OIDO
Office of the Immigration Detention Ombudsman

Evaluation of Health Care Staffing, Credentialing, and Training at Seven ICE Detention Facilities

OIDO-24-003
September 4, 2024

Department of Homeland Security
Washington, DC 20528

OIDO
Office of the Immigration Detention Ombudsman

September 4, 2024

MEMORANDUM FOR: Patrick J. Lechleitner
Deputy Director and Senior Official
Performing the Duties of the Director
U.S. Immigration and Customs Enforcement

FROM: Michelle Brané
Ombudsman
Office of the Immigration Detention Ombudsman

MICHELLE N BRANE Digitally signed by MICHELLE N BRANE Date: 2024.09.04 13:59:00 -04'00'

SUBJECT: OIDO-24-003
Evaluation of Health Care Staffing, Credentialing, and Training at Seven ICE Detention Facilities
January 9–February 3, 2023

Attached is the Office of the Immigration Detention Ombudsman's final report based on its inspection of the following detention facilities: Buffalo (Batavia) Service Processing Center, Joe Corley Processing Center, Moshannon Valley Processing Center, Otero County Processing Center, Port Isabel Service Processing Center, Prairieland Detention Facility, and South Texas ICE Processing Center.

The report contains three recommendations aimed at improving health care services at ICE facilities and their compliance with the applicable detention standards and contract terms. Your office concurred with all recommendations. Based on the information provided in your responses to the report, we consider all recommendations addressed and closed.

Attachment

OIDO
Office of the Immigration Detention Ombudsman

OIDO EVALUATION
OF HEALTH CARE STAFFING, CREDENTIALING, AND TRAINING
AT SEVEN U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT
DETENTION FACILITIES

Executive Summary

Pursuant to its statutory responsibilities, the Department of Homeland Security (DHS) Office of the Immigration Detention Ombudsman (OIDO) conducted announced inspections of seven U.S. Immigration and Customs Enforcement (ICE) detention facilities in January and February 2023 for the specific purpose of evaluating health care staffing, credentialing, and training. The inspected facilities included Buffalo (Batavia) Service Processing Center, Joe Corley Processing Center, Moshannon Valley Processing Center, Otero County Processing Center, Port Isabel Service Processing Center, Prairieland Detention Facility, and South Texas ICE Processing Center.

For the areas of review, OIDO assessed the facilities' performance and compliance with the applicable detention standards and contract terms as well as relevant national and local policies and procedures. OIDO's inspections to evaluate health care staffing, credentialing, and staff training led to several findings. For staffing, OIDO found all seven facilities complied with requirements to conduct a review of their annual staffing plan. However, OIDO found five of the seven facilities did not comply with staffing requirements. Among these five non-compliant facilities, only the three ICE Health Service Corps facilities had penalties assessed against the facility for non-compliance.

For credentialing, OIDO found three of the seven facilities were non-compliant because they had incomplete credentialing files. An additional facility was initially found non-compliant but resolved the deficiency during the inspection. In addition, OIDO found five of the seven facilities were compliant with the requirement to have an external peer review program for the facility's independently licensed health care professionals. The two facilities that were non-compliant in this area of review made corrections during or after OIDO's inspection, bringing them into compliance.

Finally, for training, OIDO found four of the seven facilities were non-compliant with the requirement to develop and approve an annual training plan, four of the seven facilities were non-compliant with requirements to train health care staff annually on certain topics, and five of the seven facilities were non-compliant with requirements to ensure health care staff are trained to implement the facility's emergency health care plan.

Based on these findings, OIDO made three recommendations designed to improve facility operations and to comply with ICE detention standards and contract terms.

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Table of Contents

OIDO
Office of the Immigration Detention Ombudsman

List of Tables

Introduction

Pursuant to its statutory responsibilities, the Department of Homeland Security (DHS) Office of the Immigration Detention Ombudsman (OIDO) Detention Oversight (DO) Division conducts independent, objective, and credible inspections of Immigration and Customs Enforcement (ICE) owned and operated facilities throughout the United States. During its inspections, OIDO often completes follow-up assessments to determine whether a facility has taken corrective action to resolve violations or concerns identified during a prior inspection. OIDO also reviews, examines, and makes recommendations to address concerns with or violations of contract terms regarding immigration detention facilities and services.

In January and February 2023, OIDO conducted announced inspections at seven ICE detention facilities operated by four different contractors to review health care (HC) staffing, credentialing, and training. The inspected facilities included Buffalo (Batavia) Service Processing Center (BSPC) in Batavia, New York; Joe Corley Processing Center (JCPC) in Conroe, Texas; Moshannon Valley Processing Center (MVPC) in Philipsburg, Pennsylvania; Otero County Processing Center (OCPC) in Chaparral, New Mexico; Port Isabel Service Processing Center (PISPC) in Los Fresnos, Texas; Prairieland Detention Facility (PDF) in Alvarado, Texas; and South Texas ICE Processing Center (STIPC) in Pearsall, Texas. For the three HC areas reviewed, OIDO assessed each facility's performance and compliance with the applicable detention standards and contract terms as well as relevant national and local policies and procedures.

Background

ICE Enforcement and Removal Operations (ERO) oversees the detention of noncitizens at facilities throughout the United States, which it manages directly or in conjunction with private contractors or federal, state, or local governments. ICE uses several detention standards to regulate conditions of confinement, program operations, and management expectations within the agency's detention system.[1] In addition, ICE uses the Post Pandemic Emergency COVID-19 Guidelines and Protocols to assist detention facility operators in sustaining operations while mitigating risk to the safety and well-being of detainees since the end of the COVID-19 pandemic.[2]

OIDO planned and executed focused inspections after identifying non-compliance trends in HC staffing, credentialing, and training across several ICE facilities during its previous inspections. Specifically, from July through December 2022, OIDO conducted seven inspections at the following ICE detention facilities: Denver Contract Detention Facility on July 26–28, 2022; Cibola County Correctional Center on August 9–11, 2022; Pine Prairie ICE Processing Center on August 30–September 1, 2022; South Louisiana ICE Processing Center on October 25–27, 2022; Eden Detention Center on December 6–8, 2022; Folkston ICE Processing Center and Annex on

[1] ICE currently has four detention standards in use at adult detention facilities throughout the United States. These include the 2000 National Detention Standards, 2008 Performance-Based National Detention Standards, 2011 Performance-Based National Detention Standards, and 2019 National Detention Standards.

[2] ICE/ERO, Post Pandemic Emergency COVID-19 Guidelines and Protocols, Version 2.0, dated July 13, 2023, https://www.ice.gov/doclib/coronavirus/eroCOVID19PostPandemicEmergencyGuidelinesProtocol_07132023.pdf.

November 15–17, 2022; and Broward County Transitional Center on December 6–8, 2022.[3]

During those inspections, OIDO found areas of non-compliance in HC staffing, credentialing, and training. OIDO's medical subject matter experts (SMEs) identified a pattern of insufficient HC staffing, disorganized and/or expired HC licensing and credentialing documents, and concerns related to HC staff training programs, such as incomplete documentation and content and knowledge gaps when applying protocols or procedures outlined in training. Based on the findings, OIDO examined whether this trend existed in other ICE detention facilities. To ensure that this inspection included a wide range of HC service providers, OIDO medical SMEs identified seven additional facilities, operated by four different contractors and under various ICE detention standards, including the 2011 Performance-Based National Detention Standards (2011 PBNDS), 2011 PBNDS as revised in 2016 (hereafter Revised 2011 PBNDS), and the 2019 National Detention Standards (2019 NDS), to conduct announced focused inspections reviewing the three focused areas of HC staffing, credentialing, and training.

The inspections required two to three days on-site at each facility. Table 1 outlines the following: facilities inspected, dates of inspection, facility owner and operator, applicable detention standards, and HC provider.

Table 1. Attributes of the Seven Inspected ICE Facilities

Facility Name	Inspection Dates	Owner/Operator	Standards	Health Care Provider
Buffalo (Batavia) Service Processing Center	January 24–26, 2023	ICE Owned; Akima Global Services (AKIMA) operated	Revised 2011 PBNDS	ICE Health Service Corps
Joe Corley Processing Center	January 31–February 2, 2023	GEO Group Inc. (GEO) owned and operated	2019 NDS	GEO Group
Moshannon Valley Processing Center	January 10–12, 2023	GEO owned and operated	Revised 2011 PBNDS	GEO Group
Otero County Processing Center	January 10–12, 2023	Otero County owned, Management and Training Corporation (MTC) operated	Revised 2011 PBNDS	MTC
Port Isabel Processing Center	January 10–12, 2023	AKIMA owned and operated	Revised 2011 PBNDS	ICE Health Service Corps
Prairieland Detention Facility	January 24–26, 2023	City of Alvarado owned, LaSalle Corrections operated	2011 PBNDS	LaSalle Corrections
South Texas ICE Processing Center	January 10–12, 2023	GEO owned and operated	Revised 2011 PBNDS	ICE Health Service Corps

[3] *See* OIDO Inspection, Denver Contract Detention Facility (OIDO-23-005), dated January 13, 2023, https://www.dhs.gov/sites/default/files/2023-02/OIDO%20Final%20Inspection%20Report%20-%20Denver%20Contract%20Detention%20Facility.pdf. The other reports are currently being finalized for publication. When published, the reports will be available at OIDO's inspection reports web page: https://www.dhs.gov/publication/oido-inspection-reports.

Objective, Scope, and Methodology

Based on trends identified during seven inspections completed in calendar year (CY) 2022, OIDO conducted a focused review of seven additional ICE detention facilities. In those focused inspections, inspectors reviewed the following three areas: (1) HC staffing, including staffing levels and penalties for staffing shortages and review of staffing plan; (2) HC credentialing, including personnel credentials and peer reviews; and (3) HC training, including training plan, annual training, and emergency medical services and first aid training.

Ten personnel from OIDO executed the inspection, including eight medical experts and two DO auditors. The inspection team conducted interviews with ICE ERO employees, facility staff, contracting officer representatives, ICE Health Service Corps (IHSC) Headquarters (HQ) staff; made direct observations of facility operations; and reviewed documentary evidence including but not limited to contractual documents, HC staff training and credentialing files, annual training plans, and facility policies and procedures.

For HC credentialing and staff training records, OIDO selected and reviewed up to 30 files. When a facility had an HC staffing roster of fewer than 30 personnel, OIDO reviewed all the available files.

Results of Inspection

The inspection findings are divided into three sections: HC staffing, HC credentialing, and HC training. Staffing is divided into two subsections: staffing levels and assessed penalties for staffing shortages and staffing plan. Credentialing is divided into two subsections: personnel credentials and peer reviews. Training is divided into three subsections: training plan, annual training, and emergency medical services and first aid training (*See* Figure 1). Finally, each subsection contains findings within the following categories: compliant facilities, non-compliant facilities, and facilities with resolved areas of initial non-compliance.

HC Staffing	HC Credentialing	HC Training
• Staffing Levels and Penalties • Staffing Plan	• Personnel Credentials • Peer Review	• Training Plan • Annual Training • Emergency Medical Services and First Aid Training

Figure 1. Areas of Review and Their Respective Subcomponents

OIDO's inspection led to several findings summarized in Table 2 under three topics: HC staffing, HC credentialing, and HC training. Table 2 shows a checkmark (✓) for a compliant area/resolved area of non-compliance and an X (✗) for non-compliant. A dollar sign ($) indicates that a penalty was assessed for staffing non-compliance, and a black circle with a white X (⊗) indicates that a penalty was not assessed, though the facility was not compliant with staffing requirements.

Table 2. Overall Findings for Each of the Inspected Facilities Delineated by Area of Review

	HC Staffing	HC Staffing	HC Staffing	HC Credentialing	HC Credentialing	HC Training	HC Training	HC Training
	Staffing	Penalties Assessed	Staffing Plan	Personnel Credentials	Peer Reviews	Training Plan	Annual Training	Emergency Medical Services/First Aid Training
Moshannon Valley Processing Center	✓	N/A	✓	✓	✓	✓	✓	✓
Prairieland Detention Facility	✓	N/A	✓	✓	✓	✗	✗	✗
Port Isabel Service Processing Center	✗	$	✓	✗	✓	✗	✗	✗
South Texas ICE Processing Center	✗	$	✓	✗	✓	✗	✓	✗
Joe Corley Processing Center	✗	⊗	✓	✗	✓	✓	✓	✗
Buffalo (Batavia) Service Processing Center	✗	$	✓	✓	✓	✓	✗	✗
Otero County Processing Center	✗	⊗	✓	✗	✓	✗	✗	✓

Note. ✓ = compliant/resolved area of non-compliance; ✗ = non-compliance; $ = penalty assessed for staffing non-compliance; ⊗ = penalty was not assessed though not compliant with staffing requirements; N/A = not applicable.

I. Health Care Staffing

A. Staffing Levels and Penalties for Staffing Shortages

Both the 2011 PBNDS and Revised 2011 PBNDS sections 4.3 on medical care require all facilities to provide medical staff and sufficient support personnel to ensure that detainees have access to appropriate and necessary medical, dental, and mental HC, including emergency services. In addition, the 2019 NDS section 4.3 on medical care requires facilities to employ sufficient medical staff to perform basic exams and treatments for all detainees. Further, all seven facilities operate under contracts with ICE ERO that require a specific number of health services positions. At four of the seven facilities, the respective contracts also include a required position fill rate, which is the total number of positions currently filled divided by the total number of specified positions.

OIDO reviewed the facilities' contracts to examine HC staffing plans and applicable national and/or local policies and procedures to identify HC staffing level requirements. OIDO also examined whether a Quality Assurance Surveillance Plan (QASP) was in place and whether the Contracting Officer's Representative (COR) had taken any action for contract noncompliance. This included reviewing the facilities' current HC staffing plans and fill rates against any contractual requirements and whether the facilities had conducted CY 2021 and 2022 annual staffing plan reviews.

Overall, OIDO found that two of the seven facilities were compliant and five were non-compliant with HC staffing requirements as outlined in the applicable contract for each location. The staffing fill rate of the seven facilities ranged from 58 percent to 93 percent. Among the five facilities that were non-compliant with staffing requirements, OIDO examined whether penalties were assessed for non-compliance. OIDO found that three of these facilities did have penalties assessed. All three of these facilities were staffed with IHSC personnel. Meanwhile, none of the non-IHSC-staffed facilities received any penalties for failure to meet contractual staffing requirements as outlined in the contract Performance Requirements Summaries.

Table 3 provides an overview of the contractual staffing requirements, actual staffing levels as measured by full-time equivalent (FTE) employees, fill rates, and OIDO findings at each facility.

Table 3. Staffing Level Compliance Findings at Seven ICE Detention Facilities

Facility	Health Care Services Provider	FTE Requirements	Contractual Fill-Rate Requirement (%)	Number of FTEs	Actual Fill Rate (%)[a]	OIDO Finding
Moshannon Valley Processing Center	GEO	40.4	80	37.4	93	Compliant
Prairieland Detention Facility	LaSalle	26.5	90	21.5	81[b]	Compliant
Port Isabel Service Processing Center	IHSC	67.5[c]	92	60	89	Non-compliant
South Texas ICE Processing Center	IHSC	64.0	92	55	86	Non-compliant
Joe Corley Processing Center	GEO	36.0	90	30.5	85	Non-compliant
Buffalo (Batavia) Service Processing Center	IHSC	30.5[d]	92	25	82	Non-compliant
Otero County Processing Center	MTC	32.85	90	19.05	58	Non-compliant

[a]OIDO calculated fill rate at each facility by dividing the number of FTEs at the time of inspection by the number of FTEs required, multiplying by 100, and comparing this fill rate to the contract's stated requirements to determine compliance findings.
[b]OIDO found Prairieland Detention Facility compliant with staffing requirements, as the facility used as-needed/on-call staff to fill vacant FTEs, which placed staffing levels at 100 percent but at only 81 percent of the contractual fill-rate requirements.
[c]Per the facility's staffing plan, a whole number is used to identify the number of positions. OIDO recalculated to account for full-time and part-time positions resulting in a change from 68 to 67.5.
[d]Per the facility's staffing plan, a whole number is used to identify the number of positions. OIDO recalculated to account for full-time and part-time positions resulting in a change from 31 to 30.5.

The details of each finding as identified in Table 3 are further specified in the following subsections: compliant facilities and non-compliant facilities.

i. Compliant Facilities

Two of the Seven Facilities Met the Contractual Requirements for Health Care Staffing

OIDO found that two of the seven facilities met contractual requirements for HC staffing, including MVPC and PDF. MVPC's Intergovernmental Service Agreement (IGSA) and its 2021 Local Operating Procedures (LOPs), 408-B Staffing Levels, state that 40.4 FTEs are required for health services staffing at the facility. The IGSA requires the facility to maintain staffing levels for health services above a monthly average of 80 percent. OIDO reviewed MVPC's October to December 2022 staffing plan and vacancy report and found that health services had no more than three monthly staff vacancies, or an average fill rate of 93 percent over the 90-day period. As such, the facility maintained a monthly average staffing level well above the required 80 percent.

PDF's Staffing Plan required 26.5 FTEs for HC staffing. In reviewing the facility HC staffing plan list, OIDO found that five out of 26.5 FTEs were vacant at the time of OIDO's inspection, resulting in a fill rate of 81 percent. The facility work schedule from October 2022 through January 2023 showed that PDF used six pro re nata (PRN), or as needed, HC staff to fill the staffing gap. Although PDF did not have all HC staff positions filled, a combination of current staff and the six PRN staff met the 26.5 FTE contractual requirement. OIDO found that these measures temporarily addressed concerns with staffing levels.

ii. Non-Compliant Facilities

Five of the Seven Facilities Did Not Meet Contractual Requirements for Health Care Staffing

OIDO found that five of the seven facilities did not meet contractual requirements for HC staffing: BSPC, PISPC, STIPC, OCPC, and JCPC. Among these five facilities, fill rates range from 56 percent to 90 percent. This section details each non-compliant facility's HC staffing requirements and rates.

IHSC Facilities: Non-Compliance and Penalties Assessed

OIDO found that all three IHSC facilities inspected were non-compliant with contractual staffing requirements. First, the BSPC 2022 Operational Staffing Pattern stated that 55.5 FTEs[4] were required for HC staffing, including positions for 30.5 contractors,[5] 12 General Schedule (GS) employees, and 13 U.S. Public Health Service (PHS) employees. Based on the contract QASP, the contractor is required to have 92 percent of all positions filled. As of the last Site Status Report, dated January 5, 2023, five full-time positions and one part-time position of the 30.5 FTE contractor positions[6] required were vacant, placing the facility at an 82 percent fill rate for contractor positions and non-compliant with contract requirements. However, BSPC has

[4] Per the facility's staffing plan, a whole number is used to identify the number of positions. OIDO recalculated to account for full-time and part-time positions resulting in a change from 56 to 55.5.
[5] Per the facility's staffing plan, a whole number is used to identify the number of positions. OIDO recalculated to account for full-time and part-time positions resulting in a change from 31 to 30.5.
[6] Per the facility's staffing plan, a whole number is used to identify the number of positions. OIDO recalculated to account for full-time and part-time positions resulting in a change from 31 to 30.5.

historically received temporary duty (TDY) support to provide HC services or to serve in administrative roles until the vacant positions are filled.

Second, PISPC's 2022 Operational Staffing Pattern required 98.5 FTEs[7] for HC staffing, including positions for 67.5 contractors,[8] 15 GS employees, and 16 PHS employees. Based on the contract QASP, the contractor was required to have 92 percent of all positions filled. OIDO found the latest Site Status Report, dated January 5, 2023, confirmed 67.5 FTE contractor positions[9] showed and the IHSC COR reported that the facility had 67. As of the January report, seven full-time and one part-time contractor positions were vacant, placing the facility at an 89 percent fill rate for contractor positions and non-compliant with contract requirements. Until the facility hires a new HC staffing contractor, the Health Services Administrator (HSA) reported that they will continue using PRN and TDY staff to ensure proper care delivery.

Third, STIPC's 2022 Site Staffing Plan, dated November 22, 2022, required 102 FTEs for HC staffing, including positions for 64 contractors, 16 GS employees, and 22 PHS employees. Based on the contract QASP, the contractor must fill 92 percent of all positions. As of the last Site Status Report dated January 5, 2023, nine of the 64 contractor positions required were vacant, placing the facility at an 86 percent fill rate for contractor positions and non-compliant with contract requirements.

The STIPC HSA and the IHSC Unit Chief of Operations complete and approve STIPC's annual staffing plan, identifying the positions needed to perform the required HC services for the facility. The HSA indicated that staffing vacancies of all three physician positions, one PHS Clinical Director, one GS employee, and one contract employee, and five PHS Registered Nurse (RN) positions, which had been vacant for three to five years, had proved exceedingly difficult to fill for extended periods. At the time of inspection, the facility had been operating without the appropriate number of designated physicians and RNs due to shortages within the PHS. These shortages had been long-standing and required either contractor overtime or federal staff TDY coverage.

OIDO notes that ICE assessed a total penalty of $19,372.41 for September, October, and November 2022 from STG International, Inc. (STGi),[10] the contractor that holds the overall contract, for non-compliance with the 92 percent position fill-rate contract requirement. The QASP outlines penalties assessed to the contractor for failing to meet the staffing requirement in the 21 IHSC-staffed facilities and IHSC HQ. Contractor deductions as specified in the QASP vary based on the HC position category.

Non-IHSC Facility Non-Compliance and Penalties

OCPC's contract modification, signed April 5, 2022, required the facility to increase HC staffing from 24.95 to 32.85 FTEs when the detainee population ranged between 501 to 740. While OIDO

[7] Per the facility's staffing plan, a whole number is used to identify the number of positions. OIDO recalculated to account for full-time and part-time positions resulting in a change from 99 to 98.5.
[8] Per the facility's staffing plan, a whole number is used to identify the number of positions. OIDO recalculated to account for full-time and part-time positions resulting in a change from 68 to 67.5.
[9] Per the facility's staffing plan, a whole number is used to identify the number of positions. OIDO recalculated to account for full-time and part-time positions resulting in a change from 68 to 67.5.
[10] OIDO notes that monetary penalties for not meeting HC staffing requirements were assessed at the contract level, not at the facility level. As such, the total assessment noted here applied to the overall contract.

was on-site on January 24 and 25, 2023, the detainee population reached 589 and 608, respectively, but the facility had not increased staffing to 32.85 FTEs as required. The facility vacancy rate report showed the facility had 19.05 positions filled at the time, a 58 percent HC fill rate or a 42 percent vacancy rate.

OIDO also reviewed the 2022 Average Daily Census from the OCPC Monthly Performance Management Report and found the detainee population had reached above 501 in six different months after the modification had gone into effect: May (551), June (518), July (529), August (585), November (630), and December (508). In short, the contractor had not increased staffing despite several months of higher detainee population numbers. The Assistant COR reported that they were not aware of any assessed penalties for non-compliance with staffing requirements.

Finally, JCPC's Site Staffing Plan, outlined in Attachment 9 of the IGSA between ICE and the County of Montgomery, Texas, requires 36 FTEs for HC staffing. OIDO reviewed the JCPC HC staffing roster, which showed the facility had 30.5 of the 36 FTEs filled, resulting in an 85 percent fill rate. Though the contract Performance Requirement Summary allows for penalties to be assessed when staffing requirements are not met, the Regional Health Services Director indicated she was unaware of any penalties assessed for deficiencies with the HC services fill rate during the contract period, though the contract provides for them. The Regional Health Services Director stated that GEO was recruiting HC staff using the GEO job website, approved social media and employment website postings, and word of mouth.

Having a fully staffed HC department with skilled and knowledgeable professionals increases quality of care. Any consistent HC staffing shortage in an ICE-owned or -contracted detention facility could jeopardize the health and safety of noncitizens in ICE custody and may increase liability for the government.

B. Review of Staffing Plan

The 2011 PBNDS and Revised 2011 PBNDS sections 4.3 on medical care require the HC staffing plan to be reviewed at least annually to identify positions needed to perform the required services. In comparison, the 2019 NDS section 2.3 on facility security and control requires the facility to develop a comprehensive staffing analysis and staffing plan to determine and meet the facility's detainee supervision needs; these shall be reviewed and updated at least annually.

All Seven Facilities Complied with the Annual Health Care Staffing Plan Review

OIDO reviewed the 2021 and 2022 annual HC staff plans for all seven facilities. OIDO found that all seven facilities complied with requirements to review the annual HC staffing plan review to identify positions needed to perform required services for both years. However, though OCPC did complete its annual staffing plan review, the facility failed to subsequently increase its HC staff from 24.95 to 32.85 FTEs after the review revealed that the facility's detainee population had increased to the range of 501 to 740, requiring a corresponding staffing increase.

II. Health Care Credentialing

A. Personnel Credentials

The 2011 PBNDS and Revised 2011 PBNDS sections 4.3 on medical care require that HC

personnel perform duties within the scope of practice for which they are credentialed by training, licensure, certification, job descriptions, and/or written standing or direct orders by personnel authorized by law to give such orders. All HC staff must be verifiably licensed, certified, credentialed, and/or registered in compliance with applicable state and federal requirements. Copies of the documents are required to be maintained on-site and readily available for review. Similarly, the 2019 NDS section 4.3 on medical care requires that HC staff have valid professional licensure and/or certification for the jurisdiction in which they practice and perform duties within the scope of their clinical license. In addition, HC practitioners must be licensed, certified, or credentialed[11] by a state, territory, or other appropriate body to provide services within the scope and skills of the respective HC profession.

OIDO reviewed credentialing files of selected HC staff to ensure they were verifiably licensed, certified, credentialed, and/or registered in compliance with contract and relevant state and federal requirements. OIDO randomly selected and reviewed up to 30 HC credentialing files at each of the seven facilities. If the facility had more than 30 HC staff, OIDO selected every third or fourth staff member from each discipline within the HC staff roster. If the facility had fewer than or equal to 30 HC staff, OIDO reviewed all the credentialing files for all licensed HC staff. Within each credentialing file, OIDO checked for the presence of the following documents: state-issued professional licensure with primary source verification; Drug Enforcement Administration license (if applicable); basic life support (BLS) certification; primary source verification for degree; privilege letter on file, if applicable,[12] collaborative practice agreement/prescriptive authority agreement (CPA/PAA), if applicable,[13] National Practitioner Data Bank (NPDB)[14] current query and expiration date, and job description.

OIDO found that four of the seven facilities had a 100 percent completion rate and complied with requirements for maintaining credentialing files for HC staff; these included MVPC, BSPC, OCPC, and PDF. Three facilities, STIPC, PISPC, and JCPC, were non-compliant because the facilities had incomplete credentialing files.

Table 4 shows the credentialing file completion rate and OIDO findings at each of the seven facilities inspected.

[11] Credentialing is a process that includes verification of licensure, education, training, experience, competency, and judgment.
[12] This requirement pertains to Licensed, Supervised Providers and Licensed Independent Practitioners only.
[13] This requirement pertains to Licensed, Supervised Providers only.
[14] The NPDB is a web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to HC practitioners, providers, and suppliers. Established by Congress in 1986, it is a workforce tool that prevents practitioners from moving state to state without disclosure or discovery of previous damaging performance.

Table 4. Credentialing File Completion Rate Compliance Finding at Seven ICE Detention Facilities

Facility	Health Care Services Provider	Standard	Credentialing File Completion Rate (%)[a]	OIDO Finding
Prairieland Detention Facility	LaSalle	2011 PBNDS	100	Compliant
Moshannon Valley Processing Center	GEO	Revised 2011 PBNDS	100	Compliant
Buffalo (Batavia) Service Processing Center	IHSC	Revised 2011 PBNDS	100	Compliant
Otero County Processing Center	MTC	Revised 2011 PBNDS	100	Resolved Area of Non-Compliance
South Texas ICE Processing Center	IHSC	Revised 2011 PBNDS	43.3	Non-compliant
Port Isabel Service Processing Center	IHSC	Revised 2011 PBNDS	80	Non-compliant
Joe Corley Processing Center	GEO	2019 NDS	97	Non-compliant

[a]OIDO calculated the credentialing file completion rate by taking the number of complete files and dividing it by the total number of files reviewed and then multiplying by 100. This gives percentage of completion.

The details of each finding as identified in Table 4 are further specified in the following sections: compliant facilities, resolved area of initial non-compliance, and non-compliant facilities.

i. Compliant Facilities

Three of the Seven Facilities Complied with Credentialing Requirements for Health Care Staff

OIDO reviewed 30 HC staff credential files at PDF, MVPC, and BSPC. OIDO found that all the HC staff credentialing files across the three facilities contained the required documents as outlined.

ii. Resolved Area of Initial Non-Compliance

One Facility Was Non-Compliant But Resolved the Problem During the Inspection

OIDO reviewed 20 credentialing files for HC staff at OCPC.[15] OIDO found that 19 HC credentialing files were complete and current. However, the facility did not have a credentialing file for the licensed mental health counselor (LMHC). The HSA did an on-site correction and retrieved a copy of the LMHC's credentialing file from the nearby county prison where the staff member worked part time. The credentialing file included all the required documentation. The on-the-spot correction resulted in the facility achieving 100 percent compliance.

iii. Non-Compliant Facilities

Three of the Seven Facilities Did Not Comply with Credentialing Requirements for Health Care Staff

OIDO reviewed 30 of the 78 HC staff credentialing files at STIPC. Of the 30 credentialing files reviewed, OIDO found 17 incomplete files, resulting in a 43.3 percent completion rate.

[15] OIDO notes that the facility had 23 medical personnel employed at the time of the inspection; however, three staff were not required to maintain credentialing folders. This included one medical records technician, one medical records clerk, and one pharmacy manager.

Specifically, OIDO noted the following missing documentation:

- 20 percent of files had an expired or missing BLS certificate. The facility located four of the six missing certificates during the inspection, resulting in a 93 percent completion rate.
- 16 percent of files did not have primary source verification (PSV) for the qualifying degree. The facility located one of the five missing PSVs, resulting in an 86 percent completion rate.
- 66 percent of files did not have a current NPDB query. The facility located 11 of the 20 missing queries during the inspection, resulting in a 70 percent completion rate.
- 13 percent of files did not have a job description. The facility located two of the four missing job descriptions during the inspection, resulting in a 93 percent completion rate.
- 45 percent of files requiring a privileging appointment/reappointment document did not have one. The facility located one of the nine missing documents during the inspection, resulting in a 60 percent completion rate.
- 11 percent of credentialing files had an expired CPA/PAA, resulting in an 89 percent completion rate.

The HSA reported that IHSC HQ informed facility leadership more than a year ago that IHSC was transitioning to a centralized credentialing and privileging process, but this change was still not complete at the time of OIDO's inspection. Due to the decentralized state of the credentialing files and the multiple copies in various places, it is difficult for one person to manage the files. Reliance on the contractor, contracted staff, and employees to bring in copies further complicates the process. The lack of current credentialing documents puts ICE and the facility at risk of utilizing HC staff members who have not maintained or met current credentialing requirements.

OIDO reviewed 31 HC staff credentialing files at PISPC and found six incomplete files, resulting in an 81 percent completion rate. Specifically, OIDO noted the following missing documents:

- 48 percent of files did not have a completed or current NPDB query; three RNs and one dental hygienist did not have any recorded search; and 11 files had expired searches. Following the inspection, the facility provided evidence of updated NPDB queries for all non-compliant files, resulting in a 100 percent completion rate.
- OIDO found the six Licensed, Supervised Providers (LSPs) that were required to have Privileges, Appointment, & Reappointment letters did not have any, resulting in a 0 percent completion rate.
- 3 percent of files had an expired BLS certificate and job description. The facility located the updated certificate and job description during the inspection, resulting in a 100 percent completion rate.

The Unit Chief for the IHSC Credentialing and Privileging Unit (ICPU) stated that IHSC HQ was aware of the issue regarding the privileging letters. ICPU had been actively working to resolve this issue. ICPU had recently finished privileging the LSPs, Nurse Practitioners, and Physician Assistants stationed at IHSC HQ in Washington, DC, and was in the process of privileging Eastern Region–assigned LSPs. In the meantime, ICPU had alerted the HSAs in the Central and Western Regions and instructed them to make sure privileging and credentialing folders were current.

Finally, OIDO reviewed 29 HC staff credentialing files at JCPC.[16] OIDO found one file was incomplete, resulting in a 97 percent completion rate. Specifically, OIDO noted the following missing documentation:

- 7 percent of files did not have a state-issued professional license. After the inspection, the facility located licenses for the two non-compliant files, resulting in a 100 percent completion rate.
- 7 percent of files did not have a job description on file. The facility located the missing job descriptions after the inspection, resulting in a 100 percent completion rate.
- 24 percent of files did not have a PSV for a degree. The facility located six of the seven missing PSV for degree documents after the inspection, resulting in a 97 percent completion rate.
- While all files had an NPDB on file, 55 percent of queries were outdated, having been completed more than a year ago. OIDO notes that the guidance in the GEO Correctional Health Services Credentialing and License Verification Policy 402 and Procedure 402-A lacked clarity regarding the required recredentialing documents for the Advanced Health Practitioners (AHPs). Specifically, it failed to mention or require the facility to conduct a biannual NPDB query for AHPs. Nonetheless, periodic and/or continuous NPDB queries allow the employer to receive new or updated report notifications related to medical malpractice payments and certain adverse actions, which aid with informed decision making and risk mitigation.

HC personnel's credentialing and periodic recredentialing process ensures that practitioners are qualified to provide care to ICE detainees. This process is vital to help reduce adverse outcomes.

B. Peer Review

The 2011 PBNDS and Revised 2011 PBNDS sections 4.3 on medical care require that the facility HSA implement an intraorganizational, external peer review program that includes at least annual reviews of all independently licensed medical professionals. While the 2019 NDS does not identify any annual peer review requirements for HC staff, Attachment 7, Quality Control Plan, of the IGSA between the ICE and the County of Montgomery, Texas, requires an external peer review program for Physicians, Mental Health Professionals, and Dentists. The IGSA states that the peer review must be conducted no less than every two years.

OIDO randomly selected and reviewed up to 30 HC staff credentialing files at each of the seven facilities. If the facility had more than 30 HC staff, OIDO selected every third or fourth staff member from each discipline within the HC staff roster. If the facility had fewer than or equal to 30 HC staff, OIDO reviewed all the credentialing files for licensed HC staff.

OIDO found that five facilities were compliant: MVPC, BSPC, OCPC, PDF, and PISPC. Two facilities, STIPC and JCPC, were initially non-compliant; however, the facilities became compliant after they made corrections during and after OIDO's inspection, respectively.

Table 5 shows the peer review completion rate and OIDO finding at each of the seven facilities inspected.

[16] OIDO notes the facility had 31 medical personnel employed at the time of the inspection; however, two staff held positions that did not require licensure or credentialing files.

Table 5. Peer Review Completion Rate and OIDO Compliance Finding at Seven ICE Detention Facilities

Facility	Health Care Services Provider	Standard	Peer Review Completion Rate (%)	OIDO Finding
Moshannon Valley Processing Center	GEO	Revised 2011 PBNDS	100	Compliant
Buffalo (Batavia) Service Processing Center	IHSC	Revised 2011 PBNDS	100	Compliant
Otero County Processing Center	MTC	Revised 2011 PBNDS	100	Compliant
Prairieland Detention Facility	LaSalle	2011 PBNDS	100	Compliant
Port Isabel Service Processing Center	IHSC	Revised 2011 PBNDS	100	Compliant
Joe Corley Processing Center	GEO	2019 NDS	100	Resolved area of initial non-compliance
South Texas ICE Processing Center	IHSC	Revised 2011 PBNDS	100	Resolved area of initial non-compliance

The details of each finding as identified in Table 5 are further specified in the following sections: compliant facilities and facilities with resolved areas of initial non-compliance.

i. Compliant Facilities

Five of the Seven Facilities Complied with the Annual Peer Review Requirement

OIDO reviewed 30 credential files at BSPC and MVPC and found the facilities completed all 30 required annual peer reviews. OIDO reviewed 16 credentialing files at OCPC and found that all contained evidence the facility completed an annual peer review.[17] OIDO reviewed 23 credentialing files at PDF and found the facility had completed the annual peer review.[18] OIDO reviewed 27 credentialing files at PISPC and found the facility had completed the annual peer review.[19]

ii. Resolved Area of Initial Non-Compliance

Two of the Seven Facilities Had Resolved Area of Initial Non-Compliance for the Peer Review

OIDO reviewed 30 out of 78 health services staff credentialing files at STIPC. Of these 30 staff files, 25 required an annual peer review. OIDO found that 24 of the 25 files had an annual peer review on file, and one had an expired peer review. The facility provided an updated peer review during OIDO's inspection, resulting in a 100 percent completion rate.

[17] OIDO notes that OCPC had 23 HC personnel at the time of inspection; however, only 16 of the 23 positions required an annual peer review.
[18] OIDO notes that it reviewed 30 credentialing files in total at PDF, but only 23 of the 30 positions required an annual peer review. The positions that did not require peer review included two medical assistants, two medical clerks, and the psychiatrist, who provided consultation services only, and two nurse practitioners, who were new hires.
[19] OIDO notes that PISPC had 31 HC staff at the time of inspection, but only 27 positions required an annual peer review. One position was exempt, and three did not require peer reviews.

Similarly, OIDO reviewed the credentialing files of 29 medical personnel at JCPC and found that 21 required an annual peer review. OIDO found that 20 had an annual peer review on file during the inspection, and one staff member had an expired peer review. However, the facility provided an updated peer review after the inspection, resulting in a 100 percent completion rate.

III. Health Care Training

A. Training Plan

The 2011 PBNDS and Revised 2011 PBNDS sections 7.3 on staff training require the training coordinator to develop and document a facility training plan that is reviewed and approved annually by the facility administrator and reviewable by ICE ERO. While the 2019 NDS does not identify any training plan requirements for HC staff, Attachment 7, Quality Control Plan, of the IGSA between ICE and the County of Montgomery, Texas, states that all new professional and support employees, including contractors who have regular or daily contact with detainees, must receive training during their first year of employment.

OIDO reviewed copies of the seven facilities' 2022 and 2023 training plans to evaluate each plan's development, review, and annual approval. OIDO found three of the seven facilities, MVPC, BSPC, and JCPC, were compliant. Four of the seven facilities, PISPC, PDF, STIPC, and OCPC, were non-compliant.

Table 6 provides an overview of the 2022 and 2023 training plan approval status and OIDO's findings at each facility.

Table 6. 2022 and 2023 Training Plan Approval Status Compliance Findings at Seven ICE Detention Facilities

Facility	Health Care Services Provider	Standard	Approved Training Plan 2022	Approved Training Plan 2023	OIDO Finding
Moshannon Valley Processing Center	GEO	Revised 2011 PBNDS	Yes	Yes	Compliant
Buffalo (Batavia) Service Processing Center	IHSC	Revised 2011 PBNDS	Yes	Yes	Compliant
Joe Corley Processing Center	GEO	2019 NDS	Yes	Yes	Compliant
Otero County Processing Center	MTC	Revised 2011 PBNDS	Yes	No	Non-compliant
Prairieland Detention Facility	LaSalle	PBNDS 2011	No	No	Non-compliant
Port Isabel Service Processing Center	IHSC	Revised 2011 PBNDS	No	No	Non-compliant
South Texas ICE Processing Center	IHSC	Revised 2011 PBNDS	Yes	No	Non-compliant

The details of each finding as identified in Table 6 are further specified in the following sections: compliant and non-compliant facilities.

iii. Compliant Facilities

Three of the Seven Facilities Met the Requirements to Review the Training Plan Annually

OIDO reviewed copies of the 2022 and 2023 training plans at BSPC, JCPC, and MVPC and found that the training coordinators at the facilities developed and documented the facility training plans. The training plans were reviewed and approved annually by the facility administrator and made reviewable by ICE ERO.

iv. Non-Compliant Facilities

Four of the Seven Facilities Did Not Meet the Requirement to Review the Training Plan Annually

First, OIDO reviewed a copy of the 2022 Annual Refresher Training Plan for PISPC. The facility did not provide the 2023 plan. In addition to the 40-hour refresher training, OIDO reviewed the required IHSC Policy Review and IHSC Annual Staff Training, which included 34 various courses. OIDO found that the training plan had been neither approved by the facility administrator nor reviewed by ICE ERO.

Second, OIDO requested copies of the 2022 and 2023 Annual Refresher Training Plan for PDF but received only an undated, untitled, and unsigned document listing 120 hours of training courses. The document did not appear to have been reviewed or approved. Moreover, the content in the training was in line with orientation training rather than annual training. For example, the document included several courses not typically taught during annual training, such as Sign-In Class Rules, Introduction, Human Resources Paperwork, Handbook, Drug Free, and ID Photos/Uniform and Grooming Standards. In addition, it included 120 hours of coursework instead of the usual 40 hours of annual refresher coursework.

Third, OIDO reviewed a copy of the 2022 Annual Refresher Training Plan for STIPC and found it had been reviewed and approved. However, during OIDO's inspection, the Assistant HSA (AHSA) reported that the facility had not created the 2023 training plan. The IHSC HQ Medical Education and Development Unit was responsible for providing the annual training for all IHSC-staffed facilities through the IHSC TRAIN Platform; however, they had not sent the training or any annual training plans as of the date of OIDO's inspection.

Finally, OIDO reviewed a copy of the 2022 training curriculum for OCPC and found it included 40 hours of annual training. HSA reported that the 2022 training curriculum would carry over to 2023 but did not provide the 2023 plan.

An approved facility training plan ensures that employees receive appropriate and timely training relevant to their roles within the facility. It also ensures facility staff know applicable standards to ensure detainee and staff safety and well-being.

B. Annual Training

The 2011 PBNDS and Revised 2011 PBNDS sections 7.3 on staff training require facilities to provide appropriate initial and annual training to all employees. The standards outline the minimum requirements for initial orientation and annual employee training. The standard further states that part-time, volunteer, or contract personnel working more than 20 hours per week must receive training appropriate to their position and commensurate with their full-time colleagues.

The 2019 NDS section 4.3 on medical care requires the responsible medical authority to provide training, including the following: recognition of signs of potential health emergencies and the required response; administration of first aid and cardiopulmonary resuscitation (CPR); recognition of signs and symptoms of mental illness; and the facility's established plan and procedures for providing emergency medical care including, when required, the safe and secure transfer of detainees for appropriate hospital or other medical services.

OIDO identified and reviewed a subset of five annual training requirements supporting safe, humane conditions within each of the facility's annual training plans: (1) Suicide Prevention and Intervention; (2) Personal Protective Equipment (PPE); (3) Medical Grievances Procedures and Protocols; (4) Hunger Strike; and (5) Emergency Medical Services and First Aid. Further, OIDO conducted a comprehensive review of the Emergency Medical Services and First Aid training to assess whether the training met the criteria in PBNDS and NDS standards.

OIDO randomly selected and reviewed up to 30 HC staff training files at each of the seven facilities. If the facility had more than 30 HC staff, OIDO selected every third or fourth staff member from each discipline within the HC staff roster. If the facility had fewer than or equal to 30 HC staff, OIDO reviewed all the training files for licensed HC staff. Within each training file, OIDO checked for the presence of the training certificate for the following training areas: suicide prevention, PPE, medical grievances procedures and protocols, hunger strike, and emergency medical services and first aid. OIDO found that three of the seven facilities were compliant, and four were non-compliant.

Table 7 provides an overview of each facility's course completion rate and OIDO's findings.

Table 7. Course Completion Rate and OIDO Compliance Findings at Seven ICE Detention Facilities

Facility	Health Care Services Provider	Standard	Training Completion Rate (%)[a]	OIDO Finding
Joe Corley Processing Center	GEO	2019 NDS	100	Compliant
Moshannon Valley Processing Center	GEO	Revised 2011 PBNDS	100	Compliant
South Texas ICE Processing Center	IHSC	Revised 2011 PBNDS	96	Compliant
Otero County Processing Center	MTC	Revised 2011 PBNDS	87	Non-compliant
Prairieland Detention Facility	LaSalle	2011 PBNDS	71	Non-compliant
Buffalo (Batavia) Service Processing Center	IHSC	Revised 2011 PBNDS	44	Non-compliant
Port Isabel Service Processing Center	IHSC	Revised 2011 PBNDS	100	Non-compliant

[a]OIDO calculated the course completion rate at each facility by taking the total number of courses completed and dividing it by the total number of courses required in the training files reviewed.

The details of each finding as identified in Table 7 are further specified in the following sections: compliant facilities and non-compliant facilities.

i. Compliant Facilities

Three of the Seven Facilities Met the Requirements for Annual Health Care Training

OIDO reviewed 26 training files at JCPC,[20] 30 files at MVPC, and 25 files at STIPC to assess the completion of the 2022 annual training for the five topics noted previously. OIDO found that all HC staff at the three facilities had completed the training in all five topics.

ii. Non-Compliant Facilities

Four of the Seven Facilities Did Not Meet the Requirements for Annual Health Care Training

OIDO reviewed 30 HC training files at BSPC and found four HC staff members did not complete First Aid training; 12 did not complete Hunger Strike training, 12 did not complete Suicide Prevention training, 28 did not complete Medical Grievances Procedures and Protocols training, and 28 did not complete PPE training. The 30 files had 84 incomplete courses, resulting in a 44 percent training completion rate.

OIDO reviewed the training PowerPoints, sign-in sheets, and policies for BSPC. The facility did not have Emergency Medical Services training covering the safe and secure transfer of detainees to an appropriate hospital or other medical services. In addition, BSPC did not have individual sign-in sheets for each training and could not provide the sign-in sheet for Emergency Medical Services, Medical Grievances, and PPE training. BSPC did not provide certificates of completion to the staff once training was completed and did not have a reliable and accurate accountability system or a centralized designated area to store training attendance sheets, certifications, and presentations. Each trainer had their own training materials and sign-in sheet, if any. BSPC's attendance sheets had missing information, such as the instructor's name and date, and unclear staff signatures, making it difficult to identify which staff attended the training.

OIDO reviewed 23 HC training files at OCPC and found three files did not contain evidence that any of the courses for the five topic areas had been completed, resulting in an 87 percent course completion rate. The HSA stated that because telehealth providers did not work on-site, they were not required to complete mandatory annual training.[21]

OIDO reviewed 21 training files at PDF and found that the six PRN HC staff had not completed any courses for the five required training topics, resulting in a 71 percent course completion rate. As required by the 2011 PBNDS section 7.3 Staff Training, part-time personnel working more than 20 hours per week shall receive training appropriate to their position and commensurate with their full-time colleagues. To understand if PRN staff worked more or less than 20 hours weekly, OIDO reviewed the HC personnel's work schedules and calculated the number of hours each PRN staff worked each week from October 2022 to January 2023. Of the six PRN staff identified, four worked 24 or more hours per week on average over the four months reviewed. The remaining two PRN staff did not meet the 20-hour per week requirement. Thus, the facility should have required the four PRN contract HC staff to complete the same 40-hour annual training as required by all

[20] OIDO notes that the facility had 31 HC staff at the time of inspection; however, five were not required to have completed annual training due to new hire status or position exemptions.
[21] The 2011 PBNDS section 7.3 related to staff training does not distinguish between on-site and telehealth professionals.

contractor staff and any other relevant training commensurate with their position.

Finally, OIDO randomly selected 31 HC training files to review at PISPC; however, because four of these employees were new hires, OIDO reviewed only 27 files for annual training requirements. OIDO found that 100 percent of the HC staff reportedly completed the five annual trainings. However, documentation did not fully support compliance.

OIDO found that each of the 27 HC training files contained two documents titled: "IHSC Policy Review" and "2022 IHSC Annual Mandatory Staff Training." The policy review document listed 95 policies, and the training document listed 34 courses. Both documents had a line at the bottom for employee signature, and the policy review document also had a line for the date (*See* Appendix A). OIDO found the documents contained numerous policies and at least 40 hours of coursework, yet there was only one line for the employee to sign and date to confirm their completion of the entire policy review and training. As such, OIDO could not determine whether or when the employee reviewed each policy or took each course. OIDO advised the HSA and AHSAs on-site that the facility's training records in their current form were not sufficient to demonstrate that personnel had completed all the requirements.

Annual training is essential and mandatory because it provides HC staff with the requisite knowledge and skills to maintain detainees' safety and well-being.

C. Emergency Medical Services and First Aid Training

The 2011 PBNDS and Revised 2011 PBNDS sections 4.3 on medical care require the HSA to ensure that medical staff has training and competency in implementing the facility's emergency HC plan appropriate for each staff's scope of practice or position. The training must include recognizing signs of potential health emergencies and the required responses; administering first aid; automated external defibrillator (AED) and CPR; obtaining emergency medical assistance through the facility plan and its required procedures; recognizing signs and symptoms of mental illness and suicide risk; and the facility's established plan and procedures for providing emergency medical care including, when required, the safe and secure transfer of detainees for appropriate hospital or other medical services, including by ambulance when indicated. Finally, the training must address expedited entrance into and exit from the facility. The 2019 NDS section 4.3 on medical care requires, in addition to the above listed criteria, detention staff and HC staff to be trained to respond to health-related emergencies within a four-minute response time.[22] Finally, the 2011 PBNDS and Revised 2011 PBNDS sections on 7.3 staff training requirements for initial and annual training require that full-time HC employees and contractors receive training on emergency medical procedures.

OIDO reviewed the training materials for emergency medical services and first aid across the seven facilities and found that two facilities were compliant, and five facilities were non-compliant.

Table 8 provides an overview of each facility's the emergency services and first aid curriculum completion rate and OIDO finding.

[22] The 2019 NDS Appendix A provides a list of required staff trainings. It notes that detention facility staff, contractors, and volunteers should receive sufficient initial and recurrent training to be competent in their job duties.

Table 8. Emergency Services and First Aid Curriculum Completion Rate and Compliance Finding for 2022 at Seven ICE Detention Facilities

Facility	Health Care Services Provider	Standard	Curriculum Completion Rate (%)[a]	OIDO Finding
Otero County Processing Center	MTC	Revised 2011 PBNDS	100	Compliant
Moshannon Valley Processing Center	GEO	Revised 2011 PBNDS	100	Compliant
Buffalo (Batavia) Service Processing Center	IHSC	Revised 2011 PBNDS	80	Non-compliant
Prairieland Detention Facility	LaSalle	2011 PBNDS	60	Non-compliant
Port Isabel Service Processing Center	IHSC	Revised 2011 PBNDS	60	Non-compliant
South Texas ICE Processing Center	IHSC	Revised 2011 PBNDS	20	Non-compliant
Joe Corley Processing Center	GEO	2019 NDS	80	Non-compliant

[a]OIDO calculated the curriculum completion rate by taking the total number of courses included in the curriculum at the facility divided by the five required courses, then multiplying by 100. This provided a completion percentage.

The details of each finding as identified in Table 8 are further specified in the following sections: compliant and non-compliant facilities.

i. Compliant Facilities

Two of the Seven Facilities' Annual Training for Emergency Medical Services and First Aid Addressed Required Content Outlined in the Standards

OIDO reviewed MVPC and OCPC's emergency response training to determine if they met the annual First Aid, CPR, and AED training requirements. In addition, OIDO reviewed these trainings to determine if they covered recognizing signs and symptoms of mental illness and suicide risk. OIDO found that the facility's training addressed the required content outlined in the standards.

ii. Non-Compliant Facilities

Five of the Seven Facilities' Annual Training for Emergency Medical Services and First Aid Did Not Comply with Required Content Outlined in the Standard

OIDO reviewed BSPC Emergency Medical Services and First Aid annual training and found the facility training deficient in one of the five required content areas. The BSPC Emergency Medical Services training did not cover the safe and secure transfer of detainees to an appropriate hospital or other medical services, including by ambulance, when indicated, or arrangements for expedited entrance into and exit from the facility.

OIDO reviewed the training material for PISPC Emergency Medical Services and found the facility was non-compliant in two of the five required areas. The facility's Emergency Medical Services and First Aid annual training material met only three of the five required training criteria. The training material lacked specific content about recognizing signs and symptoms of mental illness and suicide risk. In addition, PISPC's Emergency Medical Plan did not include content for the safe and secure transfer of detainees to appropriate hospitals or other medical services, including by ambulance. While this content did not appear in the training and emergency plan, the

content was available in PISPC 3.1.12 Escorted Trips Emergency Medical/Dental Care Escorts[23] addressing detainees' safe and secure transfer to appropriate hospitals or other medical services, including by ambulance. All medical and detention employees must receive the required training to respond appropriately to medical emergencies in a timely and sufficient manner to save the lives of both detainees and other facility staff.

Based on OIDO's review of the training material STIPC provided, the facility was not compliant in four of the five required areas. Specifically, the facility materials did not include training for recognizing signs of potential health emergencies and the required responses; administering first aid, AED, and CPR; obtaining emergency medical assistance through the facility plan and its required procedures; or having established plans and procedures for providing emergency medical care including, when required, the safe and secure transfer of detainees for appropriate hospital or other medical services, including by ambulance when indicated. In addition, STIPC's Emergency Response Plan did not include the expedited entrance and exit of emergency medical services. However, OIDO found that STIPC's emergency response training did include recognizing the signs and symptoms of mental illness and suicide risk.

The HSA and AHSA/Training Officer were unaware of the annual CPR and first aid training requirement and relied on the staff's independent completion of CPR through a certified American Heart Association course every two years. They were also unaware of the requirement per the PBNDS and IHSC National Directive. IHSC and STIPC lacked succinct emergency response training. The trainings were provided through a variety of different PowerPoints and post tests. In addition, the STIPC LOP 05-04 Emergency Preparedness Plan, revised on January 31, 2022, did not contain the required elements in accordance with the PBNDS and IHSC National Directive.

Finally, OIDO reviewed JCPC's Emergency Medical Services and First Aid training and found the course content covered all training components except for a plan for expedited entrance into and exit from the facility. While JCPC's Policy 901.12 Security-Post Orders, Mobile Patrol Officer, did contain the plan for expedited entrance into and exit from the facility, the contractor did not include this information in the HC staff Emergency Medical Services and First Aid annual training. JCPC's policy also created the potential for all staff to exceed 12 months between training periods. For example, Nurse A completed annual training for calendar year 2022 in January. By JCPC policy, Nurse A has until December 31, 2023, to complete annual training for calendar year 2023. If Nurse A completed next annual training in December 2023, there would be a 23-month span between those training periods. Failure to demonstrate competence regularly could result in a staff knowledge deficit and possible failure to respond to emergency medical situations appropriately.

[23] This is the medical emergency plan policy in the chapter on safety and emergency procedures in the Port Isabel Detention Center facility policies handbook.

Conclusion

OIDO's inspection report led to several findings. For staffing, OIDO found all seven facilities complied with requirements to conduct a review of their annual staffing plan. However, OIDO found five of the seven facilities did not comply with staffing requirements. Among these five non-compliant facilities, only the three IHSC facilities had penalties assessed against the facility for non-compliance.

For credentialing, OIDO found three of the seven facilities were non-compliant because they had incomplete credentialing files. An additional facility was initially found non-compliant but resolved the deficiency during the inspection. In addition, OIDO found five of the seven facilities were compliant with the requirement to have an external peer review program for the facility's independently licensed medical professionals. The two facilities that were found non-compliant in this area of review made corrections during or after OIDO's inspection, bringing them into compliance.

Finally, for training, OIDO found four of the seven facilities were non-compliant with the requirement to develop and approve an annual training plan, four of the seven facilities were non-compliant with requirements to train HC staff annual on certain topics, and five of the seven facilities were non-compliant with requirements to ensure medical staff are trained to implement the facility's emergency HC plan.

Compliance with ICE's national detention standards and contract terms is essential to ensuring the health and safety of detainees and staff. ICE must ensure that the facilities comply with the relevant detention standards and contract terms and take meaningful corrective action to address deficiencies.

Recommendations

It is important to comply with government procurement regulations for contracts to ensure that performance services conform to requirements.[24] Adherence is critical in, but should not be limited to, the following sections: assessment of current and discouragement of future nonconforming services;[25] recording and maintenance of contractor performance information;[26] and management accountability for the completeness of past performance evaluations.[27]

Recommendation 1: For HC staffing at facilities referenced in this report, ICE should:

(a) create and implement internal controls and oversight to ensure that comprehensive reviews of facilities are conducted when there is any perceived staffing level inadequacies or shortages to specifically address non-compliance with the prescribed HC staffing requirements.

[24] *See* Federal Acquisition Regulation (FAR) Subpart 46.4, Government Contract Quality Assurance.
[25] *See* FAR 46.407, Nonconforming Supplies or Services.
[26] *See* FAR Subpart 42.15, Contractor Performance Information.
[27] *See* FAR 42.1503, Procedures.

(b) levy suitable sanctions or penalties upon non-complying service providers until such time that the stipulated contractual requirements are fully met.

(c) prioritize a review of JCPC and OCPC for contractual compliance.

Recommendation 2: For HC credentialing and peer review at facilities referenced in this report, ICE should:

(a) create a centralized framework that is designed to systematically maintain and refresh credentialing dossiers for HC staff so that records are locally available for inspections.

(b) designate competent facility staff to conduct surveillance, periodically update, and monitor the completeness and on-site accessibility of all HC staff credentialing files. These internal controls should also ensure that external peer reviews are updated, fully documented, and stored.

(c) ensure facilities author and enforce policies that clarify the recredentialing paperwork mandated for licensed HC staff.

Recommendation 3: For HC training at facilities referenced in this report, ICE should create and implement internal controls and oversight to ensure:

(a) facilities allocate specific personnel to oversee the fulfillment of obligatory annual training sessions. These individuals should maintain and frequently update training archives and verify the consistent completion of annual training prerequisites.

(b) facilities conduct audits of training content to demonstrate full compliance with ICE detention standards.

Response from Inspected Component and OIDO Analysis

ICE Officials concurred with all three recommendations and identified corrective actions. Based on the information provided in the response to the draft report, OIDO considers all three recommendations addressed and closed. Following is a summary of ICE's response and OIDO's analysis thereof. ICE's full response is available in Appendix A.

Component Response to Recommendation 1: Regarding HC staffing at facilities referenced in this report, ICE concurred with OIDO's recommendations.

For Recommendation 1(a), ICE indicated IHSC is actively recruiting and advertising to fill vacancies and meet health care needs in ICE facilities with vacancies currently posted on USAJobs. PHS vacancies are also advertised on All Partners Access Network (APAN), a platform for unclassified information sharing and collaboration enterprise platform for the U.S. Department of Defense (DOD), providing traditional and nontraditional mission partners web-based community spaces and tools to effectively plan, train, and respond to meet their mission objectives. PISPC updates their master staffing plan annually reflecting the number of contractor positions as stated in the Site Status Report. The PISPC Medical Unit will continue to use PRN and TDY staffing to meet proper staffing requirements until a new staffing contract is complete and/or until vacancies are filled. IHSC actively monitors medical staffing contract performance through ongoing surveillance of vacancies and recruitment efforts of the vendor. The medical Staffing

Services Team, in collaboration with the COR, conducts weekly, monthly, and quarterly progress reviews of the contractor's performance and imposes penalties when a contractor does not meet Acceptable Quality Levels in accordance with the QASP. STIPC has hired a contract staff physician, and GS positions are filled above 95 percent. Contractor positions are filled above 90 percent, except for Licensed Vocational Nurses (LVNs). STIPC continuously works with the IHSC Nursing Services Unit to actively recruit applicants for PHS vacancies as well as a nurse manager. STIPC continues to request TDY staffing to meet adequate staffing requirements until vacancies are filled. JCPC's medical staffing is currently at 79 percent. ERO does not plan to issue a Contract Discrepancy Report (CDR) at this time, as the delay in onboarding is related to ICE's background check process. ERO will continue to conduct weekly meetings with JCPC and prioritize assessing health care staffing levels and reviewing contractual compliance. The IHSC Field Medical Coordinator (FMC) assesses facility medical staffing levels at least annually to ensure medical staffing levels are sufficient, in accordance with the ICE contract. BSPC updates its master staffing plan annually and reflects the number of contractor positions as stated in the Site Status Report. The BSPC Medical Unit will continue to use PRN and TDY staffing to meet staffing requirements until a new staffing contract is complete and/or vacancies are filled. The OCPC was issued a CDR by ERO addressing staffing levels. Now medical staffing levels have increased, and medical staffing percentages meet or exceed the minimum contract requirement of 80 percent. ERO will continue to work with its vendors to fill vacancies through permanent hires as well as TDYs as needed. The IHSC FMC assesses facility medical staffing levels in accordance with the ICE contract, at least annually, to ensure medical staffing levels are sufficient.

For Recommendation 1(b), ICE indicated through assigned Contracting Officers and CORs that ERO continually monitors contractor performance and will impose remedies for non-compliant service providers as stipulated in the contractual requirement on a case-by-case basis and for vendor non-compliance.

For Recommendation 1(c), ICE indicated ERO will continue to conduct weekly meetings with JCPC to prioritize the assessment of health care staffing levels and review JCPC contractual compliance. For OCPC, ERO issued a CDR addressing OCPC staffing levels resulting in medical staffing percentages now meeting compliance.

OIDO Analysis: OIDO finds these actions to be responsive to the recommendation and considers the recommendation to be addressed and closed.

Component Response to Recommendation 2: Regarding HC credentialing and peer review at facilities referenced in this report, ICE concurred with OIDO's recommendations.

For Recommendation 2(a), ICE indicated for IHSC-staffed facilities, the IHSC ICPU established an automated credentialing system for the management and tracking of credentialing requests and files for more than 1,700 clinical staff. The credentialing system centralizes where credentials are initiated and maintained and incorporates the use of an automated monitoring system allowing ICPU to manage credentials and privileges, to include reappointments, NPDB queries, as well as logging of peer reviews completion and expiration dates overseen by discipline specific leadership for all health care and community providers. The FMC assesses credentials for health care staff at non-IHSC-staffed facilities at least annually to ensure compliance with contract requirements. STIPC collaborates with ICPU to ensure privilege and appointment letters, as well as NPDB

queries for providers, are up to date. At PISPC, ICPU currently provides privilege, appointment, and re-appointment letters, as well as NPDB queries for providers, as necessary. At JCPC, ERO works closely with ICPU to ensure privilege and appointment letters, as well as NPDB queries for providers, are up to date. ERO will implement a credentialing tracking process as an internal control in the Service Provider's Quality Control Plan. Currently, JCPC maintains credentialing files that are readily accessible at the facility and an electronic SmartSheet that aids in tracking health care staff credentials.

For Recommendation 2(b), ICE indicated STIPC and JCPC became compliant due to corrections made during and after OIDO's inspection. All facilities will continue to conduct internal reviews to ensure full compliance.

For Recommendation 2(c), ICE indicated JCPC, PISPC, and STIPC will ensure facilities author and enforce policies that clarify the recredentialing paperwork mandated for licensed health care staff. ERO will ensure assigned CORs monitor contractor performance for compliance and will communicate this requirement during a monthly COR meeting led by the ERO Operational Support Division during the second quarter of Fiscal Year (FY) 2024.

OIDO Analysis: OIDO finds these actions to be responsive to the recommendation and considers the recommendation to be addressed and closed.

Component Response to Recommendation 3: Regarding HC training at facilities referenced in this report, ICE concurred with OIDO's recommendation.

For Recommendation 3(a), ICE indicated OCPC health staff will coordinate with the training manager to ensure full compliance with staff attendance at annual training sessions. The training department uses an Acadis database as a tracking platform and to generate reports in conjunction with paper sign-in sheets for capturing participant names and information for annual training sessions. At PDF, the HSA requires each employee to complete a 40-hour annual training, as well as a web-based company system to use as a backup training. The HSA, AHSA, Facility Administrator, Assistant Facility Administrator, and LaSalle Corporate Director of Credentialing track and ensure all required annual training is completed by set deadlines. At PISPC and STIPC, the medical units receive initial and annual refresher training from custody training staff that is 40 hours in addition to online training sites, such as the ICE Training System (ITS) and IHSC TRAIN, providing additional mandatory and job-specific trainings. In addition, STIPC implemented and completed staff training on emergency response, which included recognizing signs of potential health emergencies and the expedited entrance and exit of emergency medical services, and annual CPR and AED training. PISPC and STIPC supervisors ensure facility training for staff is complete. At BSPC, ERO assigned personnel to manage the fulfillment of obligatory annual training sessions in accordance with PBNDS and is currently in compliance.

For Recommendation 3(b), ICE indicated IHSC maintains an internal audit process called the IHSC Health Systems Assessment Application, which is used to conduct internal audits of staff compliance and to provide facility health care training at IHSC-staffed facilities. Further, the IHSC Medical Education and Development Unit works with other IHSC units to update annual trainings for the agency. Required initial and annual training for healthcare staff at non-IHSC facilities is assessed by the FMC at least annually to ensure compliance. Health care staff training is also assessed by other compliance inspecting entities, such as ICE Office of Detention Oversight (ODO). At OCPC, the Facility Administrator will continue to review and approve the training plan annually. At PISPC, staff are currently reviewing training documentation to ensure alignment with ICE standards, and a local policy has been drafted outlining expected requirements. At PDF, the HSA, AHSA, Facility Administrator, Assistant Facility Administrator, and LaSalle Corporate Director of Credentialing will work together to track and ensure all required annual training is completed by set deadlines and is in full compliance with ICE detention standards by annually reviewing course materials and updating as needed. At STIPC, the ERO STIPC Compliance Unit will begin tracking audits to ensure the facility complies with ICE detention standards. The STIPC HSA is working with the AHSA and Facility Healthcare Program Manager to complete annual and periodic audits as needed to the existing trainings or additional training to ensure the facility annual training plan has all the necessary topics and subject matter to meet requirements and compliance. Finally, BSPC staff will annually track required staff training participation and work with IHSC audit staff to provide relevant information regarding its compliance with PBNDS.

OIDO Analysis: OIDO finds these actions to be responsive to the recommendation and considers the recommendation to be addressed and closed.

Appendix A: Component Response

Enforcement and Removal Operations

U.S. Department of Homeland Security
500 12th Street, SW
Washington, DC 20536

U.S. Immigration and Customs Enforcement

April 25, 2024

MEMORANDUM FOR: David D. Gersten
Acting Ombudsman
Office of the Immigration Detention Ombudsman

FROM: Daniel A. Bible
Executive Associate Director
Enforcement and Removal Operations
U.S. Immigration and Customs Enforcement

DANIEL A BIBLE
Digitally signed by DANIEL A BIBLE
Date: 2024.04.26 14:35:44 -04'00'

SUBJECT: Response to OIDO Evaluation of Health Care Staffing, Credentialing, and Training at Seven ICE Detention Facilities (Case No. 22-001096)

Purpose

This memorandum is in response to the Department of Homeland Security's Office of the Immigration Detention Ombudsman's (OIDO) draft report, *OIDO Evaluation of Health Care Staffing, Credentialing, and Training at Seven U.S. Immigration and Customs Enforcement Detention Facilities*. The report is based on OIDO's inspection of the following detention facilities: Buffalo (Batavia) Service Processing Center (BSPC), Joe Corley Processing Center (JCPC), Moshannon Valley Processing Center (MVPC), Otero County Processing Center (OCPC), Port Isabel Service Processing Center (PISPC), Prairieland Detention Facility (PDF), and the South Texas U.S. Immigration and Customs Enforcement (ICE) Processing Center (STIPC).

Background

ICE Enforcement and Removal Operations (ERO) oversees the detention of noncitizens at facilities throughout the United States, which it manages directly or in conjunction with private contractors or federal, state, or local governments. ICE uses several detention standards to regulate conditions of confinement, program operations, and management expectations within the agency's detention system. OIDO planned and executed focused inspections after identifying non-compliance trends in health care (HC) staffing, credentialling, and training across several ICE facilities during previous inspections. Specifically, from July through December 2022, OIDO conducted seven inspections at the following ICE detention facilities: Denver Contract Detention Facility on July 26-28, 2022; Cibola County Correctional Center on August 9-11,

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2022; Pine Prairie ICE Processing Center on August 30-September 1, 2022; South Louisiana ICE Processing Center on October 25-27, 2022; Eden Detention Center on December 6-8, 2022; Folkston ICE Processing Center and Annex on November 15-17, 2022; and Broward County Transitional Center on December 6-8, 2022.

During those inspections, OIDO found areas of non-compliance in HC staffing, credentialing, and training. OIDO medical subject matter experts (SMEs) identified a pattern of insufficient HC staffing, disorganized and/or expired HC licensing and credentialing documents, and concerns related to HC staff training programs, such as incomplete documentation and content as well as knowledge gaps when applying protocols or procedures outlined in training. Based on the findings, OIDO examined whether this trend existed in other ICE detention facilities. To ensure that this inspection included a wide range of HC service providers, OIDO medical SMEs identified seven additional facilities, operated by four different contractors and under various ICE detention standards, to include the 2011 Performance-Based National Detention Standards (PBNDS), PBNDS 2011 as revised in 2016 (revised PBNDS 2011), and the 2019 National Detention Standards, to conduct announced focused inspections reviewing three focused areas of: 1) HC staffing; 2) HC credentialing; and 3) HC training.

ICE Response to OIDO Recommendations

Recommendation 1: For HC staffing at facilities referenced in this report, ICE should:

> (a) create and implement internal controls and oversight to ensure that comprehensive reviews of facilities are conducted when there is any perceived staffing level inadequacies or shortages to specifically address non-compliance with the prescribed HC staffing requirements.
> (b) levy suitable sanctions or penalties upon non-complying service providers until such time that the stipulated contractual requirements are fully met.
> (c) prioritize a review of JCPC and OCPC for contractual compliance.

Response to Recommendation 1(a): ICE concurs with this recommendation. OIDO found the following five facilities were non- compliant: PISPC, STIPC, JCPC, BSPC, and OCPC.ICE Health Service Corps (IHSC) staffed facilities and non-IHSC staffed facilities, face significant challenges in recruiting qualified health care personnel. Please note: IHSC only staffs its own detention facility clinics and must compete with other government agencies that offer more pay and better incentives than ICE. IHSC is actively recruiting and advertising to adequately fill these vacancies and meet healthcare needs in ICE facilities with vacancies currently posted on USAJobs. U.S. Public Health Service (PHS) vacancies are also advertised on All Partners Access Network (APAN), a platform for unclassified information sharing and collaboration enterprise platform for the United States Department of Defense (DOD), providing traditional and nontraditional mission partners web-based community spaces and tools to effectively plan, train, and respond to meet their mission objectives.

Staffing these ICE facilities with qualified personnel involves factors that are beyond ICE's control, particularly, as noted above, where ICE is at a competitive disadvantage among hiring

government agencies and the private sector industry and/or geographic considerations such as remoteness and relocation of qualified personnel. With regard to non-IHSC staffed facilities, ICE contracting officer representatives and other official frequently engage with our detention providers regarding staffing issues to include hiring and retention and take appropriate action to remedy situations when vendors do not meet contractual requirements.

PISPC: PISPC updates the master staffing plan annually, and the current updated plan is dated October 11, 2023, after the on-site review. The current master staffing plan reflects the number of contractor positions as stated in the Site Status Report quoted in Recommendation 1. The PISPC Medical Unit will continue to use *pro re nata* (PRN) and temporary duty (TDY) staffing to meet proper staffing requirements until a new staffing contract is complete and/or until vacancies are filled.

In addition to the above recruiting activities, IHSC actively monitors medical staffing contract performance through ongoing surveillance of vacancies and recruitment efforts of the vendor. The medical Staffing Services Team, in collaboration with the Contracting Officer's Representative (COR), conduct weekly, monthly, and quarterly progress reviews of the contractor's performance and imposes penalties when a contractor does not meet Acceptable Quality Levels in accordance with the Quality Assurance Surveillance Plan. IHSC works directly with the vendor to ensure prioritization of critical vacancies are addressed to meet healthcare needs of the facility.

STIPC: Following OIDO's inspection, STIPC has hired a contractor staff physician. General Schedule positions are filled above 95 percent. Contractor positions are filled above 90 percent except for licensed vocational nurses (LVNs) (currently with 5 vacancies). STIPC is continually working with the IHSC Nursing Services Unit to actively recruit applicants for PHS vacancies as well as a nurse manager. STIPC continues to request TDY staffing to meet adequate staffing requirements until vacancies are filled.

JCPC: JCPC is continuously and aggressively pursuing applicants to fill open positions. JCPC's medical staffing is currently at 79 percent. JCPC's current vacancies are two registered nurses (RNs), one licensed professional counselor (LPC,) and four LVNs. JCPC has hired and filled all vacancies and is only awaiting a background investigation decision from ICE. ERO does not plan to issue a Contract Discrepancy Report (CDR) at this point, since the delay in on-boarding staff is related to ICE's background check process. ERO will continue to conduct weekly meetings with JCPC and prioritize assessing health care staffing levels and reviewing JCPC contractual compliance. In addition, the IHSC Field Medical Coordinator (FMC) conducts an assessment of facility medical staffing levels in accordance with the ICE contract, at least annually to ensure medical staffing levels are sufficient to deliver comprehensive health care in accordance with ICE detention standards.

BSPC: BSPC updates the master staffing plan annually. The current master staffing plan reflects the number of contractor positions as stated in the Site Status Report quoted in Recommendation 1. The BSPC Medical Unit will continue to use PRN and TDY staffing to meet proper staffing requirements until a new staffing contract is complete and/or until vacancies are filled.

OCPC: On February 8, 2024, ERO issued a CDR addressing OCPC staffing levels. Since then, the medical staffing levels have increased, and medical staffing percentages meet or exceed the minimum contract requirement of 80 percent. ERO will continue to work with its vendors to fill vacancies through permanent hires as well as TDYs as needed. In addition, the IHSC FMC conducts an assessment of facility medical staffing levels in accordance with the ICE contract, at least annually to ensure medical staffing levels are sufficient to deliver comprehensive health care in accordance with ICE detention standards.

Response to Recommendation 1(b): ICE concurs with this recommendation. Through assigned Contracting Officers and CORs, ERO continually monitors contractor performance and works with its vendors to implement solutions as appropriate. ICE will levy remedies for non-compliant service providers as stipulated in the contractual requirement on a case-by-case basis and when vendor compliance is not achieved.

Response to Recommendation 1(c): ICE concurs with this recommendation. For JCPC, ERO will continue to conduct weekly meetings with JCPC to prioritize the assessment of health care staffing levels and review JCPC contractual compliance. However, it is important to note the facility is facing delays filling positions due to the time needed to process ICE background clearance, which ICE is actively working to improve. JCPC's medical staffing is currently at 79 percent. JCPC's current vacancies are two RNs, one LPC, and four LVNs. JCPC has hired and filled all vacancies and is only awaiting a background investigation decision from ICE.

For OCPC, as stated above, on February 8, 2024, ERO recently issued a CDR addressing OCPC staffing levels. Since then, the medical staffing levels have increased, and medical staffing percentages meet or exceed the minimum contract requirement of 80 percent. ERO will continue to work with its vendors to fill vacancies through permanent hires as well as TDYs as needed.

Recommendation 2: For HC credentialing and peer review at facilities referenced in this report, ICE should:

> (a) create a centralized framework that is designed to systematically maintain and refresh credentialing dossiers for HC staff so that records are locally available for inspections.
> (b) designate competent facility staff to conduct surveillance, periodically update, and monitor the completeness and on-site accessibility of all HC staff credentialing files. These internal controls should also ensure that external peer reviews are updated, fully documented, and stored.
> (c) ensure facilities author and enforce policies that clarify the recredentialing paperwork mandated for licensed HC staff.

Response to Recommendation 2(a): ICE concurs with this recommendation. For IHSC-staffed facilities, the IHSC Credentialing and Privileging Unit (ICPU) established a modernized, robust automated credentialing system for the management and tracking of credentialing requests and files for more than 1,700 clinical staff. This modernized credentialing system was implemented in September 2022 to keep up to date with credentialing requirements and has streamlined

operations by centralizing where credentials are initiated and maintained and incorporates the use of an automated monitoring system, leading to productivity gains for end-users. Most importantly, it allows ICPU to manage credentials and privileges, to include reappointments, National Practitioner Data Bank (NPDB) queries, as well as logging of Peer Reviews completion and expiration dates overseen by discipline specific leadership for all healthcare and community providers. ICPU works collaboratively with all facilities to ensure credentialing needs are met and the facilities in question have implemented additional protocols as described below. The FMC assesses credentials for healthcare staff at non-IHSC-staffed facilities at least annually to ensure compliance with contract requirements.

STIPC: STIPC collaborates with ICPU to ensure privilege, appointment letters, as well as NPDB queries for providers are up to date. Since the inspection, this process has been implemented.

PISPC: ICPU currently provides privilege, appointment, and re-appointment letters, as well as NPDB queries for providers as necessary.

JCPC: ERO works closely with ICPU to ensure privilege, appointment letters, as well as NPDB queries for providers are up to date. ERO will implement a credentialing tracking process as an internal control in the Service Provider's Quality Control Plan. Currently, JCPC maintains credentialing files that are readily accessible at the facility. Additionally, JCPC has an electronic SmartSheet that aids in tracking health care staff credentials.

Response to Recommendation 2(b): ICE concurs with this recommendation. OIDO found the following five facilities were compliant: MVPC, BSPC, OCPC, PDF, and PISPC. STIPC and JCPC were initially non-compliant; however, the facilities became compliant after they made corrections during and after OIDO's inspection. All facilities will continue to conduct internal file reviews to ensure full compliance.

Response to Recommendation 2(c): ICE concurs with this recommendation. JCPC, PISPC, and STIPC will ensure facilities author and enforce policies that clarify the recredentialing paperwork mandated for licensed health care staff. ERO will ensure assigned CORs monitor contractor performance for compliance with this requirement and will communicate this requirement during a monthly COR meeting led by the ERO Operational Support Division during the second quarter of Fiscal Year 2024.

Recommendation 3: For HC training at facilities referenced in this report, ICE should create and implement internal controls and oversight to ensure:

> (a) facilities allocate specific personnel to oversee the fulfillment of obligatory annual training sessions. These individuals should maintain and frequently update training archives and verify the consistent completion of annual training prerequisites.
> (b) facilities conduct audits of training content to ensure full compliance with ICE detention standards.

Response to Recommendation 3(a): ICE concurs with this recommendation.

OCPC: OCPC health staff will coordinate with the training manager to ensure full compliance with staff attendance at annual training sessions. The training department uses an Acadis database as a tracking platform and to generate reports. Additionally, the training department uses paper sign-in sheets for capturing participant names and information for annual training sessions. Please refer to the attached supporting documentation (Titled: *3A Supporting Documentation Pre In-Service Forms Oct Nov Dec 23*).

PDF: The Health Services Administrator requires each employee to complete a 40-hour annual training, as well as a web-based company system to use as a back-up training. The Health Services Administrator, Assistant Health Services Administrator, Facility Administrator, Assistant Facility Administrator, and LaSalle Corporate Director of Credentialing track and ensure all required annual training is completed by prescribed deadlines.

A training plan was signed by Warden Johnson on September 21, 2021, which was good for the 2022 training year, and a second training plan was signed on December 29, 2022, which was valid until December 29, 2023. Please note the calendar year 2024 training plan has not been finalized as of this writing. See refer to the attached the 40-hour training plan for 2023 (Titled: *3B supporting documentation OCPC Training plan 2023*).

PISPC: The PISPC Medical Unit receives initial and annual refresher training from custody training staff that is 40 hours in length in addition to online training sites, such as the ICE Training System (ITS) and IHSC TRAIN, that provide additional mandatory and job-specific trainings. Supervisors ensure facility training for staff is complete.

STIPC: STIPC receives initial and annual refresher training from custody training staff consisting of 40 hours in addition to online agency training platforms, such as ITS and IHSC TRAIN, that provide additional mandatory and job-specific trainings. STIPC approved the training plan following the inspection. STIPC completed 2023 required trainings based on the approved facility training plan. Additionally, STIPC implemented and completed staff training on emergency response, which included recognizing signs of potential health emergencies and the expedited entrance and exit of emergency medical services, and annual CPR and AED training. Supervisors ensure facility training for staff is complete.

BSPC: ERO assigned personnel to manage the fulfillment of obligatory annual training sessions in accordance with PBNDS 2011 (revised 2016) and is currently in compliance with the training requirement.

Response to Recommendation 3(b): ICE concurs with this recommendation. ICE is committed to ensuring its facilities regularly track and audit training compliance. IHSC maintains an internal audit process called the IHSC Health Systems Assessment Application, which is used to conduct internal audits of staff compliance and to provide facility health care training at IHSC-staffed facilities. Additionally, the IHSC Medical Education and Development Unit works with other IHSC units to update annual trainings for the agency. Required initial and annual training for healthcare staff at non-IHSC facilities is assessed by the FMC at least annually to ensure

compliance with contract requirements and ICE detention standards. Healthcare staff training is also assessed by other compliance inspecting entities, such as the ICE Office of Detention Oversight (ODO).

OCPC: The Facility Administrator will continue to review and approve the training plan annually. Please refer to the attached copy of the 2023 OCPC Training Plan (Titled: *3B supporting documentation CQI Personnel files*).

PISPC: PISPC staff are currently reviewing training documentation to ensure alignment with ICE standards. Additionally, a local policy has been drafted outlining expected requirements.

PDF: The Health Services Administrator is now requiring all HC employees complete a 40-hour annual training, as well as a web-based company system to use as back-up training. The Health Services Administrator, Assistant Health Services Administrator, Facility Administrator, Assistant Facility Administrator, and LaSalle Corporate Director of Credentialing will work together to track and ensure all required annual training is completed by prescribed deadlines and is in full compliance with ICE detention standards by annually reviewing course materials and updating as needed.

STIPC: The ERO STIPC Compliance Unit will begin tracking these audits to ensure the facility complies with ICE detention standards. The STIPC Health Services Administrator is working with the Assistant Health Services Administrator and Facility Healthcare Program Manager to complete annual and periodic audits as needed to the existing trainings or additional training to ensure the facility Annual Training Plan has all the necessary topics as well as subject matter to meet the required information and compliance.

BSPC: BSPC staff will track staff participation in required training annually and will work with IHSC audit staff to provide relevant information regarding its compliance with PBNDS 2011 (revised 2016) staff training requirements.

Attachments

- 3A Supporting Documentation Pre In-Service Forms Oct Nov Dec 23
- 3B supporting documentation OCPC Training plan 2023
- 3B supporting documentation CQI Personnel files

Additional Information and Copies

To view any of our other reports,
please visit:
www.dhs.gov/OIDO.

For further information or questions, please contact the Office of the Immigration Detention Ombudsman at:
detentionombudsman@hq.dhs.gov.