention infrastructure. ICE contracts are generally awarded for one-year intervals with a series of option periods, and ICE's detention budget is normally appropriated on a year-to-year basis. In addition, most ICE contracts contain a termination clause whereby either ICE or the vendor may terminate the agreement.

This approach has advantages, as ICE can scale detention capacity up during surges by awarding new contracts and scale capacity down when demand is reduced. However, a disadvantage to this approach is that ICE generally must utilize idle detention capacity in existing detention facilities. Although ICE's detention standards are based on American Correctional Association (ACA) standards, ICE's standards and internal policies differ enough that even ACA accreditation does not guarantee compliance within a facility.

Governments and private vendors are usually reluctant to build a facility for ICE on a year to year contract with a termination clause, so facilities are rarely purposely built to ICE's needs or detention standards. Physical plant designs frequently lead to deficiencies requiring later renovations. ICE must choose whether to accept the limitations of the facility or modify the agreement to add services requiring costly renovations. In mixed-use facilities, where ICE shares detention capacity with the local sheriff's office or USMS, such modifications are frequently not an option.

Frequent trouble spots in pre-existing facilities include the reception and discharge areas, size of the medical units, and internal space for courts, video conferencing, and legal presentations. In OIDO's visit to the Farmville Detention Center in December 2020, OIDO noted that even in facilities built to ICE specifications, a change in circumstances may lead to infrastructure problems. In this case, the facility was constructed to house primarily low-classification, non-violent detainees. However, when circumstances changed and Farmville began receiving more violent gang members, the open dorm construction and limited segregation space became problematic.

CBP differs from ICE in that most of CBP's detention infrastructure is not contracted, but rather consists of hold rooms co-located in government buildings. ICE also has hold rooms but is not reliant on these facilities to the same degree as is CBP. These CBP hold rooms were primarily designed for single adults. Because of this fixed infrastructure, CBP's footprint is difficult to quickly scale or amend as circumstances change. Expanding or constructing additional capacity is a lengthy and burdensome process.

OIDO saw this firsthand in its October 2020 visit to Border Patrol's Yuma Sector, where OIDO witnessed how the 2019 influx of children and families quickly overwhelmed the holding capacity at that location and viewed the progression of various temporary structures to address the influx and change in demographics.

As part of its mission, OIDO will make recommendations regarding infrastructure where existing facilities are inadequate.

B. Contract Management⁸⁴

As noted previously, ICE's detention system is heavily contracted. The ERO Field Office Director, reporting through ERO's Field Operations Division to the ERO Executive Associate Director, is responsible for ensuring compliance with ICE detention standards. A contracting officer in the ICE Office of Acquisition Management, reporting through the Management and Administration (M&A) Executive Associate Director, manages the detention contracts. A collection of Contracting Officer's Representatives (CORs), all reporting to the Field Office Director, assist in the management of the detention contract.

Ideally, each contract will have a Quality Assurance Surveillance Plan (QASP) outlining requirements for complying with applicable performance standards, including detention standards, and potential actions ICE can take when a contractor fails to meet those standards. If a QASP is present in an ICE agreement, ICE can take contractual action to withhold or deduct funds from a vendor as a tool to maintain compliance. However, not all ICE contracts have such a provision, and USMS contracts and agreements on which ICE is a rider are normally written to USMS specifications and require USMS concurrence for any action. In the absence of an ICE agreement with a QASP, contractually enforcing ICE standards becomes more difficult. In some circumstances, discontinuation of use of the facility is ICE's sole option.

Government contracts are generally interpreted in favor of the vendor, so any substantial change not included in the original agreement requires ICE to modify the agreement. Such modifications may be a change in detention standards or a request for additional services, such as court services requiring construction or additional medical staff requiring additional space. Vendors may accept minor changes, but large modifications result in costs for ICE.

As part of its mission, OIDO will review contracts and make recommendations regarding statements of work, contractual penalties, and contract modifications where appropriate.

C. The Impact of COVID-19 and Potential Implications for FY 2021

The effects of COVID-19 on immigration and detention health care have yet to be fully realized. The many challenges seen throughout the U.S. health care system as a result of COVID-19 are compounded in a detention environment with limited space and resources. CBP and ICE are constrained by the physical layouts of owned or contracted facilities. Furthermore, frontline staff are impacted by the communities in which they reside, bringing additional challenges on how to maintain appropriate staffing levels without impacting operations.

⁸⁴ See also DHS Office of Inspector General, ICE Does Not Fully Use Contracting Tools to Hold Detention Facility Contractors Accountable for Failing to Meet Performance Standards. <https://www.oig.dhs.gov/sites/default/files/assets/2019-02/OIG-19-18-Jan19.pdf>.

The uncertainty of an ever-changing pandemic may only be complicated by the possibility of a new migrant population surge as was seen in FY 2019. In addition, vulnerable populations overwhelming the existing infrastructure during a pandemic would only increase the risk for an outbreak, potentially inundating southwest border hospitals. Federal data⁸⁵ gathered during the week of January 1-7, 2021 showed most hospitals impacted by COVID-19 are along the southwest border. The report used the ratio of COVID-19 hospitalizations to total beds to indicate the level of stress on the infrastructure. It was hypothesized that a value greater than 20 percent represented “extreme stress.” For example, San Diego, CA reported 32 percent of beds used; Imperial County, CA, 66 percent of beds; Pima County, AZ, 42 percent of beds; El Paso County, TX, 20 percent of beds; Webb County (which includes Laredo), TX, 43 percent of beds, and Cameron County, TX reported 21 percent of beds used. These locations are highly likely to be affected by future mass migrations, potentially resulting in a humanitarian crisis.

With the possibility of an FY 2021 surge at the border, lifted Title 42 limitations, and/or the resumption of MPP proceedings, DHS components would have to develop or further expand preventive mechanisms for the safe processing and transfer of aliens in their custody, while ensuring the safety and well-being of both aliens and the staff.

It is undisputed that COVID-19 has greatly impacted the Department’s ability to address immigration detention issues. Going forward, OIDO plans to assess the operational and medical challenges of having to implement shifting emergency procedures and court orders. Based on the above-referenced site visits and medical briefings provided to staff, OIDO recognizes that it may be in a unique position to evaluate and recommend future improvements to the Department’s practices in addressing this crisis. OIDO looks forward to working with all relevant parties to improve services and agency operations not only related to COVID-19, but also to address ways to mitigate future contagious disease concerns and medical care in the detention process.

⁸⁵ McMinn, Sean, “Federal Data Reveal Which Hospitals Are Dangerously Full This Week. Is Yours?” NPR, January 11, 2021, <https://www.npr.org/sections/health-shots/2020/12/09/944379919/new-data-reveal-which-hospitals-are-dangerously-full-is-yours> (last visited January 14, 2021).

VIII. Conclusion

In the short time that the Office of the Immigration Detention Ombudsman (OIDO) has been in existence, the office has grown from one operations professional to a staff that includes the very first appointed Immigration Detention Ombudsman, Deputy Ombudsman, Director of External Affairs, Director of Detention Oversight Investigations, Director of Detention Oversight Policy, Director of Case Management, Director of Operations and staff, and a number of specialists including a Public Health Service Officer and experts with specialization in malfeasance investigations, private detention contracts, and CBP processing. The Office has moved forward with the building of a case management system for individual detainee complaints that, although modeled in some ways against the Citizenship and Immigration Services Ombudsman's case management system, is built with the recognition that OIDO will have to handle cases directly with detainees on a non-paper basis, sometimes in person. OIDO staff visited a number of detention facilities at the height of the COVID-19 pandemic to lay a groundwork for future inspections and audits. OIDO has also extensively examined medical issues that pertain to the care of detainees, in part with the anticipation that there may soon be another surge of migrants at the border similar to the one faced in 2019 – but with the additional dangers the pandemic places upon the detainee population, the officers involved, and the general public. OIDO stands ready to assist in alleviating some of the detention problems faced during that surge in 2019 in order to help prevent similar problems in case of future surges. Finally, OIDO has worked tirelessly to produce an annual report, as required by statute, to provide a straight-forward guide to detention matters in a format that should be easy for the lay reader to comprehend, and to provide detailed non-public information gathered by the office in the past year. These tasks have set the foundation for OIDO to move forward in a confident manner, build capabilities, and meet its mission in the coming year.

Appendix 1

Acronym Guide

Acronym Guide

ATD	Alternatives to Detention
ACA	American Correctional Association
ADP	Average Daily Population
BOP	Bureau of Prisons
CAE	Center for Audit Excellence (GAO)
CBP	Customs and Border Protection (CBP)
CDC	Centers for Disease Control and Prevention
CDF	Contract Detention Facilities
CHCO	Office of the Chief Human Capital Officer (DHS)
CHS	Comprehensive Health Services
CISOMB	Citizenship and Immigration Services Ombudsman
CMO	Chief Medical Officer
COR	Contracting Officer's Representative
CRCL	Office for Civil Rights and Civil Liberties (DHS)
DHS	Department of Homeland Security
DIGSA	Dedicated Intergovernmental Service Agreement
DMC	Detention Monitoring Council (ICE)
DOI	Detention Oversight Investigations (ODIO)
DOP	Detention Oversight Policy (OIDO)
DRIL	Detainee Reporting and Information Line
DRB	Discipline Review Board (CBP)
DSCO	Detention Standards Compliance Officer
DSM	Detention Service Manager
eCW	eClinicalWorks
EDS	Electronic Data System
EHR	Electronic Health Record
ERAU	External Review and Analysis Unit
ERO	Enforcement and Removal Operations (ICE)
FFS	Federal Field Specialist
FRC	Family Residential Center
FRS	Family Residential Standards
FDC	Federal Detention Center
FEMA	Federal Emergency Management Agency
FLETC	Federal Law Enforcement Training Center
GAO	Government Accountability Office
HHS	Department of Health and Human Services
ICE	Immigration and Customs Enforcement
ODO	Office of Detention Oversight (ICE)
IDOD	Inspections and Detention Oversight Division
IGSA	Intergovernmental Service Agreement
IHSC	ICE Health Service Corps
INA	Immigration and Nationality Act
ISA	Intergovernmental Service Agreement

IT	Information Technology
JFRMU	Juvenile and Family Residential Management Unit
JIC	Joint Intake Center
JICMS	Joint Integrity Case Management System
M&A	Management and Administration
MDC	Metropolitan Detention Center
MID	Management Inspection Division
MIX	Medical Information eXchange
MOA	Memorandum of Agreement
MPHISE	Medical and Public Health Information Sharing Environment
MPP	Migrant Protection Protocols
NCCHC	National Commission on Correctional Health Care
NDS	National Detention Standards
NGO	Non-governmental Organization
OCFO	Office of the Chief Financial Officer (DHS)
OFO	Office of Field Operations (CBP)
OGC	Office of General Counsel (DHS)
OIDO	Office of the Immigration Detention Ombudsman (DHS)
OIG	Office of the Inspector General (DHS)
OPR	Office of Professional Responsibility
ORR	Office of Refugee Resettlement (HHS)
ORSA	Operational Review Self-Assessment
PBNDIS	Performance-Based National Detention Standards
PHSO	Public Health Service Officer (HHS)
PLCY	DHS Policy Office
PREA	Prison Rape Elimination Act
PRR	Pandemic Response Requirements
QASP	Quality Assurance Surveillance Plan
QAT	Quality Assurance Team
SIP	Self-Inspection Program
SPC	Service Processing Center
SME	Subject Matter Expert
TAR	Technical Assessment Review
TEDS	Transport, Escort, Detention, and Search
UAC	Unaccompanied Alien Children
UFRS	Use of Force Reporting System
UIP	Unified Immigration Portal
USBP	U.S. Border Patrol (CBP)
USCIS	U.S. Citizenship and Immigration Services
USMS	U.S. Marshals Service
WebEOC	Web-based Emergency Operations Center

Appendix 2

Complaint Processing

Complaint Intake and Case Opening



Complaint filed by detainee, representative, or family member



Case file created by OIDO



Complainant receives confirmation of receipt and copy of complaint details

Initial Triage Queue Assignment



Complaint placed in initial triage queue



Assigned to analyst for initial review

Case Triage, Validation, and Assignment



Assess and validate jurisdiction



Assess authorization and consent



Review previous efforts made by complainant



Assess urgency



Complaint assigned to analyst

Case Resolution



Review case file



Conduct necessary background research



Engage ICE/CBP



Work with ICE/CBP for resolution



Communicate result to complainant

Case Closure and Storage



Complaint resolved

Appendix 3

ICE

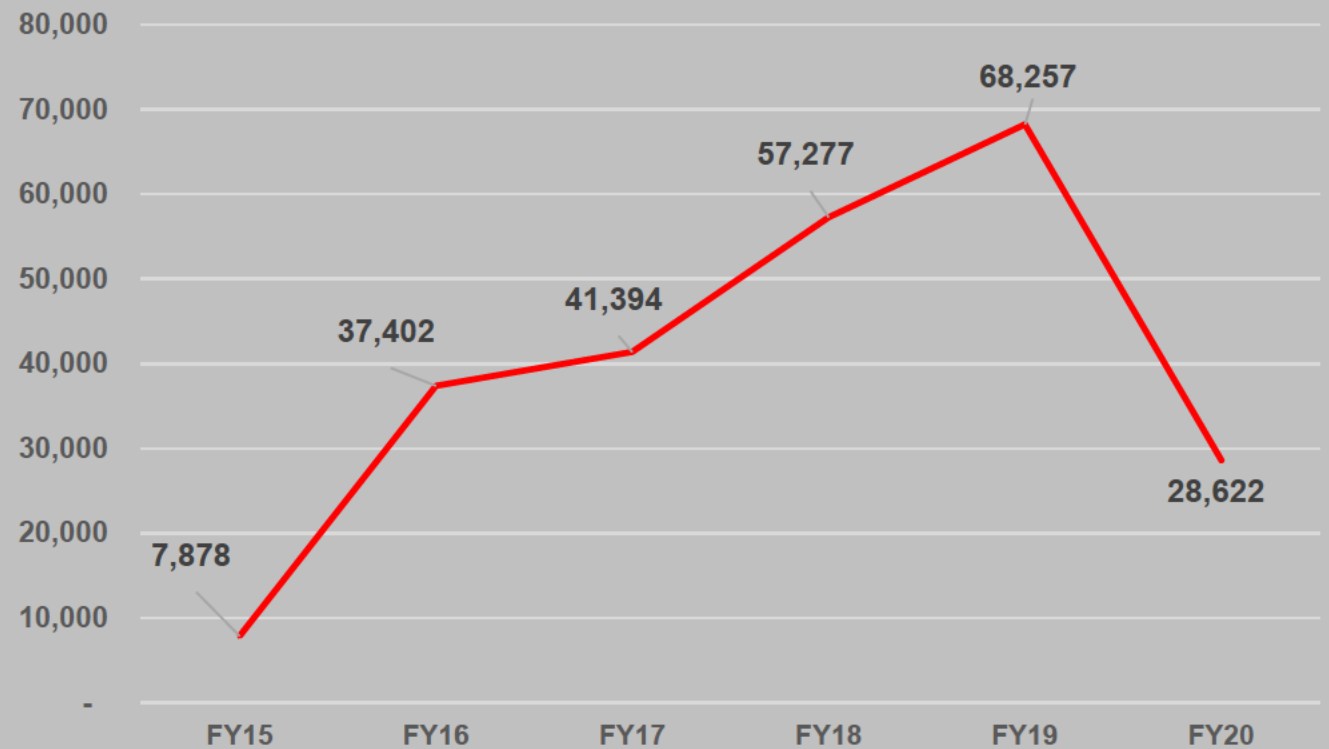
Transportation Charts

ICE



U.S. Immigration
and Customs
Enforcement

Transportation Totals by Fiscal Year



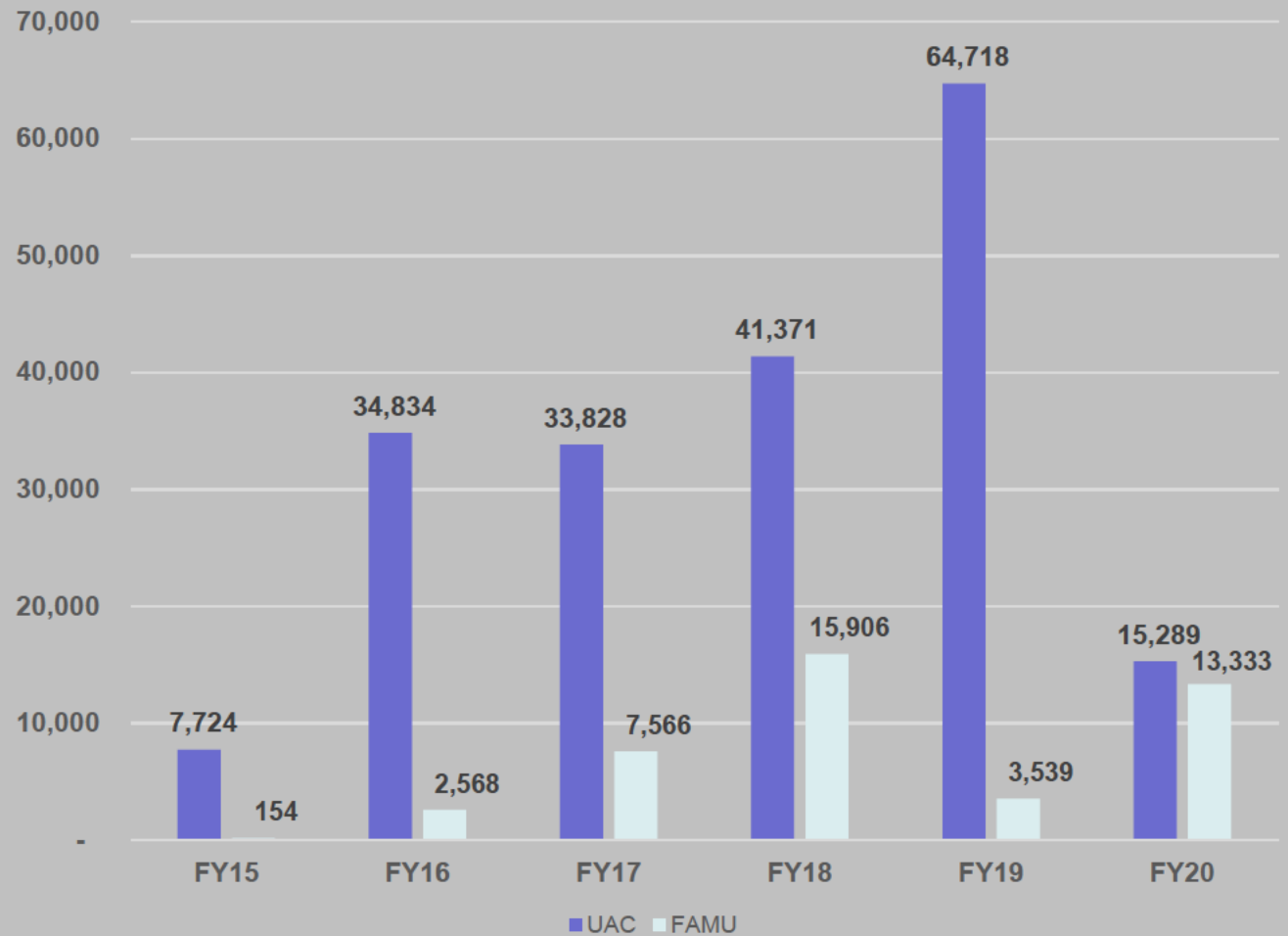
ICE



U.S. Immigration
and Customs
Enforcement

Transport Totals by Fiscal Year – UAC/FAMU

Breakout by UAC and FAMU individuals

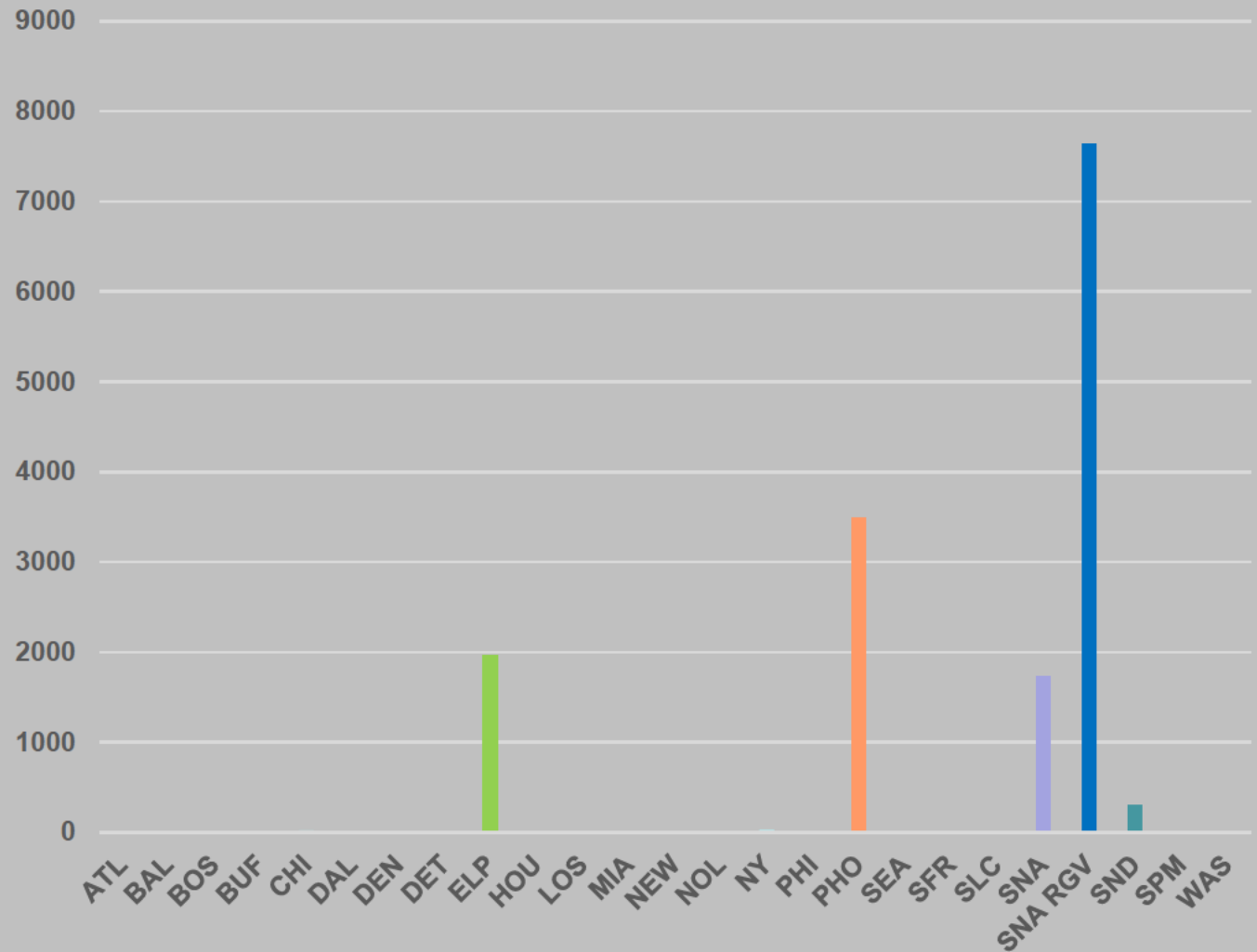


ICE



U.S. Immigration
and Customs
Enforcement

FY 20 UAC Totals by Originating AOR

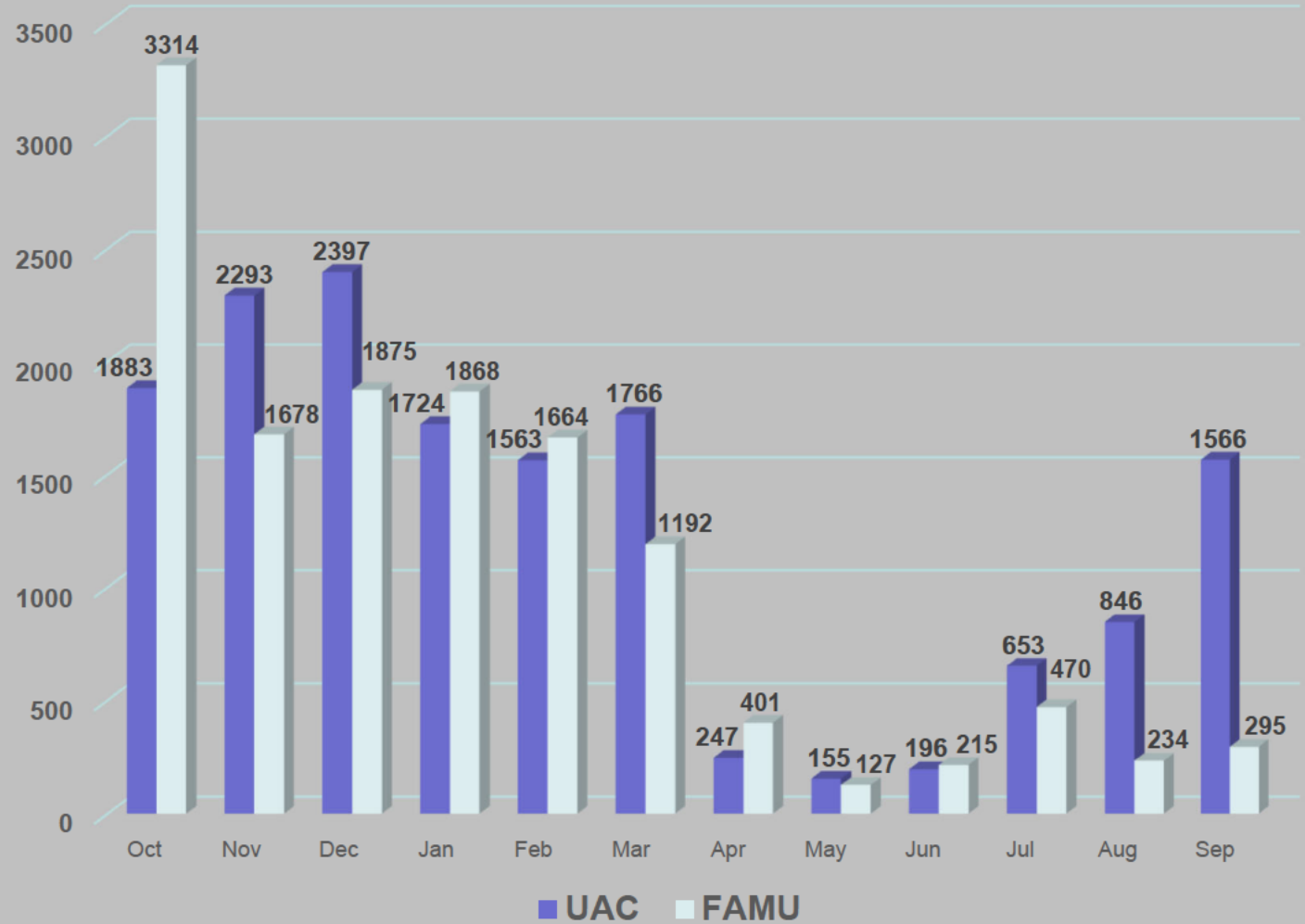


ICE



U.S. Immigration
and Customs
Enforcement

FY 20 YTD Total Transports of UAC and FAMU



Appendix 4

Introduction to ICE Health Service Corps



1



INTRODUCTION TO ICE HEALTH SERVICE CORPS

NOVEMBER 2020 - DHS OFFICE OF IMMIGRATION DETENTION OMBUDSMAN

**U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT
ENFORCEMENT AND REMOVAL OPERATIONS
ICE HEALTH SERVICE CORPS**



2



HISTORY

ICE HEALTH SERVICE CORPS



1891

Immigration Act authorizes U.S. Public Health Service (PHS) to examine and quarantine at Ellis Island.



2007

DIHS aligned with the U.S. Department of Homeland Security.



Present

Over 1,600 IHSC PHS, civilian, and contract personnel at HQ and 22 facilities nationwide.

1980s

Division of Immigration Health Services (DIHS) support legacy Immigration and Naturalization Service (INS) starts providing health care to detainees at Krome Service Processing Center near Miami, FL.



ICE

ICE Health Service Corps

2010



ICE

3



LEADERSHIP ORGANIZATIONAL CHART


ICE HEALTH SERVICE CORPS




Assistant Director




Chief of Staff



Deputy Assistant Director of Administration



Deputy Assistant Director of Clinical Services



Deputy Assistant Director of Health Care Compliance



Deputy Assistant Director of Health Systems Support



ICE

4



CAPT PHILIP FARABAUGH, MD

DEPUTY MEDICAL DIRECTOR – MEDICAL SERVICES UNIT (MSU)

- Under the DAD of Clinical Services, oversees the MSU and administers clinical service delivery through medical, dental, and pharmacy programs.
- Support detainee medical, dental, and pharmacy needs at non-IHSC sites.
- Oversees credentialing and privileging program for IHSC licensed independent practitioners.
- Provides clinical SME to IHSC leadership.



CONTINUED >>



5



CAPT CHIARA RODRIGUEZ, RN

CHIEF, IHSC INVESTIGATIONS UNIT (IIU)

- IIU falls under the Office of the Chief of Staff.
- IIU is the investigative authority of IHSC.
- Oversees inquiries into:
 - Allegations of inadequate care;
 - Morbidity/mortality reviews;
 - Employee misconduct; and
 - Tort claims.



CONTINUED >>



6



IHSC HEALTH CARE SYSTEM

ICE HEALTH SERVICE CORPS

IHSC is the medical authority for ICE

- **Advises the agency on medical care concerns**
- **IHSC ensures any and all medically necessary health care services are available and provided, whether directly or indirectly, to all ICE detainees.**
- **Field Medical Coordinators support non-IHSC facilities**
- **Pharmaceutical services**
- **Payment for detainee off-site care (hospitalizations, specialty referrals)**



7



ICE DETENTION FACILITY TYPES

Facility Type	Description
Service processing center	Facilities owned by ICE, operated by a mix of ICE employees and contractor staff that exclusively house ICE detainees.
Contract detention facility	Facilities owned and operated by private companies under direct ICE contracts that exclusively house ICE detainees.
Dedicated intergovernmental service agreement (IGSA)	Facilities owned by state and local governments, or private entities, operated under agreements with state and local governments that exclusively house ICE detainees.
Family residential	Facilities owned and operated by a local government entity that house children and their families and exclusively house ICE detainees.
Non-dedicated IGSA	Facilities owned by state and local governments, or private entities, operated under agreement by state and local governments that house ICE detainees in addition to other confined populations (e.g., detainees), either together or separately.
U.S. Marshals Service (USMS) intergovernmental agreement of contract	Facilities owned and operated by state and local governments, or private entities, under agreement of contract with USMS within the Department of Justice (DOJ) to house federal prisoners until they are acquitted or convicted. ICE takes out task orders against USMS intergovernmental agreements and contracts to house immigration detainees at the facilities, either together with or separately from other populations.



8



ICE DETENTION FACILITY TYPES AND CHARACTERISTICS

ICE HEALTH SERVICE CORPS



As of August 2020, IHSC staffs **20** facilities.

Facility Type	Number of Facilities (2015)	Detainee Population (2015)
Service processing center	6	12%
Contract detention facility	7	19%
Dedicated IGSA	9	22%
Family residential	2	<1%
Non-dedicated IGSA	103	34%
USMS	125	14%

Source: U.S. Government Accountability Office analysis of ICE information, 2016.



DIRECT HEALTH CARE DELIVERY

ICE HEALTH SERVICE CORPS

IHSC-staffed



FY19 in 20 facilities

Non-IHSC staffed



112 Facilities

- **Challenges of a transitional care environment**
- **Frequent transfer of detainees to other facilities**





DETAINEE GATEWAY TO DETENTION HEALTH CARE

ICE HEALTH SERVICE CORPS

- **All detainees at all facilities become 'known' to the health care system at entry into detention.**
 - **Medical, dental, and mental health status screening within first 12 hours.**
- **System designed for failsafe redundancy through:**
 - **Time-framed referrals to health care provider for acute and chronic conditions.**
 - **Immediate and appropriate health care setting placement.**
 - **Daily sick call.**
 - **Comprehensive health assessment at 14 days of detention.**

*Business days



11



APPLICABLE ICE DETENTION STANDARDS

IHSC-STAFFED FACILITIES VS. NON-IHSC STAFFED FACILITIES

- **All 20 IHSC-staffed facilities are required to comply with ICE Performance-Based National Detention Standards (PBNDS).**
- **Non-IHSC staffed facilities (i.e., IGSA's) follow the ICE National Detention Standards that they are contracted for.**
- **Each set of standards looks at safety, security, order, care, activities, justice, and administration and management.**



12



ICE DETENTION STANDARDS

EXPLANATION OF STANDARDS

PBND

- Performance-Based National Detention Standards
- 2011 (2016 revisions), 2011, and 2008 versions

NDS

- National Detention Standards
- 2000 and 2019 versions

FRS

- Family Residential Standards
- 2020, recently updated from 2007

ORSA

- Operational Review Self-Assessment
- Implemented in 2012
- ORSA under 72 hours and ORSA Over 72 hours less than 10 detainees



13



ACCREDITATION STANDARDS

CHALLENGES

ICE Detention Standards

- **Shaped by National Commission on Correctional Health Care Standards**
- **Do not assess quality of care**
- **Many requirements not well-defined**
- **Facility can pass detention standards review but have significant shortcomings that aren't addressed**
- **Reviewers are typically non-medical staff**



14



WHERE DOES OIDO FIT?

OIDO's role in relation to:

- **DHS OIG**
- **DHS CRCL**
- **ERO DRIL**
- **ICE & CBP OPR**



15



OBSTACLES

- **Contracts.**
- **Inspection process.**
- **Facility accountability.**
- **Continuity of care between points of service.**
- **Complaint system overly bogged down. Too many venues to complain through. Lack of coordination.**



16



QUESTIONS?



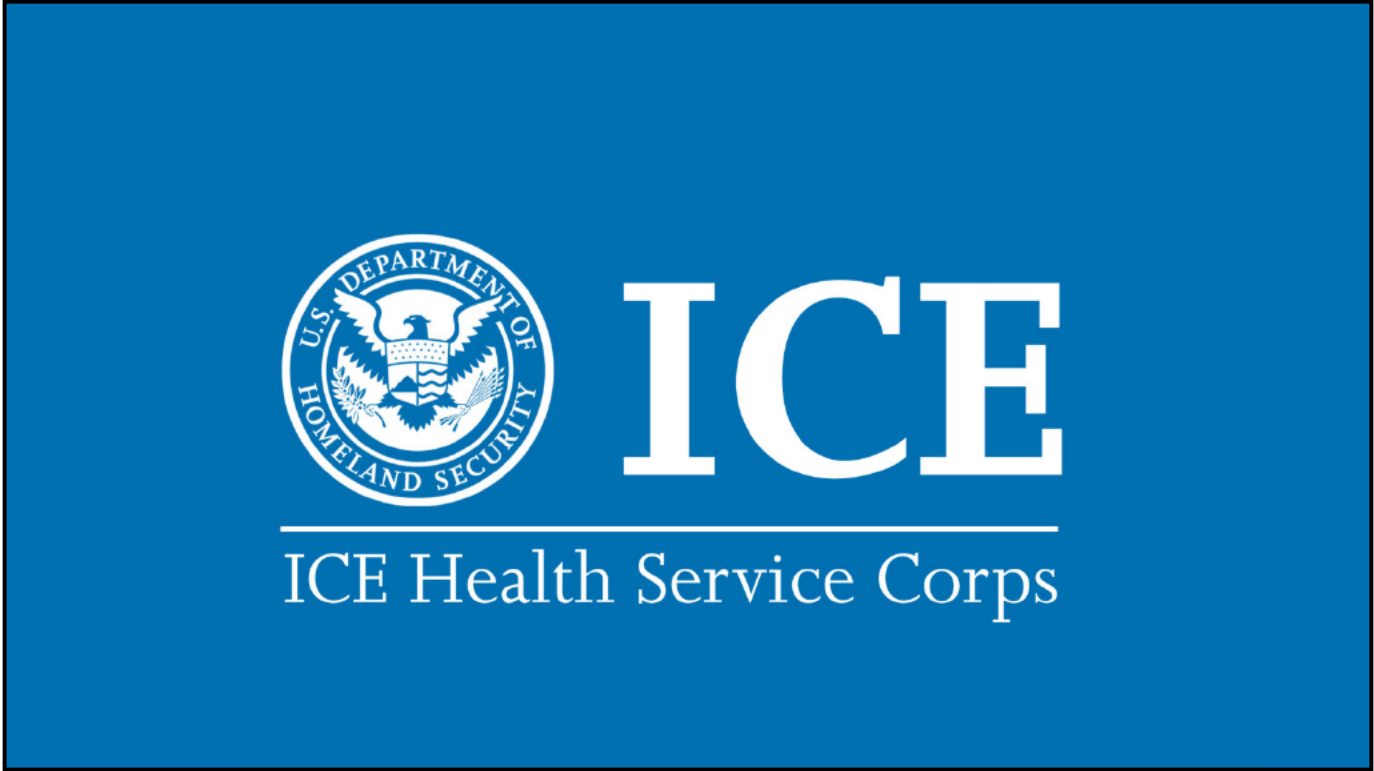
17



*IHSC: ONE TEAM, ONE MISSION...
LEADING THE WAY IN
IMMIGRATION HEALTH CARE.*



18



Appendix 5

IHSC's Health Plan

Management Processes



U.S. Immigration and Customs Enforcement



ICE

ICE Health Service Corps



IHSC 'S HEALTH PLAN MANAGEMENT PROCESSES: PRESENTATION PREPARED FOR OIDO (OFFICE OF THE IMMIGRATION DETENTION OMBUDSMAN)

NOVEMBER 12, 2020

CAPT TARA DAUGEREAU, MSPH, BSN, RN, CCHP

HEALTH PLAN MANAGEMENT UNIT CHIEF

CAPT JENNIFER MOON, MPH, FNP-BC

DEPUTY ASSISTANT DIRECTOR OF HEALTH CARE COMPLIANCE (DAD-HCC)





HEALTH PLAN MANAGEMENT UNIT

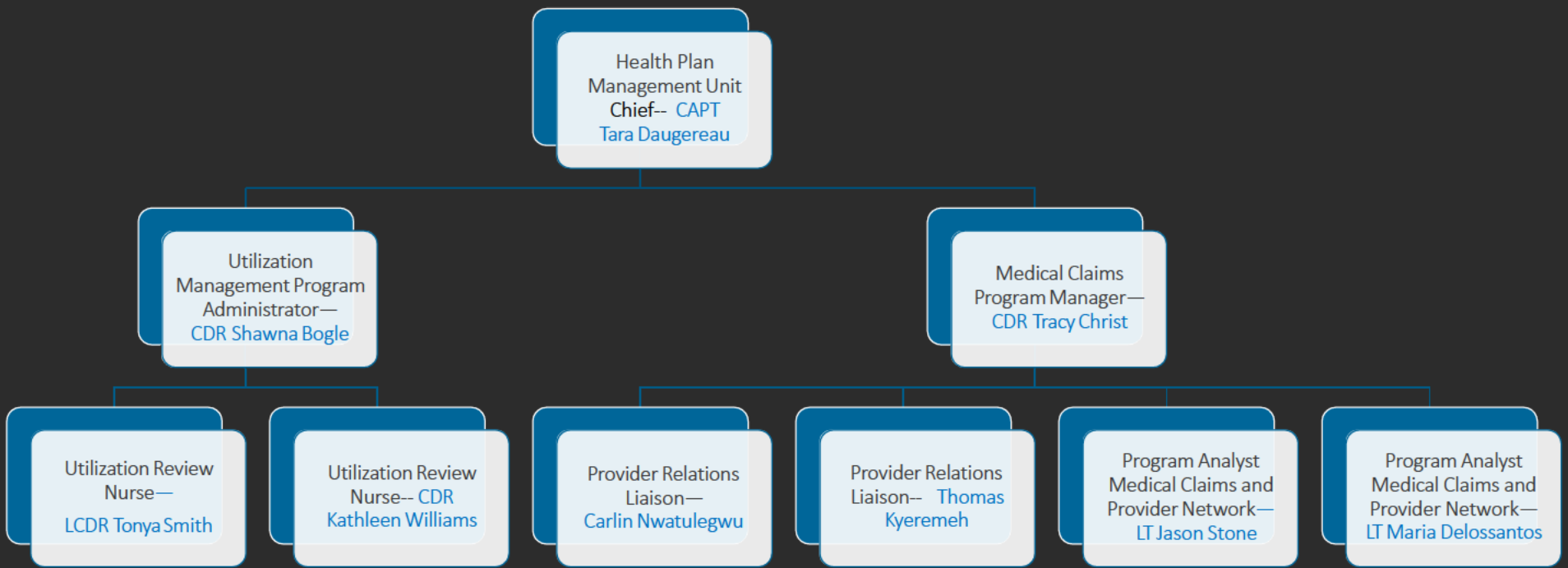
IHSC HEALTH CARE COMPLIANCE





TEAM STRUCTURE

HEALTH PLAN MANAGEMENT UNIT





OUR ROLE...WHAT WE DO

HEALTH PLAN MANAGEMENT UNIT

Provider Network Support

- Train Stakeholders on provider recruitment
- Enrollment completion with Letters of Understanding (LOUs)

Manage the Referral and Authorization Process

- Make needed process changes (eCW and MedPAR2) related to referrals, authorizations, and cancelations
- Update the MedPAR guide and standard approval language

Utilization Review: Prospective, Concurrent, and Retrospective

- Train stakeholders on use of our selected national care guidelines
- Conduct Reviews in reference to national care guidelines (MCG)
- Establish Utilization Management Review Committee
- Assess/Monitor for FWA

Oversight of Claims Processing

- Oversight of VA FSC processes
- Support claim resolution/appeals process
- Strengthen provider relations/trust
- Claim payment

Drive IT Innovation, Integration and Collaboration

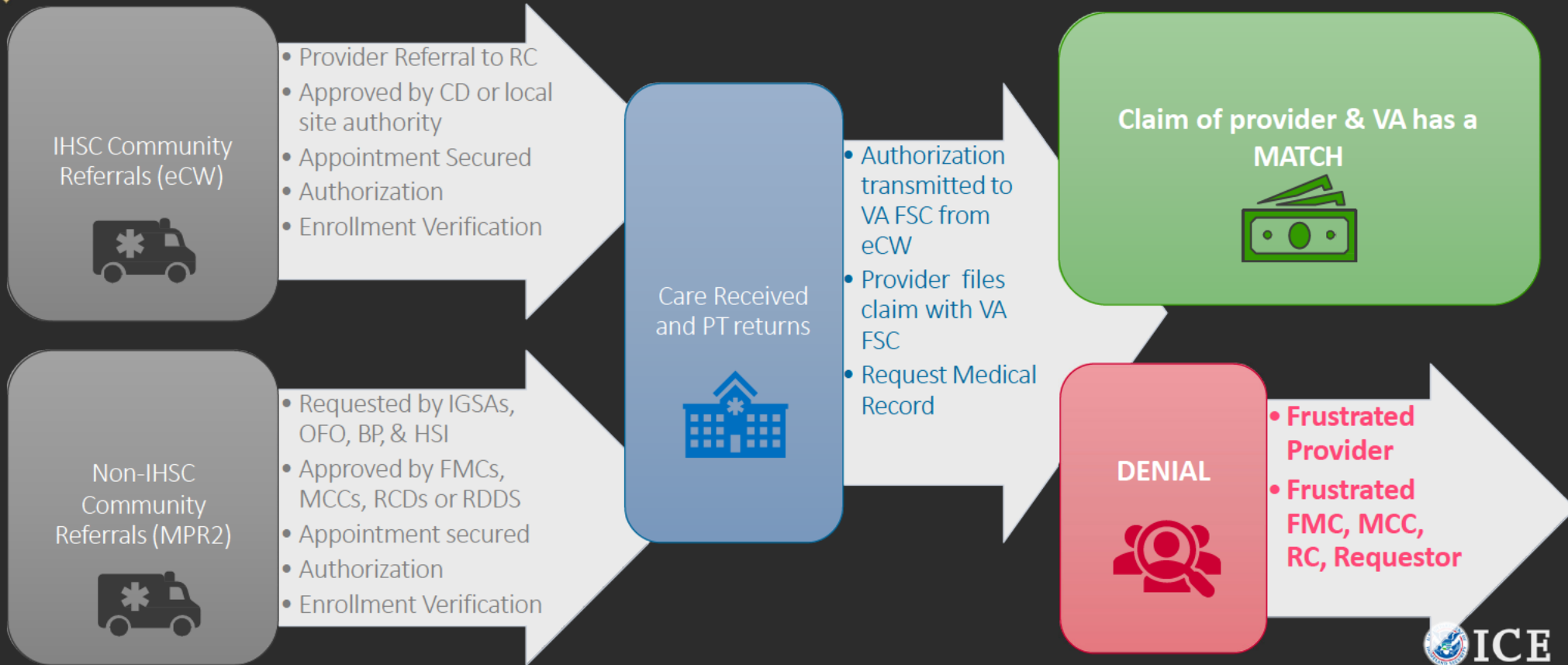
- eCAMS
- eHR (eCW and provider medical records)
- MedPAR2
- Provider network

Establish Unit Performance & Quality Assurance Measures

- Establish program audit tools
- Build in fraud, waste, and abuse monitoring/prevention
- Evaluate data trends
- Report and act on findings

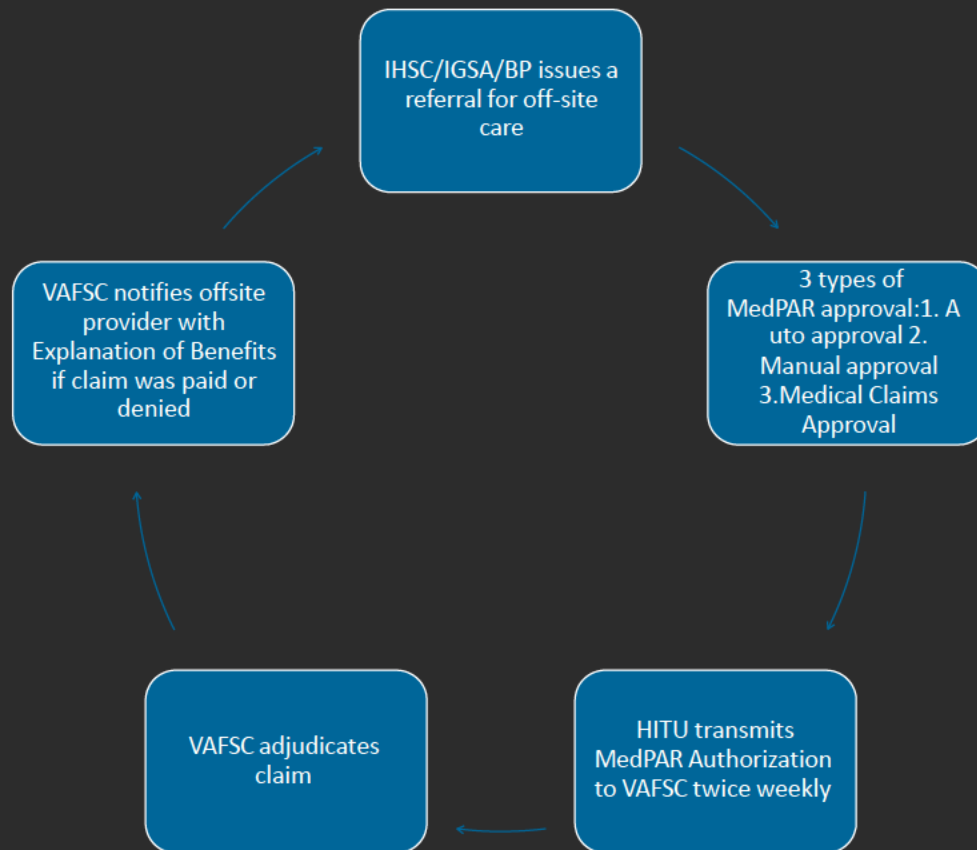
THE BIG PICTURE: REFERRAL, AUTHORIZATION, CARE & CLAIMS

HEALTH PLAN MANAGEMENT UNIT



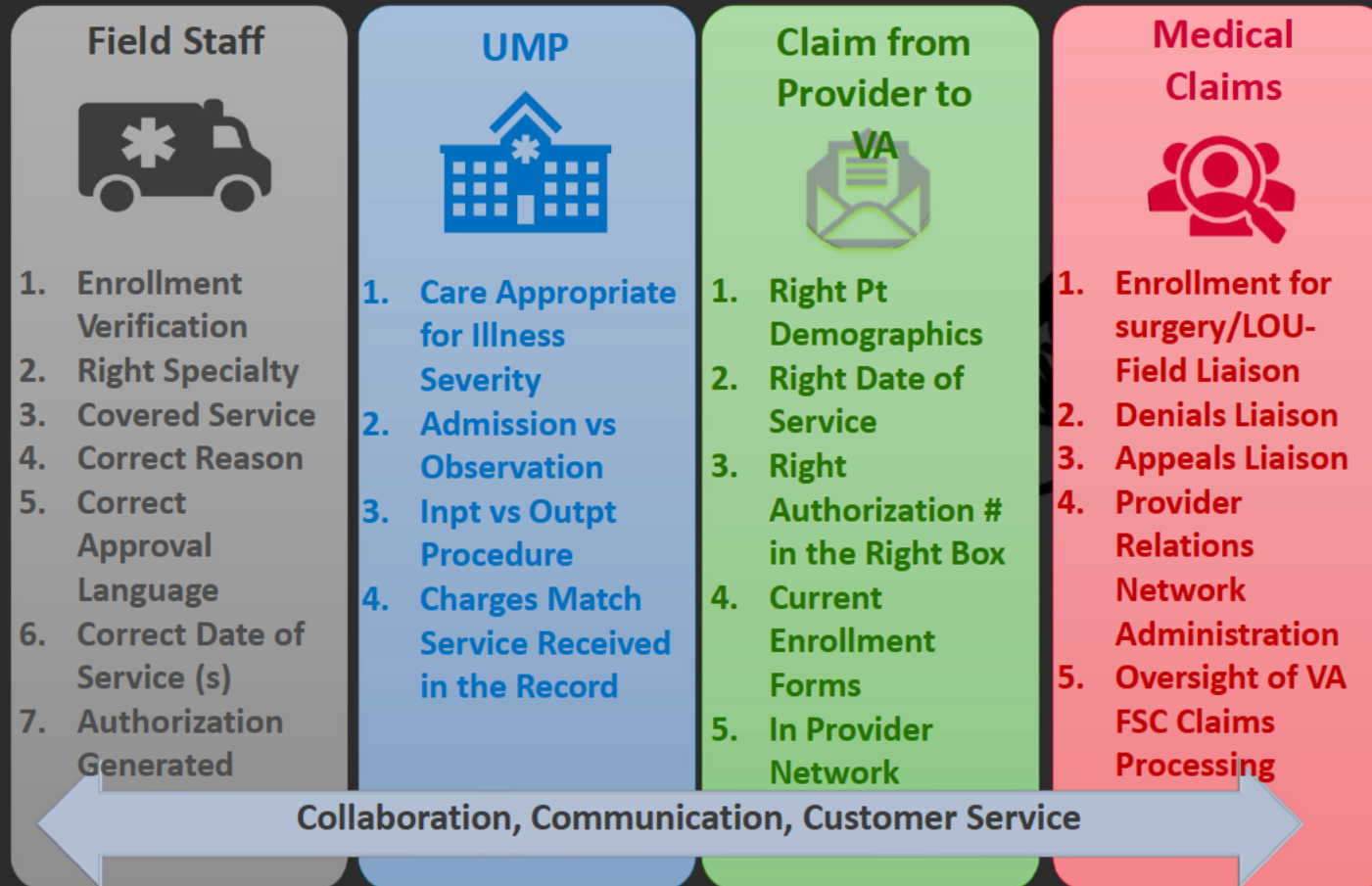
MEDICAL CLAIMS PROCESS FLOW

HEALTH PLAN MANAGEMENT UNIT / MEDICAL CLAIMS OFFICE



THE BIG PICTURE: YOU ARE CRITICAL TO THIS PROCESS

HEALTH PLAN MANAGEMENT UNIT





WHAT DOES MEDICAL CLAIMS APPROVE

HEALTH PLAN MANAGEMENT UNIT / MEDICAL CLAIMS OFFICE

Recruitment of
Offsite Healthcare
Providers

90-Day Global
Surgery for IHSC
sites

Durable Medical
Equipment

Research
of Denied Claims
for IHSC sites,
IGSA, CBP, OFO, HSI



UMP: WHERE IS OUR NEXT STEP--MCG CARE GUIDELINES

UTILIZATION MANAGEMENT PROGRAM



UM Program

- Utilization management is a three-fold mission: utilization review, risk management, and quality assurance in order to ensure the judicious use of resources and high-quality care
- UM weighs care suggested or given against a national referenced utilization care guideline that is backed by evidence (MCG or InterQual)
- Requires clinical director level oversight with a multi-disciplined review committee for care not clearly defined by the care guideline (MCG)
- We drive regulatory compliance that prevents FWA while ensuring high quality care, and is backed by national evidenced guidelines



Future with MCG CareWebQI Licensing

- Receive most comprehensive evidence driven clinical content to support UR determinations
- Receive UM/UR support, user competency training, UR MCG certifications; workflow development and consulting
- Conduct prospective, concurrent, and retrospective reviews based on determined criteria's
- Perceived benefit: aligned care decisions between providers and payers based on evidence; decreases denials, fraud, waste, & abuse; supports the appeals process



Challenges/Risks without national evidenced based care guidelines (MCG)

- Without a national care guideline, there is no evidence or reference point to determine the appropriateness of medical care and utilization of IHSC resources
- Associated liabilities increase, costs will continue to exceed congressional funding levels and our offsite care delivery continues to go unchecked
- IHSC risks the diversion of resources that could otherwise be used to further advance the agency's mission



QUESTIONS?

CAPT TARA DAUGEREAU
CHIEF OF THE HEALTH PLAN MANAGEMENT UNIT
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CDR SHAWNA BOGLE
UTILIZATION MANAGEMENT PROGRAM ADMINISTRATOR
SHAWNA.G.BOGLE@ICE.DHS.GOV



Appendix 6

IHSC Behavioral Health Unit Operations Overview



ICE

ICE Health Service Corps



1



IHSC BEHAVIORAL HEALTH UNIT OPERATIONS OVERVIEW

JANUARY 14, 2021

PRESENTER: CDR SEAN BENNETT

PRESENTER: LCDR RENEE CANNON



2



MISSION

MISSION

BHU provides high-quality patient care, behavioral health-related training, and is the ICE subject matter expert (SME) on behavioral health issues and concerns. As a culturally sensitive, multi-disciplinary program, BHU oversees and delivers these services to adults, children and their families across the nation.



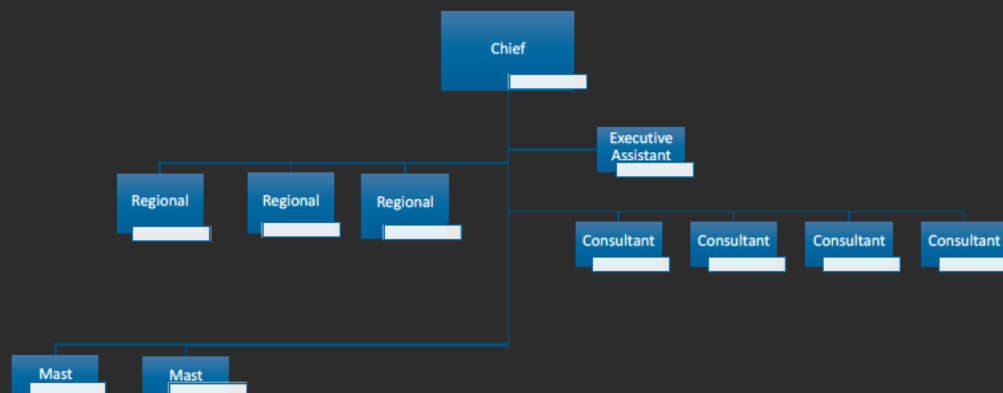
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OPERATIONAL STRUCTURE

OPERATIONAL STRUCTURE

IHSC BHU HEADQUARTERS STAFF



4



OPERATIONAL STRUCTURE

OPERATIONAL STRUCTURE

Headquarters

- Chief
- Regional Behavioral Health Consultants (3)
- Behavioral Health Clinical Consultants (4)
- Medical Asset Support Team – Senior Behavioral Health Providers (2)
- Senior Program Assistant (1)



BHU Field Operations

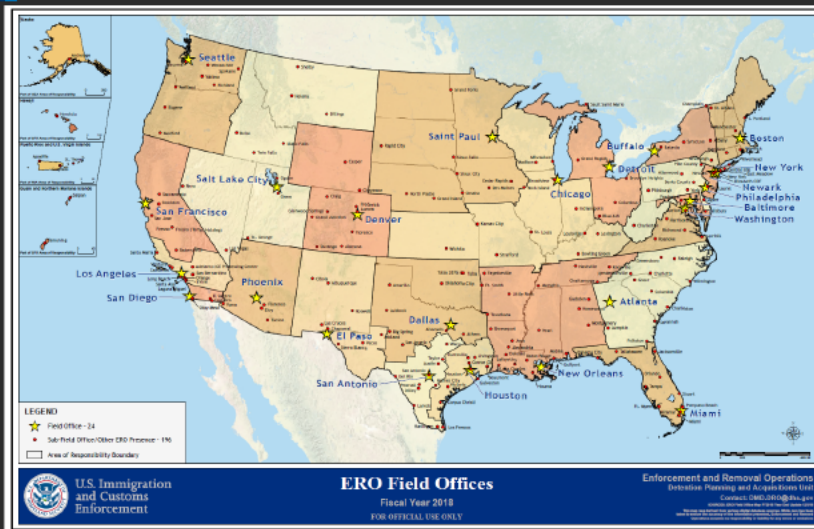
- Clinical Psychologists (14)
- Clinical Social Workers (48)
- Behavioral Health Technicians (14)



5



BEHAVIORAL HEALTH OPERATIONS: OUR REACH



IHSC provides direct care to approximately 15,300 detainees housed at 20 designated facilities throughout the Nation and provides medical case management and oversight for an additional 22,600 detainees housed at approximately 112 non-IHSC staffed detention facilities.



6



7



REASONS FOR USE OF BEHAVIORAL HEALTH SERVICES

REASONS FOR USE OF BEHAVIORAL HEALTH SERVICES

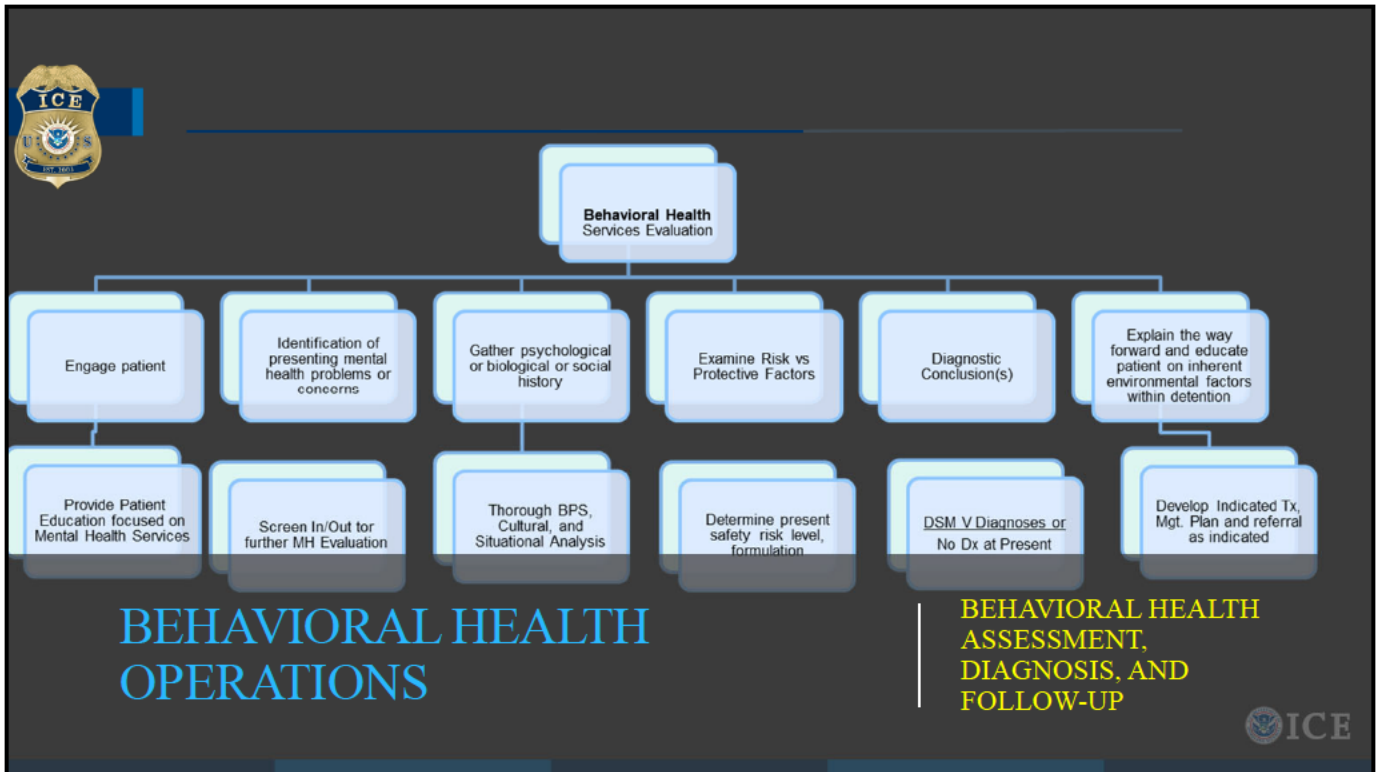


While coping with fear, anger, uncertainty, emotional distress, and other complex thoughts and feelings are common for many detainees, certain factors often lead to an inability to manage those thoughts, feelings, and behaviors in a healthy manner.

Individuals often seek or require behavioral health services when their ability to function is impaired as a result of a chemical imbalance, impaired thought processes, or inadequate coping.



8



9

The slide features the ICE logo in the top left corner. The main title is "COLLABORATIVE PROGRAM GOALS" in white text. Below the title, the subtitle "COLLABORATIVE PROGRAM GOALS" is written in yellow text. The content consists of a bulleted list of goals:

- Training and Support for the Field
 - Expand clinical trainings to enhance provider competency and integrated care service provision
 - Provide program and clinical support to detention staff and field services
- Coordination
 - Advised on PBNDS 2016 Revisions (segregated housing, detainee management of special vulnerability population, collaborative effort to update clinical guidance on suicidal detainee treatment and continuity of care plan)
 - Site visit to IHSCs and IGSA (impact of litigation, current best practices for detainees in ICE custody)
- Process and Procedures

The ICE logo is located in the bottom right corner of the slide.

10



CURRENT BEHAVIORAL HEALTH OPERATIONS

SPECIAL BEHAVIORAL HEALTH POPULATIONS

- Serious Mental Illness (SMI)/Serious Mental Disorder (SMD)
- Suicide Risk
- Substance Abuse
- LGBTQI
- Sexual Assault
- Hunger Strike Patients
- Special Housing
- Higher Level of Care



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SPECIAL BEHAVIORAL HEALTH POPULATIONS

SERIOUS MENTAL ILLNESS/SERIOUS MENTAL DISORDER

I. **Definition:** a detainee has a "serious mental disorder or condition" if either: or • A qualified medical provider determines the detainee has a mental disorder that is causing serious limitations in communication, memory or general mental and/or intellectual functioning (e.g., communicating, conducting activities of daily living, social skills); or a severe medical condition(s) (e.g., traumatic brain injury or dementia) that is significantly impairing mental function; or o is exhibiting one or more of the following active psychiatric symptoms and/or behavior: severe disorganization, active hallucinations or delusions, mania, catatonia, severe depressive symptoms, suicidal ideation and/or behavior, marked anxiety or impulsivity;

II. Resources

- Local NHU, PSU, Medical Team
- 883, 884
- HQ Monitoring (BHU, ERO, CPD, OPLA, etc.)



12



SPECIAL BEHAVIORAL HEALTH POPULATIONS

SUICIDE RISK BEHAVIORS

I. Definition:/Guidance: Ensures consistent and continued care of all detainees and residents to prevent significant self-harm and potential suicides. All IHSC facilities will implement an IHSC Suicide Prevention and Intervention Program (SPIP) to ensure patients are screened for suicidal ideation, plan, and/or intent. *IHSC Directive: 07-04.*

II. Resources

- Local BHU, PSU, Medical Team
- Suicide Risk Assessment, Indicated Treatment Plan (including Appropriate Housing, Hospitalization, or HLOC)
- HQ Monitoring (BHU, ERO, CPD, OPLA, etc.)



13



SPECIAL BEHAVIORAL HEALTH POPULATIONS

SUBSTANCE USE DISORDERS

I. Definition:/Guidance: Health care providers screen, evaluate and make appropriate treatment plans for those detainees (self-identified or staff-identified) who are dependent upon or abuse mood and mind-altering substances to include alcohol, opiates, hypnotics, sedatives, other depressants, stimulants, and other non-prescribed, mind-altering drugs.. *IHSC Directive: 03-13.*

II. Resources

- Local BHU, PSU, Medical Team
- SUD protocols, Indicated Treatment Plan (including Appropriate Housing, Hospitalization, or HLOC)
- HQ Monitoring (BHU, ERO, CPD, OPLA, etc.)



14



SPECIAL BEHAVIORAL HEALTH POPULATIONS

LGBTQI DETAINEES

I. **Definition:/Guidance:** The GD clinical guidelines recommend that all patients be referred to a behavioral health provider for the initial evaluation of GD as well as a multidisciplinary approach to care. A medical provider (MP) must complete a physical examination, and a behavioral health provider (BHP) must complete a mental health evaluation, for all transgender detainees within two business days of intake to determine if treatment for GD is clinically indicated and for a general mental health assessment. *IHSC Directive: 03-25.*

II. Resources

- Local BHU, PSU, Medical Team
- Mental Health Assessment , Indicated Treatment Plan (including Appropriate Housing, Hospitalization, or HLOC)
- HQ Monitoring (BHU, ERO, CPD, OPLA, etc.)



15



SPECIAL BEHAVIORAL HEALTH POPULATIONS

SEXUAL ABUSE AND ASSAULT PREVENTION

I. **Definition:/Guidance:** :

- ICE has a zero-tolerance policy for any form of sexual abuse or assault. IHSC will provide immediate medical and mental health treatment to all detainees with a current and/or history of sexual abuse. *IHSC Directive: 03-01.*
- Ensure all facility medical staff are trained in the proper procedures to identify, assess, examine, refer, and treat victims of sexual abuse, in accordance with the NCCHC 2018 standards. 4-2.
- Provide emergency medical and mental health services to detainees who are victims of sexual abuse

II. Resources

- Local BHU, PSU, Medical Team, PREA Coordinators, Custody staff
- Mental Health Assessment, Indicated Treatment Plan (including Appropriate Housing, Hospitalization, or HLOC)
- HQ Monitoring (BHU, ERO, CPD, OPLA, etc.)



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SPECIAL BEHAVIORAL HEALTH POPULATIONS

HUNGER STRIKE DECLARATION/DESIGNATION

I. Definition:/Guidance: IHSC considers a detainee who has not eaten food for 72 hours to be on a hunger strike. Food is any substance consumed to provide nutritional support for the body to sustain life and vital functions. IHSC is responsible for the medical and mental health evaluation, monitoring, and treatment of detainees on hunger strike. *IHSC Directive: 03-24.*

II. Resources

- Local BHU, PSU, Medical Team
- Mental Health Assessment, Indicated Treatment Plan (including Appropriate Housing, Hospitalization, or HLOC)
- HQ Monitoring (BHU, ERO, CPD, OPLA, etc.)



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SPECIAL BEHAVIORAL HEALTH POPULATIONS

DETAINEES IN SPECIAL MANAGEMENT UNITS (SMU)

I. Definition:/Guidance:

- The purpose of this issuance is to set forth the policies and procedures for the delivery and administration of healthcare evaluations for detainees housed in a Special Management Unit (SMU). *IHSC Directive: 03-06.*
- The BHP or medical provider makes face-to-face weekly visits in the SMU to assess behavioral health needs. He or she documents these weekly visits in both the detainee's health record and in the SMU Log Book.
- The BHP or medical provider triages detainees who request sick call for behavioral health issues and plans appropriate follow-up.

II. Resources

- Local BHU, PSU, Medical Team
- Suicide Risk Assessment, Indicated Treatment Plan (including Appropriate Housing, Hospitalization, or HLOC)
- HQ Monitoring (BHU, ERO, CPD, OPLA, etc.)



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SPECIAL BEHAVIORAL HEALTH POPULATIONS

DETAINEES NEEDING HIGHER LEVEL OF CARE (HLOC)

I. Definition:/Guidance:

- The purpose of this directive is to set forth the policies and procedures to support a reporting process that aligns with the ICE Significant Event Notification (SEN) Program, specifically related to significant medical events; and, to ensure that the appropriate update/summary on the detainee's medical condition is provided.. *IHSC Directive: 01-25.*
- IHSC health care providers attempt to stabilize patients with mental illness within the detention facility. If providers initiate treatment and cannot stabilize the patient within the detention facility, facility staff may transport the patient to an inpatient treatment facility. The BHP, psychiatric services provider, CD, or primary care physician may initiate hospitalization at any time. Primary care APPs and clinical pharmacist (CP) may initiate hospitalization after consulting with a BHP, psychiatric advanced practice provider (Psych-APP), or physician. *IHSC Directive 07-02, G-01*

II. Resources

- Local BHU, PSU, Medical Team
- Suicide Risk Assessment, Indicated Treatment Plan (including Appropriate Housing, Hospitalization, or HLOC)
- KBHU, CRCC, Larkin, PVH, API, etc.
- HQ Monitoring (BHU, ERO, CPD, OPLA, etc.)



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ALIGNMENT WITH ODID

ALIGNMENT WITH ODID

I. Employee Conduct.

- Recruitment, Background Screening, and Hiring,*
- Credentialing, Orientation, Training, and Staff Development*
- Peer Review and Performance*
- Grievances, etc.*
- Disciplinary Actions*

II. Facility Audits

- Policy and Procedures
- Self/Internal Audits
- Records Review

III. Contract Management/Adherence

- IHSC
- IGSA

IV. Victim Assistance:

- Grievances
- PREA
- Employee Misconduct



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POINT OF CONTACTS

BHU POINT OF CONTACT

CAPT Indira Harris, DHSc, LCSW, BCD, ACTTP
Chief, Behavioral Health Unit
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Behavioral Health Clinical Consultant
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LCDR Renee Cannon, LCSW, BCD, CCHP
Western Regional Behavioral Health Consultant
Renee.Cannon@ice.dhs.gov



Appendix 7

IHSC Pharmacy Program



U.S. Immigration and Customs Enforcement



1



IHSC PHARMACY PROGRAM

12/10/2020

ICE HEALTH SERVICE CORPS



2



OVERVIEW

PHARMACY PROGRAM

IHSC

Clinical Services – Dr. Ada Rivera, Medical Director

Medical Services Unit – CAPT Philip Farabaugh, Deputy Medical Director

Pharmacy Program – CAPT Jeff Haug, Chief Pharmacist, CDR Stephanie Daniels-Costa, Regional Pharmacy Consultant (East), CDR Jai Patel, Regional Pharmacy Consultant (West)



3



OVERVIEW

IHSC PHARMACY PROGRAM

IHSC Pharmacy locations:

- **17 IHSC staffed pharmacy locations across the country**

Pharmacy staffing:

- **pharmacists and pharmacy technicians**
- **clinical pharmacists**



4



OVERVIEW

IHSC PHARMACY PROGRAM

Pharmacy operations:

- **Pharmacy staff on site Monday through Friday**
 - **Weekend service available at S. Texas Family Residential Ctr**
 - **No on-site pharmacy at Berks Family Residential Ctr, Varick/NY Hold Room**
- **VA Prime Vendor (McKesson Corp.)**
- **After-hours medication access**
- **Script Care network**
 - **Authorizes prescriptions to be filled at local/mail-order pharmacies for emergent/urgent access**
- **National Formulary –comprehensive, including vaccines**



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NON-IHSC FACILITIES

MEDICATION ACQUISITION

- **Local pharmacies**
- **Mail order pharmacies**

Prescription claims are adjudicated through the Script Care network

- **-screened for eligibility (A#/Subj ID structure), drug interactions, duplicate therapy, drug formulary and program parameters.**



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IHSC PHARMACY VS NON IHSC STAFFED PHARMACY

IHSC Facility Pharmacy	Non-IHSC Staffed Pharmacy
Pharmacy staff on site	Mail order (off site) pharmacy services
Same day service available	Next day prescription delivery
VA Prime Vendor Contract Pricing	Pricing per contract terms
Inventory control/returns/credits	ICE detainees may be co-located with inmates
Mass vaccination coordination	
Prepare transfer medications	



7



NON IHSC FACILITY FORMULARY

- **Non-IHSC facility formulary – reviewed annually at National Pharmacy & Therapeutics Meeting**
- **Available on public-facing IHSC website**
- **Non-Formulary Review Process – non formulary requests are reviewed by the IHSC Regional Pharmacy Consultants**
- **Average review/response time is <1 business day**
- **Influenza vaccine – initiating new program in an effort to increase vaccination rates**



8



CUSTOMS AND BORDER PROTECTION

- **The Script Care Network is also used by Customs and Border Protection to obtain medications.**
- **IHSC works closely with Customs and Border Protection to align prescription services to the needs of the program.**
- **Dr. Tarantino, CBP Senior Medical Advisor – Formulary modifications, expanded days supply**



9



PHARMACY STATISTICS

Location of care provided	FY2018		FY2019	
	Prescriptions	Cost	Prescriptions	Cost
U.S. Customs and Border Patrol	25,628	\$439,964	72,473 (↑182.8%)	\$1,553,467 (↑253%)
Script Care (non-IHSC staffed facilities)	273,394	\$14,635,382	366,221 (↑34%)	\$18,901,030 (↑29.1%)
IHSC Staffed Facilities	371,406	\$7,218,345	341,114 (↓8%)	\$7,980,470 (↑10.6%)

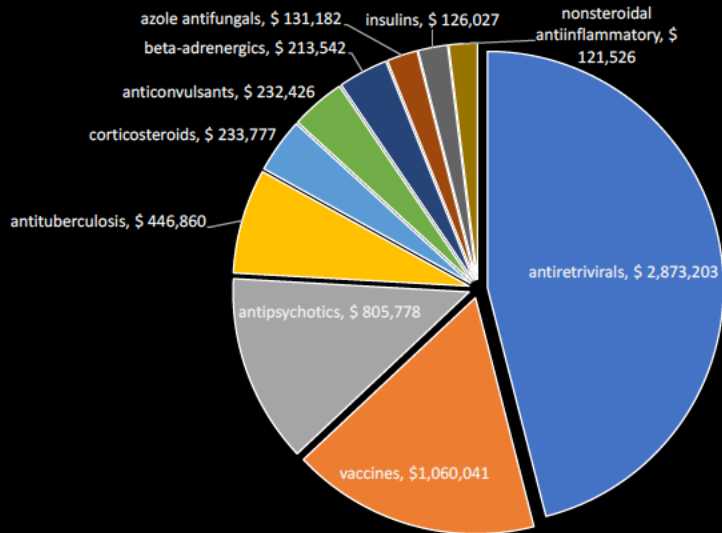


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PHARMACY STATISTICS 2019

TOP TEN THERAPEUTIC CATEGORIES (BY COST)



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REFERENCES

ICE Health Service Corps public facing website:

<https://www.ice.gov/ice-health-service-corps>

Customs and Border Protection Medication Formulary:

<https://www.ice.gov/doclib/about/offices/ihsc/pdf/medicationFormularyCBP.pdf>

Formulary for Non-IHSC Staffed Detention Facilities:


<https://www.ice.gov/doclib/about/offices/ihsc/pdf/medicationFormularyNonIHSC.pdf>




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Appendix 8


IHSC Dental Program




 **IHSC DENTAL PROGRAM**

DENTAL SERVICES

CAPT Todd Tovarek, DDS
Chief Dentist, IHSC Dental Unit
ICE HEALTH SERVICE CORPS


 ICE


1

 **IHSC DENTAL PROGRAM**

MISSION:

To provide high quality dental care for our patient population consistent with evidence based practice and in accordance with professional standards



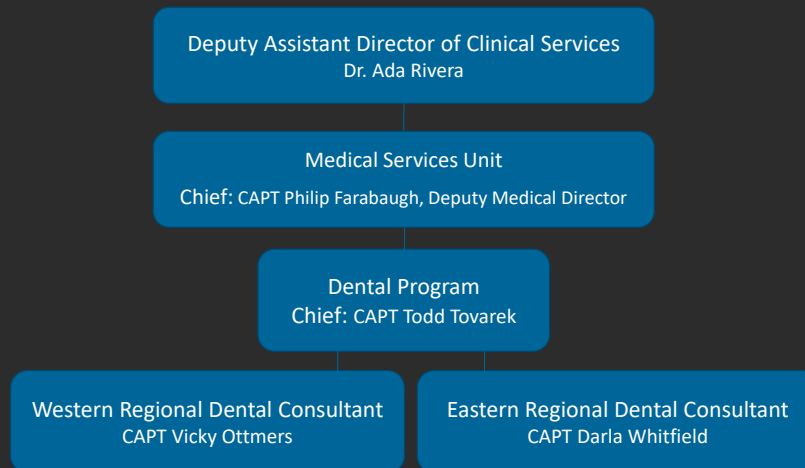
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IHSC DENTAL PROGRAM

DENTAL PROGRAM ALIGNMENT AND LEADERSHIP



3



IHSC DENTAL SERVICES

OPERATIONAL ENVIRONMENT

Due to the nature of its mission, the immigration detention program maintains custody of one of the most highly transient and diverse populations of any correctional or detention system in the world.

- **This administrative custody environment presents significant challenges and influences how our healthcare delivery system operates**



4



IHSC DENTAL PROGRAM

OPERATIONAL ENVIRONMENT

- Each dental clinic is located within the facility medical unit.
- Detention environment presents barriers to optimal patient flow and clinical efficiency. There is no predictable daily schedule and we must rely upon security staff and controlled patient movements to coordinate patient scheduling.
- The average length of stay at our ICE facilities is approximately 40 days
- The transient nature of our patients impacts our treatment planning and disease management and sometimes requires innovative problem solving and collaboration with ICE, border patrol and/or consulates from their countries of origin to assure patient safety and continuity of care.



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DENTAL SERVICES

OPERATIONAL ENVIRONMENT

Efficiency and Capacity challenges

- Patient movement barriers (security levels, gender, medical cohorts, segregation)
- Holding capacity in the medical clinic
- Dental clinic capacity
- Security based detention standards
- Unpredictable terms of detention
- Acuity of disease
- Language barriers
- Generally low health literacy



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IHSC DENTAL SERVICES

STANDARDS AND GUIDELINES

Dental care delivered in accordance to nationally recognized standards, professional guidelines, and IHSC policy and procedure

- ✓ Performance Based Detention Standards (PBNDS)
- ✓ Office of Detention Oversight (ODO)
- ✓ American Correctional Association (ACA)
- ✓ The National Commission on Correctional Health Care (NCCHC)
- ✓ All applicable ICE Health Service Corps directives and guides
- ✓ Occupational Safety and Health Administration (OSHA) Standards
- ✓ Centers for Disease Control (CDC) infection control guidelines



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IHSC DENTAL SERVICES

DELIVERY OF CARE

Dentists and trained health care staff provide quality dental care to individuals in ICE custody for maintenance and stabilization of oral health.

Dental health services include:

- Dental Screenings
- Emergency Dental Care
- Urgent Dental Care
- Routine Dental Care
- Oral Health Education
- Off-Site Dental Care



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IHSC DENTAL PROGRAM

PRIORITIES OF CARE

The oral health care provided within IHSC is organized to reflect priorities for the provision of care.

- Higher priority services relieve pain and prevent the further deterioration of the dentition while lower priority services are generally rehabilitative in nature, and may be deferred so that all patients are assured access to basic services.

This is a Public Health model of care intended to assure daily access to problem focused dental treatment to maintain and stabilize the oral health of our patients



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IHSC DENTAL SERVICES

ACCESS TO CARE

Oral health needs are identified through:

- Screenings (intake, physical exam assessment)
- Scheduled exams (comprehensive oral exam)
- Patient requests (daily sick call system)
- Referrals from qualified health care professionals

This oral health care delivery system is directed towards:

- early identification and treatment of all emergent/urgent dental conditions
- ensures a plan of care is established for more chronic dental conditions that if left untreated would present significant risk of tooth loss or pain/infection during extended terms of detention.



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IHSC DENTAL SERVICES

TRAINING

A licensed dentist provides initial and annual comprehensive dental training to all qualified health care professionals (Physicians, APPs, Nurses)

Dental Training for Qualified Health Care Professionals Includes:

- Overview of Dental Policy and Procedures
- Explanation of scope and priorities of care
- Explanation of the components of a thorough oral screening exam
- Recognition of normal, healthy oral anatomy
- Identification of common abnormal oral findings
- Discrimination between “normal” vs “abnormal” dental anatomy and detection of suspected oral pathology
- Differentiation between chronic dental disease and acute dental conditions
- Management of trauma and intermaxillary fixation
- Recognition of emergent versus non-emergent dental needs and related referral protocols
- Recommendations for management of dental infections
- Identification of appropriate antibiotics and analgesics for common dental problems
- Review of appropriate oral hygiene instructions for patients



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IHSC DENTAL SERVICES

SCOPE OF CARE: DENTAL SCREENINGS

Intake Dental Screening

Patients are queried about their oral health status as part of the intake screening (*within 12 hours*) conducted by trained health care professionals (Physicians, APPs, and Nurses).

Dental Screening at physical exam assessment:

A visual inspection of the oral cavity with notation of any gross abnormality requiring immediate referral to the dental clinic is conducted within **14 days**_(adult)/**7 days**_(juvenile) of intake during the physical examination by trained health care professionals (Physicians, APPs, and Nurses).



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IHSC DENTAL SERVICES

DENTAL SCREENING REFERRALS

Emergent findings during dental screenings are immediately referred to the dentist and/or managed within the medical healthcare system per IHSC Directive 03-05, *All Hazards Emergency Preparedness and Response*.

Urgent findings during dental screenings such as severe pain, cardinal signs of infection, or active antibiotic treatment are referred to the facility dentist or designee within the eHR. The dentist or designee schedules the patient no later than the next business day for management

Non-urgent findings during dental screenings such as chronic dental disease (asymptomatic decay), chronic gingival inflammation (bleeding gums), or requests for routine care prompt patient education about self-care/oral hygiene, the dental sick call system and access to care.



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IHSC DENTAL SERVICES

SCOPE OF CARE: EMERGENCY DENTAL CARE

Emergency dental conditions are of an immediate, acute, or grave nature which, without care, would cause rapid deterioration of health, significant irreversible loss of function, or may be life threatening.

- Emergency dental care is accessed through patient self-report or Qualified Health Care Professional referral
- All patients have access to emergency dental care on a 24 hour basis

Business Hours: Dental staff assess the patient as soon as possible the same day and determine a plan of care based on the acuity of need

After Hours (no dentist onsite): The Qualified Healthcare Professional on duty manages after hours dental emergencies per the *Dental Training for Medical Providers*. Contacts the on-call Provider and/or the dentist, if immediate referral for care or consultation is necessary.



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IHSC DENTAL SERVICES

SCOPE OF CARE: URGENT DENTAL CARE

Urgent dental care is provided to address symptomatic acute dental conditions (i.e problem focused care)

- **Urgent dental conditions are not immediately life threatening but may require treatment for the relief of acute pain and/or acute infection exhibiting the cardinal signs.**
- **Patients have an unrestricted daily opportunity to request urgent dental care through a well-defined sick call process**



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IHSC DENTAL SERVICES

URGENT DENTAL CARE: DENTAL SICK CALL

Each IHSC facility has a defined process that provides patients with an unrestricted daily opportunity to request health care services using a face-to-face sick call process

Dental requests are managed in the sick call system in the following ways:

- **Qualified Health Care Professionals assess daily dental sick call requests and refer to dental for further evaluation and management**
- **Dental Staff may assess daily dental sick call requests as patient movement and staffing permits.**



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IHSC DENTAL SERVICES

URGENT DENTAL CARE: DENTAL SICK CALL

When dental sick call patients are assessed by Qualified Health Care Professionals:

- **The Qualified Health Care Professional generates a referral within the electronic medical record to the dentist describing the patient's complaint and clinical observations. The dentist reviews the encounter and schedules the patient based on acuity of need.**
- **The Qualified Health Care Professional directly contacts the dental staff by phone or in person, if immediate referral for care or consultation is necessary due to emergency signs/symptoms (outlined under emergency dental care).**



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IHSC DENTAL SERVICES

URGENT DENTAL CARE: DENTAL SICK CALL

After evaluation by the dentist, urgent dental treatment may be provided the same day or treatment may be scheduled based on the acuity of the need.

Urgent dental treatment by the dentist is prioritized to address acute pain, acute infection exhibiting the cardinal signs, active antibiotic treatment for dental infection (upon intake), traumatic injuries, and abnormal masses/ lesions or other oral pathology.



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IHSC DENTAL SERVICES

EXTENT OF CARE

The following dental services are typically provided in IHSC dental clinics to manage emergent and urgent dental conditions:

- Sedative/intermediate/permanent fillings
- Oral surgery and extraction of non-restorable teeth
- Problem focused gross debridement (cleaning) of symptomatic areas
- Orofacial trauma management, consultation and referral to dental specialists, including oral surgeons when necessary
- Biopsies
- Fixed and removable prosthetic repair when feasible



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IHSC DENTAL SERVICES

ROUTINE DENTAL CARE

A licensed dentist completes a comprehensive oral examination, necessary radiographs, and develops a plan of care for all IHSC patients according to an established schedule:

Adults: Comprehensive exam is completed no later than 12 months of continuous ICE custody

Juveniles: Comprehensive exam is completed within 60 days of admission



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IHSC DENTAL SERVICES

ROUTINE CARE

Dental conditions documented in the eHR during the comprehensive oral exam are treatment planned according the acuity of problem: *priority treatment and elective treatment.*

Priority treatment: conditions that if left untreated would present significant risk of tooth loss or pain/infection during expected term of detention

Elective treatment: Asymptomatic, chronic/arrested conditions that present minimal risk of significant progression during the expected term of custody



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IHSC DENTAL SERVICES

ROUTINE CARE

- **Routine care needs are subordinate to emergent/urgent care needs and may be deferred to assure daily access to acute care**
- **Emergent/Urgent conditions receive scheduling priority in our dental clinics**
- **Routine care may be initiated sooner in unusual circumstances (e.g. stabilization prior to critical medical treatment such as chemotherapy, radiation therapy, or bisphosphonate therapy).**



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IHSC DENTAL SERVICES

OFFSITE CARE: REFERRALS

- **Off-site dental services are available when the IHSC dental clinic/facility cannot provide the required treatment, or when the dental condition of a patient does not stabilize with on-site dental treatment.**
- **When patients are referred for outside care, the referring IHSC dentist or medical provider provides a diagnosis, reason for referral, and the anticipated requested services within a referral document in the eHR to assure this information is communicated to the outside provider.**



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IHSC DENTAL SERVICES

OFFSITE CARE: REFERRALS

- **Requests/referrals for offsite dental/oral surgery care are reviewed and adjudicated by our Regional dental consultants**
- **The dental consultants review and approve requests for offsite dental care for both IHSC and IGSA facilities**
- **The dental consultants collaborate with our Elizabeth and Berks medical and administrative support teams to assure access to necessary dental services at these sites**
- **The consultants communicate regularly with established community providers to assure access to care**



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IHSC DENTAL SERVICES

EXTENT OF CARE

Accessory Dental Care NOT typically available:

Accessory treatment is generally considered elective and extends beyond the scope of routine dental care in a public health setting. These procedures include but are not limited to:

- Fixed Prosthodontics (crowns, bridges, implants, etc.)
- Removable Prosthodontics (partial and complete denture)
- Orthodontics
- Mouth guards
- Cosmetics (bleaching, front tooth bonding in the absence of pain or infection.)
- Esthetic reconstructive jaw surgery



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IHSC DENTAL SERVICES

DENTAL CLINIC DISTRIBUTION AND CAPACITY

There are currently 14 IHSC facilities with an onsite dental clinic

- ✓ 60% of dental clinics are one chair 1DDS/1DA staffing model
- ✓ All dental clinics have digital x-ray systems and panoramic capabilities
- ✓ Graphical charting software for exams and treatment planning
- ✓ All clinics equipped with intraoral cameras



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IHSC DENTAL SERVICES

DENTAL CLINIC DISTRIBUTION AND CAPACITY

The Berks and Elizabeth facilities do not have an onsite dental clinic

- Necessary dental services are referred to a community provider
- Medical staff receive comprehensive annual dental training
- The Regional dental consultants review and adjudicate offsite care requests.
- Well established community resources



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IHSC DENTAL SERVICES

DENTAL COMPLAINTS AND INQUIRIES

Formal dental complaints and inquiries are relatively uncommon and comprise only a handful of the cases that our IHSC investigations unit manages

Informal grievances at the facility level are most commonly related to immediate:

- ✓ requests for advanced levels of care (accessory care)
- ✓ requests routine cleanings
- ✓ requests for esthetic procedures



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IHSC DENTAL SERVICES

DENTAL OPERATIONS REVIEW

A spectrum of dental services are available to our patients:

- *Oral screenings at intake (within 12 hrs) and the 14 day physical exam*
- *24/7 emergency care*
- *Daily access to urgent care through established sick call and referral processes*
- *Oral health education and preventive services*
- *Routine care that may begin after 12 months of continuous ICE custody to include a comprehensive exam, diagnostic radiographs, and treatment planning.*



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IHSC DENTAL SERVICES

Questions ?




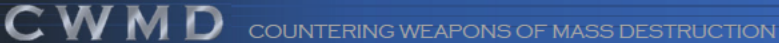
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Appendix 9

DHS


Detainee

Health IT



DHS Detainee Health IT


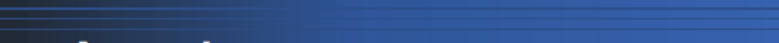
Tom Wilkinson MD & Jacqueline Genaille
20 Nov 2020
Brief for the Office of Immigration Detention Ombudsman



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Agenda

- CBP: WebEOC medical record plans
 - The Unified Immigration Portal
- IHSC: eClinicalWorks EHR
- CW-1: The Medical Information eXchange (MIX)



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CBP Health IT

- The CBP plan for their medical record system is to continue to use WebEOC (Web-based Emergency Operations Center), which is the current platform used across all CBP facilities
 - It already fits into all their operations
- Health intake and evaluation forms have been designed using WebEOC, and all the captured data will be stored there
- Additionally, they have designed tracking boards that roll up all the medical information for a given detention facility

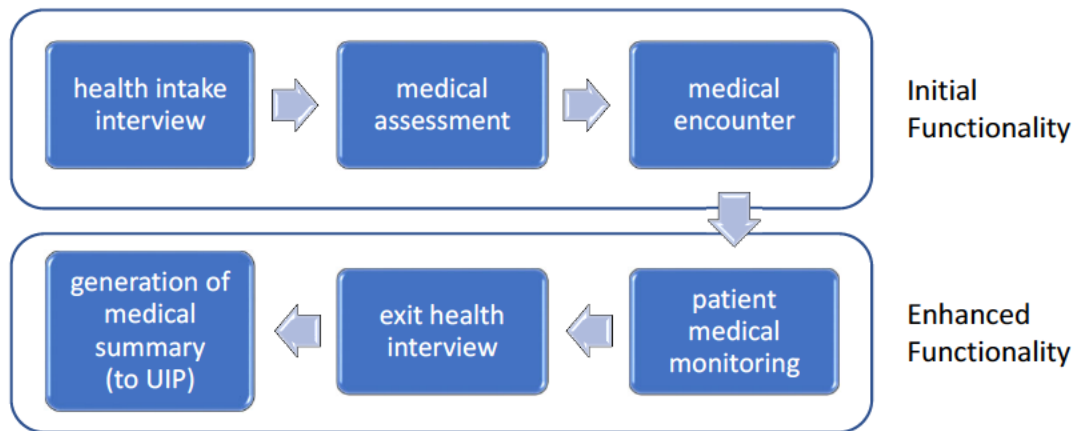


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CBP Health IT



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CBP Health IT

- WebEOC is a proprietary product by Juvare and was never designed for interoperability
 - It's very challenging to exchange information
- WebEOC is already currently integrated with Athena, which is a contact tracing visualization tool
- The timeline is active, I believe they will have already deployed the initial features in beta test sites
- Contact
 - Dr. David Tarantino, CBP CMO
 - david.a.tarantino@cbp.dhs.gov



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The Unified Immigration Portal

- The UIP is a platform that connects a number of federal agencies with data across the immigration lifecycle
- The program is located within CBP but will ultimately connect to HHS, ICE, USCIS, and the DOJ
- The project has direct Congressional funding and support

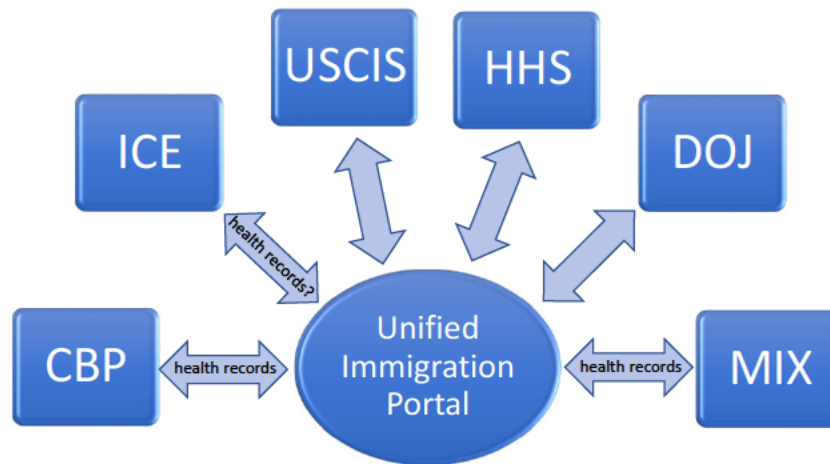


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The Unified Immigration Portal



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The Unified Immigration Portal

- The UIP is built on Salesforce CRM platform
- Although Salesforce is a proprietary system, and its technology stack is complex, it is much easier to integrate with than WebEOC
- The timeline is active:
 - Summer of 2019 they had granted access to the first HHS user
 - I do not believe they have met the IT security requirements to allow the UIP to host personal health information (ePHI) protected by HIPAA



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The Unified Immigration Portal

- Contacts:
 - Wes Gould, UIP Program Manager
 - robert.w.gould@cbp.dhs.gov
 - Bob Costello, Executive Director Border Enforcement and Management Systems Directorate (BEMSD)
 - robert.j.costello@cbp.dhs.gov
 - Rachelle Henderson, current ICE CIO, past Executive Director BEMSD
 - rachelle.b.henderson@ice.dhs.gov



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IHSC Health IT

- ICE Health Service Corps (IHSC) uses eClinicalWorks (eCW) commercial electronic health record (EHR) system
- They have expended considerable energy creating custom configurations to facilitate the needs of detention facility medical activities
- They added a small data analytics team last year, which is still getting underway



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IHSC Health IT

- IHSC has struggled to adapt a commercial EHR system to the medical activities and operational requirements of detention facilities
 - A particular thorn is eCW does not readily export the captured data
 - A second challenge is that the majority of ICE detention facilities are contracted and don't use eCW
- eCW was the target of a class action lawsuit filed in November 2017 for \$999M for faulty software
 - eCW updated the medical history without saving its sequence



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IHSC Health IT

- IHSC recently renewed the eCW contract for another 5 years
 - The intent was to buy more time to find a better solution or to improve on the current one
- Contact
 - CDR Francis Bertulfo, Chief Health Information and Technology Unit
 - francis.p.bertulfo@ice.dhs.gov



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CW-1 Health IT

In December 2020, Congress mandated the DHS Chief Medical Officer (CMO) to:

1. Develop and establish **interim and long-term electronic systems** for recording and maintaining information related to the health of individuals in the Department's custody
2. Facilitate automated reporting requirements for Electronic Health Records (EHR)
3. Conduct disease surveillance and outbreak response across detention facilities and related partner systems
4. Monitor performance, support peer review processes, and conduct other health system administration functions

* Points here are quoted from the DHS Appropriations Act of 2020 Joint Explanatory Statement



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CW-1 Health IT

- The CMO has additional statutory mandates from the CWMD Act of 2018 to collaborate across Federal, state, local, tribal, territorial, and private domains on issues regarding medical and public health situations and events
- The office of the CMO was substantially reduced during a major reorganization in December 2018, and did not have the infrastructure to fulfill that collaboration by the time COVID-19 became a pandemic in February 2020



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CW-1 Health IT

- We stood up a platform known as Medical and Public Health Information Sharing Environment (MPHISE) to support the CMO's response to the national and public health emergencies
- We have positioned MPHISE to transition to the Medical Information eXchange (MIX), through iterative Agile refinement, to fulfill the Congressional mandate for a DHS-wide EHR



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The vision for the MIX

- **Create a system of systems**, agnostic to the specifics of source systems, but able to detect and strengthen their interconnections and unify them as a single information network.
- **Create functional interoperability** across DHS components' individual medical record systems by leveraging all the tools of modern data science and AI to avoid mandating preconceived EHR requirements.
- Layer medical and contextual **data**, supply **models** and analytics, and support collaboration and **decisions** across the Department and the FSLTTP, using a single secure medical information platform.
- **Perpetuate the public health collaboration** functionality initiated by MPHISE.



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Relationship between MPHISE and the MIX

➤ MPHISE (current)

- A data pipeline and collaboration platform stood up to support medical and public health response to COVID-19
- A simpler version of what will iteratively become the MIX

➤ The MIX (future)

- An enduring data integration and collaboration platform for medical record systems across DHS and its partners to fulfill statutory mandates
- AI-enabled functional interoperability to shield components from an HQ mandated single commercial EHR solution
- Built upon experience with the MPHISE platform



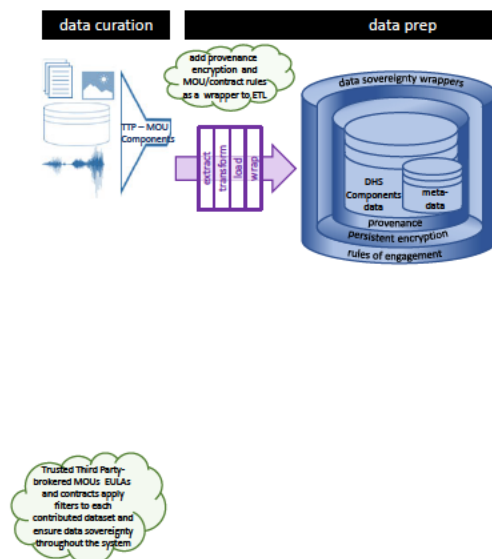
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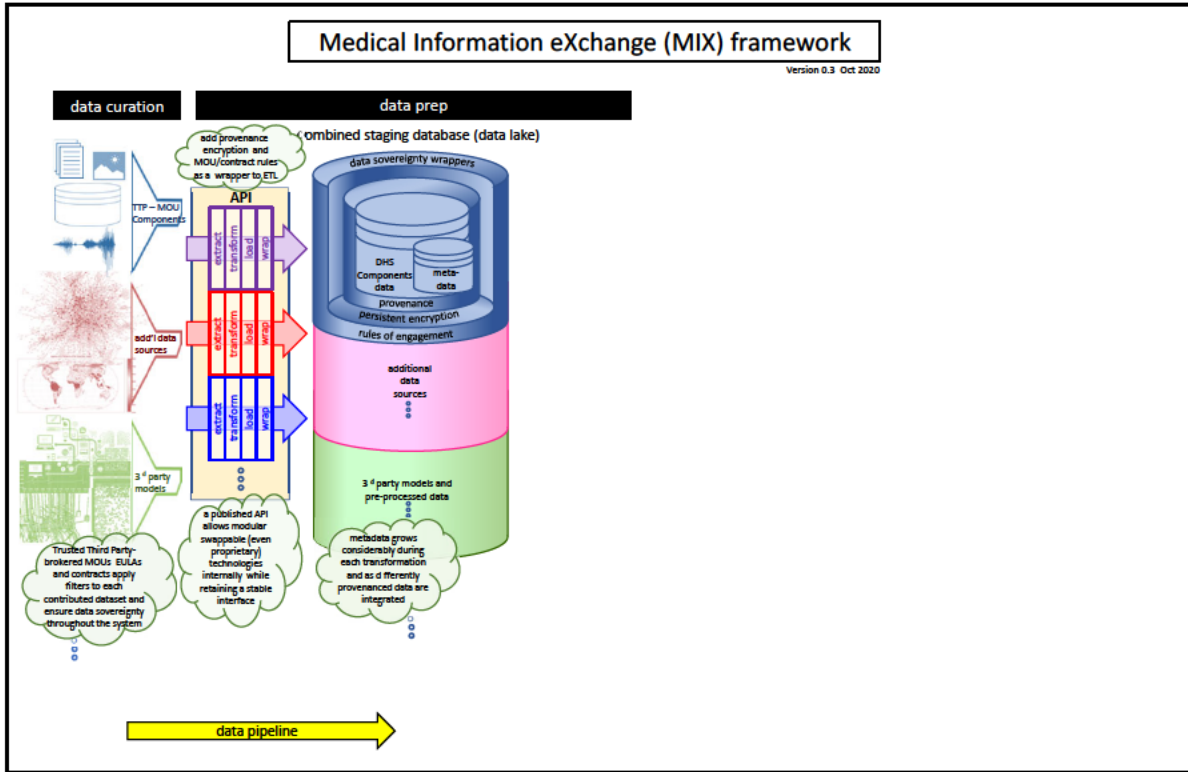
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Medical Information eXchange (MIX) framework

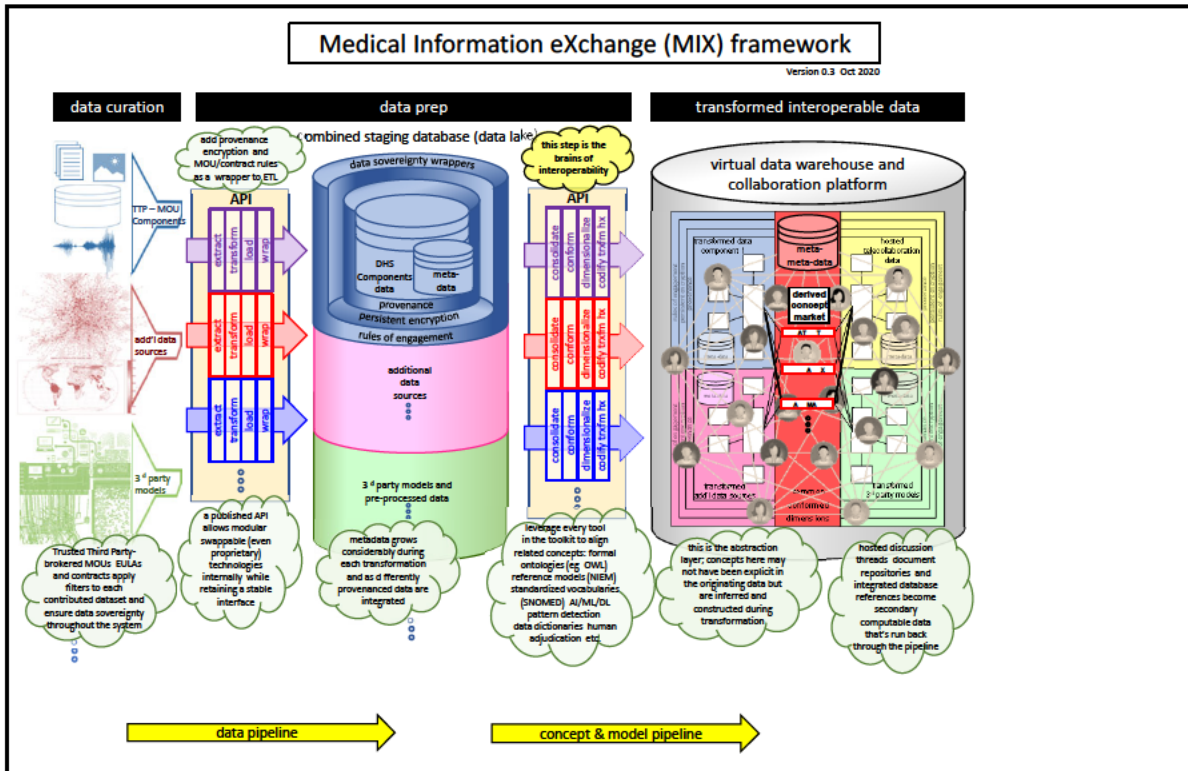
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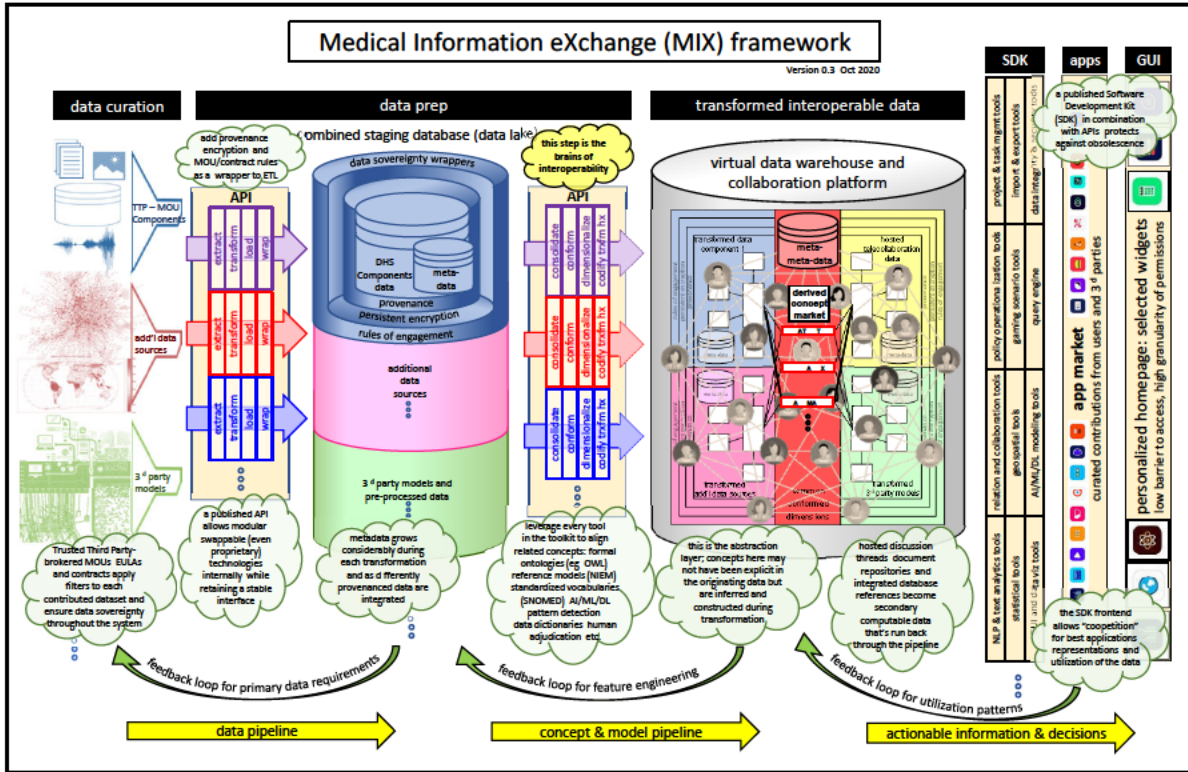
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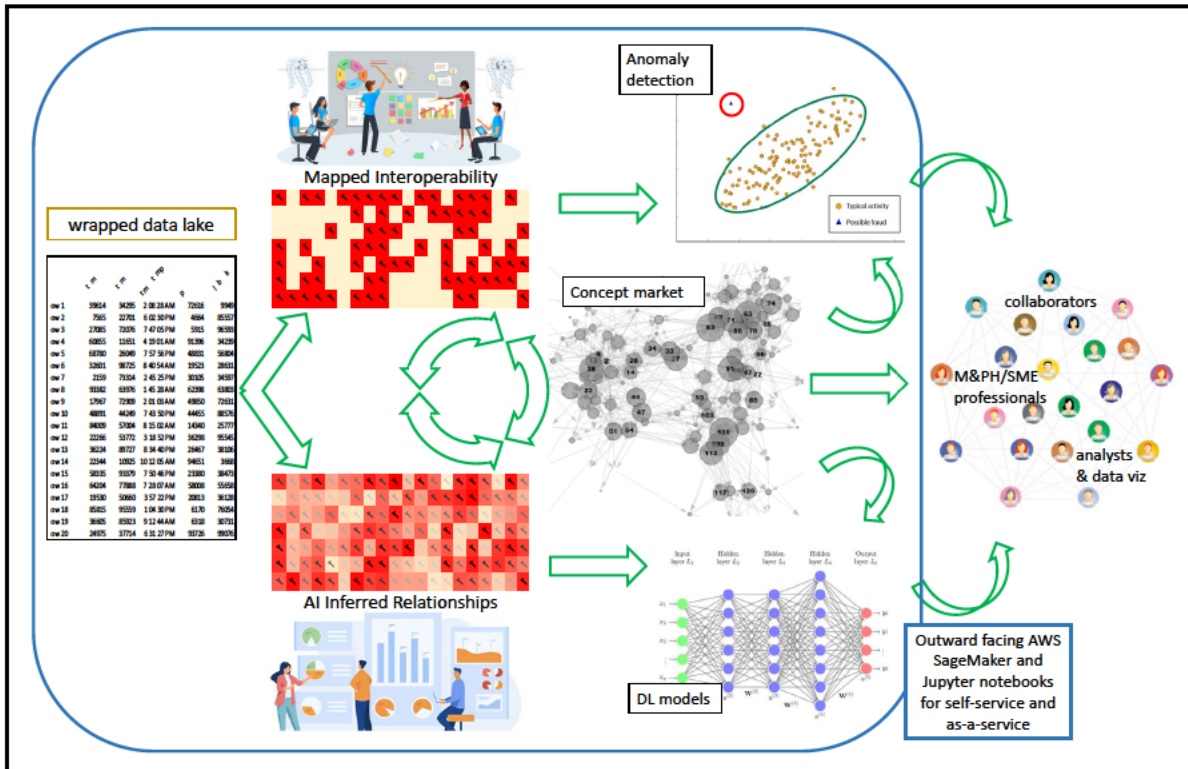
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How do we get there?

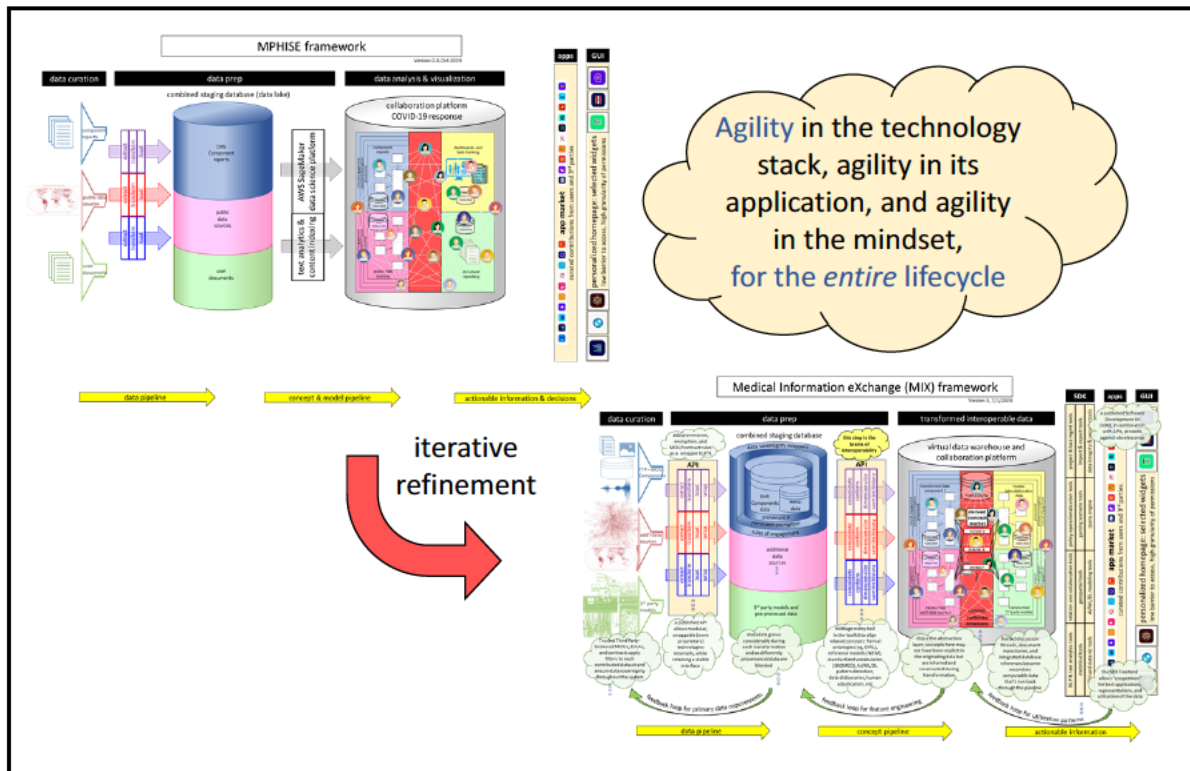
- MPHISE is an existing platform that we stood up to coordinate and support CMO COVID-19 response activities
- MPHISE is a collaborative platform bolted onto an analytics pipeline
- MPHISE will be iteratively refined to build the initial operating capability of the MIX



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How is the MIX an EHR?

An electronic health record system needs to perform the following functions:

- 1) Collect health information
- 2) Manage medical results
- 3) Manage medical orders
- 4) Provide medical decision support
- 5) Provide record interconnectivity
- 6) Provide patient support
- 7) Support administrative processes and resource management
- 8) Support forward reporting and public health aggregation



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How is the MIX an EHR?

- The MIX is a complete reimagining of what an EHR can be
- It meets DHS components where they are, whether supplying the user interface to replace a paper-based system or electronically integrating with a fully-featured EHR system
- It allows components to determine for themselves what products and processes best; it does the heavy lifting of fulfilling whatever EHR functionality still remains



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How is the MIX an EHR?

- Because the MIX retains all the collaboration and analytics tools of the MPHISE platform, it brings many more tools than a commercial product could to the unique mission space of DHS
- The MIX is exceptionally cost effective as an EHR system for DHS
 - As a comparison, the USCG is currently implementing a commercial EHR system (in conjunction with a larger DOD initiative) at a cost of \$180M over 7 years; those same 7 years will cost the MIX about \$50M



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MIX timeline

- Because MPHISE is the initial version of the MIX and is already active, we are operational, albeit lacking in full functionality
 - We are using MPHISE as the platform to integrate with WebEOC through the UIP, waiting for CBP to be ready; we might take periodic reports issued from WebEOC as an interim solution
- The MIX is a major acquisition for CWMD and we expect it to be procured and have its complete EHR initial operating capability ready in 18-24 months



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MIX challenges

- There are challenges for the MIX
 - It is not the technology, which is mature, although its being used in very novel ways
- We have three areas of existential challenge:
 - 1) Funding: Congress allocated some funds for this but those were only a down payment; health IT infrastructure is an expensive investment
 - 2) Staffing: The Health Informatics Branch is severely understaffed for a program of this size and scope
 - 3) Leadership: New leadership at DHS, Congress, and the White House may decide to go in a new direction



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MIX contacts

- Tom Wilkinson, Chief Medical Information Officer for DHS
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- Jacqueline Genaille, MPHISE/MIX Program Manager
 - jacqueline.genaille@associates.hq.dhs.gov



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Questions?



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