Appendix: Key Documents

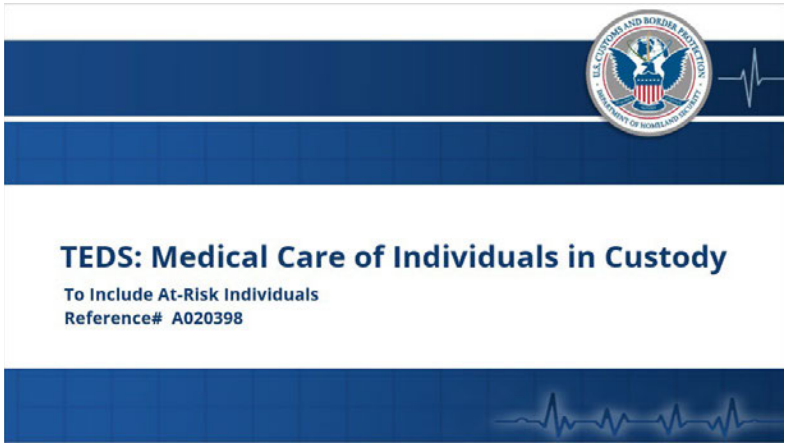
Document	Description
A	TEDS: Medical Care of Individuals in Custody PowerPoint
B	TEDS: Duration, Conditions, and Monitoring of Individuals in CBP Custody PowerPoint
C	U.S. Customs and Border Protection, Alien Initial Health Interview Questionnaire, Form 2500
D	Loyal Source Communications: CBP Reply to EMR Inputs from Loyal Source – January 11, 2021
E	Loyal Source Communications: Medical Processing Issues – January 29, 2021
F	Loyal Source Communications: EMR Issues – February 9, 2021
G	Loyal Source Communications: Inability to Perform Medical Chart Previews – February 11, 2021
H	Loyal Source Health Evaluation SOP – April 17, 2023
I	Memo from Herbert O. Wolfe, Acting Chief Medical Officer to Troy Miller, Acting CBP Commissioner, *Initial Observations and Recommended Medical Improvement Actions for Care of Individuals in CBP Custody* – June 8, 2023
J	U.S. Customs and Border Protection, Office of the Chief Medical Officer, Medical Process Guidance – June 2023
K	CBP "Cure Notice" to Loyal Source Government Services – August 10, 2023
L	U.S. Customs and Border Protection, Office of the Chief Medical Officer, Medical Process Guidance, Annex A: Elevated in-Custody Medical Risk (ECMR) – October 2023
M	U.S. Customs and Border Protection, Office of the Chief Medical Officer, Management of Sentinel Event – December 28, 2023
N	Contractor Performance Assessment Report Rating Inconsistencies, Response from Dr. Eastman, Acting CMO, to James W. McCament, Chief Operating Officer, CBP – February 12, 2024
O	List of CBP facilities where Loyal Source Government Services is providing medical care – July 2, 2024
P	U.S. Customs and Border Protection Office of the Chief Medical Officer, Border Health System Briefing PowerPoint – August 1, 2024
Q	CBP response to request from Chairman Durbin regarding video surveillance at CBP facilities – August 20, 2024
R	CBP response to request from Chairman Durbin regarding medical guidance and staffing policies – September 24, 2024
S	U.S. Department of Homeland Security, Office of Health Security, PowerPoint Briefing – September 27, 2024

Key Document A

TEDS Medical Care of Individuals in Custody

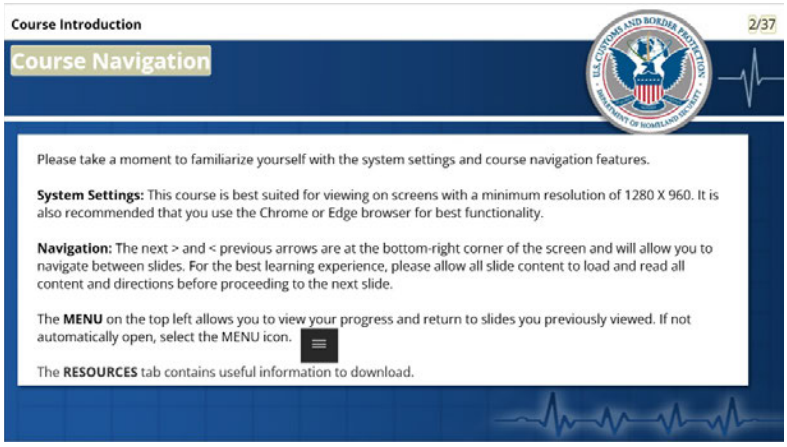
1. Introduction

1.1 TEDS: Medical Care of Individuals in Custody

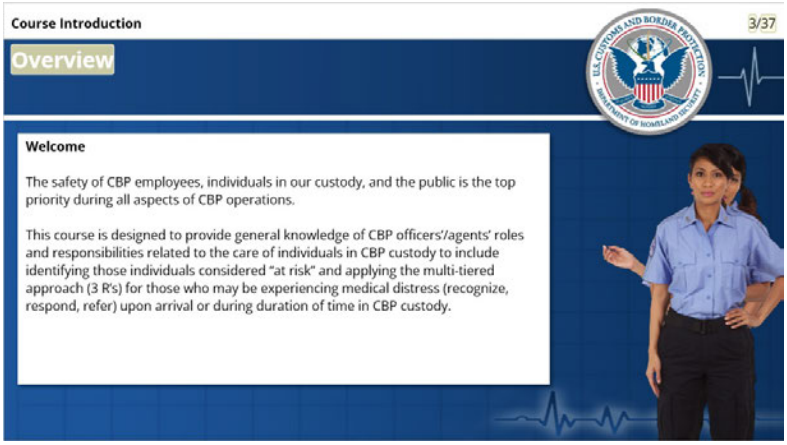


Notes:

1.2 Course Navigation



1.3 Overview

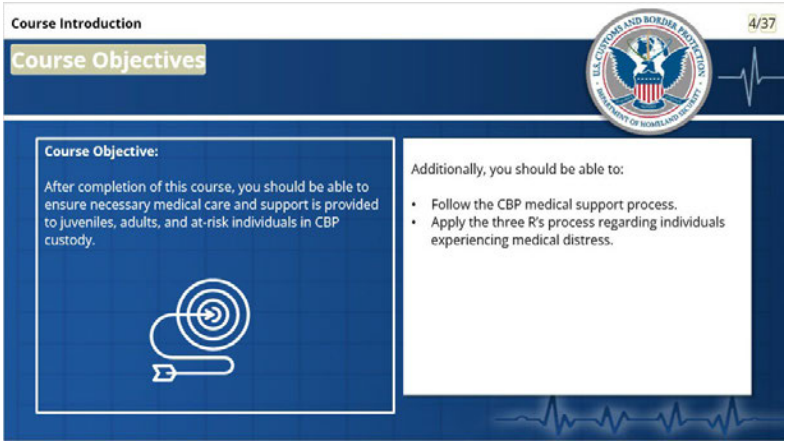


Notes:

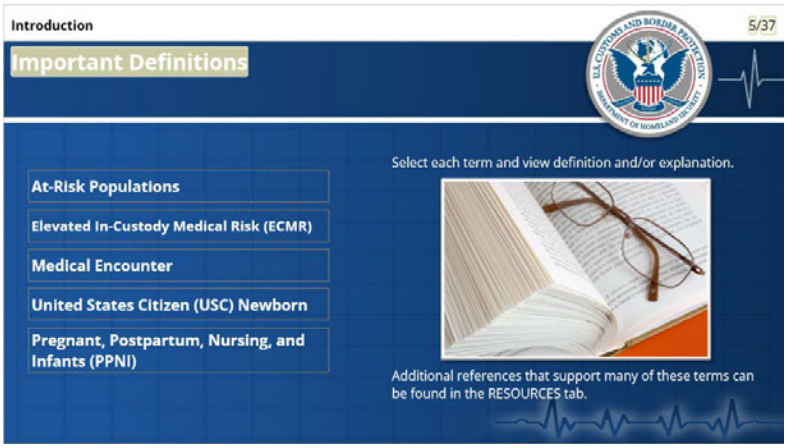
Audio Narration:

Welcome to the Medical Care of Individuals in Custody course. This course is one in a series of specialized courses focused on the TEDS Policy, as established by CBP, focused on the transport, escort, detention and search of individuals in CBP's custody.
The safety of CBP employees, individuals in our custody, and the public is the top priority during all aspects of CBP operations.
As CBP officers or agents, you may not always be on the frontlines of tasks of transporting of individuals, overseeing holding facilities, or administration of medical care, but your ethical responsibility is pivotal. Due to the stress and complexities surrounding individuals entering CBP custody, we must maintain vigilance and speak out when something seems awry, advocating for the well-being of our CBP staff and those temporarily in our care.
This course is designed to provide general knowledge of CBP officers' and agents' roles and responsibilities related to the care of individuals in CBP custody, to include identifying those at higher risk, and applying the multi-tiered approach (3 R's) for those who may be experiencing medical distress (recognize, respond, refer) upon arrival, or during duration of time in CBP custody.

1.4 Course Objectives

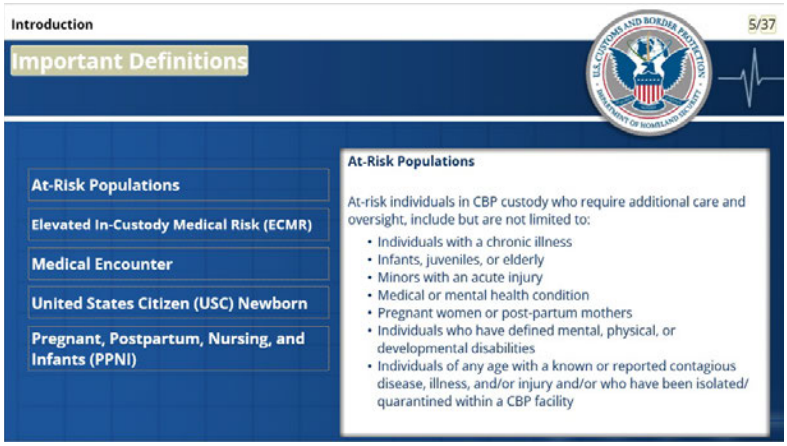


1.5 Important Definitions

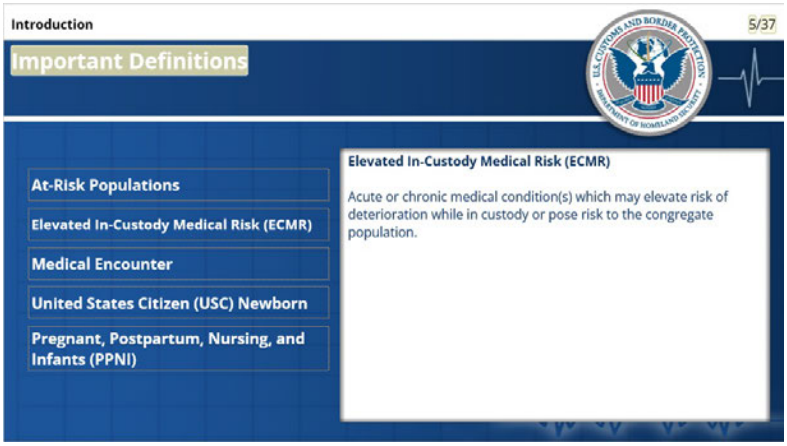


Notes:

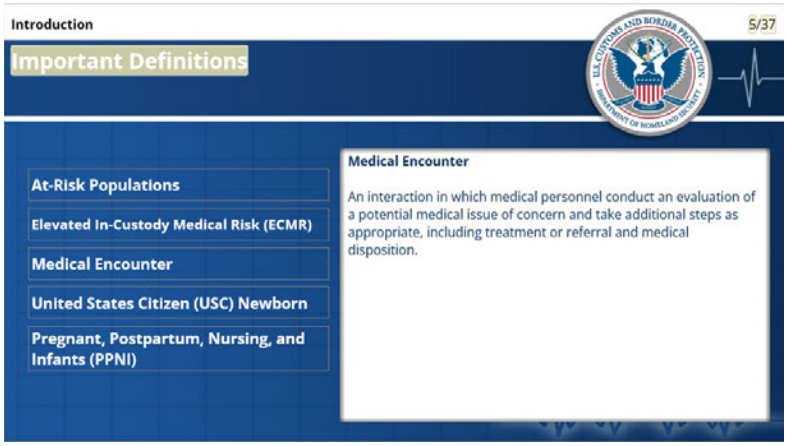
At Risk Populations (Slide Layer)



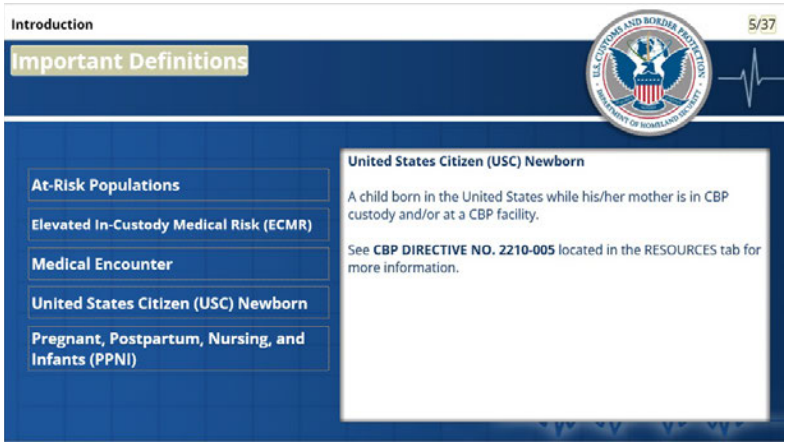
ECMR (Slide Layer)



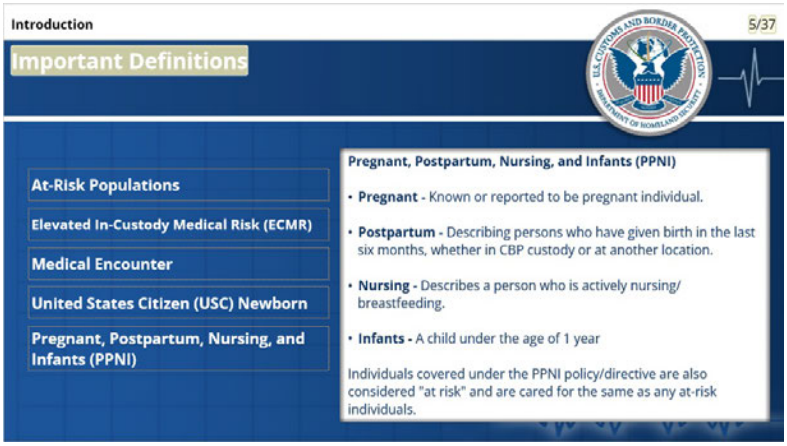
Medical Encounter (Slide Layer)



USC Newborns (Slide Layer)

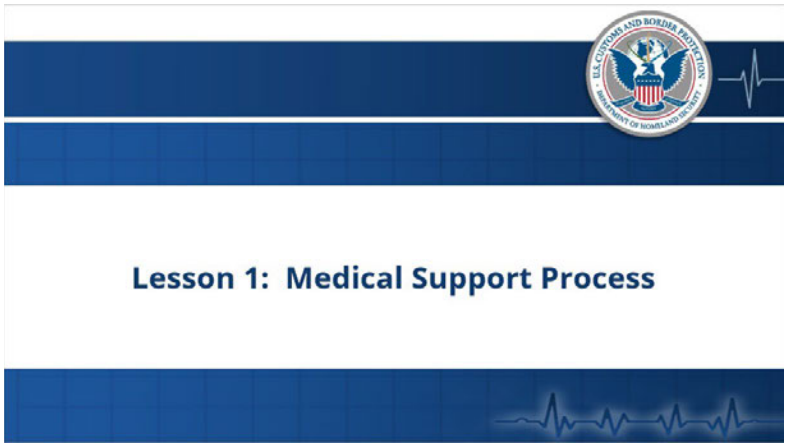


PPNI (Slide Layer)

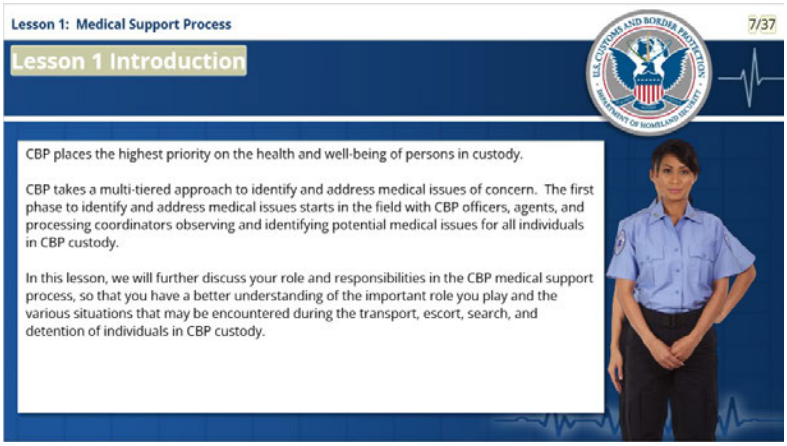


2. Lesson 1: Medical Support Process

2.1 Lesson 1: Medical Support Process



2.2 Lesson 1 Introduction



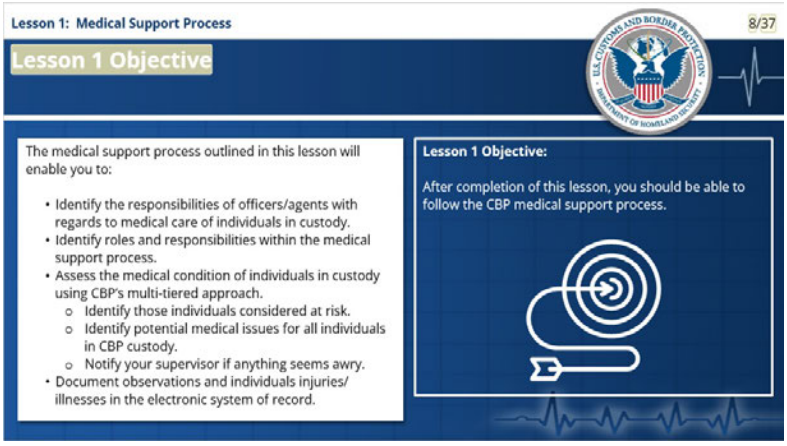
Notes:

Audio Narration:

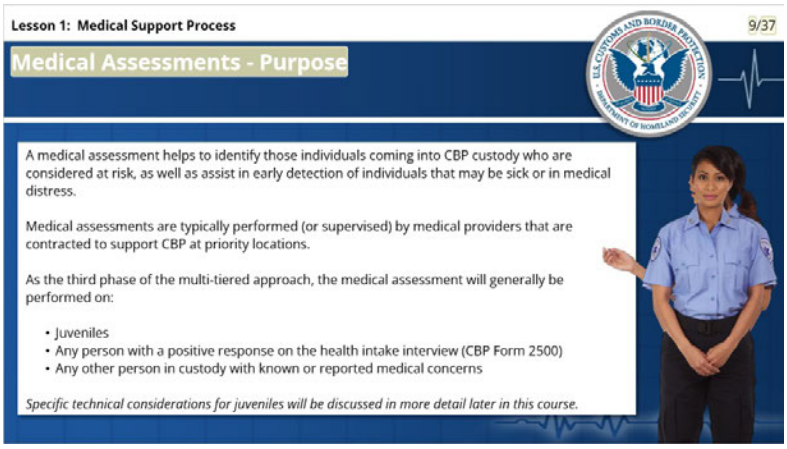
CBP takes a multi-tiered approach to identify and address medical issues of concern. The first phase to identify and address medical issues starts in the field with CBP officers, agents, and processing coordinators observing and identifying potential medical issues for all individuals in CBP custody.

In this lesson, we will further discuss your role and responsibilities in the CBP medical support process, so that you have a better understanding of the important role you play and the various situations that may be encountered during the transport, escort, search, and detention of individuals in CBP custody.

2.3 Lesson 1 Objective



2.4 Medical Assessments - Purpose



Notes:

Audio Narration:

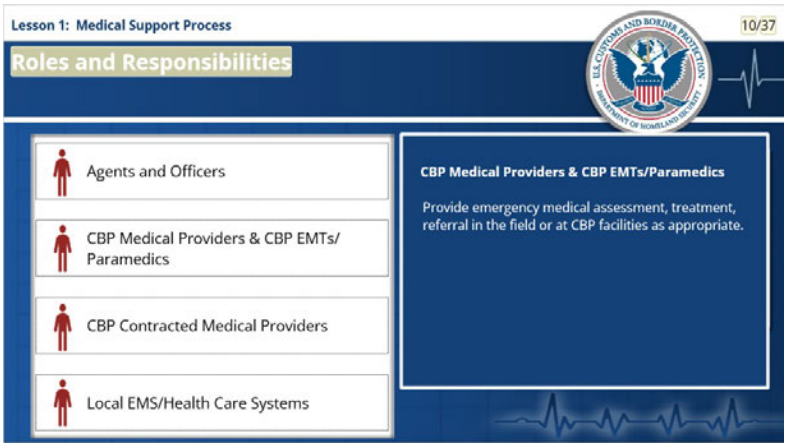
A medical assessment helps to identify those individuals coming into CBP custody who are considered at risk, as well, as assist in early detection of individuals that may be sick or in medical distress.

Medical assessments are typically performed (or supervised) by medical providers that are contracted to support CBP at priority locations.

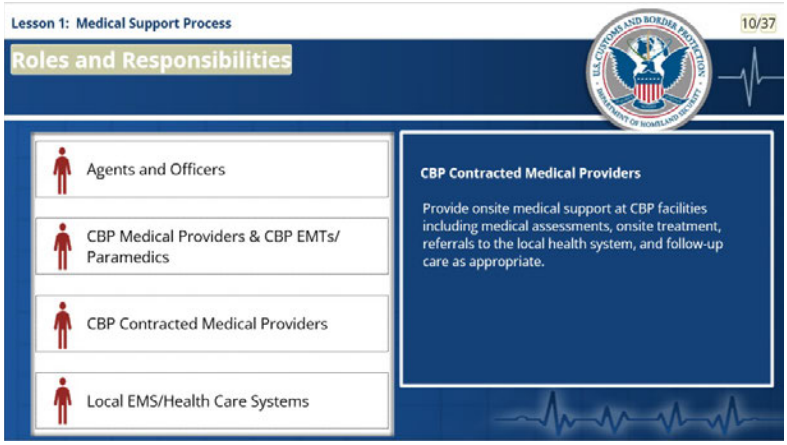
As the third phase of the multi-tiered approach you reviewed in lesson one, the medical assessment will generally be performed on juveniles, any person with a positive response on the health intake interview (CBP Form 2500), or any other person in custody with known or reported medical concerns.

2.5 Roles and Responsibilities

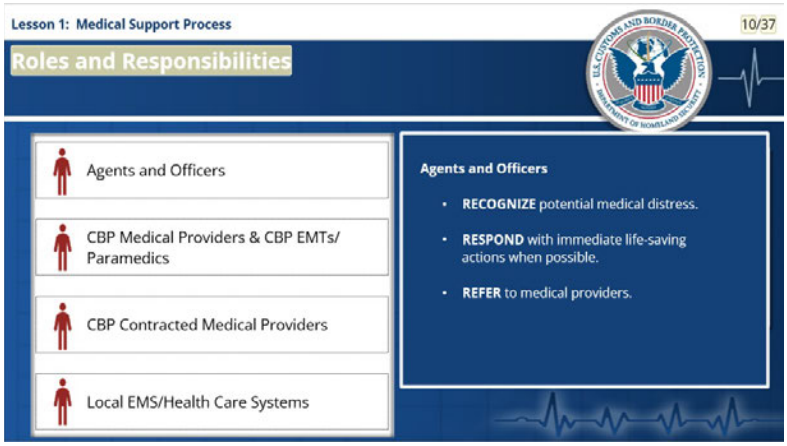
CBP Medical Providers (Slide Layer)



Contracted Medical Providers (Slide Layer)

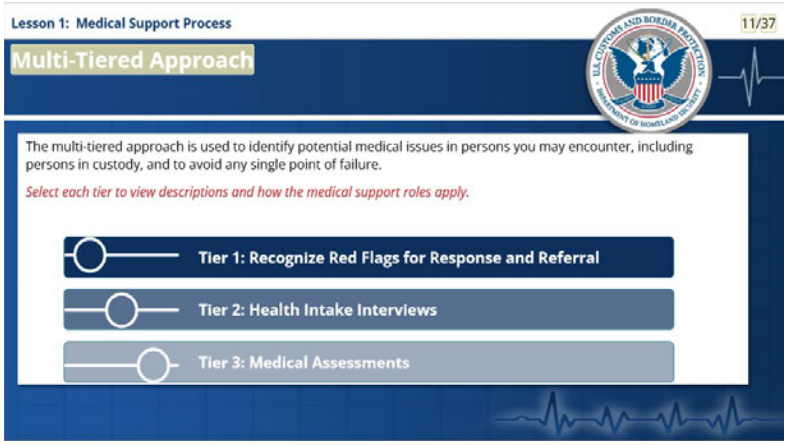


Agents and Officers (Slide Layer)

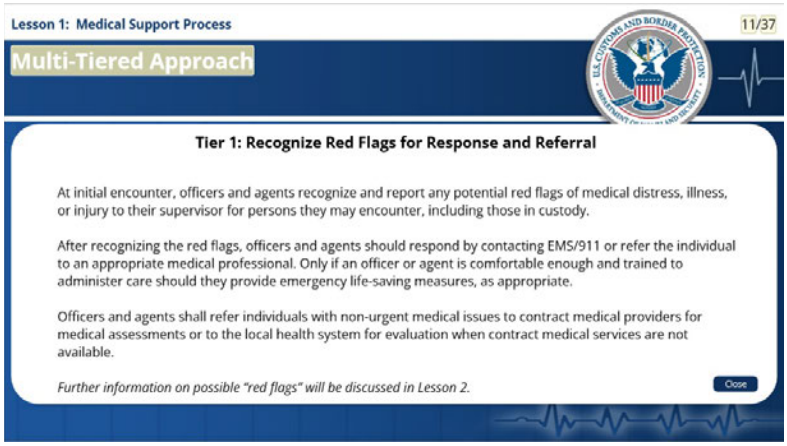


Local EMS Health Care Systems (Slide Layer)

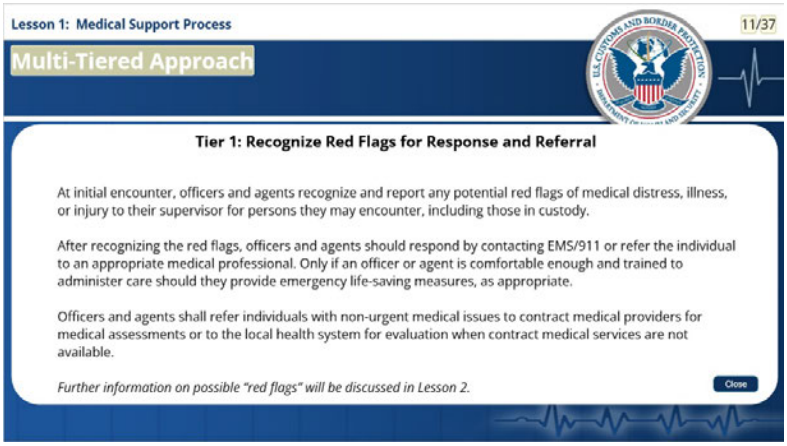
2.6 Multi-Tiered Approach



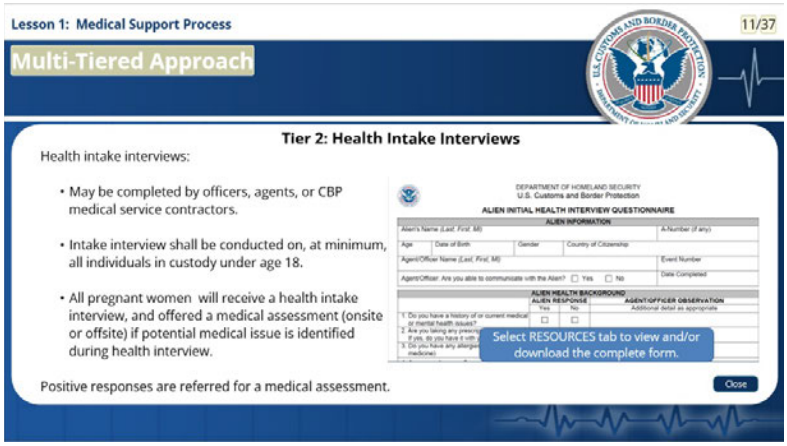
Tier 1 (Slide Layer)



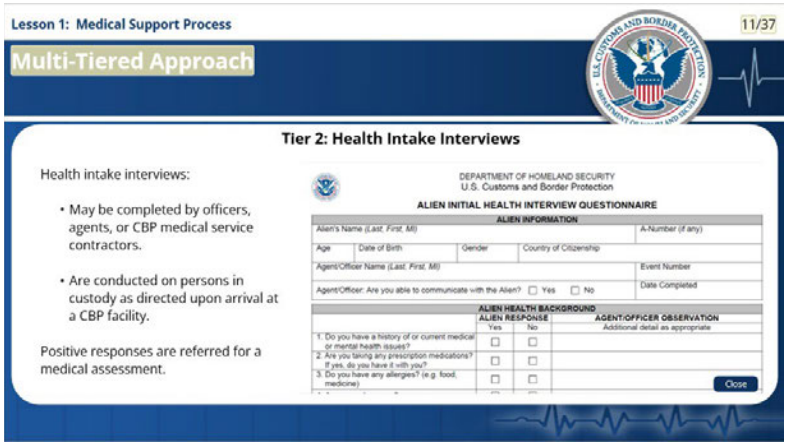
Tier 1 - Close (Slide Layer)



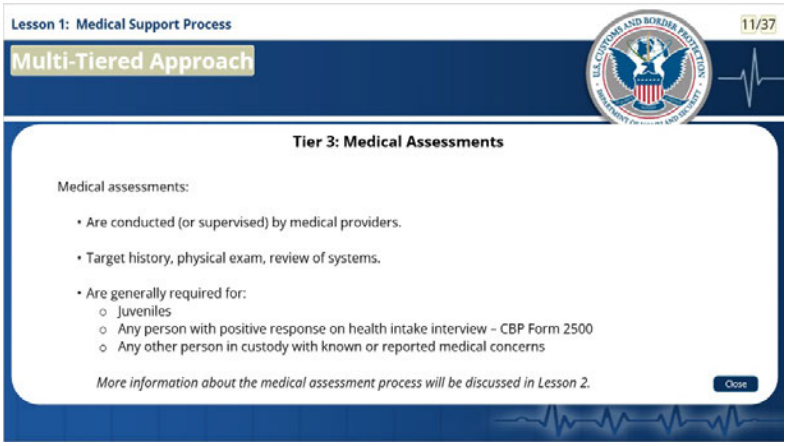
Tier 2 (Slide Layer)



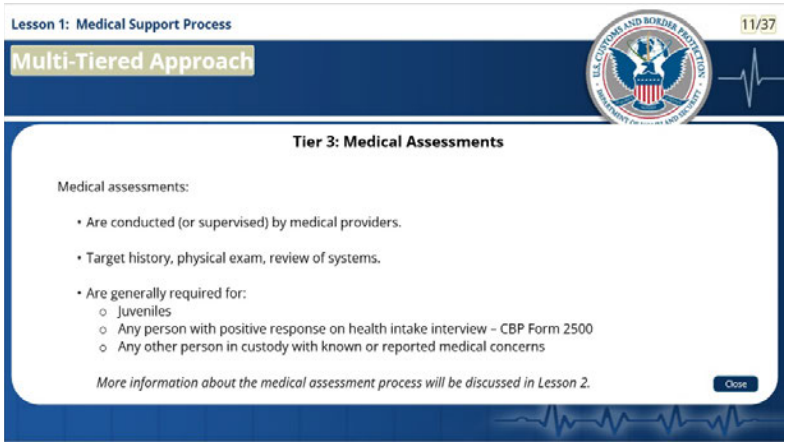
Tier 2 - Close (Slide Layer)



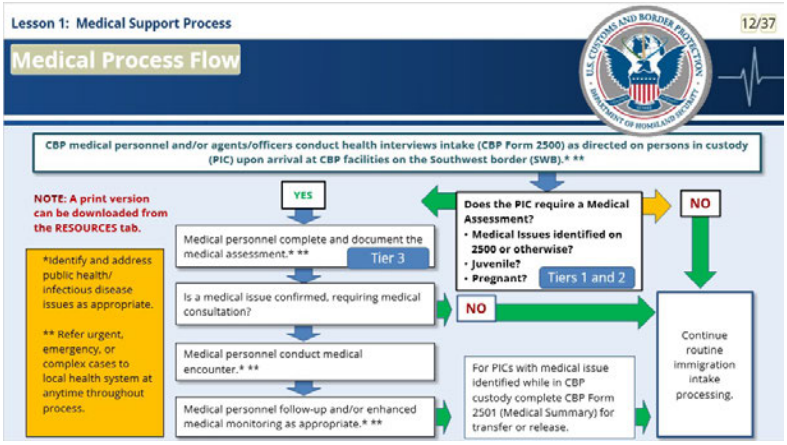
Tier 3 (Slide Layer)



Tier 3 - Close (Slide Layer)



2.7 Medical Process Flow



Notes:

Audio Narration:

Contract medical personnel, and CBP agents or officers, conduct Health Intake Interviews (CBP Form 2500), on persons in custody upon arrival at a CBP facility, as directed by local leadership.
At this time, public health or infectious disease issues will be addressed as appropriate, and any urgent, emergent, or complex cases, will be referred to the local health system, or 9 1 1 will be activated as appropriate.
Persons with a medical issue identified during the health intake interview, and juveniles, will also receive a medical assessment by contract medical personnel. Pregnant women will also be offered a medical assessment.
Persons with medical issues confirmed on the medical assessment, will receive a medical encounter by contract medical personnel. Persons without medical issues identified during the health intake interview, or medical assessment, will continue routine processing. Persons receiving medical encounters will be treated on site, or referred to a local health facility, and will receive follow-up care, and/or enhanced
medical monitoring as appropriate.
Persons in custody with medical issues identified, or addressed in CBP custody, will have a Medical Summary Form,(CBP Form 2501) completed upon transfer or release.

2.8 Knowledge Check 1 of 5

(Multiple Choice, 10 points, 1 attempt permitted)

Correct	Choice
	Conduct follow up care for persons in custody.
	Provide treatment for acute medical issues.
	Perform advanced medical assessment and support.
X	Recognize, respond, and refer persons in medical distress.

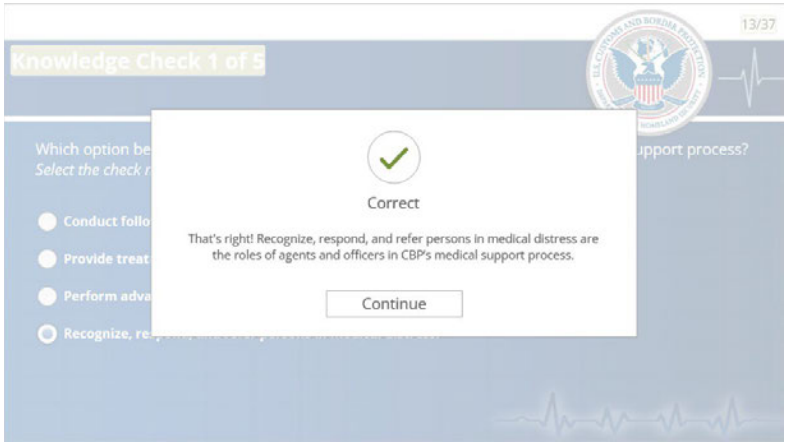
Feedback when correct:

That's right! Recognize, respond, and refer persons in medical distress are the roles of agents and officers in CBP's medical support process.

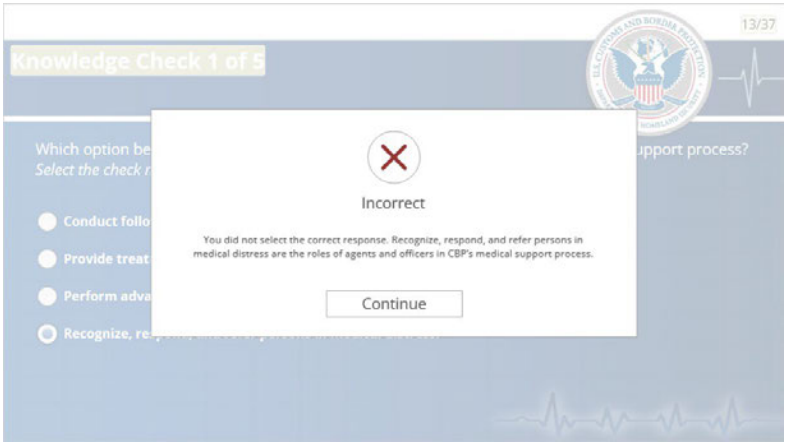
Feedback when incorrect:

You did not select the correct response. Recognize, respond, and refer persons in medical distress are the roles of agents and officers in CBP's medical support process.

Correct (Slide Layer)

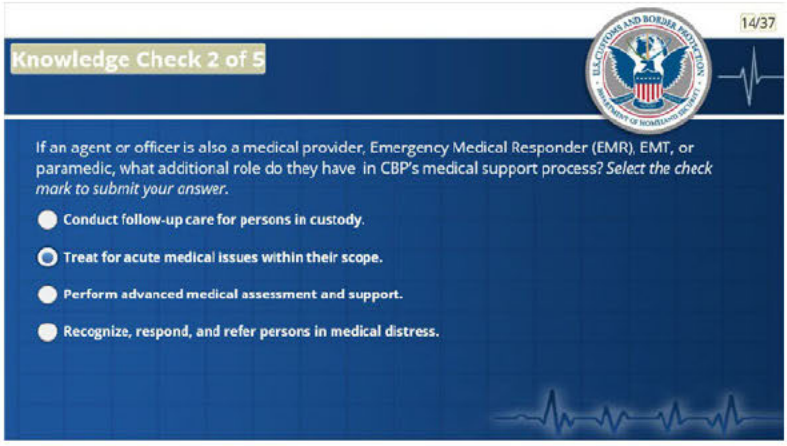


Incorrect (Slide Layer)



2.9 Knowledge Check 2 of 5

(Multiple Choice, 10 points, 1 attempt permitted)



Correct	Choice
	Conduct follow-up care for persons in custody.
X	Treat for acute medical issues within their scope.
	Perform advanced medical assessment and support.
	Recognize, respond, and refer persons in medical distress.

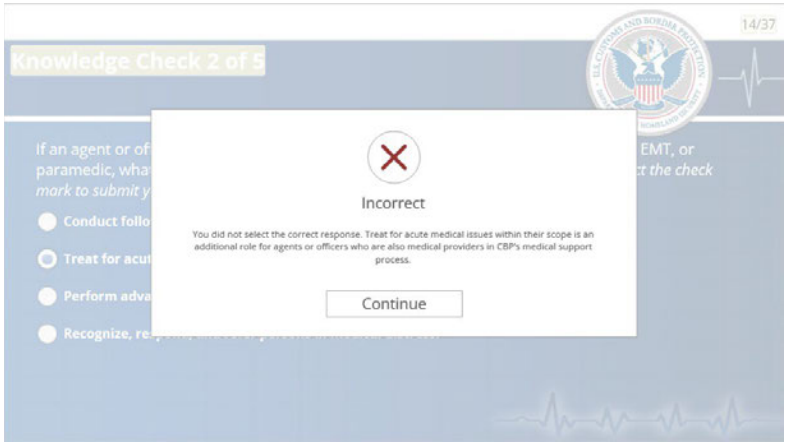
Feedback when correct:

That's right! Treat for acute medical issues within their scope is an additional role for agents or officers who are also medical providers in CBP's medical support process.

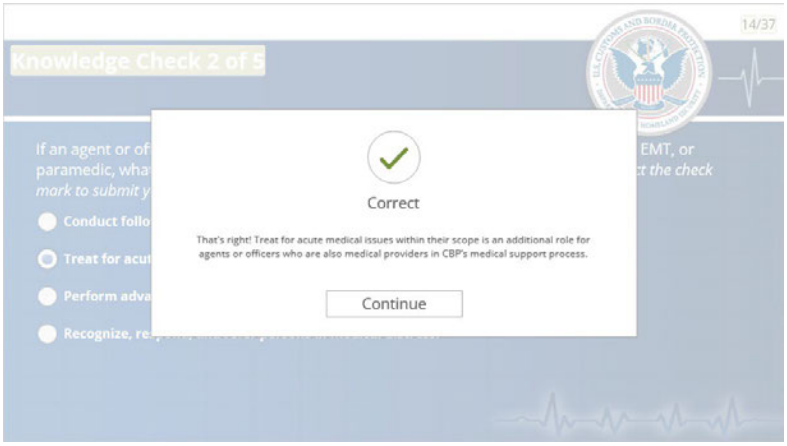
Feedback when incorrect:

You did not select the correct response. Treat for acute medical issues within their scope is an additional role for agents or officers who are also medical providers in CBP's medical support process.

Incorrect (Slide Layer)

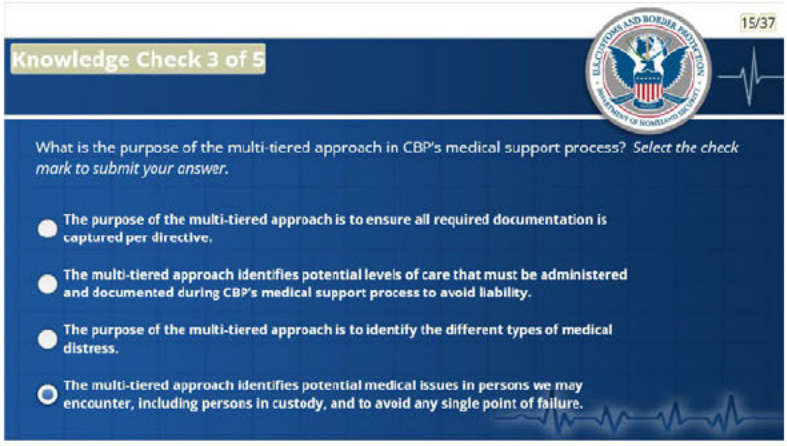


Correct (Slide Layer)



2.10 Knowledge Check 3 of 5

(Multiple Choice, 10 points, 1 attempt permitted)



Correct	Choice
	The purpose of the multi-tiered approach is to ensure all required documentation is captured per directive.
	The multi-tiered approach identifies potential levels of care that must be administered and documented during CBP's medical support process to avoid liability.
	The purpose of the multi-tiered approach is to identify the different types of medical distress.
X	The multi-tiered approach identifies potential medical issues in persons we may encounter, including persons in custody, and to avoid any single point of failure.

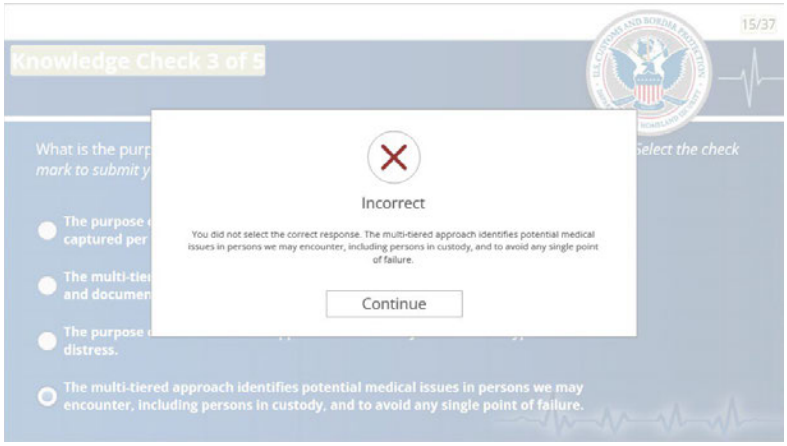
Feedback when correct:

That's right! The multi-tiered approach identifies potential medical issues in persons we may encounter, including persons in custody, and to avoid any single point of failure.

Feedback when incorrect:

You did not select the correct response. The multi-tiered approach identifies potential medical issues in persons we may encounter, including persons in custody, and to avoid any single point of failure.

Incorrect (Slide Layer)



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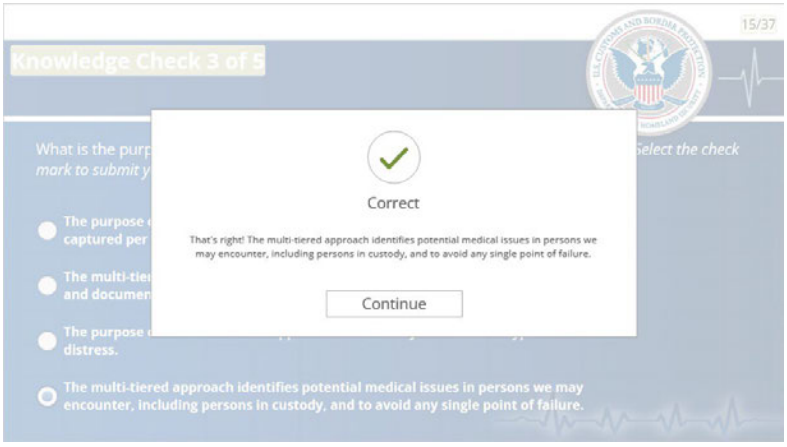


2.11 Knowledge Check 4 of 5

(Multiple Choice, 10 points, 1 attempt permitted)

Correct	Choice
	Complete Medical Summary Form 2501.
	Conduct medical assessments.
X	Recognize red flags for response and referral.
	Conduct health intake interviews using CBP Form 2500.

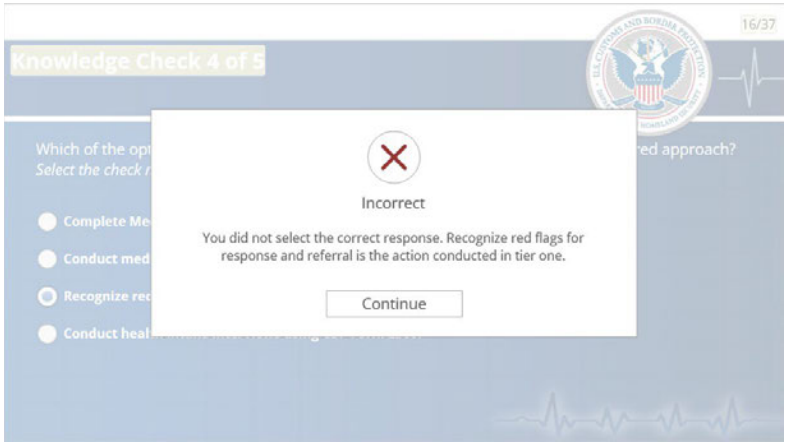
Feedback when correct:

That's right! Recognize red flags for response and referral is the action conducted in tier one.

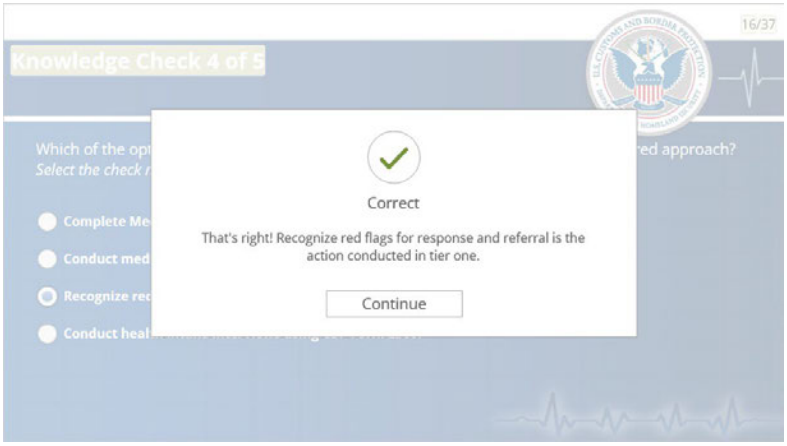
Feedback when incorrect:

You did not select the correct response. Recognize red flags for response and referral is the action conducted in tier one.

Incorrect (Slide Layer)

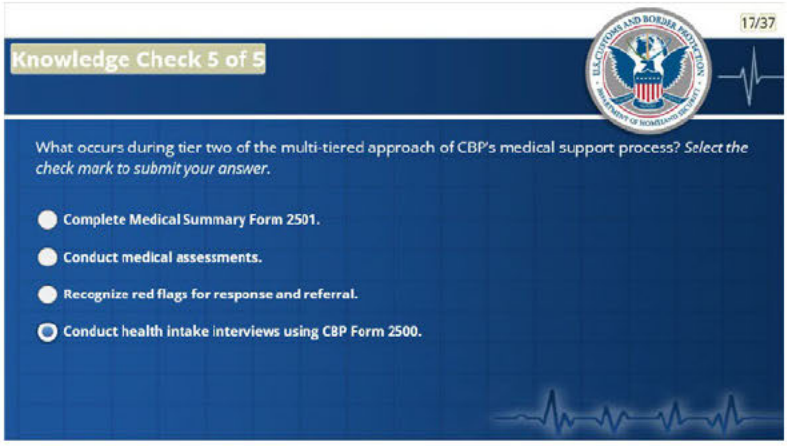


Correct (Slide Layer)



2.12 Knowledge Check 5 of 5

(Multiple Choice, 10 points, 1 attempt permitted)



Correct	Choice
	Complete Medical Summary Form 2501.
	Conduct medical assessments.
	Recognize red flags for response and referral.
X	Conduct health intake interviews using CBP Form 2500.

Feedback when correct:

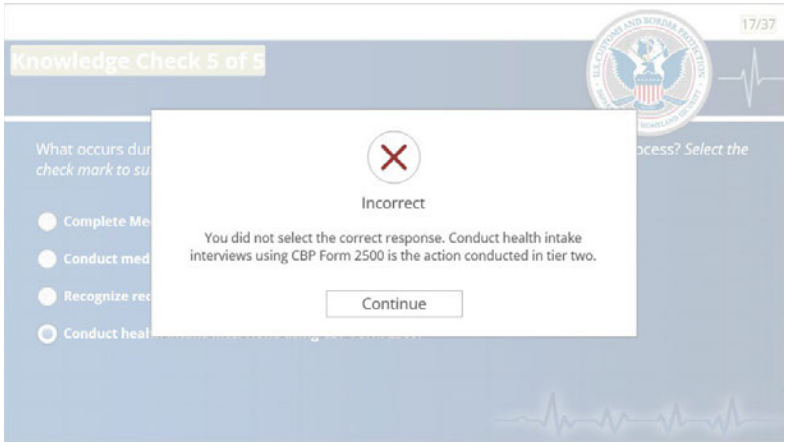
That's right! Conduct health intake interviews using CBP Form 2500 is the action conducted in tier two.

Feedback when incorrect:

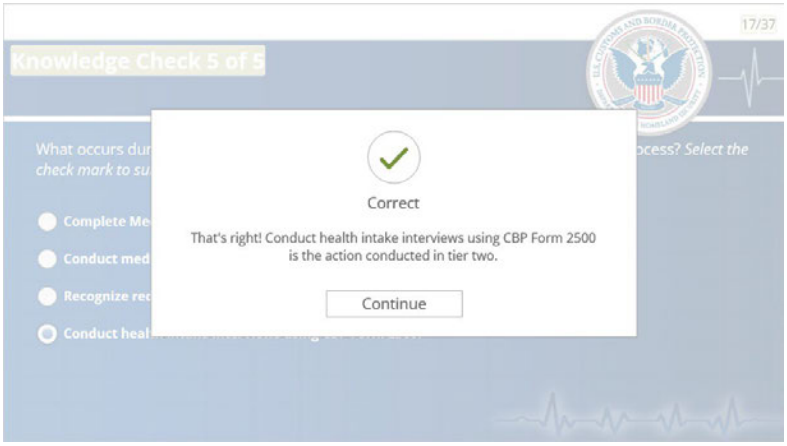
You did not select the correct response. Conduct health intake interviews using CBP Form 2500 is the action conducted in tier two.

Notes:

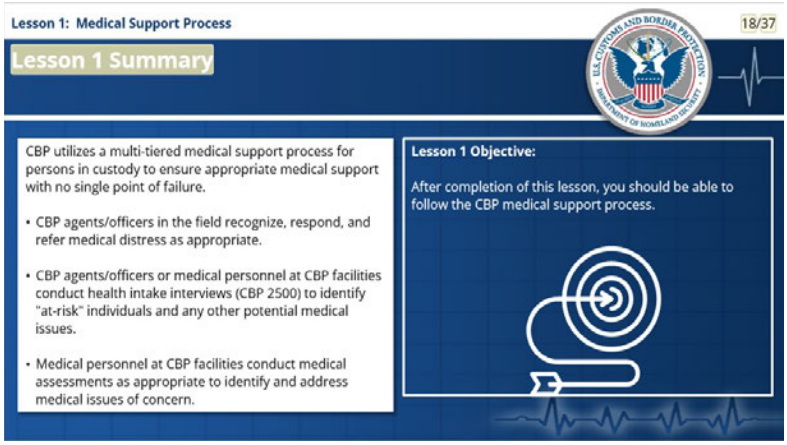
Incorrect (Slide Layer)



Correct (Slide Layer)



2.13 Lesson 1 Summary



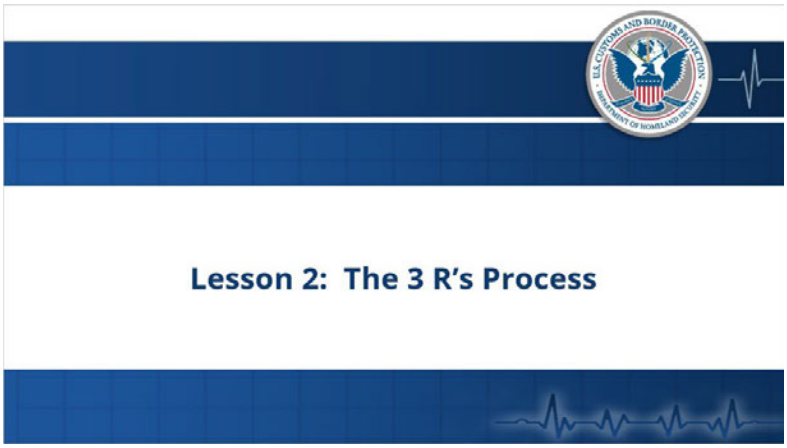
Notes:

Audio Narration:

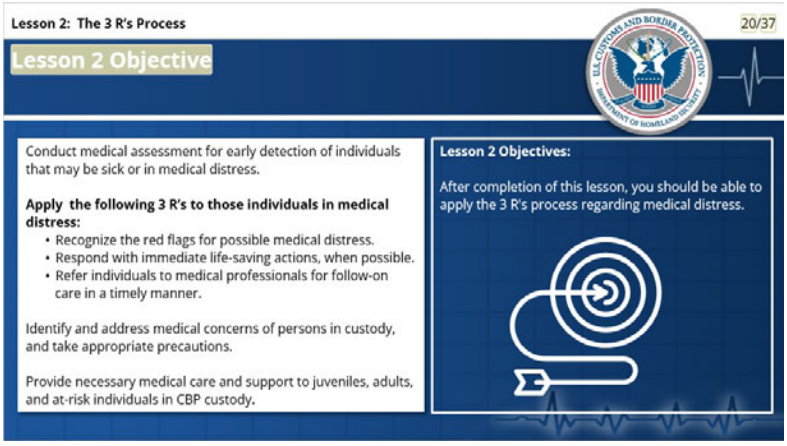
As we conclude this lesson, where we reviewed the medical support process, remember that – although others may have direct responsibilities in responding to an individual needing medical attention, your ethical responsibility as a CBP employee remains. You play a key role in recognizing and ensuring the health and safety of individuals in CBP custody. This is CBP's highest priority.

3. Lesson 2: The 3 R's Process

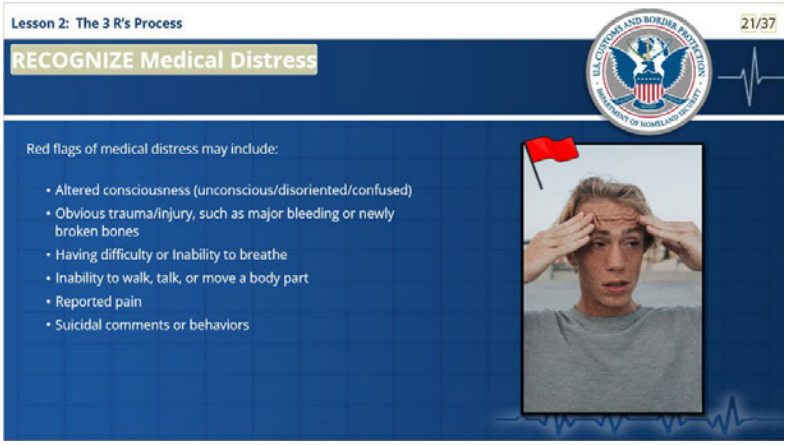
3.1 The 3 R's Process



3.2 Lesson 2 Objective



3.3 RECOGNIZE Medical Distress



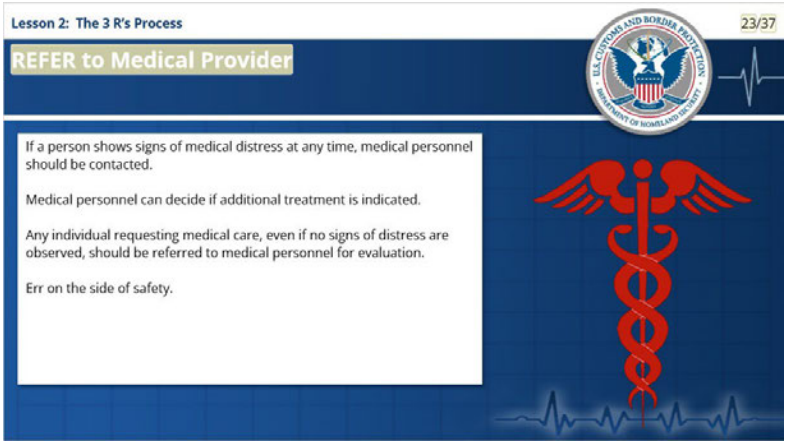
Notes:

Audio Narration:

As we discussed in lesson one, in the multi-tiered approach, Tier 1 is Recognizing Red Flags for Response and Referral. Here are some of the possible red flags that indicate possible medical distress.

3.4 RESPOND to Medical Distress Red Flags

3.5 REFER to Medical Provider

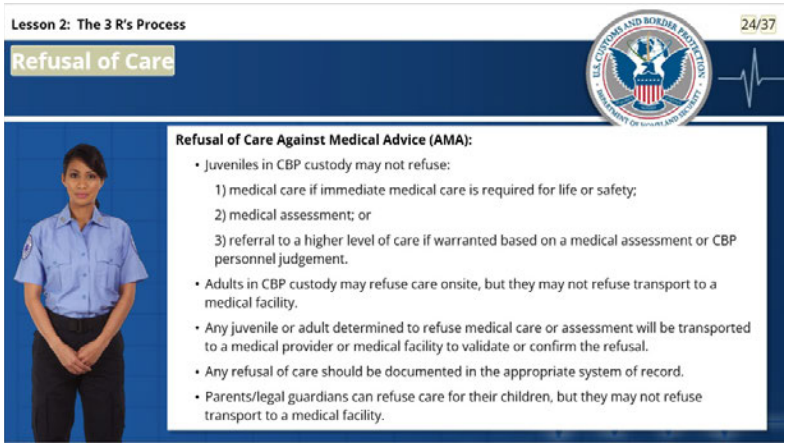


Notes:

Audio Narration:

If a person shows signs of medical distress at any time, medical personnel should be contacted. But let's not forget our shared ethical responsibility. Despite not being directly involved in the medical assessment process, each one of us as CBP employees has an obligation to ensure procedures are followed and that individuals are treated timely, and with respect and care.
If you see something, it's better to err on the side of safety, and say something – to your supervisor or a medical provider.

3.6 Refusal of Care

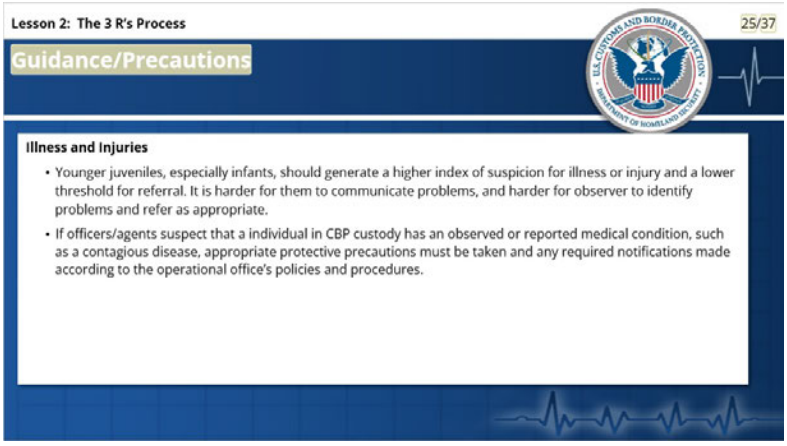


Notes:

Audio Narration:

Juveniles in CBP custody may not refuse medical care, if it's required for life or safety. They do not have the right to refuse that.
They cannot refuse a medical assessment and they cannot refuse referral to a higher level of care, if warranted, based on your judgment in the field.
Adults, on the other hand, may refuse care on site, but they may not refuse transport to a medical facility. Therefore, any juvenile or adult determined to require medical care, or further assessment will be transported to a medical provider on site for a medical determination of the requirement for care, and any refusal of care considerations.
You do not have to address that in the field.
You should transport them to a medical provider, or a medical facility, where those issues can be addressed.

3.7 Guidance/Precautions

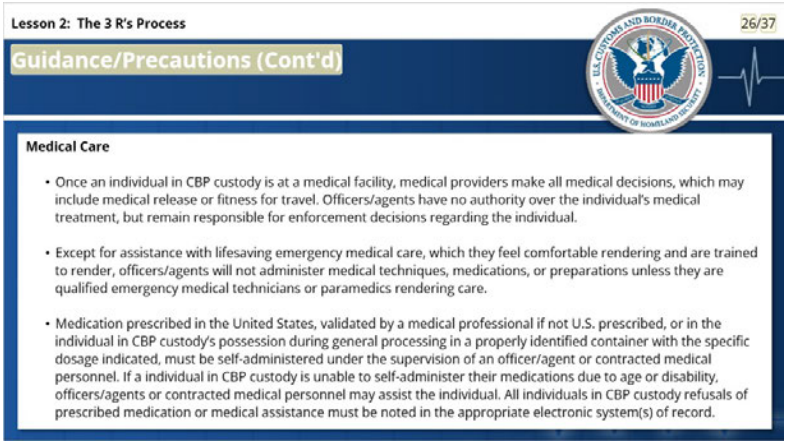


Notes:

Audio Narration:

In general, it's important for CBP agents and officers to understand that they should err on the side of caution.
At any time if there is any concern for an urgent or emergent illness or injury, they should activate nine one one, or transport, or refer the juvenile to the local healthcare system.
Younger juveniles, especially infants, should generate a higher index of suspicion for illness or injury, and have a lower threshold for referral. We need to be very vigilant about the unique circumstances of children.
It can be harder for them to communicate problems. It can also be harder for the observer to identify problems, and referring as appropriate.

3.8 Guidance/Precautions (Cont'd)



Notes:

Audio Narration:

In general, it's important for CBP EMTs to understand that they should err on the side of caution, if directed to conduct medical assessments.
At any time if there is any concern for an urgent or emergent illness or injury, the EMT should activate nine one one, or transport, or refer the juvenile to the local healthcare system.
Younger juveniles, especially infants, should generate a higher index of suspicion for illness or injury, and have a lower threshold for referral. We need to be very vigilant about the unique circumstances of children.
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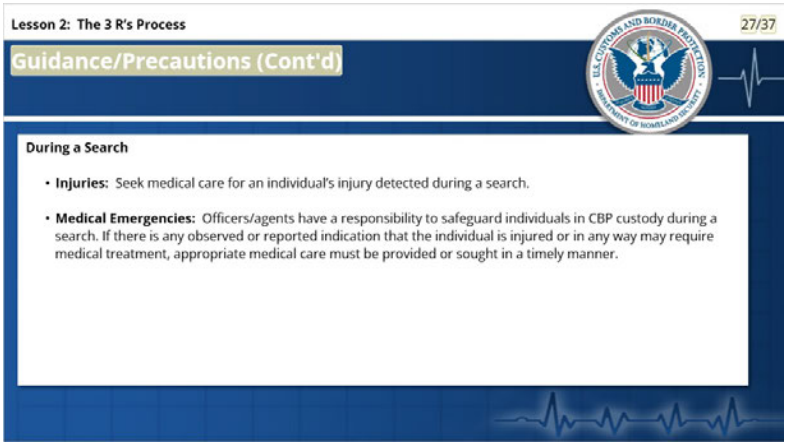
3.9 Guidance/Precautions (Cont'd)



Notes:

Audio Narration:

In general, it's important for CBP EMTs to understand that they should err on the side of caution, if directed to conduct medical assessments.
At any time if there is any concern for an urgent or emergent illness or injury, the EMT should activate nine one one, or transport, or refer the juvenile to the local healthcare system.
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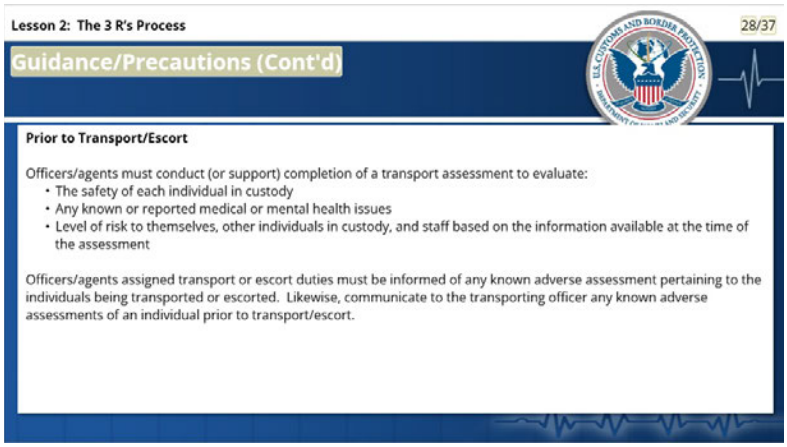
3.10 Guidance/Precautions (Cont'd)



Notes:

Audio Narration:

In general, it's important for CBP EMTs to understand that they should err on the side of caution, if directed to conduct medical assessments.
At any time if there is any concern for an urgent or emergent illness or injury, the EMT should activate nine one one, or transport, or refer the juvenile to the local healthcare system.
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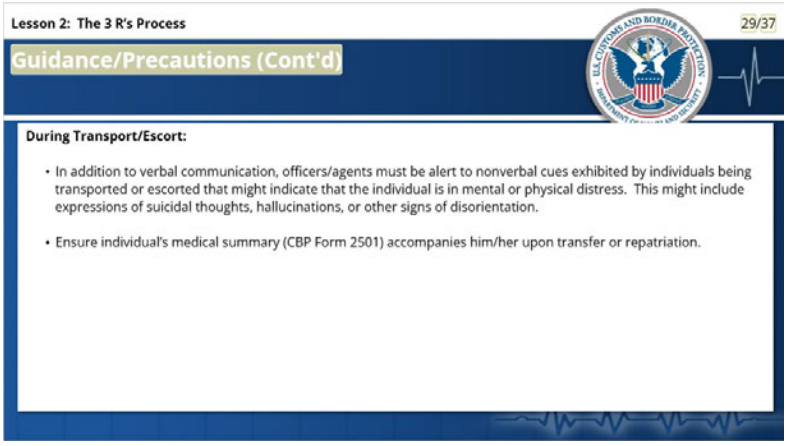
3.11 Guidance/Precautions (Cont'd)



Notes:

Audio Narration:

In general, it's important for CBP EMTs to understand that they should err on the side of caution, if directed to conduct medical assessments.
At any time if there is any concern for an urgent or emergent illness or injury, the EMT should activate nine one one, or transport, or refer the juvenile to the local healthcare system.
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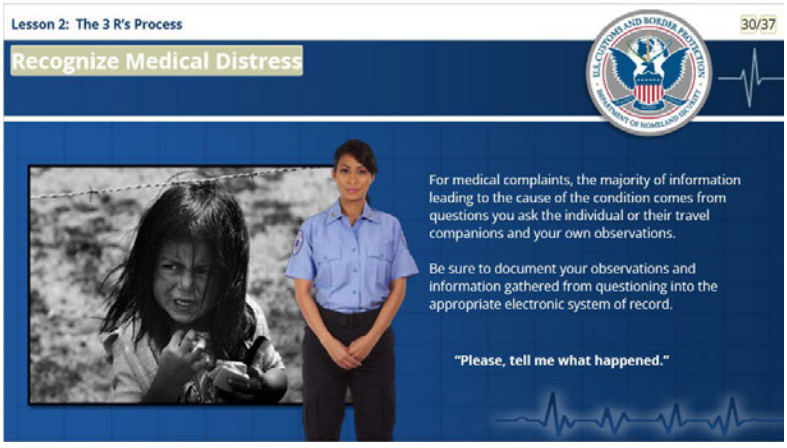
It can be harder for them to communicate problems. It can also be harder for the observer to identify problems, and referring as appropriate.

3.12 Recognize Medical Distress

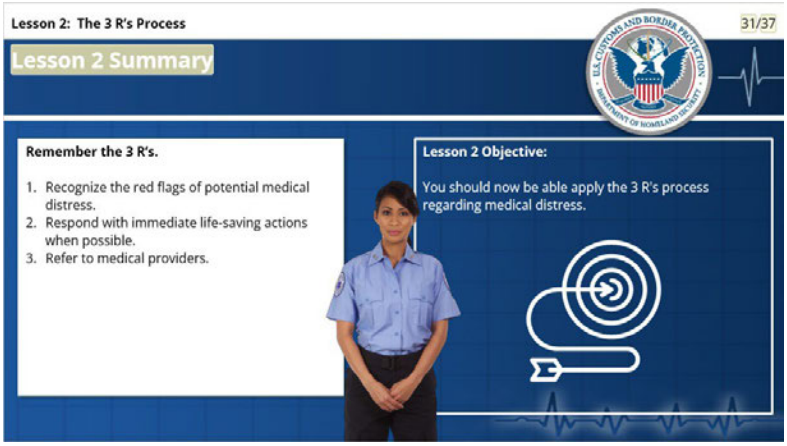


Notes:

Audio Narration:

For medical complaints, the majority of information leading to the cause of the condition comes from questions you ask the individual or their travel companions and your own observations.

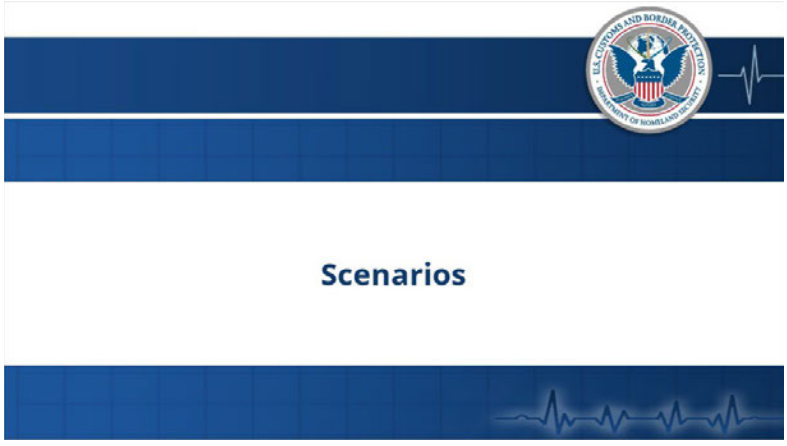
3.13 Lesson 2 Summary



Notes:

4. Scenarios

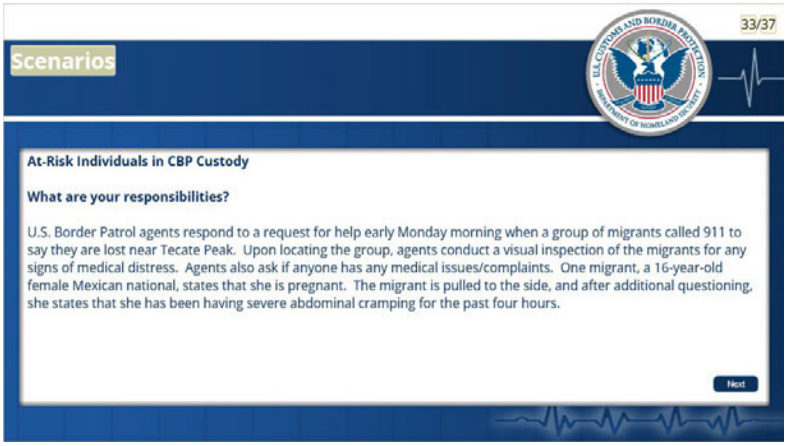
4.1 Scenarios



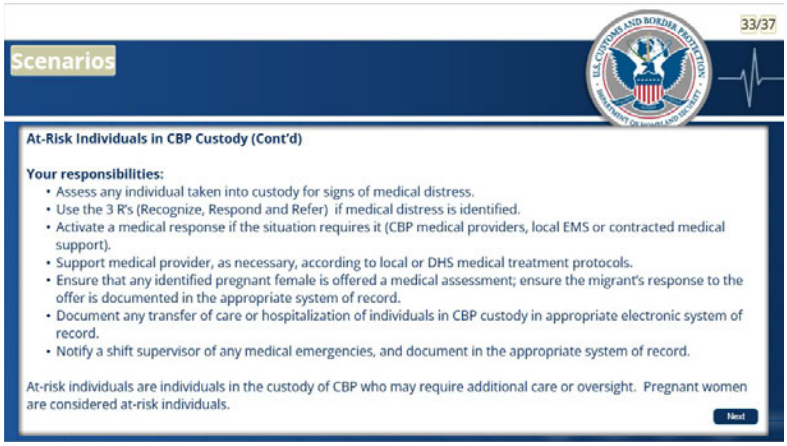
4.2 Scenarios

Notes:

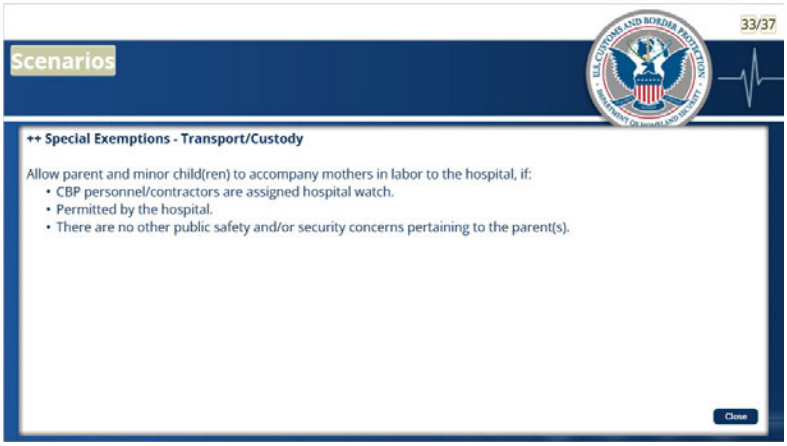
At-Risk Individuals in CBP Custody (Slide Layer)



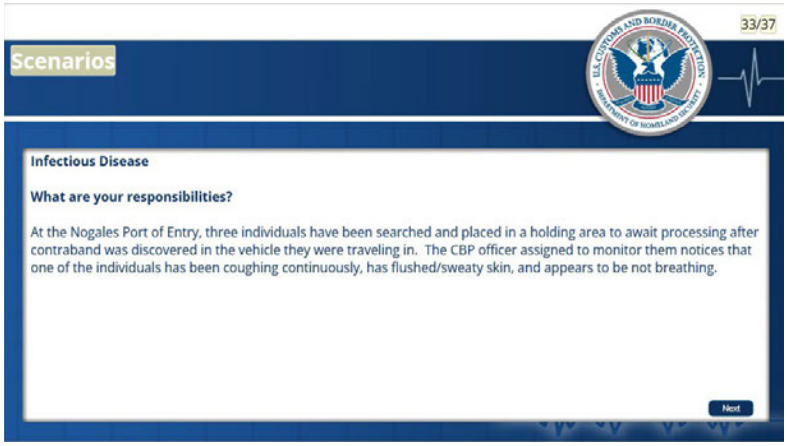
At-Risk Responsibilities (Slide Layer)



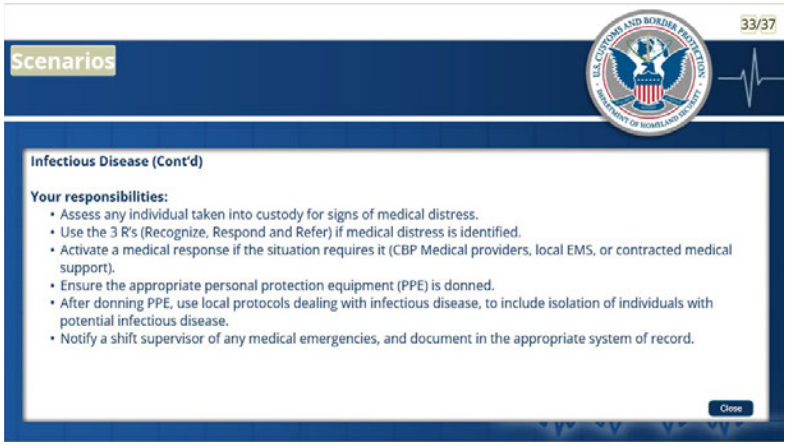
At-Risk Responsibilities - Copy (Slide Layer)



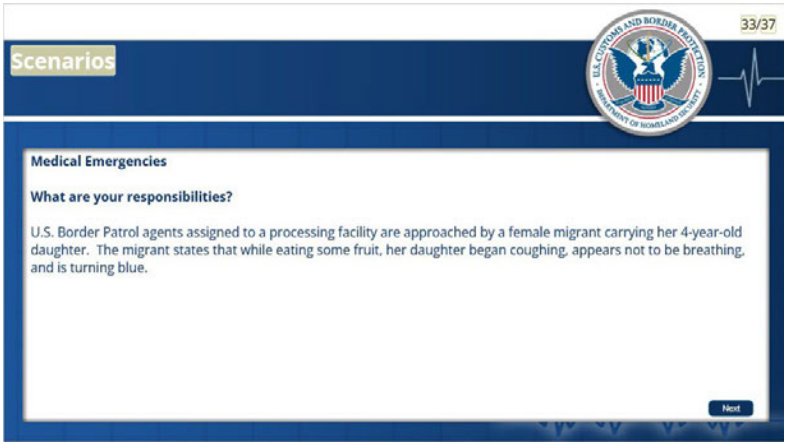
Infectious Disease (Slide Layer)



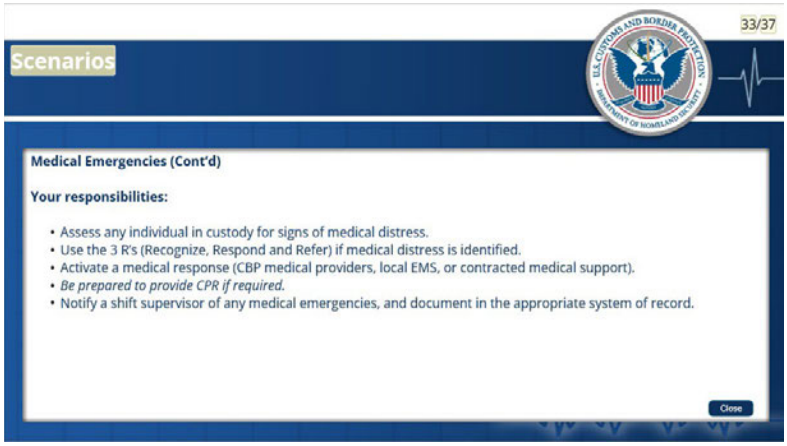
Infectious Disease Responsibilities (Slide Layer)



Medical Emergencies (Slide Layer)



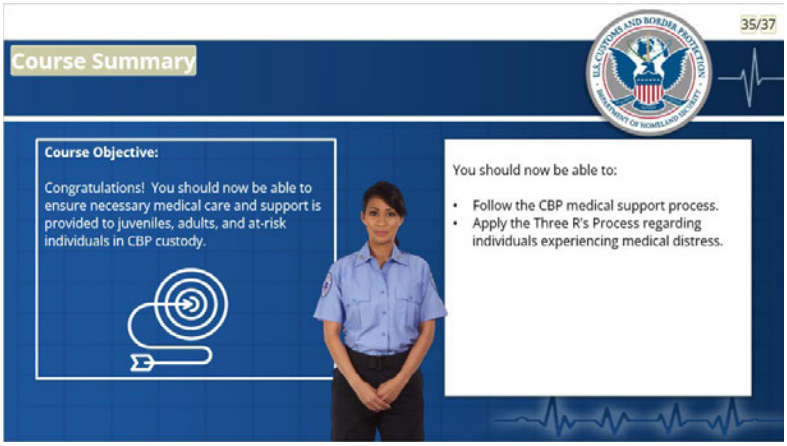
Medical Emergencies (Cont'd) (Slide Layer)



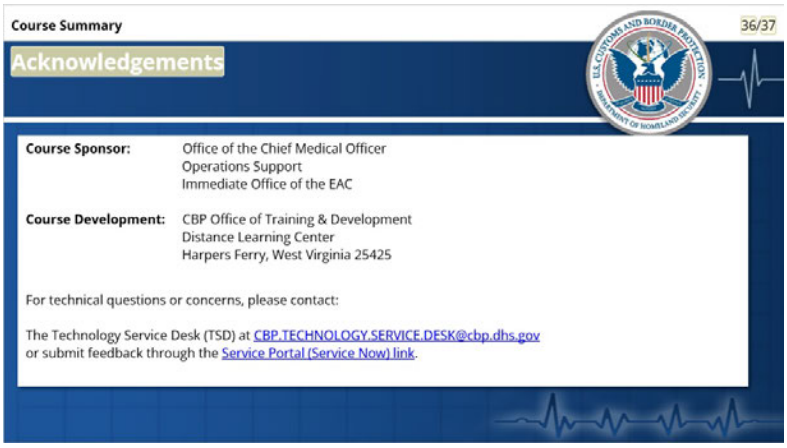
5. Course Summary

5.1 Course Summary

5.2 Course Summary

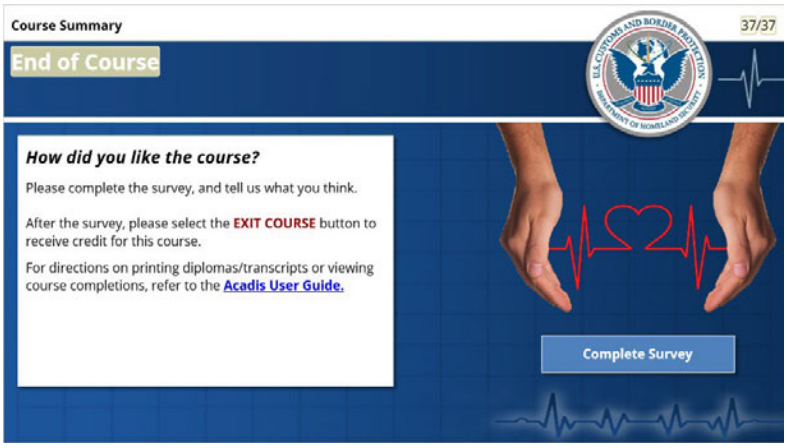


5.3 Acknowledgements



Notes:

5.4 End of Course

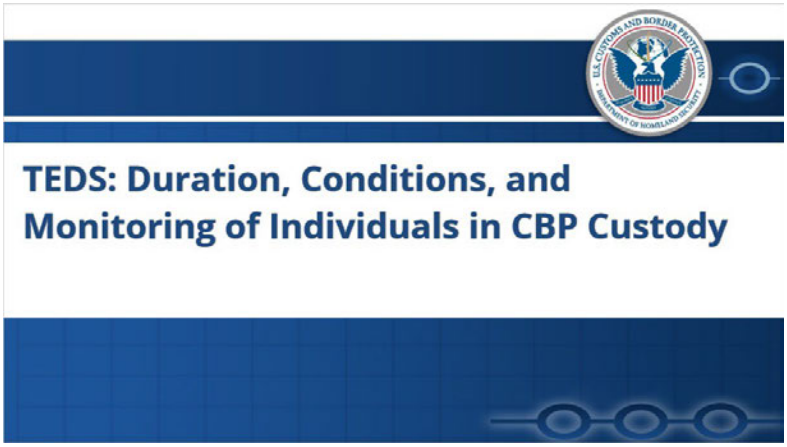


Key Document B

TEDS: Duration, Conditions, and Monitoring of Individuals in CBP Custody

1. Course Introduction

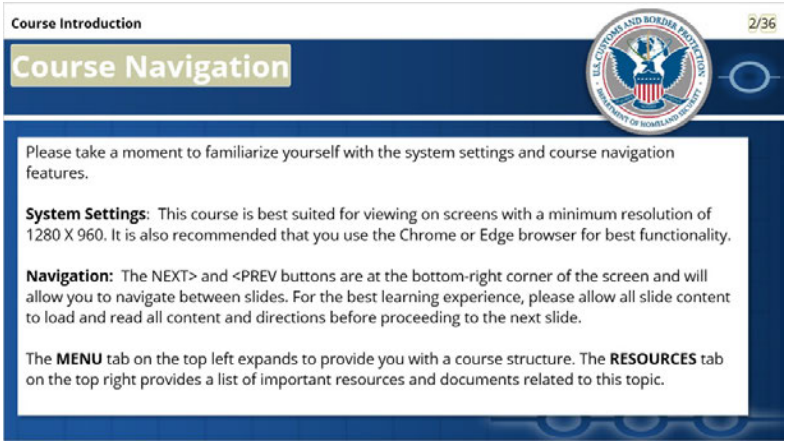
1.1 TEDS: Duration, Conditions, and Monitoring of Individuals in CBP Custody



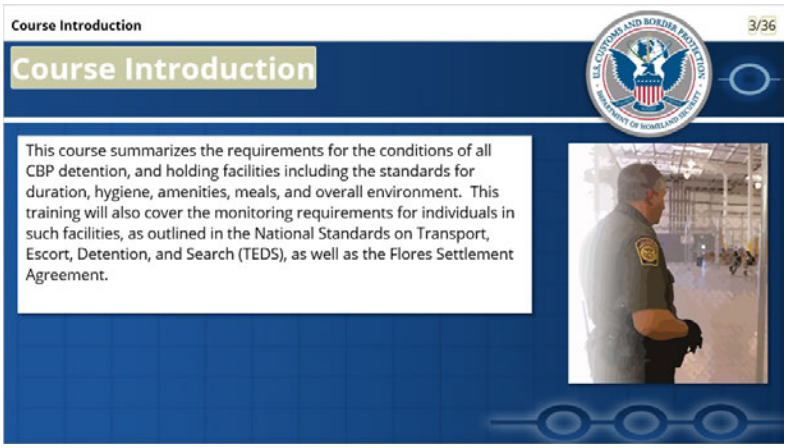
Audio:

Welcome to the Duration, Conditions, and Monitoring of Individuals in CBP Custody course, a part of our series on the TEDS Policy of CBP. As CBP officers or agents, you may not always be on the frontlines of tasks like the initial medical assessment, transportation, or direct medical care, but your ethical responsibility is pivotal. Due to the stress and complexities surrounding individuals entering CBP custody, we must maintain vigilance and speak out when something seems awry, advocating for the well-being of our CBP staff and those temporarily under our supervision. Select the **NEXT** button to begin the course.

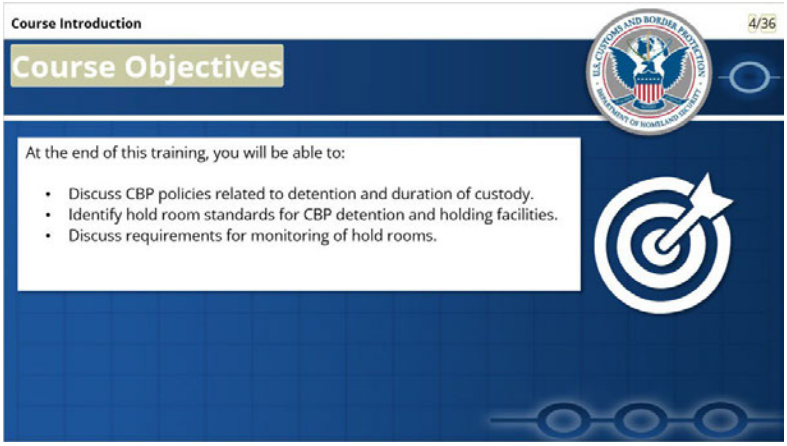
1.2 Course Navigation



1.3 Course Introduction



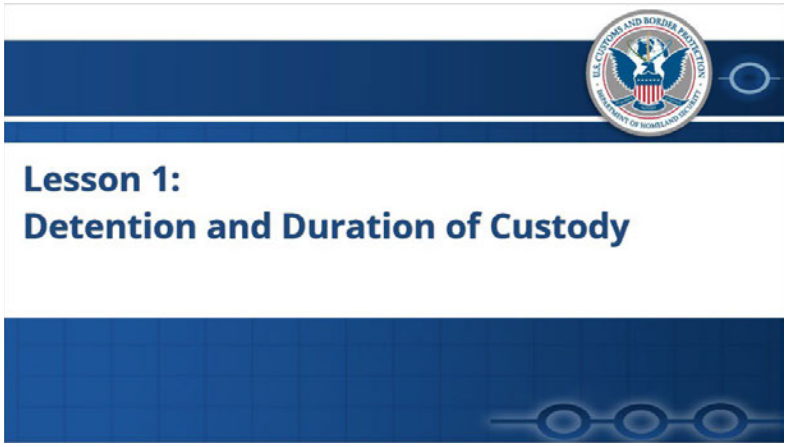
1.4 Course Objectives



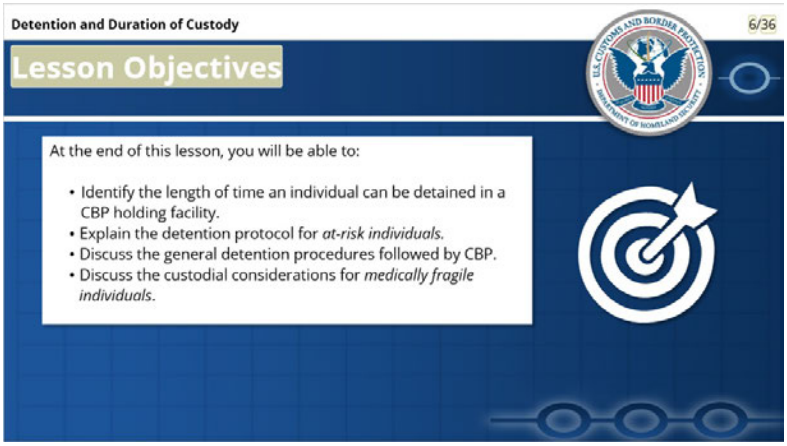
2. Detention and Duration of Custody

2.1 Lesson 1:

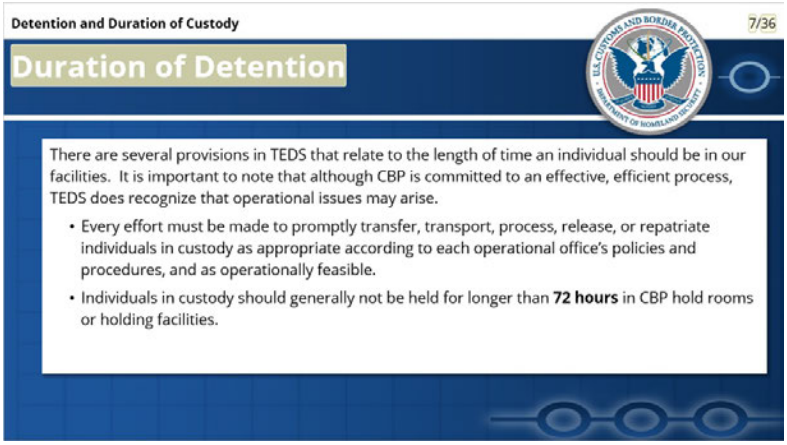
Detention and Duration of Custody



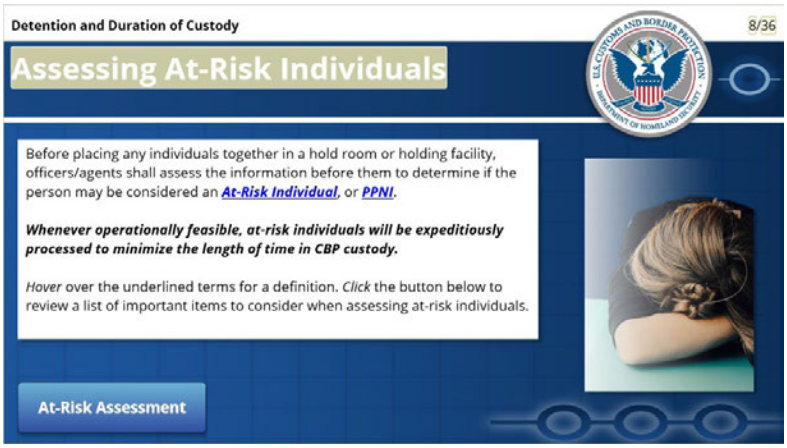
2.2 Lesson Objectives



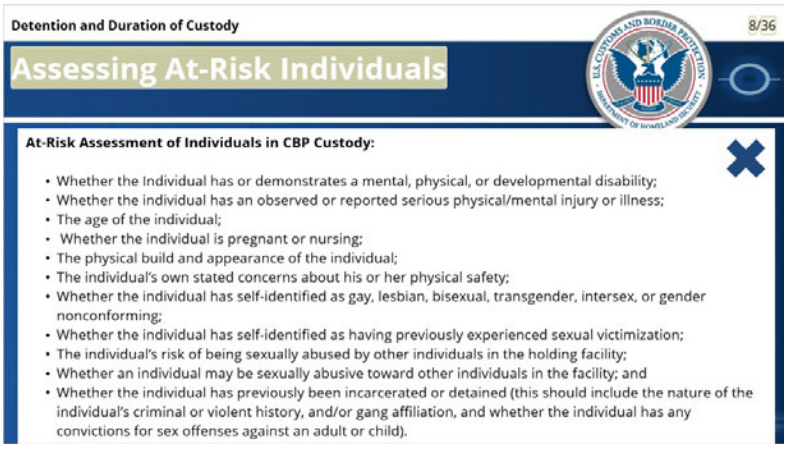
2.3 Duration of Detention



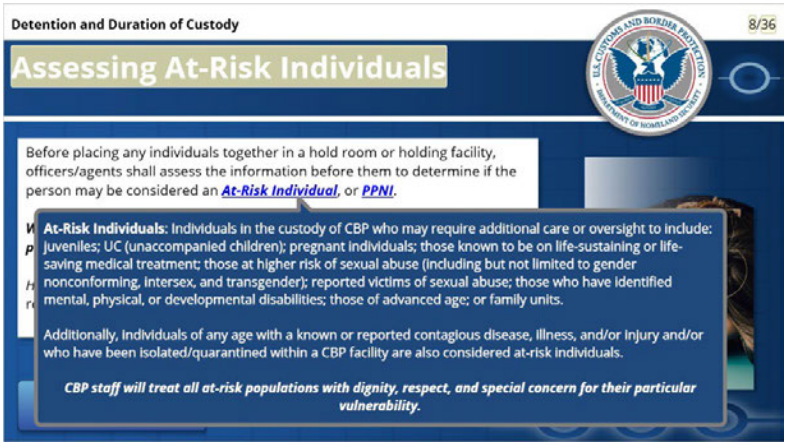
2.4 Assessing At-Risk Individuals



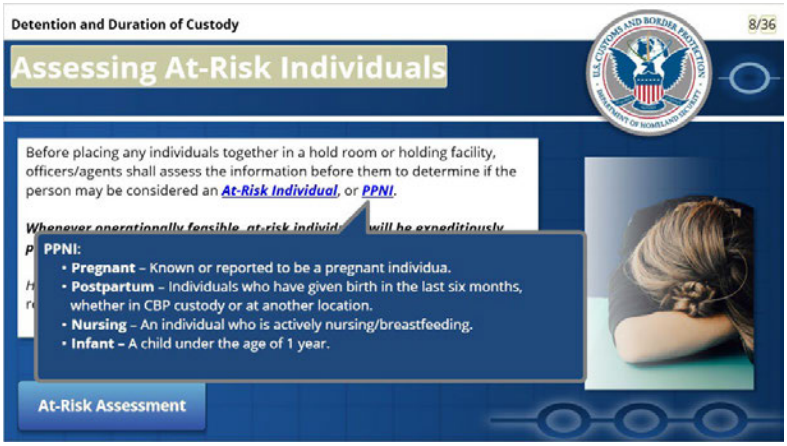
Assessment (Slide Layer)



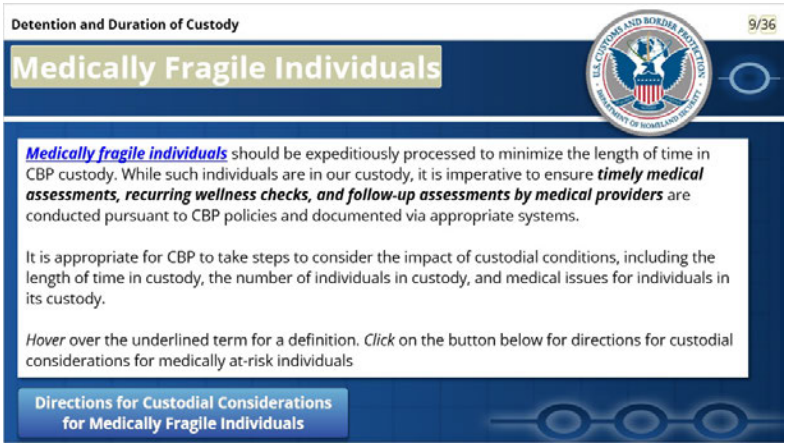
At-Risk Individuals (Slide Layer)



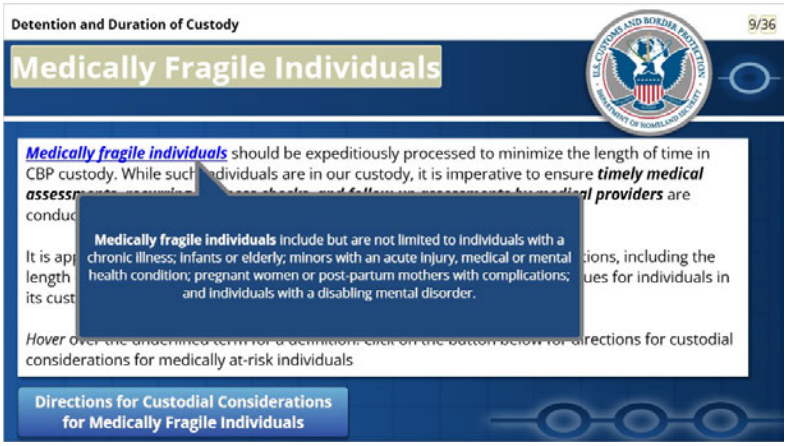
PPNI (Slide Layer)



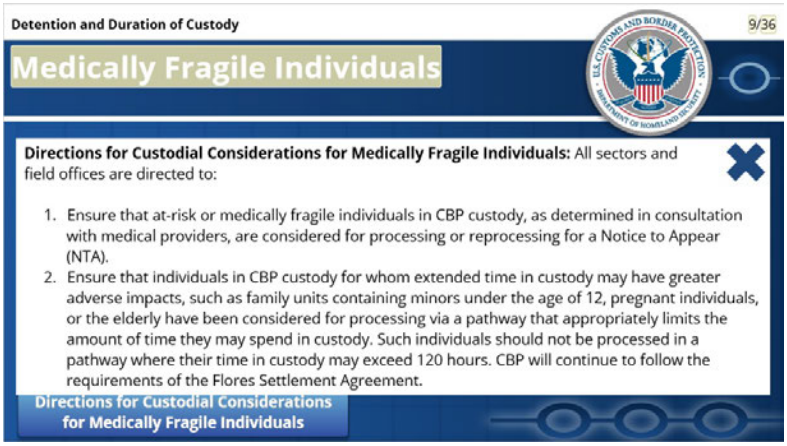
2.5 Medically Fragile Individuals



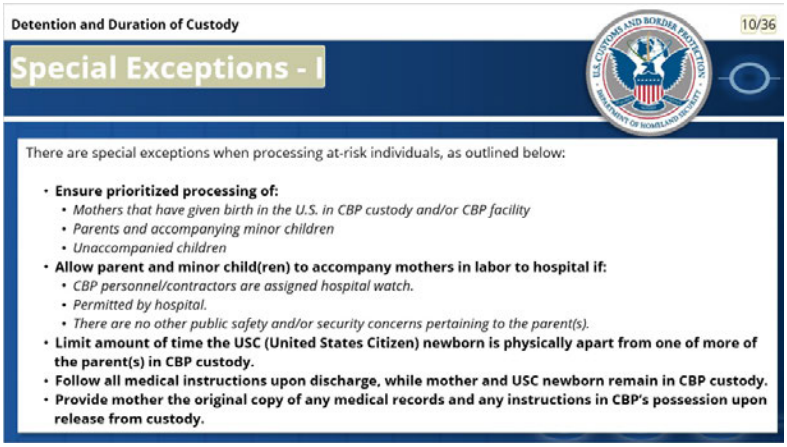
Medically Fragile (Slide Layer)



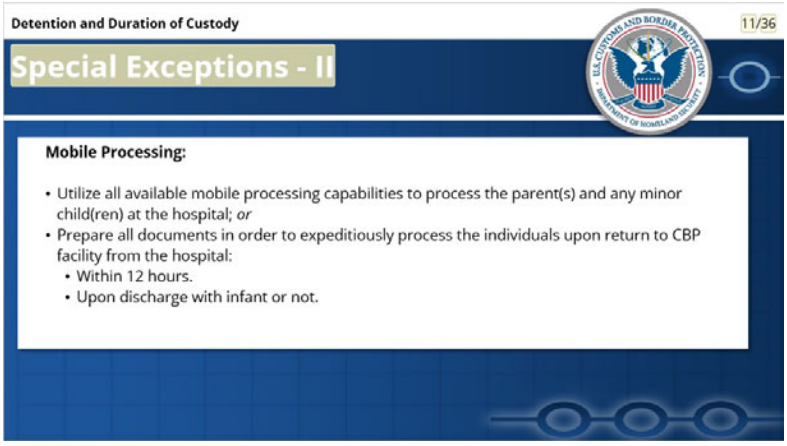
Directions (Slide Layer)



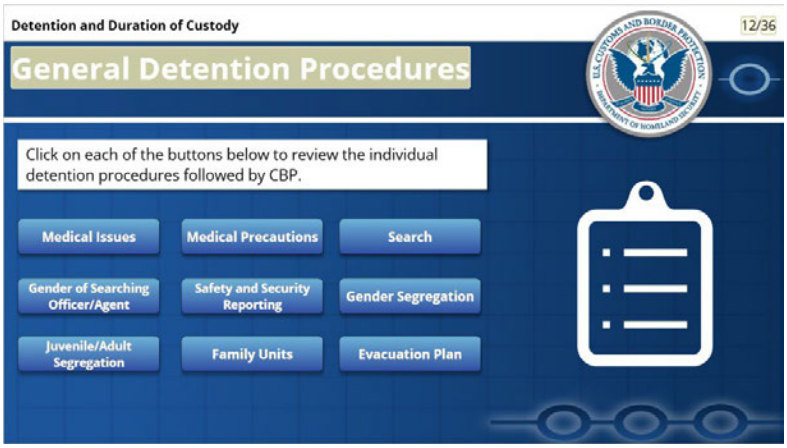
2.6 Special Exceptions - I



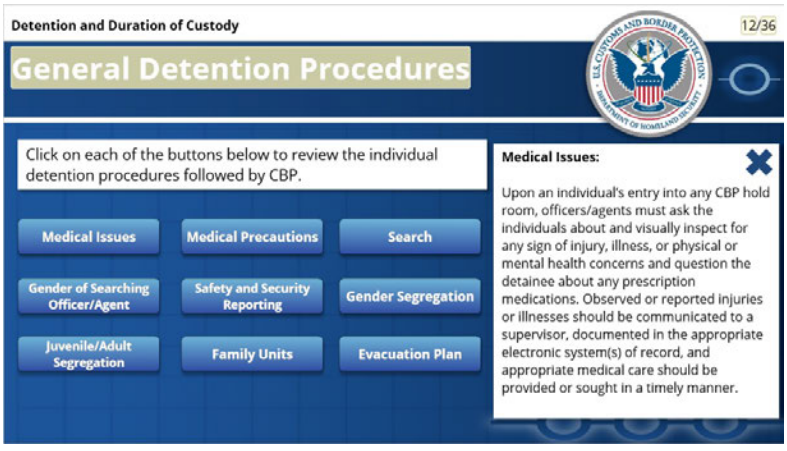
2.7 Special Exceptions - II



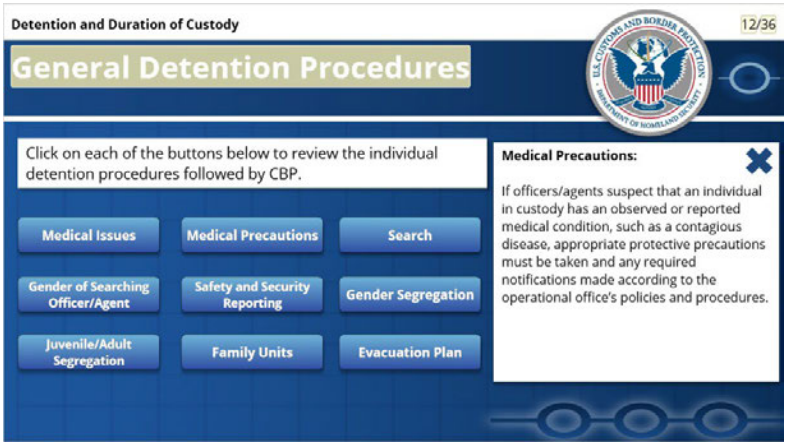
2.8 General Detention Procedures



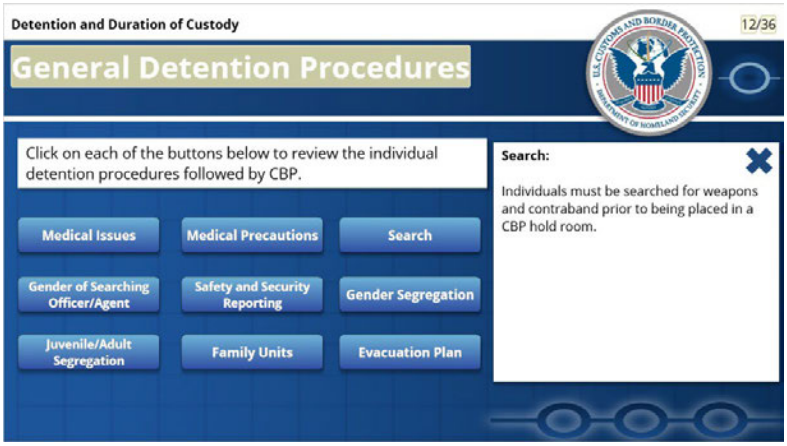
Medical Issues (Slide Layer)



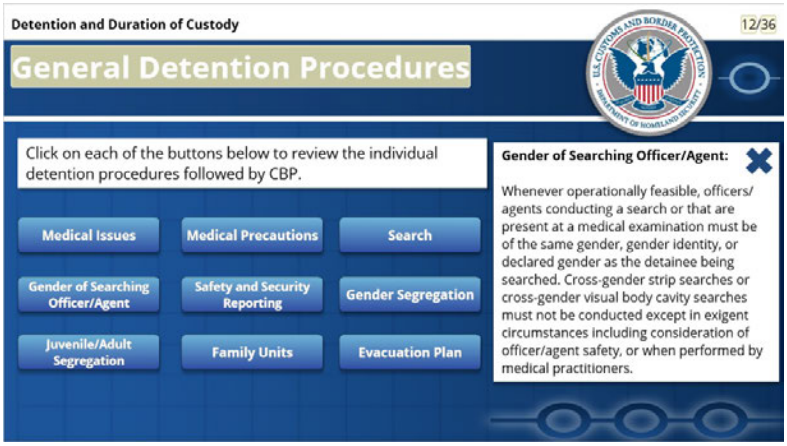
Medical Precautions (Slide Layer)



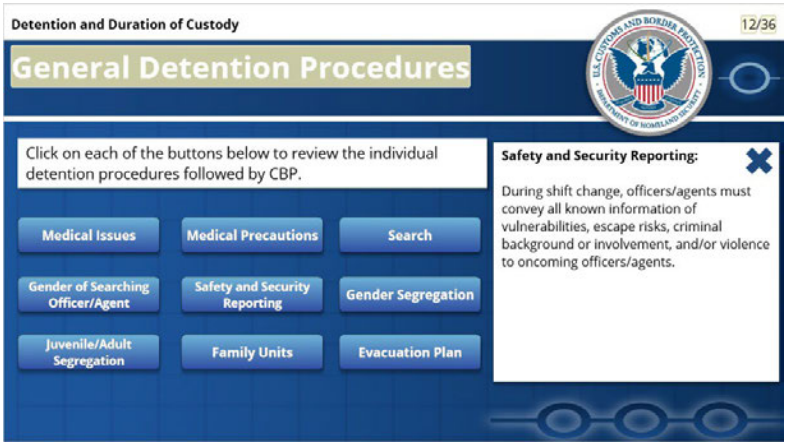
Search (Slide Layer)



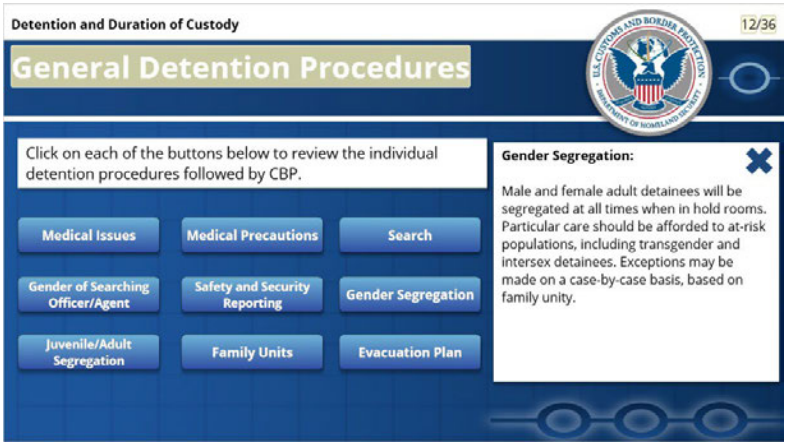
Gender Search (Slide Layer)



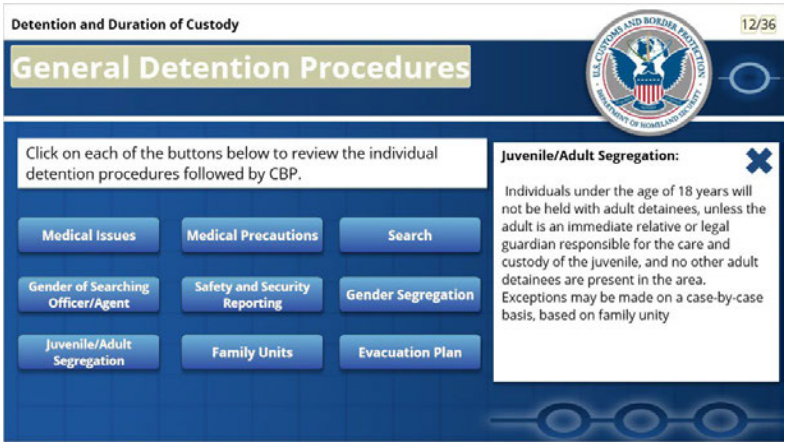
Safety and Security Reporting (Slide Layer)



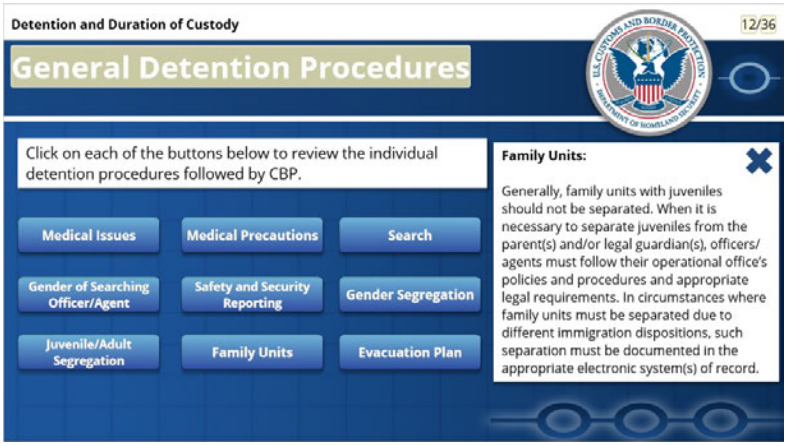
Gender Segregation (Slide Layer)



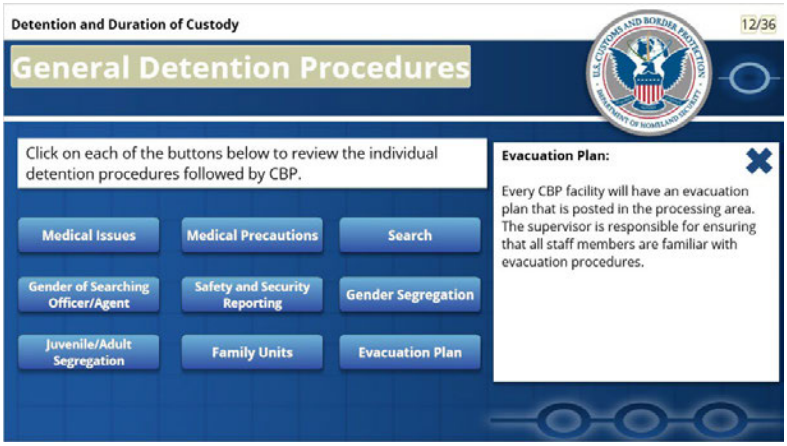
Juvenile Segregation (Slide Layer)



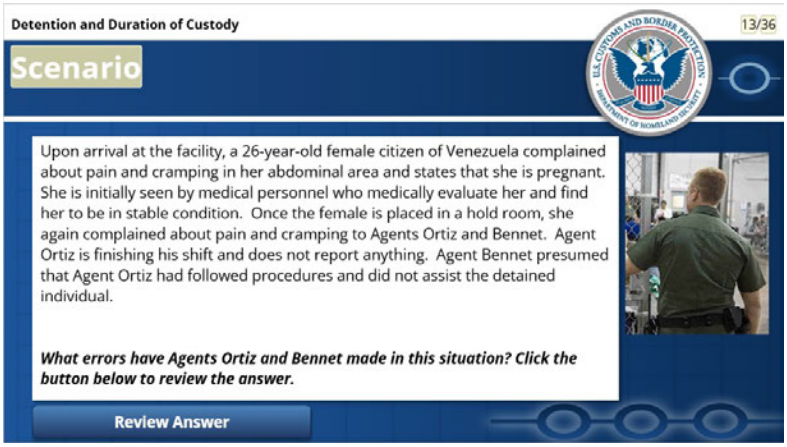
Family Units (Slide Layer)



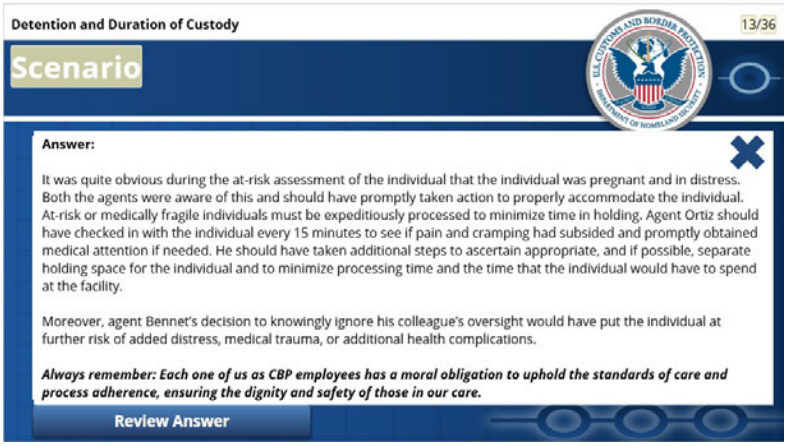
Evacuation Plans (Slide Layer)



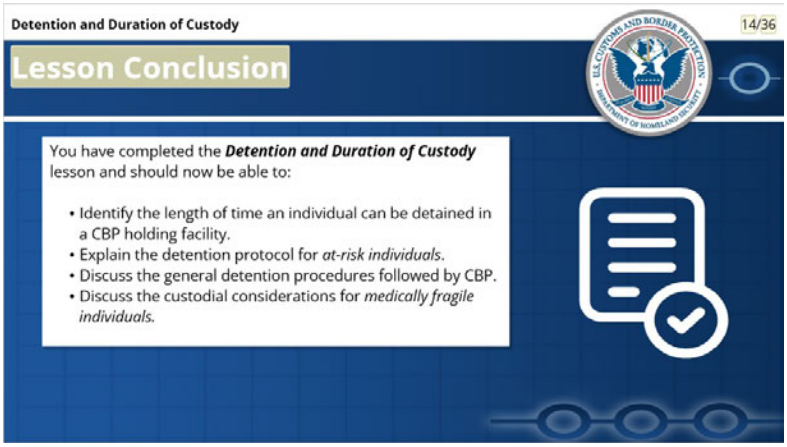
2.9 Scenario



Answer (Slide Layer)



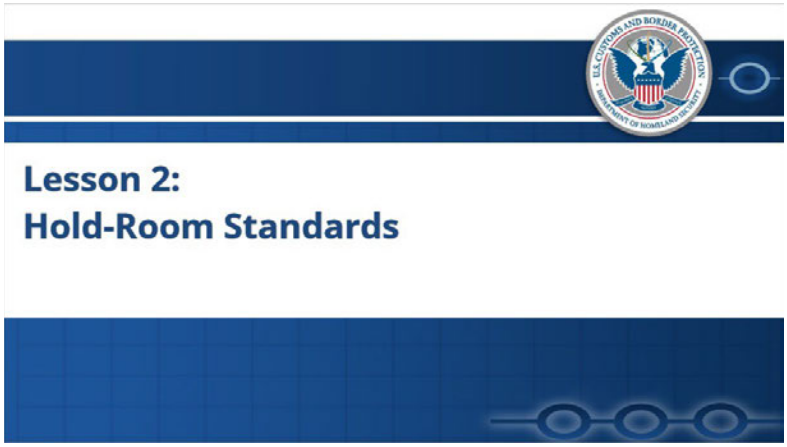
2.10 Lesson Conclusion



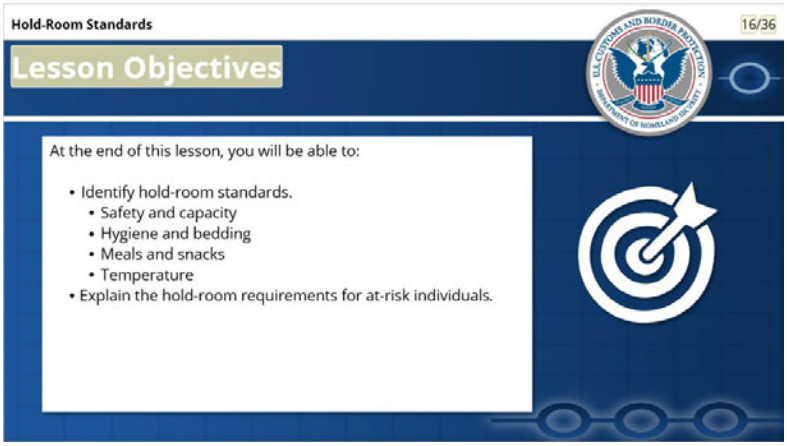
3. Hold-Room Standards

3.1 Lesson 2:

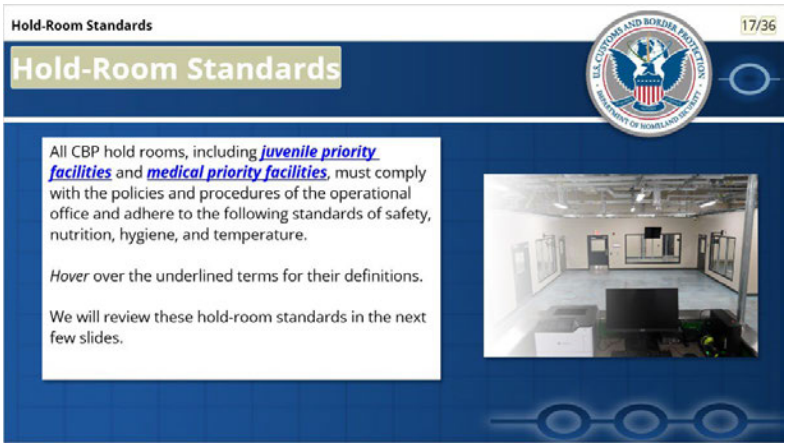
Hold-Room Standards



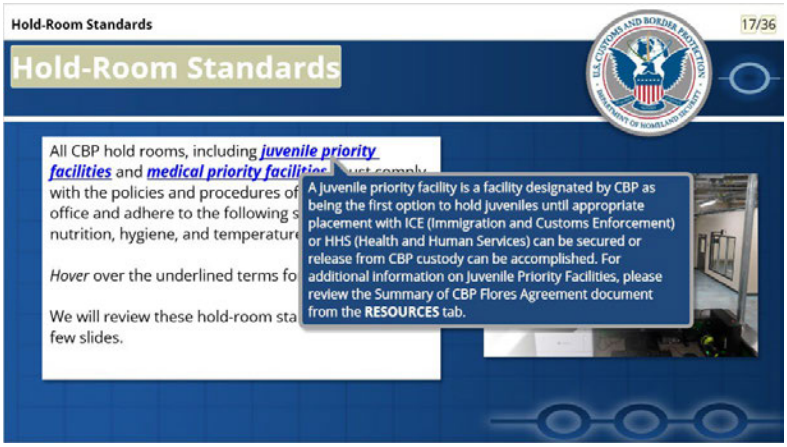
3.2 Lesson Objectives



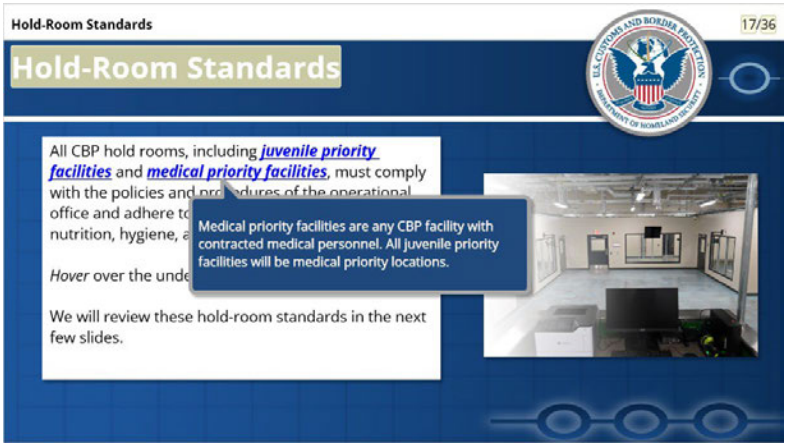
3.3 Hold-Room Standards



Juvenile Priority Facility (Slide Layer)

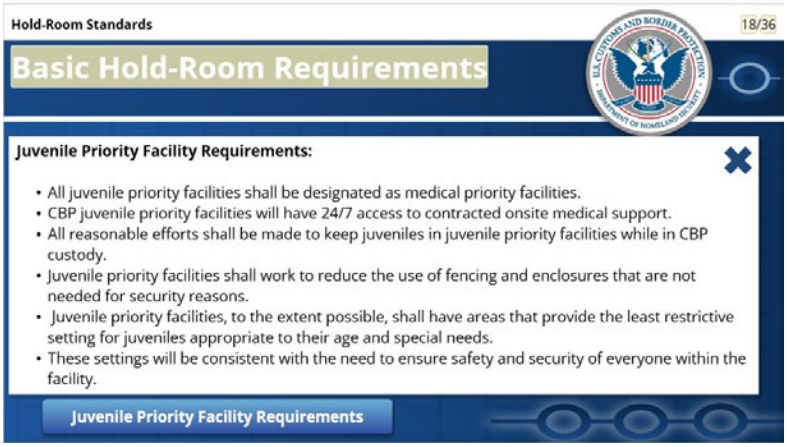


Medical Priority Facility (Slide Layer)

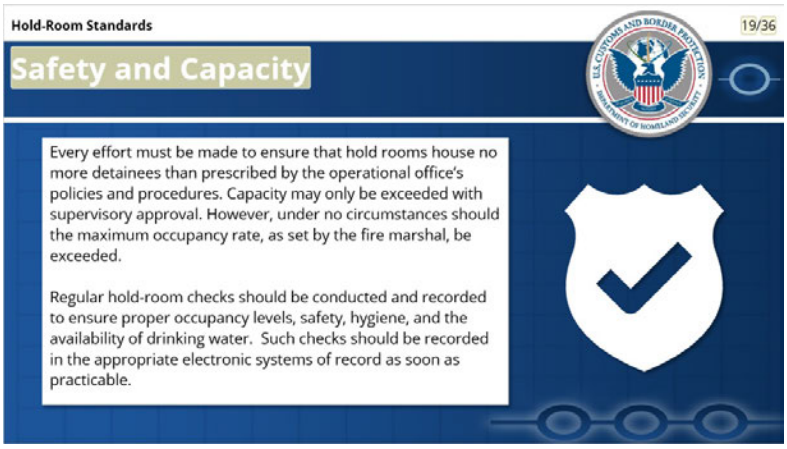


3.4 Basic Hold-Room Requirements

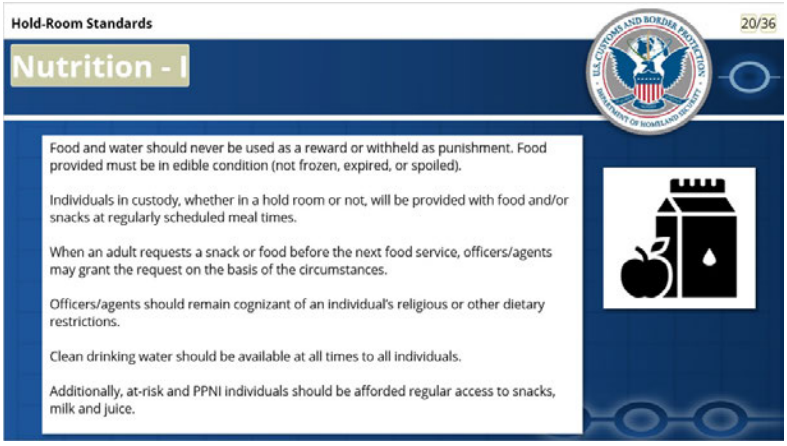
Juveniles (Slide Layer)



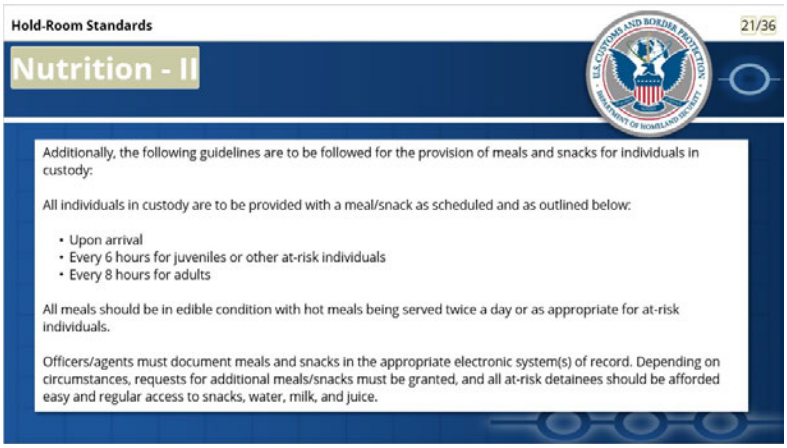
3.5 Safety and Capacity



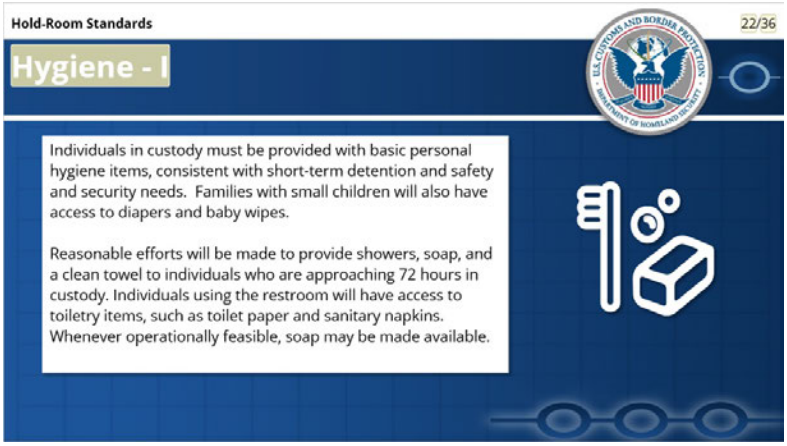
3.6 Nutrition - I



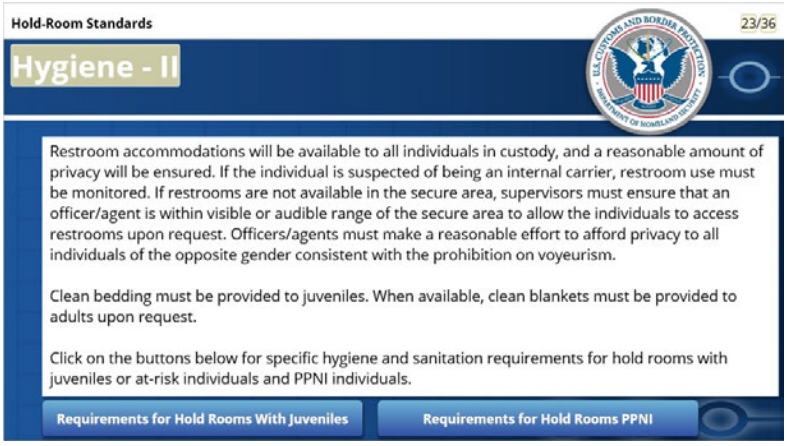
3.7 Nutrition - II



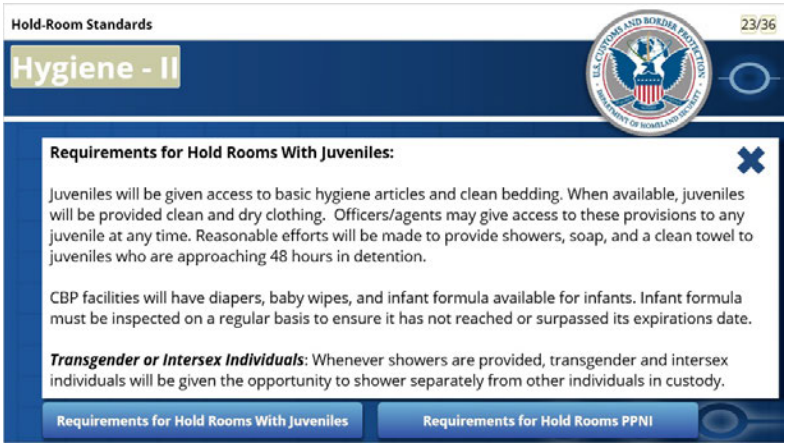
3.8 Hygiene - I



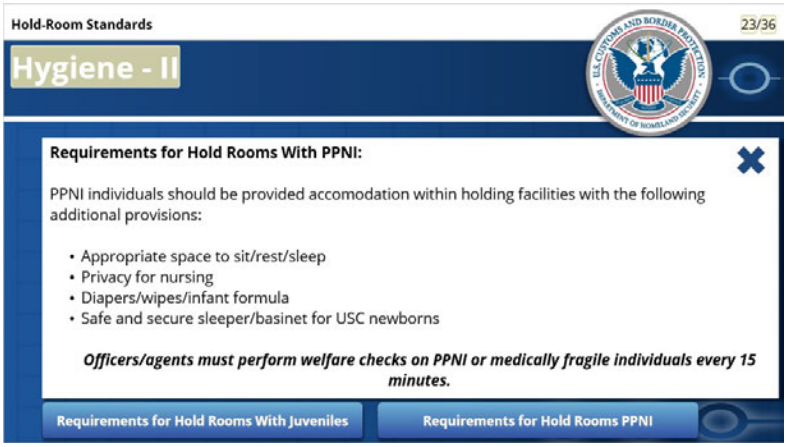
3.9 Hygiene - II



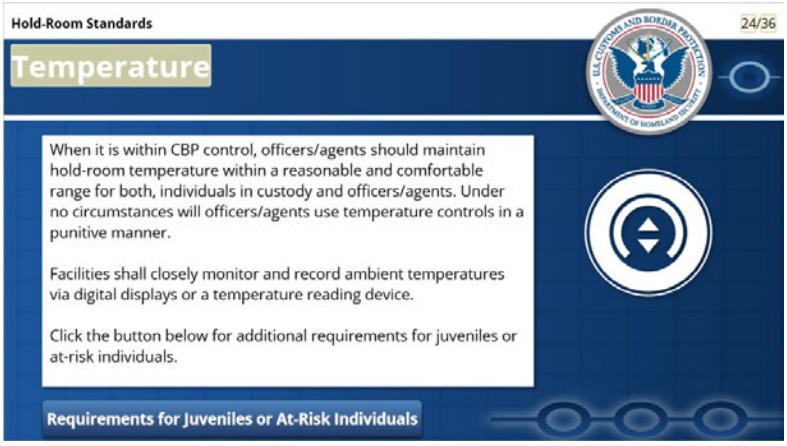
Juveniles (Slide Layer)



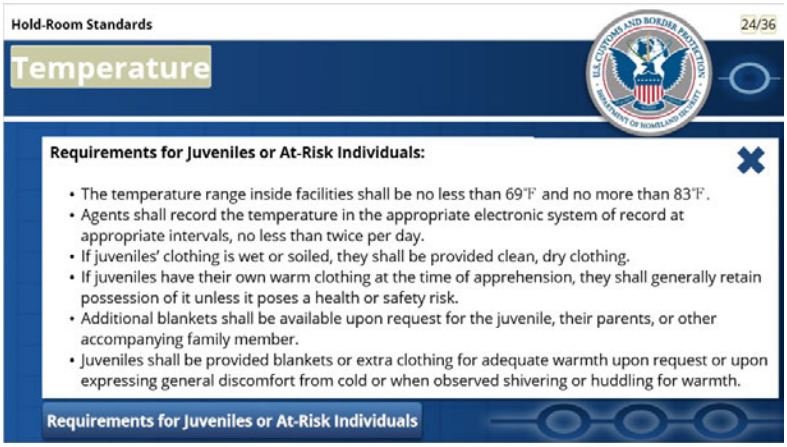
PPNI (Slide Layer)



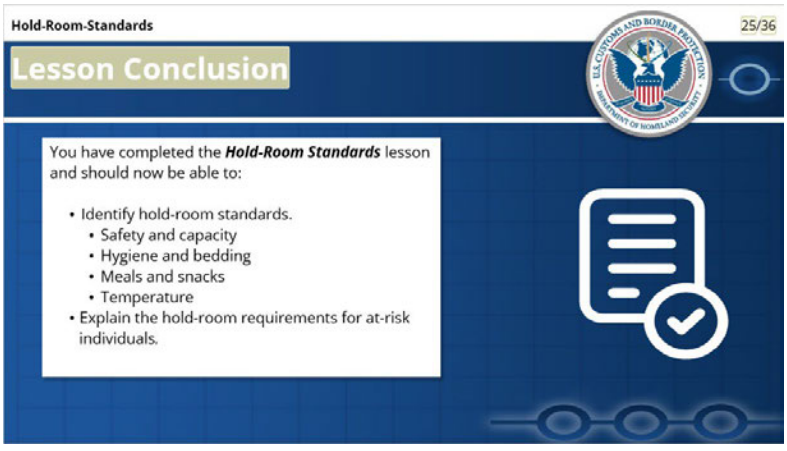
3.10 Temperature



Juveniles (Slide Layer)



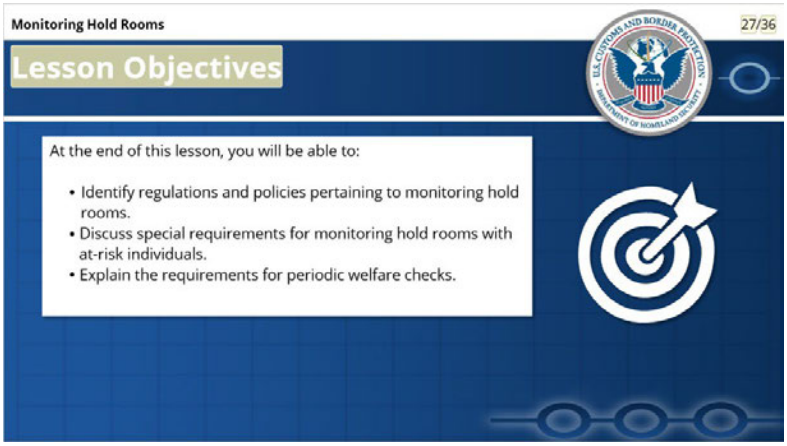
3.11 Lesson Conclusion



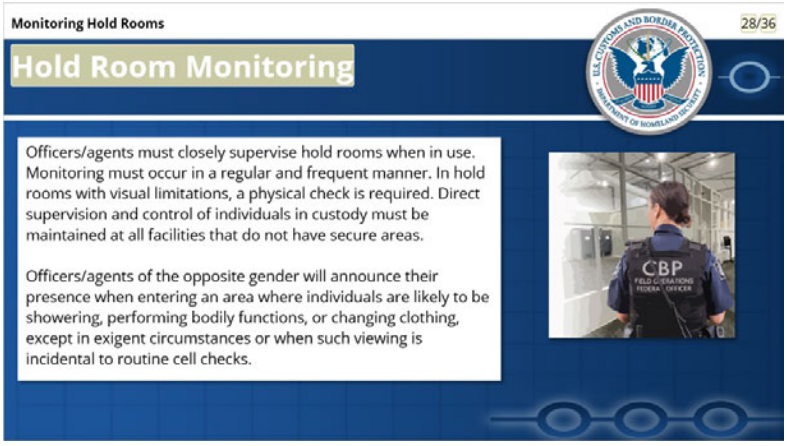
4. Monitoring Hold Rooms

4.1 Lesson 3:

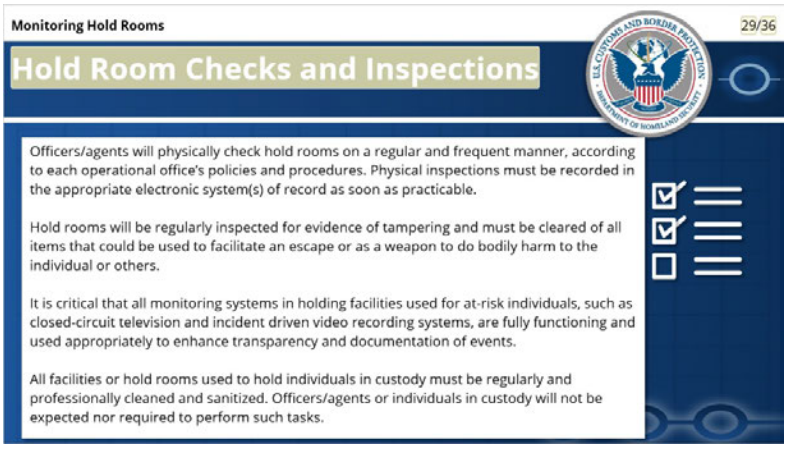
4.2 Lesson Objectives



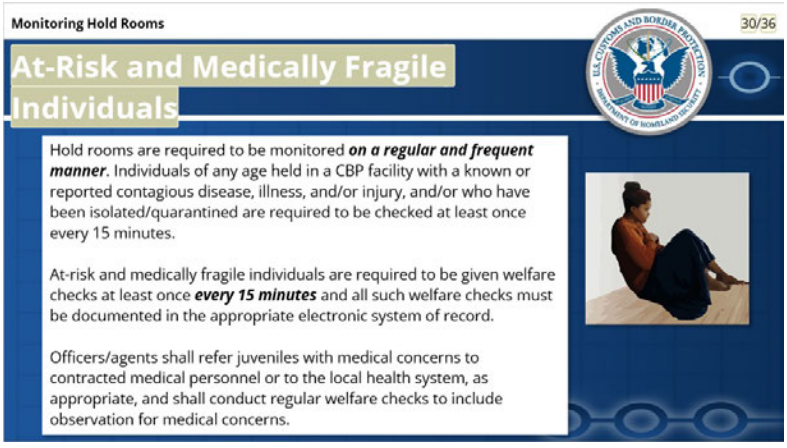
4.3 Hold Room Monitoring



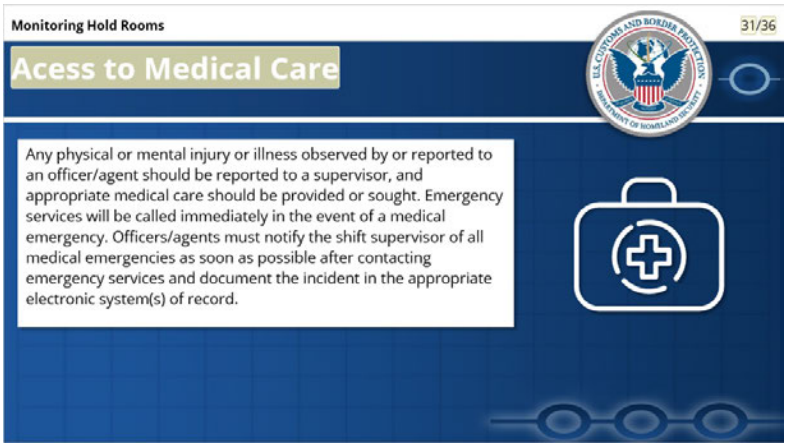
4.4 Hold Room Checks and Inspections



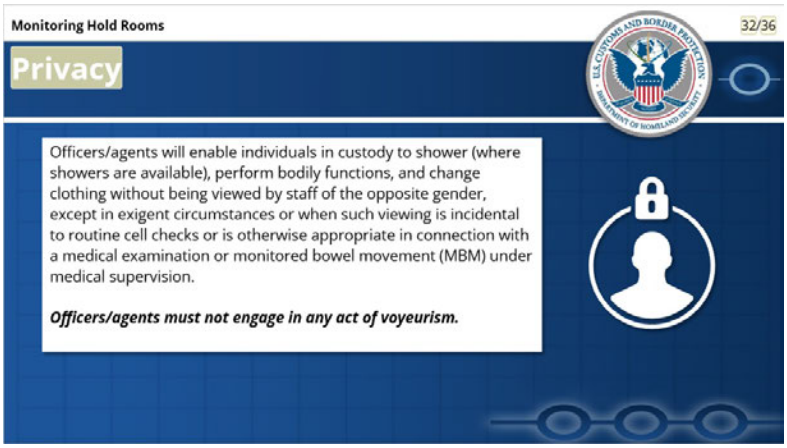
4.5 At-Risk and Medically Fragile Individuals



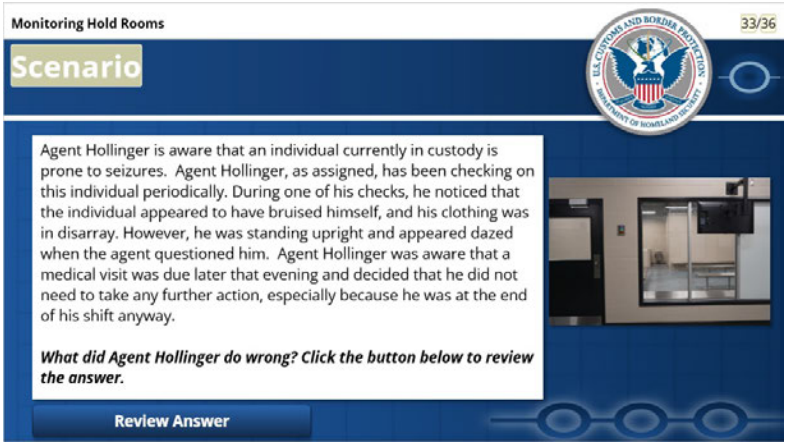
4.6 Acess to Medical Care



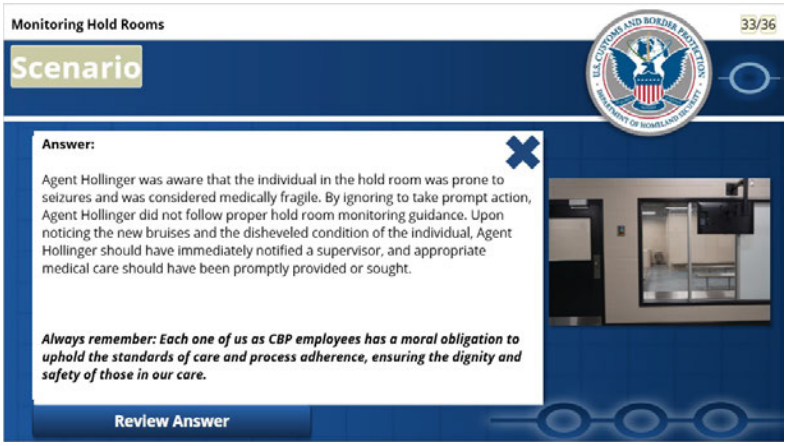
4.7 Privacy



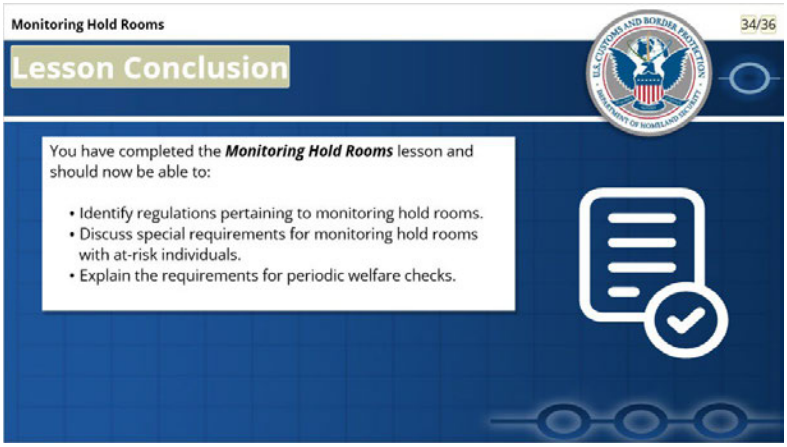
4.8 Scenario



Answer (Slide Layer)

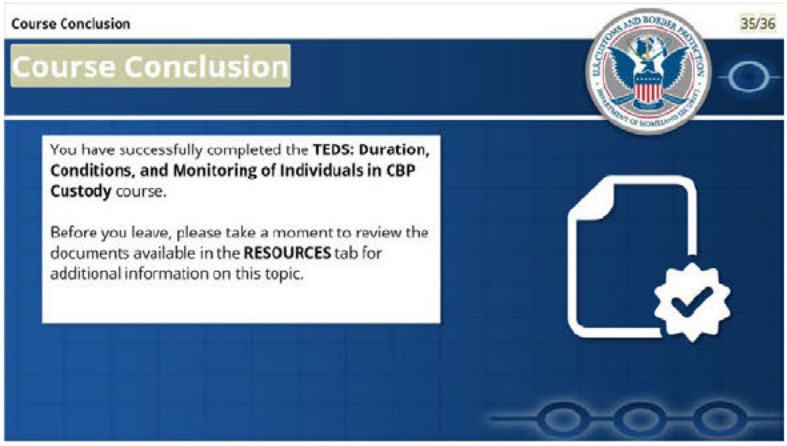


4.9 Lesson Conclusion



5. Course Conclusion

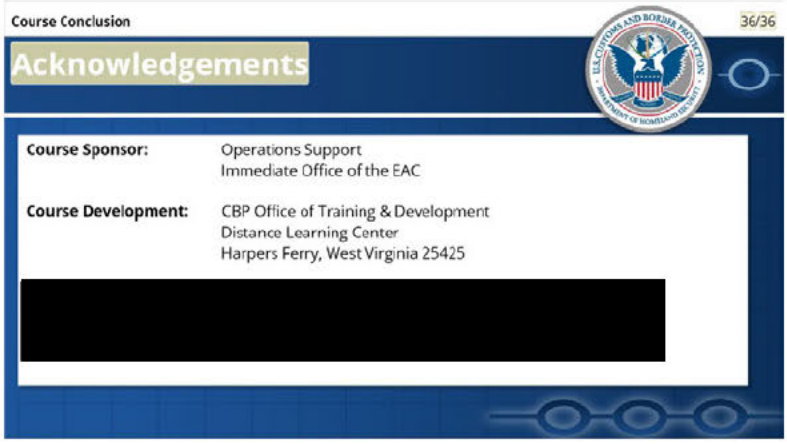
5.1 Course Conclusion



Audio:

In summarizing today's exploration of the Duration, Conditions, and Monitoring of Individuals in CBP Custody course, let's not forget our shared ethical responsibility. Despite not being directly in charge of specific responsibilities outlined within this course, each one of us as CBP employees has a moral obligation to uphold the standards of care and process adherence, ensuring the dignity and safety of those in our care.

5.2 Acknowledgements



Key Document C

DEPARTMENT OF HOMELAND SECURITY
U.S. Customs and Border Protection

ALIEN INITIAL HEALTH INTERVIEW QUESTIONNAIRE

ALIEN INFORMATION

Alien's Name *(Last, First, MI)*			A-Number (if any)
Age	Date of Birth	Gender	Country of Citizenship
Agent/Officer Name *(Last, First, MI)*			Event Number
Agent/Officer: Are you able to communicate with the Alien? Yes No			Date Completed

ALIEN HEALTH BACKGROUND

	ALIEN RESPONSE		AGENT/OFFICER OBSERVATION
	Yes	No	Additional detail as appropriate
1. Do you have a history of or current medical or mental health issues?			
2. Are you taking any prescription medications? If yes, do you have it with you?			
3. Do you have any allergies? (e.g. food, medicine)			
4. Are you a drug user?			
FEMALES ONLY			
5. Are you pregnant? If yes, how many months?			
6. Are you nursing?			

ALIEN HEALTH INTERVIEW

If answered or observed "Yes" to any of the health interview questions below, then refer for a medical assessment.	ALIEN RESPONSE		AGENT/OFFICER OBSERVATION
	Yes	No	Additional detail as appropriate
7. Are you currently ill or injured or do you have significant pain?			
8. Do you have a skin rash?			
9. Do you have a contagious disease?			
10. Are you thinking about hurting yourself or others?			
11. Do you feel feverish or do you feel that you have a fever?			
12. Do you have a cough or difficulty breathing?			
13. Do you have nausea, vomiting, or diarrhea?			

ADDITIONAL AGENT/OFFICER OBSERVATIONS

Are there any other observations or concerns? Examples are: disorientation, bruising/bleeding, yellow eyes/skin, environment-related illness (heat stroke, hypothermia, severe dehydration)

MEDICAL ASSESSMENT REFERRAL

Was the alien referred for a Medical Assessment? Yes No

Key Document D

From: [redacted]
Sent: Wednesday, May 31, 2023 11:49 AM
To: [redacted]
Subject: FW: EMR Inputs from LSGS - [redacted]

Categorization | Private

[redacted]

From: [redacted]
Sent: Monday, January 11, 2021 5:27 PM
To: [redacted]
Cc: [redacted]
Subject: RE: EMR Inputs from LSGS - [redacted]

[redacted]

I had the team review all of you concerns and here are the responses. You will see there were numerous items that were fixed or addressed in subsequent versions. Some were addressed while we were in RGV in 1.0.1 and others the next week in 1.0.2.

Some are good points that we can talk about in the RMWG.

Main View

Need to be able to search by encounters or JIMAs.
This is a Phase 3 requirement with reporting and QA items to be discussed during the RWG meetings

Medication "Active" reverts to "N/A" when viewed. Should stay as "Active"
You are correct and this issue is being addressed in the current (1.0.5) Sprint

Every time I view a record no matter where it was in the cue (according to date) it pops to the top of the cue with the latest time I looked at it. Should be cued by time of last signature, not when someone last viewed it.
We can look to address this issue, however this path was selected to show "last time updated (last view) because the last signature date isn't placed on the main record to be sorted by and this would require significant effort. Is there a priority/need for this feature?

Demographics

Hitting ENTER kicks you out when filling in data blocks
Completed in V1.0.2 and V1.0.3 Fixes

Location unable to enter data
This is working as designed. These fields should be filled by UIP.

Won't let me save and record without a Sub Id number or one that I enter.
This is correct if they select a facility type. This method prevents blank and duplicate records. A subject without an ID can currently be entered if you do not select BP or OFO

Gender is the only info item displayed when updating record
Completed in the V1.0.1 Fix

Business Rule for Biological Sex?
Completed and was made a required field in V1.0.2 after RGV discussion with Dr. Tarantino. Manually entered in each case

When sorting by name, only lasts for a couple of seconds….doesn't isolate to user?
Working as designed. Use search feature to filter results by subject name.

When updating demographics, if UIP is the gold standard, why allow this option?
This is needed because staff need the ability to correct Subject ID, Civilian ID, and Biological Sex if incorrectly entered.

Should be able to hit enter on subj id to GET the record
We have this on our list of items to do, and will be addressed in future updates.

Individual Information

Why print this page?
This is a default in Web EOC applications allowing all pages to be printed. Working as designed. It can be removed, but it was deemed very low priority to remove an existing capability.

Medical Assessment

Why First name in capitals
This is how the name is provided by UIP and is standard for all portions of the name.

When I type in vital sign and then click on next box, it doesn't save the number I typed
If typing in vitals, you have to press enter or select the value in the list to get it to save.

"?" after HEENT

Was fixed in V1.0.3

Hitting ENTER when I'm writing in the text box in the review of systems kicks me out
This was fixed in V1.0.3

Patient Information should include "Sex"
Can be added. Please provide requirements (Gender or Biological Sex) and priority

When printing out, the PDF should be a more useable form (e.g., "Admission/Disposition" repeated, Addendums shouldn't be listed if there are none, Should just have provider's name and title not everything else,

Currently we have not seen any requirements on how this page should be printed. If there need to be changes to how it looks when printed, please provide requirements.

No date/time on print out of Assessment
We have no print requirements except for the 2501 which has a signature date/time. Please elaborate the specific requirement and priority.

Is location important on this form (question to CBP)
It was removed V1.0.2

"(Select Weight)" can be selected in the Weight data box, it should not
Fixed in 1.0.4

"Negative" cannot be a checked box. "Normal" should be used instead. Should discuss if that is what we want to do, Normal vs actually typing in normals.
This is based on the LSGS form. We can change to normal if it is a requirement.

Why Assessment Comments? Need to get rid of.
This was left for any notes that provider or support wanted to make about the assessment that did not fit anywhere else on the assessment form. We can remove it.

Why "History" hot link in Addendum when you have an addendum?
This was removed during V1.0.2

Encounter Form
Vital Sign lay out different from Assessment; SYS and DIA far apart; Kg/Lb separate from weight a bit
We are looking to address this in a current sprint (1.0.5)

No date/time on print out of encounter form
There are no requirements for this, Open for requirements discussion
.
No date/time on form when viewing it on screen
There are no requirements for this, Open for requirements discussion .

In PE free text box. Hitting ENTER does nothing. Cannot do lists…everything runs together
Shifting the style of these controls to add a full range of entry in 1.0.5.

Need "Neuro" section added
Was added in V1.0.2

Will save whatever is typed in DIAGNOSIS section; prefer "Other" selection and then free text box.
Working as designed. Is there a reason to add an additional step?

NO sex on demographics in view mode or with print out
Can be added. Please provide requirements (Gender or Biological Sex)

Spacing very wide on print out of all data
No printing requirements have been made for this form. Open for requirements discussion

"Diagnosis Selection" printed again in view and print form in DIAGNOSIS
Correcting in version 1.0.5

DIAGNOSIS section titled "Diagnosis Selection" should just be Diagnosis
Correcting in version 1.0.5

No LMP information in view form: People are writing it in under "Other" in the PE section
This has been added in Version 1.0.3

Medication and Enhanced Monitoring
Selecting "Other" just puts Other…no text box
Any text can be entered in this control. We can remove "Other" if it is confusing. All changes held over to Phase 3

Will save whatever typed….same above
Working as designed, as the list is not fully loaded with all medications available for use. Planned feature for Phase 2.0

"Show More" green button probably should be "Add another med" or something like that
Working as designed, as the list is not fully loaded with all medications available for use. Planned feature for Phase 2.0

Medical Summary Form
"Exposures Identified" after Title
Was fixed in V1.0.2

Summary information is repetitive – look at form
Was fixed in V1.0.2

No date and time on form when printed
Was Fixed in V1.0.2

Form Title on printed form should probably be changed
If this is related to the file name, was fixed in 1.0.4. If related to the form itself, fixed 1.0.2

Medical Summary conducted at location isn't very user friendly for those outside of CBP
This is required based on the original document. We are required to document where the CBP 2501 (Medical Summary Form) was conducted and filled out.

"Referred to another facility" repeated; Not sure why this is separately listed
This was fixed in V1.0.2

Wording for "Referred to Medical Facility Description"…drop description
This was fixed in V1.0.2

Repeat wording after Medications Prescribed
This was fixed in V1.0.2

Unnecessary "Medications Prescribed" section
This is required based on the original document. We are required to document where the CBP 2501 (Medical Summary Form) was conducted and filled out.

Should only have Name and title of person signing form. Does it have to be wet signature?
Fixed in V1.0.2
Wet signatures are still required at this time until a MOU is made with partners and stakeholders.

We can set up a meeting to discuss prioritization of outstanding items for the upcoming updates. I hope we were able to answer your concerns. Please feel free to contact us if we can help clarify any responses.

V/R

[redacted]

[redacted]
Program Manager
Electronic Medical Records
Office of Chief Medical Officer
US Customs and Border Protection

[redacted]

From: [redacted]
Sent: Wednesday, January 6, 2021 12:29
[redacted]
Subject: EMR Inputs from LSGS [redacted]

These are the inputs that I have written out and submitted this past year. Some of the items have been addressed, some have not. I have seen no adjudication on any items. I don't need to be or want to be the quality reviewer of the system. There are issues that need to be addressed, in my opinion, that would enhance

usability, decrease confusion, and meet regular medical record standards. If you do not want my input or don't agree, I'm okay with that, but if you are interested in LSGS's input on the EMR, then I'm the mouthpiece for now. Some of the items listed are pretty straight forward, some may require some discussion to understand fully the issue. I have found some other issues as I have worked in the system since November, but have not listed them yet. I will set aside some time to generate another list by the middle of next week.

[redacted]

LoyalSource
Government Services

Supporting the US Customs and Border Protection (CBP)
1300 Pennsylvania Ave
Washington, DC 20004

[redacted]

Key Document E

From: [redacted]
Sent: Wednesday, May 31, 2023 11:10 AM
To: [redacted]
Subject: FW: EMR Medical Processing Issues

Categorization | Private

[redacted]

From: [redacted]
Sent: Friday, January 29, 2021 9:48 AM
To: [redacted]
Subject: FW: EMR Medical Processing Issues

Team,

Here's the input from the provider at McAllen Station yesterday and just for your situational awareness. We're encouraging member to submit these topic points directly through the PMO help desk or survey. Yesterday, we informed the receiving facilities to completed the JIMA and any encounter notes that may have been missed at the McAllen Station. Glad to see the awareness of the CBP process and impacts to the EMR from the PMO on the call but we'll work through the issues - together.

We'll continue to advocate complete use of the EMR system and revert back to paper at the direction of CBP leadership– preferably in writing. Thanks team and let me know if you have any questions or need clarification. RP

---

1. System is redundant in windows when printing out one clearance form and requires navigation through several individual windows of several different programs in order to print a singal clearance form, let alone 30 or 40 of them. Example: Time required for several manifest of 20, 10, and 30 all leaving at the same time is an exceedingly large amount of time.

2. The ability to do intake screening with this EMR is contingent on CBP placing scannable bracelets on detainees wrist, this is sometimes postponed due to other steps/procedures that cbp needs to manage first. This is completely understandable, but nevertheless this situation leads to falling further behind on Juvenile Intake Medical Assessments (JIMA) and becomes very difficult to catch up; leading ultimately to some juveniles being overlooked in regards to documentation or being transfered prior to medical staff having the opportunity to perform JIMA paperwork.

3. Internet further prolongs time required to carry out EMR documentation by lagging and taking long to load pages leading to freezing or requiring refresh of screen (this will sometimes cause all information on current form to be deleted).

These small hinderences when multiplied by the hundreds of bodies moving in and out of the station daily become more problematic and increasingly more time consuming, leading to entire workload not being able to be completed. Pending workload is then passed on to next shift further placing them behind and making it more difficult to catch up , if not impossible (all the while, we are seeing patients for sick visits and administering medications to patients currently on our tracking board.)

RP

Best,

[redacted]

LoyalSource
Government Services

Supporting the US Customs and Border Protection (CBP)
12612 Challenger Parkway Suite 365
Orlando, Florida 32826

[redacted]

Key Document F

From: [redacted]
Sent: Wednesday, May 31, 2023 11:06 AM
To: [redacted]
Subject: FW: EMR ISSUES

Categorization | Private

[redacted]

From: [redacted]
Sent: Tuesday, February 9, 2021 12:37 PM
To: [redacted]
Subject: RE: EMR ISSUES

Was calling to let you know that we're sending out mass communication to reinforce the need to use the help line in real time. [redacted]

From: [redacted]
Sent: Tuesday, February 9, 2021 12:01 PM
To: [redacted]
Subject: RE: EMR ISSUES

Agree and yes! We are working on the amendment we're proposing to the SOW currently and it will include SOPs from the EMR team – of course these will have to be shared with LSGS, negotiated etc.

Thanks for collaborating with us on this!
[redacted]

From: [redacted]
Sent: Tuesday, February 9, 2021 11:52 AM
To: [redacted]
Subject: RE: EMR ISSUES

Thanks [redacted] and perfect feedback – now we can go back and continue to reinforce using the helpdesk in real-time with our employees. Also illustrates the need for an SOP, user manual and business rules. There's no feedback-loop so we don't know how to communicate this information to all sectors/stations currently using the EMR.

I don't send this emails to highlight short-comings or deficiencies but more to ensure the information is being shared with the EMR PMO team. We all want this to succeed but let us know how best to communicate these concerns with systems and technology.

Would you be interested in a call with yourself, [redacted] and I to have a quick huddle to layout an interim process for us to officially respond to give and receive feedback. We want to do it in a way that is collaborative in nature and not put anyone on defense. Thoughts?

[redacted]

From: [redacted]
Sent: Tuesday, February 9, 2021 11:39 AM
To: [redacted]
Subject: FW: EMR ISSUES
Importance: High

FYSA

From: [redacted]
Sent: Tuesday, February 9, 2021 11:13 AM
[redacted]
Subject: RE: EMR ISSUES
Importance: High

[redacted]

Reading through all of this, it appears to be a technology issue and not a CBP EMR issue.

The scanners need to be plugged into the computer that they are using, if the scanner is not plugged in it will not work for that computer. Using the back button on the browser and not the return button will cause the issue described below. When they upload, they need to click "ADD" then click "BROWSE" and select the file. Using the browser's back button and not the buttons with in the program will cause this issue.

Also any issues arising from the computer itself, the scanner or any of the equipment and not the software should be reported to the local OIT Field Technology Officer. The EMR Support Team can attempt to help, but most likely will refer to FTO.

And the only reason if defaulted to HRL was because the other positions were not available. Now that it is available, it defaults alphabetically to the top, i.e. Brownsville. This is due to LSGS management wanting all area employees to have access to all locations in the area. The system does not allow for a default position to be set, it automatically goes to the beginning of the alphabet.

And just as a side note, none of these issues have been raised to the EMR Support Team whether via EMR Support Website, the EMR Support Phone Number, or the Technology Service Desk. We have been trying to push the Support System, however there are users that are still going up the chain before even reaching out, thus causing what appears to be "Concern" with the system. Most of the "issues" that are getting reported turn out to be user error and/or technology issues and not specifically related to the CBP EMR software.

Thanks,
[redacted]
Office of the Chief Medical Officer
US Customs and Border Protection
[redacted]

From: [redacted]
Sent: Tuesday, February 9, 2021 10:00 AM
[redacted]
Subject: FW: EMR ISSUES

Good morning EMR team,
Pls see the issues identified below for follow up as required.
Thanks.
[redacted]

From: [redacted]
Sent: Tuesday, February 9, 2021 10:46 AM
[redacted]
Subject: FW: EMR ISSUES

Team,

Forwarding feedback from the staff at the Harlingen Station to the LSGS PM, [redacted] Can you please share with the EMR Team. We'll get through this, together.

Thanks [redacted]

From: [redacted]
Sent: Sunday, February 7, 2021 4:23 PM
[redacted]
Subject: EMR ISSUES

Hello Good afternoon [redacted]
This is the medical staff from Harlingen Station. We are having these issues with our EMR system, at times when documents are being uploaded the page will glitch and a info box will come out saying to reload the page but that the info will be lost and we have to reupload. Not a big issue but an issue nonetheless. Also our scanners are at times not connecting to the computers and we have to switch computers and hope it will work. Today we had to try three

different computers and two scanners, at the end it worked. It's just frustrating having to switch around trying to find something that works correctly. Also when we first sign onto the EMR system it will automatically show up in Brownsville. It used to show up automatically with our current station but after an update that changed. Altogether there are not too many issues on our end with the EMR, we also don't have as much traffic as other stations, averaging 3 detainees daily and those detainees do not always have medications to administer. Currently we have 3 detainees in house. It's possible if there is more traffic we would be able to identify more issues with the EMR. If there are any questions or we are missing anything please let us know.

Thank you [redacted]

Key Document G

From: [redacted]
Sent: Wednesday, May 31, 2023 10:33 AM
To: [redacted]
Subject: FW: Inability to perform Medical Chart Reviews at locations with the EMR

Categorization | Private

[redacted]

From: [redacted]
Sent: Thursday, February 18, 2021 3:33 PM
[redacted]
Subject: RE: Inability to perform Medical Chart Reviews at locations with the EMR

Not in writing but verbally gave a 10-4 to [redacted]n his meeting yesterday. [redacted] was also there and concurred.

From: [redacted]
Sent: Thursday, February 18, 2021 1:55 PM
[redacted]
Subject: RE: Inability to perform Medical Chart Reviews at locations with the EMR

[redacted] was there a reply from [redacted] in ref to this?

VR
[redacted]

From: [redacted]
Sent: Thursday, February 11, 2021 8:13 AM
To: [redacted]
Subject: FW: Inability to perform Medical Chart Reviews at locations with the EMR

Just keeping you in the loop.

From: [redacted]
Sent: Thursday, February 11, 2021 8:52 AM
[redacted]
Subject: Inability to perform Medical Chart Reviews at locations with the EMR

[redacted]
Just wanted to make sure that we were on the same page about the Medical Chart Reviews at the locations that have rolled out the EMR.
LSGS is unable to complete Medical Chart reviews at the locations that have the EMR running due to the inability to access charts from the previous month at these locations.
As we discussed, there are multiple issues and multiple possible solutions.
IPC was going to work the issue and then get back with us, correct?
As always, LSGS is ready and willing to assist where we can to reach a rapid solution.

[redacted]

Key Document H

ORG	CBP MED	Effective Date	04.17.2023	Email	[redacted]
Version	02	Contact	[redacted]	Phone	

HEALTH EVALUATION SOP

PURPOSE

The purpose of this SOP is to inform the LSGS medical staff of the required intake medical evaluations, interim medical care processes, exit assessments, to identify documentation requirements for patients in the Medical Units, to outline the Medical Unit Scope of Care as well as to provide clarification regarding Electronic Medical Record (EMR) use and documentation.

SCOPE

This SOP applies to all providers and staff working in the CBP Medical Units.

PROCEDURES

1) All detainees must be cleared and searched for weapons by the CBP or contract security agents prior to an interview, assessment, and treatment by LSGS Medical Staff. The CBP or designated agent will screen patient's property for medications or other medical devices and medical information.
2) *For safety reasons, LSGS staff members will NOT remain alone with a patient without a CBP Agent in the line of sight during the evaluation and treatment (includes the medical unit, shower, cell, or anywhere else).*
3) All medical actions will conform to the approved Medical Unit Scope of Care (ATCH 2).
4) Support staff will not perform medical assessments except for, according to CBP protocol, EMTs working without an APP).
5) **Intake Health Interview** will be conducted in the Sally-Port area (prior to entering the facility). and will include the following:
   a) Review 13 scripted questions (ATCH 1) with each detainee.
      i) Adults presenting ***without*** signs/symptoms AND with negative responses to the last 7 of the 13 questions shall be referred to the CBP for continued processing. Otherwise, refer to the APP for further evaluation.
      ii) Any patient in the 1st or 2nd trimester of pregnancy, will be offered a medical assessment. If they decline the medical assessment, they continue their processing with the CBP.
   b) Skin & Scabies Assessment: Perform a visual inspection of arms, stomach, back, and legs, and assess for any rashes and injuries.
   c) Lice Assessment: Perform visual inspection of head, hairline, and crown.
   d) Once the Intake Interview in the Sally Port area is complete, ANY required Medical Assessment or Encounter will be conducted as indicated in the next section.
      i) Patients requiring **Medical Assessments** always include juvenile patients less than 12 years of age, juvenile patients between the ages of 12 and18 when operationally feasible, and pregnant patients (3rd trimester required; 1st and 2nd trimester if requested by patient).
      ii) Patients requiring **Encounters** will include patients who answer ***yes*** to any of the last 7 of the 13 questions (ATCH 1), who are currently taking medication, and/or have a medical complaint.

e) Additional intake requirements, ***as directed*** by the provider, for enhanced medical monitoring during specific upticks in prevalence of communicable disease (e.g., temperature, Influenza like Illness (ILI) or COVID-19 Like Illness (CLI) questions) may be required.

6) Initial Assessment & Evaluation
   a) Advanced Practice Provider (APP)
      i) Perform Medical Assessments as required (in the EMR or on Form 002 if the EMR is down).
      ii) Perform Encounter as required to include Medical Assessments that reveal any clinical concerns (EMR or Form 001 if the EMR is down).
   b) Support Staff
      (1) With APP Present:
         (a) Complete Lice & Scabies Encounter forms as needed
         (b) Document vital signs, complete allergies and demographic information as needed
         (c) Perform medication observation duties
         (d) Follow the guidance of the APP on all clinical matters
      (2) With APP Absent
         (a) Perform all steps annotated in sections 5. a-c (above)
         (b) Call Physician (supervising physician / pediatric advisor) for any clinical issues. Any discussion with the physician, any emergency response, and any referral to the ER will be documented in the EMR Medical Encounter (or on Form 001 if EMR is down).
         (c) May recommend direct referral to the ER and document on the medical encounter form. Always maintain a low threshold for referral to ER/advanced levels of care
         (d) Notify the CBP of all patients requiring Medical Assessments.
         (e) Solo Support Staff will not:
            (i) Do Not administer medications without direction from a physician. (physician only or APP too)
            (ii) Do Not determine continued use of foreign medication without direction from a physician.
            (iii) Do Not perform any treatments other than Lice & Scabies protocols or BLS without direction from a physician
            (iv) Do Not perform Medical Assessments (except for EMTs when APP is absent, See ATCH 4 for EMT Assessment Guidance/Protocol).

7) Interim Healthcare Provision:
   a) Perform Encounters on any patient requesting medical attention (sick call). All Encounters will be documented in the EMR (or Form 001 if the EMR is down).

b) Perform medication observation and document via the EMR "Med App" (Medication Observation Log (MOL) if EMR is down). Clinical assessments/actions (i.e., vital signs, asking about symptoms, wound eval, etc.) will not be performed during medication observation. Any clinical assessments/actions deemed necessary will be referred to the MU for a Medical Encounter.
c) Perform any enhanced medical monitoring required per protocol.
d) Any patient returning from the ER / hospital will be evaluated and a completed Medical Encounter in EMR (or Form 001 if EMR is down).

8) Exit Health Interview & Assessment:

When notified by the CBP agents that patients are being transferred out of the facility, LSGS medical staff MUST complete an Exit Health Interview and include the following:

i) Review the 13 scripted questions (ATCH 1) as required with each patient.
ii) Check for any patient medications (review Med App, MOLs) and notify the CBP Agents to help avoid patients departing without their medications.
iii) Completion of the Medical Summary Form 2501 in the EMR or Medical Summary (Form 009) if documenting on paper.
   (1) Document all other information as directed by the CBP to assist with the placement, expedited removal, or outside agency requirements.
   (2) If notified that a patient is being transferred to another station where we have an LSGS Medical Team, LSGS staff at the sending station will call the receiving station provider and provide a verbal report on all patients with significant follow-up care requirements as well as any significant medical concerns.

ROLES AND RESPONSIBILITIES

Responsible	Accountable	Consulted	Informed
All Medical Staff	[redacted], National Program Director	Chief Physician, Health Quality and Education Manager, Chief Nurse	All CBP Medical & Management Staff

DEFINITIONS

APP: Advanced Practice Provider
BLS: Basic Life Support
CLI: Covid-19 like illness
EMR: Electronic Medical Record
Encounter: A medical form within the EMR that is completed when a provider or staff member determines a patient needs treatment, continued monitoring, and or medications.
ILI: Influenza like illness
Med App: Medication Application located within the EMR
Port of Entry: POE

REFERENCES/LINKS

13 Scripted Questions for Patient Intake
Medical Unit Scope of Care
Electronic Medical Record Requirements
EMT Assessment Guidance/Protocol
Form 001
Form 002
Form 003
Form 009
Form 2501

[redacted]

4/17/2023

ATTACHMENT 1

LoyalSource
Government Services

13 Scripted Questions for Detainee Intake

1. Do you have a history of current medical or mental health issues?
   Tiene o ha tenido problemas medicos o condiciones de enfermedad mentales?
2. Are you taking any medications (prescription or OTC)? If yes, do you have it with you?
   Esta tomando medicamento recetadas?
3. Do you have any allergies (food or medicine)?
   Tiene alergias a cualquier medicicamento o comida?
4. Are you a drug user?
   Usa drogas?
5. (If female) Are you pregnant? If yes, how many months?
   Esta embarasada? Quantos meses/semanas?
6. (If female) Are you nursing?
   Estas amamantando?
7. Are you currently injured or do you have significant pain?
   Esta erido or tiene dolor en algun lugar?
8. Do you have a skin rash?
   Tiene una condicion en la piel?
9. Do you have a contagious disease?
   Tiene una enfermedad contagiosa?
10. Are you thinking about hurting yourself or others?
    Esta pesando lastimarte a ti miso o algien mas?
11. Do you feel feverish or do you feel that you have a fever?
    Te sientes febril o tiene fiebre?
12. Do you have a cough or difficult breathing?
    Tiene toz o problemas respirando?
13. Do you have nausea, vomiting, or diarrhea?
    Tiene nausea, vomitos or diarea?

ATTACHMENT 2

Medical Unit Scope of Care

Each medical specialty has its own "Scope of Practice", many of which are managed by individual State Boards. Defining the Medical Unit Scope of Care ensures all LSGS Medical Team Members understand our constraints as we operate in the CBP MEDICAL UNIT, and under the auspices of the contract Loyal Source Government Services has with the U.S. Customs and Border Protection.

Our **Scope of Care** is limited to Public Health Assessments, Limited Acute/Chronic Care, and Basic First Aid and Life Support.

1. **Public Health Assessments:** Nurse Practitioners, Physicians Assistants (hereafter referred to as APPs) and trained Support Staff (CNAs, CMAs, EMTs, paramedics) can participate in basic Public Health assessments to identify vectors or diseases that could pose a public health threat. Assessments are accomplished using a standardized tool for questions, visualizing skin on arms, legs, abdomen and back for rashes or injuries, and checking hair around the neckline, ears, and crown for presence of lice. Various "enhanced medical monitoring" items (e.g., temperature, ILI, CLI questions) may be required based on disease surveillance trends.
    a. Standing orders are published for treatment of lice and scabies. All support staff shall successfully complete skills verification assessments (signed off by Patient Safety RNs or APPs) on lice and scabies identification & treatment prior to working alone.
    b. Detainees with positive responses to the standardized questions shall be evaluated by an APP. If support staff is working without an Advanced Practice Provider, the support staff will notify the supervising physician to receive instructions for care or referral to the Emergency Room (ER) or Urgent Care. Solo support staff may also refer to the ER prior to calling a supervision physician. Loyal Source maintains a low threshold for referral to advanced levels of care.
2. **Limited Acute Care:** The MEDICAL UNITs do not have access to routine laboratory, radiology diagnostic or confirmatory tools. We provide acute care for limited diagnoses, chronic illnesses, and minor injuries. Assessments are largely based on clinical judgment vs. confirmatory lab tests. Patients with illnesses or injuries that require advanced diagnostic tools will be referred to ER or Urgent Care. Most of the ailments we manage can be treated with OTC medications or limited prescription medications. Evaluating chronic medications, and continuing them if no additional labs are required, falls within our scope. Examples of care **outside the scope of the MEDICAL UNIT** include:
    a. Injections (other than epi pens and sub-q insulin)
    b. IVs
    c. Suturing
    d. Incision & drainage
    e. Prescribing narcotics or scheduled medications
    f. Nebulizer treatments
    g. Oxygen therapy

Any clinical questions should be directed to Supervising Physicians, Pediatric Advisors or Patient Safety RNs who are available at each sector for consultation.

3. **Basic First Aid and Life Support**: All employees are expected to be certified in Basic Life Support (BLS). During emergencies, our role is to provide BLS functions and respond to any "life, limb or eyesight" emergency within the CBP or Port of Entry (POE) station assigned. Our scope includes calling 911 and keeping the patient stable following BLS tenants until the emergency response team arrives. AEDs and Airway Bags are available for emergency response.

ATTACHMENT 3

All LSGS Medical Staff:

Please review the requirements below. Some deal solely with the use of Electronic Medical Record (EMR) and others pertain to all locations with or without the EMR.

Effective as of January 2021:

DO NOT upload any documents into the EMR other than those documents that come with the detainee from the ER/Hospital and Medication Observation Log (MOL) (if used) after detainee is discharged.

The **ONLY** items required for entry into EMR are the Intake Medical Assessment (IMA), the Encounter Form, and the Medical Summary Form (Use the EMR for these forms as if you would on the paper version)

Temperatures taken during initial intake screening and outbound screening are NOT entered into the EMR.

Remember:

1. All patients under the age of 18 (not including 18) and all third (3rd) trimester pregnant patients require a medical assessment to be filled out.
2. All orders for medications or monitoring will be entered into the Medication Application (Med App) on the EMR with the corresponding encounter note that adequately describes why the medication is ordered.

Ensure that all the patients on the whiteboard (hanging whiteboard or within the EMR) have an encounter form in the EMR or in the File Folders that gives a reason and an order for what is reflected on the whiteboard.

ATTACHMENT 4

EMT Assessment Guidance/Protocol (Working as Solo Support Only)

1. In general, EMTs/paramedics should err on the side of caution when conducting medical assessments. EMTs/paramedics can call a supervising physician, sector Pediatric Advisor for pediatric patients, or the medical director for medical direction. If at any time, there is any concern for urgent or emergent illness or injury, the EMT/paramedic should activate EMS, recommend transport or refer the detainee to the local health system.

2. Tender age patients, especially infants, should generate a higher index of suspicion for illness or injury and a lower threshold for referral.

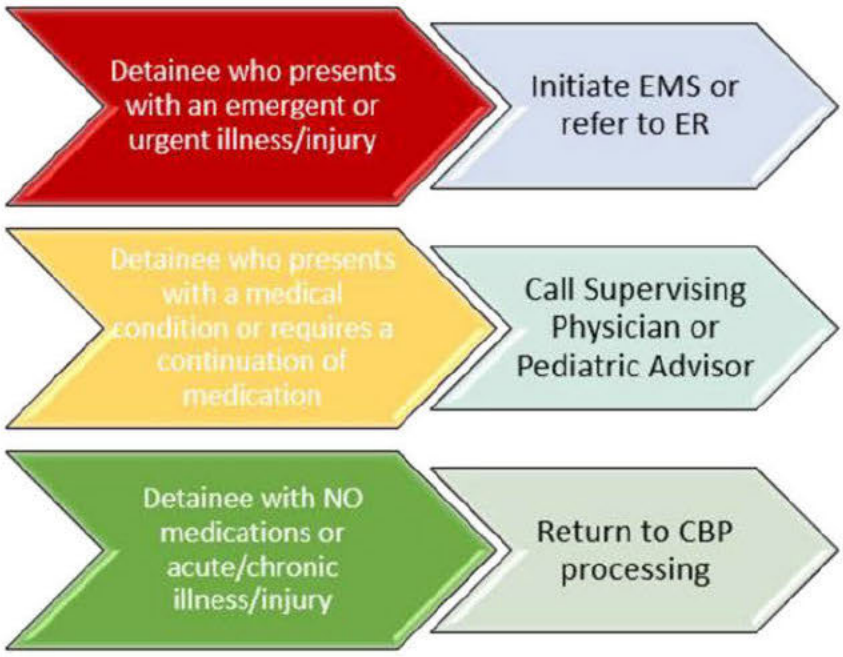
3. Medical Assessment should consist of:

i. Vital signs

ii. Chief Complaint/History/Review of Systems

iii. Physical Examination

iv. Disposition (see Flow-Chart)



4. Referral for Significant Findings

1. A patient found to have any significant subjective or objective assessment findings will be referred to local ER/Hospital for further evaluation. Significant assessment findings are as follows (**CAUTION:** this is not an all-inclusive list):

Significant Assessment Findings

Fever (>100.4 degrees Fahrenheit or reliable history of fever in past 3 days)
Disorientation/Confusion/Altered mental status
Muscle weakness or paralysis
Other abnormal vital signs
Abnormal physical examination
Apparent physical injury
Adult with chest pain
Cough or difficulty breathing
Nausea/Vomiting/Diarrhea
Any indication of potential harm to self or others
Any indication of a communicable illness
Unusual rash
History of significant illness without proper/current treatment or medications

Key Document I

Office of Health Security
U.S. Department of Homeland Security
Washington, DC 20528

PRE-DECISIONAL / DELIBERATIVE

June 08, 2023

MEMORANDUM

TO: Troy Miller
Acting Commissioner
U.S. Customs and Border Protection
Department of Homeland Security

FROM: Herbert O. Wolfe
Acting Chief Medical Officer
Acting Director, Office of Health Security
Department of Homeland Security

SUBJECT: **Initial Observations and Recommended Medical Improvement Actions for the Care of Individuals in CBP Custody**

The health and safety of individuals in the care and custody of the Department of Homeland Security (DHS), our employees, and the public are of paramount importance. Following the in-custody death of an eight-year-old child in U.S. Customs and Border Protection (CBP) custody in Harlingen, Texas, Acting Commissioner Miller requested a review of CBPs medical care practices by DHS's Office of Health Security (OHS).[1] In response to this request and pursuant to OHS oversight authority[2], OHS conducted an in-person site visit to evaluate medical care, practices, and procedures at multiple CBP facilities in the RGV Sector. As Acting Chief Medical Officer, and Acting Director of OHS, I directed and participated in this Rio Grande Valley (RGV) Sector evaluation along with the OHS Senior Medical Officer for Operations (Dr. Alexander L. Eastman), staff from CBP's Office of the Chief Medical Officer (OCMO), and the court-appointed Juvenile Care Monitor (JCM) overseeing CBP's compliance with the *Flores* Settlement Agreement for RGV and El Paso Sectors (Dr. Paul H. Wise).

The purpose of this site visit was to make initial observations on the delivery of medical care, practices, and procedures inside CBP's facilities in the RGV Sector. The following recommended medical improvement actions were directly informed by these initial observations.

[1] Statement from CBP Acting Commissioner Troy Miller on the Investigation of the in-custody death of a child | U.S. Customs and Border Protection.

[2] DHS Delegation 26000, *Delegation to the Chief Medical Officer/Director of the Office of Health Security,* issued December 14, 2022, delegates, in relevant part, the CMO the authority to "[o]verse all medical, public health, and workforce health and safety activities of the Department of Homeland Security" (section II.A.1.), and "[s]erve as the senior medical review authority for determinations regarding whether the standard of care for individuals in DHS custody has been met when there are claims or allegations of improper or substandard healthcare against the Department or any of its Components, employees, detailees, or contractors" (section II.C.2.).

Each of these recommended medical improvement actions is critical to ensuring that individuals in CBP custody receive safe, effective, and humane medical care while in DHS custody, and that such care is well-documented.

1) Medical Risk Reduction

Observations: Average family unit time in custody exceeded established standards.[3] Processes to identify and communicate the presence of medically at-risk individuals (to include children) did not appear to be in place to enable CBP awareness of the presence of medically at-risk individuals in their facilities.

Recommended Medical Improvement Action:

Ensure that medically at-risk individuals in CBP custody, as determined in consultation with the medical services contract providers, with oversight[4] from CBP OCMO, and in accordance with Acting Commissioner Miller's Memorandum on *Custodial Considerations for Medically At-Risk Individuals*[5], are expeditiously processed to minimize the length of time in CBP custody.

2) Contract Management and Operations

Observations:

CBP's management of the current CBP Medical Services Contract (MSC) is leading to unsafe medical care delivery conditions and the increased likelihood for preventable harm. Unable to verify that sentinel event reviews[6] are being conducted and/or documented. Lack of CBP visibility regarding contract supervising physician's role, involvement, and presence as well as clinical guidance standard operating procedures (SOPs).

Recommended Medical Improvement Actions:

CBP should improve awareness of day-to-day clinical operations. Subject to the federal acquisition regulation, CBP should review the current MSC to determine what improvements to the monitoring of contractor delivered care are required or should be implemented, which should include but are not limited to:

A) Providing OHS a list of all sentinel events reviewed over the past twenty-four (24) months.
B) Establishing a sentinel event review process in accordance with DHS Medical Quality Management (MQM) policies[7], and contract requirements.

3) Enhanced Medical Monitoring (EMM)

Observations:

Lack of implemented objective utilization criteria, clinical guidance, protocols, and procedures led to the inadequate use of EMM in the RGV Sector. The CBP electronic medical record (EMR) system was not properly utilized; specifically, medical care provided to individuals in the Harlingen Isolation Unit was either inadequately documented or, in other instances, not documented at all.

---

[3] CBP's Transport, Escort, Detention and Search (TEDS) standards state that detainees generally should be held in custody for no more than 72 hours.

[4] *See* section 4.B. below for Recommended Medical Improvement Actions related to Clinical Care Communication and Documentation.

[5] Memorandum, *Custodial Considerations for Medically At-Risk Individuals, from Acting Commission*, Troy A. Miller, dated May 19, 2023.

[6] DHS Directive 248-01, *Medical Quality Management,* dated October 02, 2009, and DHS Instruction 248-01-001, Revision 01, *Medical Quality Management,* dated September 10, 2012.

[7] *Id.*

The supervising physician contact roster was out of date, and in addition, the MSC providers and support staff neither contacted nor consulted the supervising physicians or on-call pediatric advisors.

Recommended Medical Improvement Actions:

A) Ensure all individuals placed in isolation have an EMR-documented consultation with the supervising physician and/or a pediatric advisor. This may occur during their initial medical assessment or a subsequent encounter where the decision to place in isolation is made.
B) Supervising physician and/or pediatric advisor should also be contacted for any potential referral to emergency or outside healthcare resources. [Note: Under medical emergency conditions, if time and clinical conditions do not permit notification prior to transfer, notification should be made to the supervising physician as soon as possible.]
C) Publish updated EMM guidance in consultation with OHS, to include directing the use of the EMR EMM module within seven (7) days of the issuance of this memorandum.
D) Update the EMM guidance and revise the MSC to ensure that EMR-documented clinical assessments be conducted every four (4) hours for all juveniles in isolation, every twelve (12) hours for all adults in isolation, and daily for any individuals seen for a medical complaint and considered to have elevated in-custody medical risk.

4) Clinical Care Communication and Documentation

Observations:

Critical clinical information, including medical history, was initially documented in the EMR by medical providers but was not reviewed by the medical providers responsible for subsequent care while in isolation. Requests for medical care were not consistently documented. Clinical interactions, medical assessments, and encounters were documented inaccurately within the EMR, not documented in the EMR, and/or not shared with subsequent medical service providers. The current EMR lacks functionality to facilitate continuity of care between shift providers or easily produce a complete care-in-custody summary. There was no documented communication between the custodial and medical personnel regarding awareness of at-risk individuals or acute medical care issues.

Recommended Medical Improvement Actions:

A) Update the EMR to include near-term functionality to comprehensively document all clinical history (including but not limited to at-risk designation and acute medical care issues), medical findings, and medical care provided by CBP's contract medical staff for individuals in CBP custody.
B) Ensure information sharing and accountability at shift change for medically at-risk individuals in CBP custody to include musters with operational, medical, and support staff across the CBP facility. This information sharing and accountability must be electronically documented.
C) Develop and provide to all individuals, to include both verbal instructions and visible posting in isolation areas, the procedures for requesting medical attention and for escalation.
D) Improve the transfer of medical information to U.S. Immigration and Customs Enforcement (ICE) and to the U.S. Department of Health and Human Services' (HHS) Office of Refugee Resettlement (ORR), with a specific focus on those who are at elevated in-custody medical risk and/or who had medical assessments and encounters

during their time in CBP custody, to ensure the accurate and timely official transfer of chronic and acute medical condition information.

E) Producing a CBP Medical Care Manual, inclusive of SOPs, within ninety (90) days.

5) USBP Isolation Unit Operations

Observations:

Medical care at the USBP Harlingen Isolation Facility was inadequate and lacked sufficient medical engagement and accountability to ensure safe, effective, humane, and well-documented medical care of individuals who were placed in medical isolation.

Recommended Medical Improvement Actions:

A) Cease utilization of the Harlingen Isolation Unit and transition operations to the Donna Processing Center designated isolation pod.

B) Establish a process that requires consultation with OHS prior to the establishment of any new isolation unit(s).

C) Develop and publish written guidance, in consultation with OHS, for Isolation Unit standards and operating procedures within thirty (30) days.

Lastly, pursuant to the Department's May 21, 2023, request for assistance to HHS, the United States Public Health Service (USPHS) have deployed a cadre of USPHS uniformed clinicians to multiple CBP sites starting this week. These USPHS Commissioned Corps clinicians will work for up to 30 days, under the immediate direction of Dr. Eastman, and in close collaboration with CBP, to provide additional medical recommendations, guidance, and oversight capability as you implement the above recommended medical improvement actions. We are continuing our evaluation of medical care, practices, and procedures inside CBP's facilities.

Key Document J

U. S. Customs and Border Protection
Office of the Chief Medical Officer

Medical Process Guidance

June 2023

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Background

CBP places the highest priority on the health and well-being of persons in CBP custody. To address this and to keep pace with increasing operational tempo and migrant flows over recent years, CBP has significantly enhanced its medical support efforts in scope and scale. CBP has developed a robust, trauma-informed, front-line medical support system for persons encountered and in custody along the Southwest border.

CBP's medical support system is designed to complement CBP's operational mission. It is the responsibility of each component to establish an operational workflow to ensure that all medical needs for persons in custody are coordinated with and complement existing policies and procedures.

The following medical process guidance supports CBP policy including the National Standards on Transport, Escort, Detention, and Search (TEDS) and the Enhanced Medical Support Efforts Directive 2210-004, and the Pregnancy and Childbirth Guidance memo dated 8/18/21. This medical process guidance is intended to facilitate coordination and execution of medical support efforts by CBP contract medical personnel and CBP operational personnel as appropriate. It does not replace or supersede existing policy.

CBP medical support is designed to provide health interview, medical assessment, medical care, and referral of persons in CBP custody, in support of and in accordance with CBP operational requirements. As always, emergent, and life-threatening medical needs should be immediately referred to the local health system by activating 911 or other emergency transport methods.

CBP Medical Process & Forms

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I. Health Intake Interview (CBP 2500)

This tool is known as Alien Health Intake Interview Questionnaire CBP 2500 in the enforcement system (e3/USEC) and as the Health Intake Interview in the CBP Electronic Medical Record (EMR) used by Medical Service Contractors (MSC). The tool is used by CBP personnel (BP Agents or CBP Officers) and/or MSC personnel to record the observation and identification of potential medical issues for persons in custody (PIC) upon initial entry to a CBP facility.

When to use it-

1. Where contract medical personnel are available, **all** persons brought into custody, will have an initial (first phase) Health Intake Interview conducted by MSC medical personnel upon initial arrival at a CBP facility. The first phase is the verbal administration of the health interview questions in the 2500 form to identify persons with potential medical issues.

2. If operationally feasible, this will occur prior to entry into the general population of the facility (e.g., in the Sally Port).

3. If contract medical personnel are not available, then CBP personnel will conduct and document CBP 2500s on all persons as operationally feasible. At minimum, CBP personnel will conduct and document a CBP 2500 for all juveniles and any person identified with a potential health issue of concern brought into custody in a CBP facility.

4. The Health Intake Interview will be utilized to document and identify:

    a. Any person with an urgent/emergent medical condition requiring immediate external medical referral, transport, and/or activation of 911/EMS.
    b. Juveniles who will be referred for a medical assessment.
    c. Any person with a potential illness, injury, medication requirement, or other medical issue to be referred to onsite MSC personnel for a medical assessment.
    d. Pregnant females, who will be offered a medical assessment.

5. Health Intake Interviews (second phase)-will be conducted and documented by MSC personnel for the persons identified in 4.b.c.d. above at the time of the medical assessment. The second phase is the formal completion of the health interview with documentation in the EMR.

6. Health intake interviews will be conducted as appropriate and documented by MSC (or CBP) personnel but will be repeated and documented for juveniles every 5th day while in CBP custody. CBP will monitor juveniles' time in custody

and will escort juveniles to the Medical Unit as needed. (NOTE: See Assessment section for additional requirements for tender age juveniles (12 and under) and Noncitizen Unaccompanied Children (NUCs) in custody for 5 or more days).

7. Persons in custody who are transferred from other CBP facilities may receive an additional health interview upon arrival at the receiving CBP facility. A health interview is required upon arrival at a CBP facility if there was significant distance or time in transport – greater than 12 hours – or the individual's medical condition is known or reported to have changed during transport. CBP will notify the MSC of any person in custody that meets this requirement.

Who can do it-

1. The Health Intake Interview will be conducted by MSC personnel and/or by CBP personnel where MSC personnel are not available, as appropriate. Appropriate translation services should be utilized in compliance with applicable policy. (CBP Language Access Directive 2130-031)

Where to Record It-

1. Health Intake Interviews for all juveniles and persons with affirmative responses (requiring a medical assessment) will be documented by MSC personnel in the CBP EMR (where available) either directly upon conduct of the initial (first phase - verbal) health intake interview or during the second-phase health intake interview at the time of the medical assessment.

2. If no MSC personnel are available (or where the EMR is not available) CBP personnel will document the completed CBP 2500 in the enforcement system of record.

II. Medical Assessment

A medical assessment is a structured tool used by medically trained personnel to assess and confirm potential medical issues in juveniles, pregnant females, or any persons in custody identified with potential medical issues during the CBP Health Intake Interview as part of initial intake processes at CBP facilities.

When to use it-

Medical assessments will be conducted by MSC personnel on all juveniles, anyone with a potential medical issue identified by the Health Intake Interview/CBP 2500, or otherwise identified with a potential injury, illness, medication requirement, or other medical issue. Medical assessments will also be offered to all pregnant females.

1. Medical assessments, as required, will be conducted as expeditiously as possible upon arrival at a CBP facility for processing, in accordance with other law enforcement requirements, at a minimum within 24 hours of arrival.
2. Medical assessments:
    a. Will be conducted on all juveniles (see below for additional detail)
    b. Will be conducted on anyone with a potential medical issue identified by the Health Intake Interview/CBP 2500 or otherwise identified with a potential injury, illness, medication requirement, or medical issue.
    c. Will be offered to all pregnant females.
3. In the above situations, related to initial medical intake, medical assessments will be conducted in addition to a medical encounter, if required.
    a. Medical issues identified during custody after initial medical intake may be addressed directly through medical encounters without medical assessments.
4. It is expected that **all** juveniles have a medical assessment conducted.
    a. In rare situations where operational dynamics and/or lack of medical resources make medical assessments of all juveniles not feasible, then medical assessments on non-tender age juveniles may be temporarily paused to focus limited medical resources on tender age juveniles and persons with identified medical issues.
    b. A pause as described in (a) above requires written approval by Facility leadership and OCMO and should cease as soon as operationally possible.

c. There are no exceptions to the requirement of tender-age juveniles receiving a medical assessment. If MSC personnel are not on-site, the juvenile will be referred to a local healthcare facility for a medical assessment.

5. Pregnant females in custody will be offered a medical assessment.
    a. All pregnant females who refuse the offer of a medical assessment, will be documented in the assessment section of the CBP EMR by MSC personnel and in e3/USEC by CBP personnel.
6. Following completion of medical assessments, for individuals identified as requiring additional medical evaluation or treatment, MSC personnel or CBP personnel shall make the appropriate disposition, based on the circumstances and medical recommendations.
    a. For example: BPA/CBPO and medical personnel may activate 911/EMS; refer/transport to local health system; or conduct medical encounter/treatment onsite.
7. Medical assessments will be repeated every 5th day for tender age juveniles and for Noncitizen Unaccompanied Children (NUCs) in custody.

Who can do it-

The assessment will be conducted by MSC advanced practice providers (APP), when available. In the absence of an APP on shift, an MSC EMT or Paramedic may perform the assessment with appropriate remote supervision. If MSC personnel are not available, persons in custody may be referred to the local health system for a medical assessment, as appropriate.

Where to Record It-

The medical assessment will be documented in the CBP EMR by MSC personnel. MSC medical support personnel can initiate and input objective data in the record, but only a MSC APP can complete the assessment and sign and record it in the CBP EMR.

- An MSC EMT or Paramedic can sign the record when no MSC APP is staffed at the facility, with appropriate remote supervision.

III. Medical Encounter

A medical encounter is a structured medical interaction conducted or supervised by MSC APPs for evaluation, treatment, disposition, and follow-up of medical issues identified in the Health Intake Interview, Medical Assessment, or throughout the time in custody.

When to use it-

1. Medical encounters will be conducted to address medical issues identified through initial intake processing (Health Intake Interviews, Agent/Officer interviews, Medical Assessments).
2. Medical encounters will be conducted to address medical issues that arise or are identified throughout the time in custody.
3. Medical encounters will be conducted for persons returning from referral to a medical facility – to review the findings and disposition and to ensure appropriate follow-up care.
4. NOTE: Medical encounters are not intended to substitute for immediate/emergent activation of 911/EMS and/or transport to medical facility

Who can do it-

MSC medical APPs can conduct medical encounters. In limited circumstances, subject to appropriate protocols and medical supervision, MSC EMT/Paramedics may conduct pre-designated, supervised medical encounters, such as routine lice and/or scabies treatments.

Where to Record It-

The medical encounter will be documented in CBP EMR by the MSC provider. MSC medical support personnel can initiate and input objective data in the record, but only a MSC APP can complete the encounter and sign and record it in the CBP EMR.

- In limited circumstances, per above, medical encounters conducted by remote MSC EMT/Paramedics with medical supervision, may be documented in the EMR by MSC EMT/Paramedics, with appropriate medical supervision and review.

IV. Medication Application (Med App)

An application in the CBP EMR and in the e3/USEC enforcement systems that monitors and documents MSC or CBP personnel supervision of medication self-administration by persons in custody.

When to use it-

1. The application is used when a person requires medication, either prescription or over the counter, while in CBP custody.
2. The medication may be prescribed by a MSC APP or may have arrived with the person.
3. MSC personnel (or CBP personnel if no MSC personnel available) document the observation of self-administration of required medication by entering each instance into the medication application.

Who can use it-

1. Only a MSC APP can prescribe medication or recommend the continued administration of medication in the persons possession.
2. MSC support personnel or CBP personnel can observe the self-administration of medication per the medication application and must document each instance as described in the section above.

Where to record it-

1. MSC personnel will document the date, time, medication, dosage, etc. in the Medication Application (Med App).
2. When no MSC personnel are available, CBP personnel will document each observation of medication self-administration in the Med App portion of the Enforcement System (E3 and USEC).

When the MSC APP (or local healthcare facility provider) prescribes a medication, CBP will ensure that every effort is made to fill the prescription as soon as possible.

If the person is transferred or released from the CBP facility prior to the receipt of a medication, the written prescription should accompany the person's transfer or release paperwork and be documented on the Medical Summary Form which should also accompany them. It is the MSC provider's responsibility to communicate the need for a prescription on CBP's behalf.

- ***<u>Any medication belonging to a person in custody being transferred should be identified and provided to CBP upon transfer or to the individual upon release.</u>***

- The MSC APP may assess medications (including foreign) in the person's possession, determining whether the medication is clinically indicated and appropriate for the person's illness or condition.

    - If the MSC APP identifies no issues or concerns with the medication, then its usage may be continued and documented in the CBP EMR.

    - If the medications packaging, label, or contents do not seem verifiable or appropriate (i.e., loose pills in an unlabeled bag), the MSC APP should prescribe the proper medication to be obtained by CBP.

V. Medical Outtake Process

The Medical Outtake Process ensures medical issues are addressed by MSC and CBP personnel during out-processing for transfer or release from CBP custody, including, as appropriate, the CBP Medical Summary Form (CBP 2501), provision of medications or prescriptions, provision of external medical discharge forms.

Medical Summary Form (CBP 2501) – The Medical Summary Form is a tool used by MSC personnel to provide a summary of medical issues identified or addressed in CBP custody, including disposition, medication, and follow-up care requirements. The Medical Summary Form will accompany the persons in custody upon travel, transfer, or release from CBP custody and identify medical issues addressed or observed while in CBP custody.

1. Medical Summary Forms will be completed for persons with medical issues identified or addressed in CBP custody upon transfer to a non-CBP facility or release. Medical Summary Forms may be required by external agencies even if no medical issues were observed while in CBP custody.

2. If a person is being transferred from one CBP facility to another CBP facility, a Medical Summary Form (CBP 2501) is not required.

Who can do it-

Medical summary forms can be filled out by MSC personnel only.

Where to record it-

1. The Medical Summary Form will be documented in the CBP EMR by the MSC and should include the name of the hospital if the person was referred.
    a. For transfers - a hard-copy will be included by CBP in the transfer file.
    b. For releases – a hard copy will be provided by CBP to the person upon release from custody.

Additional Requirements

1. Medications/Prescriptions
    b. Prior to transfer or release, persons in custody will be provided medications or prescriptions, as appropriate.
    c. The medication or prescription will be documented on the Medical Summary Form by the MSC.
2. External Medical Documentation

a. Prior to transfer or release from custody, persons will be provided any external medical documentation (e.g., hospital discharge summaries) that were provided to CBP.
    - For transfers - the documentation will be placed by CBP with the person's transfer paperwork
    - For releases – the documentation will be provided by CBP to the person upon release from custody.

VI. EMR Outages/Use of Paper Medical Records

During emergent situations or CBP EMR outages, paper documentation may be necessary and required to meet timelines and support decompression efforts. If the need arises to pause the use of the CBP EMR, the local Patrol Agent in Charge (PAIC) or Port Director (PD), or their designee, will decide whether to allow this pause in coordination with the CBP Office of the Chief Medical Officer (OCMO) Program Manager (PM) or his/her designee. The coordination and agreement will be made in writing.

1. Any paper documentation must be entered into the CBP EMR by the MSC by the end of their shift, if possible. If not possible, then it should be completed within 24 hours after they are instructed to begin using the CBP EMR again.

2. When paper medical records have been entered electronically into the CBP EMR, the paper document should be disposed of in accordance with CBP records management policy (within a CBP locked shred bin or shredder).

Key Document K

U.S. Customs and Border Protection
6650 Telecom Drive Suite 100
Indianapolis, IN 46278

Department of Homeland Security

August 10, 2023

Brian Moore
Chief Executive Office
Loyal Source Government Services
12612 Challenger Parkway | Suite 365
Orlando, FL 32826

SUBJECT: Request to Cure Deficiencies of Task Order (TO) 70B03C23F00000272

Mr. Moore:

United States Customs and Border Protection (CBP) is sending this Cure Notice to Loyal Source Government Services (LSGS) in accordance with Federal Acquisition Regulation (FAR) Subpart 12.403, for deficient performance of Task Order 70B03C23F00000272, medical support services. The noted areas of concern below are endangering Task Order performance and require immediate corrective action by LSGS.

LSGS' performance under the Task Order show deficiencies in the following tasks within the Task Order Statement of Work (SOW) and Appendix B: CBP Medical Services Contract Deliverables:

Task Category 2 – SOW Section 3.5.6 and Service Performance Measure 2 & 8 - Appendix B

- **Business Management Practices:**
  - Inadequate shift fill rate at several medical units. Staff shift fill rates have not reached 95% required by the SOW for all sites (there is an allowance of 5% for absenteeism).
  - Cost Management – contract travel cost increases are excessive and continue to be a concern.

Task Category 3 – SOW Section 3.3.9 and Service Performance Measure 2 & 8 - Appendix B

- **Ineffective Staffing:**
  - Each weekly sync specifically details staffing gaps and specific MUs with subpar shift fill rates.
    - On-Going discussions between Office of the Chief Medical Officer (OCMO) and LSGS regarding recruitment, retention, and strategies for shifting staff to priority sites have not yielded the desired SOW results.
  - Week ending July 22, 2023 – 24 of 86 MUs with less than 69% of provider shifts filled.
    - Each weekly sync between OCMO and LSGS specifically details staffing gaps and specific MUs with subpar staffing fill rates.

Task Category 4 – SOW Section 3.4 and Service Performance Measure 4, 5 & 7 – Appendix B

- **Safety and Quality of Care:**
  - Incorrect and absent reporting on deliverable reports and medical encounters are not being input into the Electronic Medical Records.
  - Non-compliance with SOW MQM requirements (i.e., patient chart reviews).
  - Staff are failing to escalate care and consult physicians.
- **Safety and Quality of Care:**
  - Incorrect and absent reporting:
    - LSGS reported medical interactions average 19% to 40% higher than documented in the EMR.
    - QA project report submitted by LSGS showed multiple data collection errors contributing to errors in reporting.
    - No Performance Improvement plans were developed or initiated, and therefore there has been no change in the percentage of data reporting errors.
  - LSGS infectious disease (to include Flu Response Plan); Quarantine and Isolation Plan; Respiratory Protection Plan) weekly report with significant errors in 42% of reports.
    - LSGS was informed of the root cause of the errors, no corrective action has been presented to OCMO to show how LSGS will prevent repeated errors that continue to occur.
  - Sentinel Event Reporting.
    - LSGS reports reviewing zero sentinel events during this bridge contract period of performance, however, there have been at least 2 sentinel events.
  - LSGS Staff continue to site HIPPA when asked for information about migrants in their care.
    - HIPPA does not apply to providing information to CBP for persons within CBP custody; emails and EMR banners are being ignored by LSGS staff.
- **Non-compliance with SOW MQM requirements:**
  - Updated MQM Program Guidance released February of 2023 and LSGS has not adopted.
  - Lack of Ongoing Professional Performance Evaluation Standards. Specifically, including chart reviews of provider peers.
    - LSGS indicates that to follow the MQM program guidance as issued February 2023, additional administrative support staff would be required to focus on this task alone.
    - Noncompliance with multiple sections of the SOW related to MQM (SOW Sections – 2.1.5, 3.3.16, 3.4.1, and 3.4.6).
- **Failure to Escalate Care and Consult Physicians:**
  - Identified as significant deficiency by external stakeholders in publicly filed reports as discussed in multiple meetings.
  - Contract modification P00002, Supplemental SOW, addressed the failure to escalate care and consult physicians, as it was identified as an immediate need by the DHS/OHS team investigating recent death in custody.
  - A recent quality assurance chart review was completed by the OCMO to ascertain if contract modification P00002, effective May 30, 2023, was being

followed in accordance with section 3.1.12. The results of the QA project revealed that physician consultation remains below 10% of indicated.
- No corrective action plan identified by LSGS to date.

This letter serves as a formal cure notice in accordance with Federal Acquisition Regulation 52.212-4 Contract terms and Conditions – Commercial Items and the terms and conditions set forth in Task Order 70B03C23F00000272 and its supporting Statement of Work. Loyal Source Government Services is hereby notified that the Government considers your performance under the subject task order to be unsatisfactory. Therefore, Loyal Source Government Services has 10 days to provide a corrective action plan to address the stated deficiencies after receipt of this notice.

Please promptly acknowledge receipt of this Notice via reply e-mail.

Sincerely,

[redacted] Digitally signed by [redacted]
Date: 2023.08.10 18:40:51 -04'00'

Contracting Officer

Key Document L

U. S. Customs and Border Protection
Office of the Chief Medical Officer

Medical Process Guidance

Annex A
Elevated in-Custody Medical Risk (ECMR)

October 2023

Background

The following contains supplemental guidance on specific actions and timelines for implementation of the recommended medical intervention actions referenced in Department of Homeland Security (DHS) Office of Health Security (OHS) Memorandum dated June 08, 2023, and Acting commissioner Troy Miller's response dated June 09, 2023, which states, in part, "*At-risk or medically fragile individuals, which includes but is not limited to individuals with a chronic illness; infants or elderly; minors with an acute injury, medical or mental health condition; pregnant women or post-partum mothers with complications; and individuals with a disabling mental disorder, should be expeditiously processed to minimize the length of time in CBP custody. While such individuals are in our custody, it is imperative to ensure timely medical assessments, recurring wellness checks, and follow up assessments by medical providers are conducted pursuant to CBP policies and documented via appropriate systems.*"

The CBP Chief Medical Officer has implemented the following protocol to identify and categorize persons in custody according to the medical risk indicators.

Definitions

APP	Advanced Practice Provider (Nurse Practitioner/Physician Assistant
BHS	Border Health System
CBP EMR	CBP Electronic Medical Record
MSC	Medical Services Contract
PIC	Persons in Custody

I. Elevated In-Custody Medical Risk (ECMR)

Elevated medical risk may result from a condition itself, from the risk for sudden worsening or decompensation, or due to the complexities of medical care required to effectively stabilize and treat the condition when the medical needs reasonably exceed the CBP facility's capabilities.

The CBP Health Intake Interview (CBP 2500), a 13-question medical screening tool is used to identify individuals with a medical condition and in need of additional evaluation.

A subsequent Medical Assessment is then performed as the first contact with CBP Border Health System (BHS) qualified providers. This is designed to assess individuals quickly yet comprehensively for current and past medical diagnoses/conditions that may place the individual at elevated risk for deterioration while in custody. Acute medical needs will be addressed and appropriate consultations with physicians made. Individuals determined to be at elevated in-custody medical risk (ECMR) during the medical assessment and/or medical encounter will be identified using the below listed category definitions.

II. ECMR Category Definitions:

When a PIC is medically assessed and found to have an elevated medical risk (ECMR), the color category is determined by the diagnosis selected in the CBP EMR.

The following categories define different levels of in custody medical risk:

- **Green** – PIC with no known/indicated medical issues based on responses to the Health Intake Interview

- **Yellow** – PIC has a medical condition identified based on responses to the Health Intake Interview and/or was determined that the PIC's condition has been well-controlled, is able to be managed while in CBP Custody, and presents low risk in-custody medical risk based on the Medical Assessment or Medical Encounter.

- **Orange** – PIC has a medical condition identified based on responses to the initial health interview and/or was determined that the PIC's condition presents moderate in-custody medical risk and requires treatment and enhanced medical monitoring while in CBP Custody based on the Medical Assessment or Medical Encounter.

- **Red** –PIC has a medical condition based on responses to the Health Intake Interview (CBP 2500) and/or was determined to present high in-custody medical risk while in CBP Custody and requires enhanced medical monitoring while in CBP Custody based on the Medical Assessment or Medical Encounter. These specific conditions are outlined in the document below.

III. ECMR Process Requirements:

- **Green** –
    - Does not require further action unless the PIC presents later in custody with a new medical issue or concern. A Medical Encounter shall be performed as per policy and a color designation change should be clearly documented in the CBP EMR.

- **Yellow** –
    - Must be annotated in the CBP EMR

- **Orange** –
    - must be annotated in the CBP EMR,
    - the PIC should be placed in the Enhanced Medical Monitoring (EMM) protocol receiving checks every 12 hours at a minimum.
    - The PIC should be evaluated for medical isolation (see list of isolatable conditions below).

- **<u>Red</u>-**

  Acute Medical Distress (including but not limited to, increased work of breathing/retractions, somnolence/agitation, inability to hydrate, decreased urine output, and abnormal vital signs based on age) requires *immediate hospital referral*; do not delay for physician consult.

  - must be annotated in the CBP EMR
  - PIC shall be evaluated by the Advanced Practice Provider (APP) who then **<u>must</u>** consult with a supervising physician or pediatric advisor* within 20 minutes of initial evaluation to determine the treatment plan--*including the potential need for immediate medical transport for outside care.*
  - Consultation information (name, date, time, reason, and outcome) shall be annotated in the CBP EMR in either the Medical Assessment or Medical Encounter section, dependent upon the medical action being taken.
  - PIC shall be placed in the Enhanced Medical Monitoring protocol and monitored in custody every 4 hours at a minimum.
  - PIC shall be evaluated for medical isolation (see list of isolatable conditions).
  - PIC's condition shall be communicated to CBP for consideration for expedited processing.
  - A red wristband will be placed on the PICs left wrist for identification while in CBP custody. This colored wristband is in addition to the APIP wristband, if used.

    **For juveniles, if the pediatric advisor is not available, then the supervising physician must be contacted.*

IV. ECMR Medical Process Guidance

A. Medical Services Contractor

a. Clinical Staff shall complete a medical encounter within the CBP Electronic Medical Records (EMR) system.
   i. ECMR At Risk Category is based on the following criteria:
      1. Age of patient.
      2. Pregnancy Status if, person in custody is a biological female.
      3. Diagnoses selected.
   ii. If the patient is classified as RED, a consult with the Supervising Physician or Pediatric Advisor is required and notation of the interaction is required.
   iii. Enhanced Medical Monitoring action is automatic for 4-hour follow-up
   iv. If the patient in custody requires medical isolation, the CBP EMR will automatically select Medical Isolation disposition.

b. When clinical staff sign and record the Medical Encounter, the following process will happen:
    i. A pop-up will appear to inform the clinical staff of the patients At Risk category, isolation status, and provide further instructions.
    ii. If a patient is classified as RED, it will send an update to the Enforcement System and mark the patient as "***At-Risk***" and set a predefined comment that is automatically generated by the CBP EMR.
c. When the clinical staff returns to the whiteboard, they will see the ECMR category color to the far-left side of the row.
    i. The ECMR category color is based on the most recent Medical Encounter.
    ii. If a subsequent Medical Encounter results in a lesser category color (non-Red), the provider will need to ensure that the prior, more acute diagnosis is entered into the current Encounter if it is still relevant.

B. CBP Agents/Officers

a. PICs categorized as ECMR Red are of the highest vulnerability within CBP custody. These PICs should be expeditiously processed to minimize the length of time in CBP custody per the memo.
b. If CBP Agents/Officers notice any medical changes in conditions of a PIC, it shall be reported to the MSC clinical staff immediately for evaluation. Any change requiring hospitalization shall be taken seriously and immediate transport (by ambulance or CBP vehicle) shall occur within in a reasonable time.
c. The MSC will use a red wristband on the PICs left wrist to signal that they are ***At-Risk.*** This is in addition to the APIP wristband if used. *Any use of red wristbands for reasons other than ECMR should be ceased.*
d. USBP PIC designated as an ECMR Red will automatically be enrolled in ***At-Risk*** status checks within the e3 Detention Module and USBP will comply with TEDS ***At-Risk*** hold room monitoring standards.
e. OFO PIC designated as an ECMR Red will not be automatically enrolled in any status checks due to pending integration between USEC and the CBP EMR system. OFO Officers shall select the "Medical/Risk Summary" link within the Custody section of the Traveler Details Page to update the "Risk Indicator" to "High" when the Medical Services Contractor indicates that the subject has a medical condition that is considered an "Elevated" medical risk (RED).
f. The MSC providers are responsible for 4 hour-medical checks for PIC identified as ECMR Red status.

V. Diagnoses/Conditions of ECMR RED

A. Juvenile ECMR RED category includes (but not limited to):

Medical Providers are encouraged to consult with pediatric advisors and/or supervising physicians if/when they are concerned about medical status of a juvenile in their care even in the absence of an identifiable medical diagnosis/condition.

General Considerations:

- Juveniles with acute or chronic medical conditions that:
  - require medication to maintain daily function.
  - require intensive management by a sub specialist.
  - require durable medical equipment, specialty diet, intensive OT/PT/rehab to maintain daily function.
  - impact daily function.
- Juveniles with significant developmental delays and/or requiring special needs care.
- Infants less than 12 weeks old.
- Juveniles placed in medical isolation or quarantine (see below for more detail).
- Juveniles with congenital syndromes and anomalies, especially when requiring ADL assistance (cerebral palsy, etc.)

Specific Clinical Conditions:

- Congenital heart disease (especially if surgical repair was required, attempted, or recommended)
- Sickle cell disease
- Infectious Disease
  - Including possible or confirmed measles, malaria, Dengue, COVID-19, influenza, varicella
  - Infants < 12 weeks old with fever *must* be referred to ED
- Oropharyngeal conditions
  - Including laryngomalacia, tracheomalacia
- Structural lung disease
  - Including asthma, bronchomalacia, pulmonary dysplasia, cystic fibrosis
- Hematologic conditions
  - Including cancer, all anemias including sickle cell-associated, thalassemia, blood dyscrasias [Von Willebrand Disease/hemophilia]
- Endocrine conditions
  - Including insulin-dependent diabetes, adrenal insufficiency
- Neurologic conditions
  - Including epilepsy, seizure disorder, cerebral palsy
- Sexual Assault allegation

B. Adult ECMR RED category includes (but not limited to):

General considerations

- Need for medication(s), medical equipment and/or interventions which exceed a facility's medical support capability, including:
  - specialized or intra-venous medication, feeding tubes, ostomy care, specialized diets, recurrent seizures, risk for injury to self/others due to behavior, ongoing complex wound care
  - requires assistance with activities of daily living (ADL); precludes living independently.
- Condition limiting communication and/or mobility.

Specific clinical conditions

Cardiovascular:

- Cardiac dysfunction, including but not limited to congenital heart disease, cardiomyopathy, congestive heart failure, prior myocardial infarction with active symptoms (chest pain, dyspnea, palpitations, syncope), exertional or at-rest chest discomfort/dyspnea, aortic disease, valvular disease, dysrhythmia

- Elevated blood pressure
  - Asymptomatic + SBP > 180 and/or DBP 120 a physician consult at minimum
  - Symptomatic + SBP > 180 and/or DBP 120 a physician consult or immediate referral
- Signs or symptoms suggestive of possible end organ dysfunction, including but not limited to, chest pain, syncope, headache, acute vision change, dyspnea, decreased urination/hematuria/dark urine
- Evidence of peripheral vascular disease including but not limited to, extremity pain, pallor, abnormal/absent peripheral pulses, non-healing wounds

HEENT: (Head, Eyes, Ears, Nose, Throat)

- Need for daily prescription eye or ear drops
- Acute change in visual acuity, visual field deficit, monocular/binocular vision loss, flashes/floaters, blurred vision
- Eye pain with extra-ocular motion
- Periorbital swelling and/or erythema
- Advanced periodontal disease with active infection (abscess, bleeding, severe inflammation), especially when associated with difficulty swallowing
- Neck swelling, difficulty swallowing
- Pharyngitis associated with difficulty swallowing or breathing

Dermatology:

- Skin condition placing individual or population at risk, cutaneous abscess, cellulitis/erysipelas, denuded skin (including mucus membrane lesions), untreated burn
- Acute rash plus fever or other symptoms of acute, systemic infection

Endocrine:

- Hyperglycemia
  - Asymptomatic + point of care blood glucose > 200 mg/dL a physician consult
  - Point of care blood glucose > 500 mg/dL a physician consult or immediate referral
- Endocrine condition (e.g., diabetes mellitus, thyroid disorder, etc.) with abnormal vital signs or acute symptoms (e.g., mental status change, N/V, abdominal pain, etc.)

Environmental:

- Hypothermia <95 degrees Fahrenheit
- Hyperthermia (Note: prioritize the clinical status more than absolute temperature)
- Heat stroke symptoms (T>101.5, combined with hot/red/dry skin, nausea, weakness/passing out, confusion, altered mental status)

Gastrointestinal:

- Recent upper or lower GI bleed (< 30 days)
- Intractable nausea, vomiting, abdominal pain, and/or diarrhea
- History of cirrhosis or other chronic liver disease in the context of abdominal pain/distension, mental status change and signs/symptoms suggestive of GI bleeding

Immunologic:

- Conditions impacting immune function (Cystic Fibrosis, Sickle Cell Disease, cancer, HIV, post-splenectomy)
- Regular and/or daily use of immunosuppressive medications or immunomodulatory medications

Hematologic:

- Chronic anemias associated with acute symptoms or requiring treatment within the last 30 days
- Acute anemia associated with chest pain, shortness of breath, persistent dizziness
- Congenital conditions including but not limited to sickle cell disease, thalassemia, blood dyscrasias [Von Willebrand Disease/hemophilia), especially when associated with acute symptoms

Infectious Disease:

- Communicable diseases of public health/congregate setting significance (including measles, polio, active tuberculosis, mumps, pneumonic plague, SARS, viral hemorrhagic fevers)
- Any concern for meningitis (constellation of two or more of the above: headache, fevers, stiff neck, nausea, vomiting, change in mental status)
- Any concern for sepsis including, but not limited to, hyperthermia or hypothermia in the context of any combination of elevated heart rate (>100 beats/min), elevated respiratory rate (>20 breaths/min), low blood pressure (systolic BP < 100mmHg) plus clinical concern for an infectious source.

Neurologic:

- Seizure disorder requiring daily medication with acute seizure, seizure within last 7 days, or recent missing or underdosed seizure medications
- Stroke or stroke-like event (transient ischemic event, etc.) within last 30 days
- Baseline cognitive deficit that precludes performance of activities of daily living

- Movement disorder with Impaired mobility or fall risk (Parkinson's Disease, Alzheimer's Dementia)
- Impaired communication ability (hearing, vision, or speech impaired)
- Acute neurologic symptoms, including sudden/maximal onset headache, focal motor weakness, generalized weakness/gait instability, monocular/binocular vision loss, visual field deficit, flashes/floaters, decreased visual acuity from baseline with corrective lenses (where applicable)

Behavioral Health and Substance Abuse:
- PIC having ANY behavioral health condition which may place the individual or population at risk (delusional behavior, dementia, chronic psychosis/schizophrenia, anorexia/bulimia, etc.)
- History of active substance abuse of any kind with:
  - last use equal to/less than 14 days
  - risk for acute withdrawal (especially alcohol and benzodiazepines) or prior withdrawal syndrome episodes (e.g., seizure, delirium tremens, hospitalization requirement)

Pulmonary:
- Emphysema, asthma, COPD/chronic bronchitis, or other structural lung conditions with active symptoms (shortness of breath, cough, wheezing, chest pain, etc.)
- Medically dependent upon supplemental oxygen, mechanical ventilator, or continuous positive airway pressure (CPAP)

Renal:
- Acute renal failure or chronic kidney disease, including requirement for hemodialysis or peritoneal dialysis
- Flank pain suggestive of acute pyelonephritis (urinary tract infection symptoms associated with fevers, nausea, vomiting)

Trauma:
- Acute or chronic traumatic injury requiring on-going treatment, including wound/burn care, splints/casts, assistive devices (brace, crutches, wheelchair)
- Evidence of wound infection or non-healing wounds
- Any injury requiring frequent follow-up care (surgery, physical therapy, occupational therapy, wound care)

C. Women's Health ECMR RED category includes (but not limited to):

Medical providers should utilize the following criteria when providing additional care to women with obstetric or gynecologic conditions.

- Pregnant female above 20 weeks of gestation.
- Vaginal bleeding/discharge and/or pelvic/abdominal pain during pregnancy
- Pre- or post-partum mothers with the following complications/symptoms:
    - Abdominal/pelvic pain
    - Vaginal bleeding, discharge, or leak of fluid
    - Fever/other symptoms of infection
    - Intractable vomiting that has not responded to anti-emetic therapy with difficulty hydrating/nourishing
    - Change in fetal movement
    - Elevated blood pressure or other abnormal VS for stage of pregnancy
    - New onset headache or other neurological symptoms
- Vaginal bleeding/discharge beyond routine menses and/or pelvic/abdominal pain (not in the setting of known/documented pregnancy)
- General medical distress with any abnormal vital signs, including tachycardia, tachypnea, hypotension/hypertension, and/or hypoxia.

VI. Medical Conditions That Require Medical Isolation:

- COVID-19
- Influenza
- Influenza Exposure
- Influenza - Confirmed (via point of care test or referral)
- COVID - Confirmed (via point of care test or referral)
- Respiratory Pathogen - Other confirmed (e.g., RSV) via referral
- Lice (During treatment)
- Measles
- Meningitis
- Mumps
- Scabies (During treatment)
- Varicella
- Varicella Exposure

Key Document M

U.S. Customs and Border Protection
Office of the Chief Medical Officer

OCMO Policy No. 0001-01 **DATE: December 28, 2023**

ORIGINATING DIVISION:
Quality Division
SUPERSEDES: Not applicable
DATE: Not applicable

MANAGEMENT OF SENTINEL EVENT

1. PURPOSE. This policy governs the Office of the Chief Medical Officer (OCMO) development of processes and procedures to properly manage Medical Sentinel Events (SE). This policy shall be executed in compliance with all applicable statutes, regulations, and U.S. Customs and Border Protection (CBP) and U.S. Department of Homeland Security (DHS) policies.

2. SCOPE. This policy is applicable to all Medical Sentinel Events that require actions from OCMO.

3. POLICY.

3.1 OCMO ensures safety and quality of all medical services provided to all authorized recipients.

3.2 OCMO develops and implements processes and procedures to manage Medical Sentinel Events.

3.2.1 Processes include Sentinel Event Review, Root Cause Analysis, Death in Custody Mortality Review.

3.2.2 Procedures include all sequence of steps or work instructions to complete all major activity or tasks within each of the processes mentioned above.

3.5 OCMO establishes and follows reporting requirements as directed by the OCMO Chief Medical Officer (CMO) or higher authority.

3.6 OCMO reviews and updates this policy annually and reviews and updates processes and procedures as needed.

4. AUTHORITIES.

4.1 42 U.S.C. §13727(a)

4.2 DHS Directive No. 248-01, Medical Quality Management (May 11, 2009)

4.3 U.S. Customs and Border Protection National Standards on Transport, Escort, Search, and Detention (TEDS)

4.4 CBP Directive No. 2210-004, Enhanced Medical Support Efforts (December 30, 2019)

4.5 U.S. Customs and Border Protection Notification and Review Procedures for Certain Deaths and Death in Custody, (May 26, 2021)

5. DEFINITIONS.

5.1 Medical Sentinel Event - an unexpected occurrence involving a person in custody who experiences death or serious physical and/or psychological injury or illness, not related to the natural course of their illness or condition. The event may be associated with health care that was or was not provided. The term sentinel refers to an issue that may result in similar events in the future, or risk thereof, warranting immediate further investigation and/or root cause analysis. Below are examples of Medical Sentinel Events.

5.1.1 Unexpected outcome of a medical interaction including medication error, or other medical care delivery error.

5.1.2 Suicide and/or suicide attempts resulting in injury or the need for higher level of care for evaluation of need for inpatient psychiatric admission.

5.1.3 Any patient death, paralysis, coma, or other major loss of function associated with a medication error, or other medical care delivery error.

5.1.4 A fall, or other accident involving a person in custody that results in death or major permanent loss of function as a direct result of injuries sustained in the fall.

5.2 Death in Custody – the death of a person meeting the details outlined below:

5.2.1 Detained, under arrest, or is in the process of being arrested by any officer of such Federal law enforcement agency (or by any State of local law enforcement officer while participating in and for the purposes of a federal law enforcement operation, task force, or any other Federal law enforcement capacity carried out by such Federal law enforcement agency); or

5.2.2 In route to be incarcerated or detained or is incarcerated or detained at (A) any facility (including any immigration or juvenile facility) pursuant to a contract with such Federal law enforcement agency; (B) any State or local government facility used by such Federal law enforcement agency; or (C) any Federal correctional or Federal pre-trial detention facility located within the United States.

5.3 Root Cause Analysis – a process for identifying the basic or contributing causal factor(s) associated with adverse outcome and/or sentinel event.

5.4 Corrective Action – an action taken to improve clinical performance, delivery of care, and reduce medical risk based on the findings of the root cause analysis, level of relative harm, and likelihood of occurrence and/or recurrence.

6. RESPONSIBILITIES.

6.1 The CBP Deputy Chief Medical Officer (DCMO) will provide overall direction and oversight in the implementation and compliance to this policy.

6.2 The Quality Management Officer will:

6.2.1 Develop and maintain processes and procedures to properly manage Medical Sentinel Events.

6.2.2 Facilitate the implementation and compliance to this policy.

6.2.3 Coordinate with other OCMO Divisions and external OCMO stakeholders to facilitate the implementation and compliance to this policy to properly manage Medical Sentinel Events.

6.3 All OCMO Divisions will support the Quality Management Division in the implementation and compliance to this policy to properly manage Medical Sentinel Events.

7. APPROVAL.

Alexander L. Eastman
Acting Chief Medical Officer
Office of the Chief Medical Officer

Key Document N

1300 Pennsylvania Avenue, NW
Washington, DC 20229

U.S. Customs and Border Protection

February 12, 2024

MEMORANDUM FOR: James W. McCament
Chief Operating Officer

THROUGH: Casey Durst
Executive Assistant Commissioner
Operations Support

FROM: Alexander L. Eastman, MD, MPH, FACS, FAEMS
Acting Chief Medical Officer
U.S. Customs and Border Protection

SUBJECT: Contractor Performance Assessment Report Rating Inconsistencies

The Contractor Performance Assessment Report (CPAR) rating filed by the CBP Office of Acquisitions (OA) on January 17, 2024, does not accurately rate nor reflect contractor performance on task order 70B03C20F00001383 for the period of performance of September 30, 2021, through March 29, 2023, does not accurately reflect the assessments jointly performed by OA and Office of the Chief Medical Officer (OCMO) for the period of performance and misrepresents or is lacking key data provided.

CBP's OCMO serves as the Program Management Office of Record (PMO) for the CBP Medical Services Contract (MSC) and has served that role since February 14, 2022. As such, and at the request of OA, OCMO submitted a CPAR rating for the period of performance (POP) of September 30, 2021, through March 29, 2023. The CPAR rating was discussed, drafted, reviewed, and submitted to the OA Contracting Officer (CO) on July 14, 2023. A team consisting of the Office of Chief Counsel (OCC), the OCMO Contracting Officer's Representatives (CORs) and the OCMO PMO worked in concert to submit an accurate, legally defensible, and unbiased CPAR rating on August 23, 2023.

On January 18, 2024, OCMO was called to meet with representatives from Enterprise Services executive leadership, and the CBP Component Acquisition Executive Assistant Commissioner. During this meeting, OCMO was informed that material changes had been made to the CPAR by the CO and that the CPAR had been filed officially the day prior to the meeting.

Of specific concern, the jointly crafted CPAR submitted on August 24, 2023, made clear that the incumbent contractor should not be considered eligible for similar assignments in the future and stated:

> *Given what I know today about the contractor's ability to perform in accordance with this contract or order's most significant requirements, I **would not** recommend them for similar requirements in the future.*

The final version of the CPAR, which was submitted and signed by the Rating Official and the Reviewing Official on January 17, 2024, stated:

> *Given what I know today about the contractor's ability to perform in accordance with this contract or order's most significant requirements, I **would** recommend them for similar requirements in the future.*

CPAR

The chart below represents a summary of the changes made to the jointly crafted CPAR that was originally filed. These changes were made without input from the OCMO PMO and a final version was filed prior to notification or discussion with the OCMO PMO.

EVALUATION AREA	Submitted CPAR rating	ORIGINAL JOINT RATING
Quality	SATISFACTORY	MARGINAL
Schedule	SATISFACTORY	MARGINAL
Cost Control	SATISFACTORY	MARGINAL
Management	SATISFACTORY	MARGINAL
Small Business Subcontracting	N/A	N/A
Regulatory Compliance	SATISFACTORY	MARGINAL

In a six-month period between September 2022 and March 29, 2023, the Juvenile Court Monitor made five site visits and noted two specific cases of juvenile migrants with chronic medical issues who were not assessed by contract medical personnel and did not have their chronic medical issues documented or communicated to CBP Officers and agents. Further critical documentation failures during this period of performance led to the transfer of an unaccompanied child to Health and Human Services Office of Refugee Resettlement (HHS/ORR) with inaccurate documentation and the child subsequently perished. The joint team that authored the original CPAR did not concur with the assertion that the incumbent contractor made sufficient changes to remedy this issue. Despite that, the CPAR filed does not reflect the above assessment nor the marginal performance.

The assertion that we are unable to determine a single point of failure in the form of CBP Form 2501 is incorrect. Neither CBP nor the US Border Patrol (USBP) personnel have electronic access to the CBP Electronic Medical Record (EMR). The EMR is the System of Record where medical information obtained during the CBP Medical Assessment is documented. This information is then used to populate the CBP 2501. While the CPAR obfuscates this fact, the

CBP 2501 can only be generated in the EMR by contracted medical staff. Any errors or incompleteness would be solely the result of actions (or inaction) from MSC personnel. Several times during the period of performance, as documented in weekly quality meetings with the incumbent contractor, recurrent staffing failures impacted this critical process.

MSC scheduling and staffing, has been the subject of many inquiries, requests for information and audits. While staffing rates briefly improved at the end of this period of performance, it was not satisfactory, and deficiencies have both persisted and worsened recently. During the period of performance, the contractor provided the PMO and the CO a staffing report outlining the percentage of shifts covered on a weekly basis. In June 2022, the incumbent contractor staffed 60.46% of shifts and in July 2022 the contractor staffed 64.56% of shifts. The Statement of Work (SOW) target for satisfactory performance was 95%. Profound staffing shortages persisted during the period of performance referenced by the CPAR in question and continue to the present day. These deficiencies persist today and resulted in a recent letter issued to the incumbent contract that was cosigned by the acting CMO and the current CO.

Travel by contracted medical support personnel went beyond contractually approved levels. From September 2022 through March 2023, more than $5M was added to the MSC to cover unanticipated and elevated travel expenses. Due to the profound budgetary impact, as well as discrepancies noted in invoicing, CBP Operations Support formed a "tiger team" to specially examine this issue. Additionally, the SOW required the incumbent contractor to notify the CO and CORs when they surpassed, invoiced, or executed 25%, 50%, 75% and 85% of their travel budget. These notifications were never made, and this failure was documented by the CORs while also being discussed with the CO yet is not mentioned in the CPAR rating.

During the period of performance, the management of contracted medical support personnel and the execution of the contract by the contractor was a documented topic of concern during multiple bi-weekly sync meetings. The original, jointly crafted CPAR outlined the following concerns:

- non-cleared incumbent contractor personnel working on federal property
- personnel not completing required CBP training
- contract personnel not having a PIV card as required
- EMR not being used by contract personnel as required by contract
- Several breaches in CBPs policies and procedures for handling Personally Identifiable Information (PII)

All the above contributed to the jointly OCMO/CO filed CPAR rating of MARGINAL however none of them are mentioned in the final CPAR.

Regulatory compliance was also a regular topic discussed during the biweekly regulatory, quality improvement and contractor review meetings that occurred throughout the referenced period of performance. Areas for compliance improvement were identified as required from the CORs, including sharing results of audits from regulatory agencies and assessments conducted by the OCMO PMO. All findings were shared with the contractor verbally and/or in writing at multiple times during the period of performance. As a part of the jointly filed CPAR, the OCMO PMO and CORs provided examples of compliance deficiencies including:

- a lack of adherence to the Foreign Medication Guidance
- lack of follow through with the MQM program guidance
- nonadherence to schedules
- inaccurate invoices submitted by the contractor
- PII / data integrity issues, and
- lack of follow through on the USBP Implementation Plan for Enhanced Medical Efforts Directive.

The CPAR rating filed on January 18, 2024, is inaccurate, deviates from the jointly authored and edited version filed on August 24, 2023, and does not adequately reflect incumbent contractor performance during this period of performance. Improving the performance of the MSC is of paramount importance to CBP. This must be based on accurate data and a forthright assessment of performance that can be used as the foundation for improvement. The CPAR fails to achieve those fundamental goals and is not supported by the Acting CMO or MSC experts from CBP OS/OCMO.

Attachment
LSGS CPARS ratings

Key Document O

List of CBP facilities where Loyal Source Government Services is providing medical care as of July 2, 2024.

Description of frontline medical staff roles and responsibilities. Frontline medical staff, consisting of the provider and support positions, provide medical services to persons in CBP custody. Frontline medical services includes: initial health interview, initial triage, conducting medical assessments, onsite basic diagnosis, treatment of basic medical conditions, condcuting medical encounters, conducting enhanced medical monitoring, referring complex, urgent or emergency medical conditions to the local health syste, conducting follow-up care, public health infectious disease support, and providing medical summaries.
Provider: advanced practice providers, consisting of nurse practitioners and physician assistants, who are trained, licensed and credential to provide basic assessment and treatment for persons in CBP custody.
Support: medical support personnel, consisting of emergency medical technicians, certified medical assistants, certified nursing assistants, licensed vocational nurses, and license practical nurses, who are trained, licensed and credentialed to provide assessment and treatment for persons in CBP custody.

CBP Facility	Address of Facility	Daily Hours of Operation	Providers Required Per Shift	Support Required Per Shift
Presidio Port of Entry	Border Station Highway 67 Presidio, TX 79845	24	0	1
Alpine Station	3003 West Highway 90 Alpine, TX 79830	24	1	1
Presidio Station	Highways 170 and 67 Presidio, TX 79845	24	1	1
Sanderson Station	Hwy 90 West Sanderson, TX 79848	24	0	1
Sierra Blanca Station	900 Aztec Drive Sierra Blanca, TX 79851	24	1	1
Van Horn Station	500 Laurel Street Van Horn, TX 79855	24	0	1
Del Rio Port of Entry	3140 Spur 239 International Bridge Del Rio, TX 78840	24	0	1
Eagle Pass Port of Entry	160 Garrison St. Eagle Pass, TX 78852	24	1	2
Brackettville Station	802 W. Spring St. Brackettville, TX 78832	24	1	1
Carrizo Springs Station	1868 Hwy 85 East Carrizo Springs, TX 78834	24	1	1
Comstock Station	27685 Highway 90 West Comstock, TX 78837	24	1	1
Del Rio Station	2300 Highway 90 East Del Rio, TX 78840	24	2	3
Eagle Pass South Station	4156 El Indio Highway Eagle Pass, TX 78852	24	1	2
Del Rio Sector North Processing Facility	Fire Fly Lane Eagle Pass, TX 78852	24	10	18
Uvalde Station	#30 Industrial Park Uvalde, TX 78801	24	1	2
Calexico Port of Entry	200 East First Street Calexico, CA 92231	16	1	1
San Luis Port of Entry	Highway 95 & International Border San Luis, AZ 85349	24	1	1
Calexico Station	1150 Birch Street Calexico, CA 92231	24	0	1
El Centro Station	221 West Aten Road Imperial, CA 92251	24	1	3
Wellton Station	10888 Avenue 31E Wellton, AZ 85356	24	0	1
Yuma Station	4151 S. Avenue A Yuma, AZ 85365	24	1	1
Yuma Sector Centralized Processing Center	4151 S. Avenue A Yuma, AZ 85365	24	5	12
Bridge of the Americas Port of Entry	3600 E. Paisano El Paso, TX 79905	24	1	1
Columbus Port of Entry	State Highway 11 Mile Marker 0 Columbus, NM 88029	16	0	1
Paso Del Norte Port of Entry	1000 South El Paso Street El Paso, TX 79901	24	1	1
Santa Teresa Port of Entry	170 Pete Domenici Hwy Santa Teresa, NM, 88008	16	0	1
Tornillo Port of Entry	1400 Lower Island Rd. Tornillo, TX 79853	16	0	1
Ysleta Port of Entry	797 South Zaragoza Road El Paso, TX 79927	24	1	1
Clint Station	13400 Alameda Ave Clint, TX 79836	24	0	1

Deming Station	3300 J Street SE Deming, NM 88030	24	1	1
El Paso Sector Modular Centralized Processing Center	9201 Gateway South Boulevard El Paso, TX 79924	24	1	1
El Paso Sector Hardened Facility	12501 Patriot Freeway El Paso, TX 79934	24	12	23
Fort Hancock Station	828 South HWY 1088 Fort Hancock, TX 79839	24	1	1
Lordsburg Station	26 Pipeline Road Lordsburg, NM 88045	24	1	1
El Paso Station Paso Del Norte Texas Processing Center	1000 South El Paso Street El Paso, TX 79901	24	2	3
Santa Teresa Station	1005 NM Highway 9 Santa Teresa, NM 88008	24	1	2
Ysleta Station	12245 Pine Springs Drive El Paso, TX 79936	24	2	3
Laredo Gateway to the Americas International Bridge	100 Convent Ave. Laredo, TX 78040	24	1	2
Cotulla Station	3423 Interstate Highway 35 Cotulla, TX 78014	24	0	1
Hebbronville Station	34 East Highway 359 Hebbronville, TX 78361	24	1	1
Laredo North Station	11119 McPherson Road Laredo, TX 78045	24	1	1
Laredo South Station	9001 San Dario Avenue Laredo, TX 78045	24	1	1
Laredo Sector Centralized Processing Center	7210 Highway 83 Laredo, TX 78046	24	4	7
Laredo West Station	202 State Highway 255 Laredo, TX 78045	24	0	1
Dania Beach Station	1800 NE 7th Avenue Dania Beach, FL 33004	12	0	1
Marathon Station	3770 Overseas Highway Marathon, FL 33050	12	1	0
West Palm Beach Station	3301 Lake Shore Drive Riviera Beach, FL 33404	12	0	1
Brownsville Port of Entry	1500 W. University Blvd Brownsville, TX 78520	24	1	4
Hidalgo Port of Entry	1023 International Blvd. Hidalgo, TX 78557	24	1	3
Brownsville Station	940 N. FM 511 Olmito, TX 78575	24	1	2
Rio Grande Valley Sector Donna Processing Facility	1414 S FM493 Donna, TX 78537	24	13	20
Falfurrias Station	933 County Road 300 Falfurrias, TX 78355	24	1	1
Fort Brown Station	3305 S. Expressway 83 Brownsville, TX 78521	24	1	2
Harlingen Station	3902 S. Expressway 77 Harlingen, TX 78552	24	1	1
McAllen Station	3000 West Military Highway McAllen, TX 78503	24	0	1
Rio Grande Valley Sector Central Processing Center	3700 W. Ursula Ave. McAllen, TX 78503	24	4	7
Rio Grande City Station	730 Border Patrol Lane Rio Grande City, TX 78582	24	1	1
Weslaco Station	1501 E. Expressway 83 Weslaco, TX 78559	24	1	1
Otay Mesa Port of Entry	9777 Via De La Amistad San Diego, CA 92154	24	1	1
San Ysidro Port of Entry	720 East San Ysidro Blvd San Ysidro, CA 92173	24	1	2
Boulevard Station	2463 Ribbonwood Rd. Boulevard, CA 91905	24	1	3
Brown Field Station	7560 Britannia Ct. San Diego, CA 92154	24	1	2
Campo Station	32355 Old Highway 80 Pine Valley, CA 91962	24	1	2
Chula Vista Station	311 Athey Ave San Ysidro, CA 92173	24	1	2
Campo Station Forrest Gate Facility	799 Forest Gate Road Campo, CA 91906	24	0	1
Imperial Beach Station	1802 Saturn Blvd. San Diego, CA 92154	24	1	3

Newton & Azrak Station	25762 Madison Avenue Murrieta, CA 92562	24	1	1
San Clemente Station	I-5 N Bound Mile Marker 67.5 San Clemente, CA 92673	24	1	1
San Diego Sector Pogo Row Soft-Sided Facility	7685 Pogo Row San Diego, CA 92154	24	2	5
Douglas Port of Entry	First Street and Pan American Avenue	24	0	1
Nogales Port of Entry	9 North Grand Ave. Nogales, AZ 85621	24	1	1
Ajo Station	850 North Highway 85 Why, AZ 85321	24	2	6
Brian A. Terry Station	2136 South Naco Highway Bisbee, AZ 85603	24	1	1
Casa Grande Station	396 Camino Mercado Casa Grande, AZ 85122	24	1	1
Douglas Station	1608 S. Kings Highway Douglas, AZ 85607	24	1	2
Nogales Station Nogales Processing Facility	1500 West La Quinta Road Nogales, AZ 85621	24	3	6
Sonoita Station	3225 Highway 82 Sonoita, AZ 85637	24	1	1
Tucson Sector Tucson Coordination Center	2430 S. Swan Road Tucson, AZ 85711	24	1	2
Tucson Sector Soft-Sided Facility West	4550 East Los Reales Rd. Tucson, AZ 85711	24	3	3
Tucson Sector Soft-Sided Facility East	4550 East Los Reales Rd. Tucson, AZ 85711	24	6	10
Three Points Station San Miguel FOB	Federal Route 19, Milepost 2 San Miguel, AZ 85639	24	1	1
Willcox Station	200 South Rex Allen Jr. Road Willcox, Arizona 85643	24	1	1

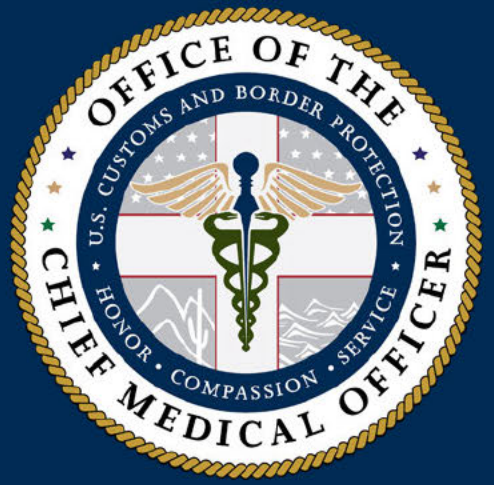
Key Document P

Border Health System

Briefing August 1, 2024

U.S. Customs and Border Protection

Office of the Chief Medical Officer



Alexander L. Eastman, MD, MPH, FACS, FAEMS
Chief Medical Officer (A)

Who We Are | Office of the Chief Medical Officer (OCMO)

OCMO MISSION STATEMENT

We vigilantly safeguard those entrusted to our care, while countering health security threats at our nation's borders.

OCMO VISION STATEMENT

To be at the forefront of border health security.

Our Processes | Medical Support Provided to Persons in Custody

This process highlights the health interview, medical assessments, and medical care provided to individuals while they are in CBP custody.

Initial Health Interview Completed

If a person in custody is a juvenile, pregnant female, or answered yes to any CBP medical interview questions:

Medical Assessment Conducted by CBP Medical Services Personnel

If a person in custody needs additional medical care at any point while in CBP care:

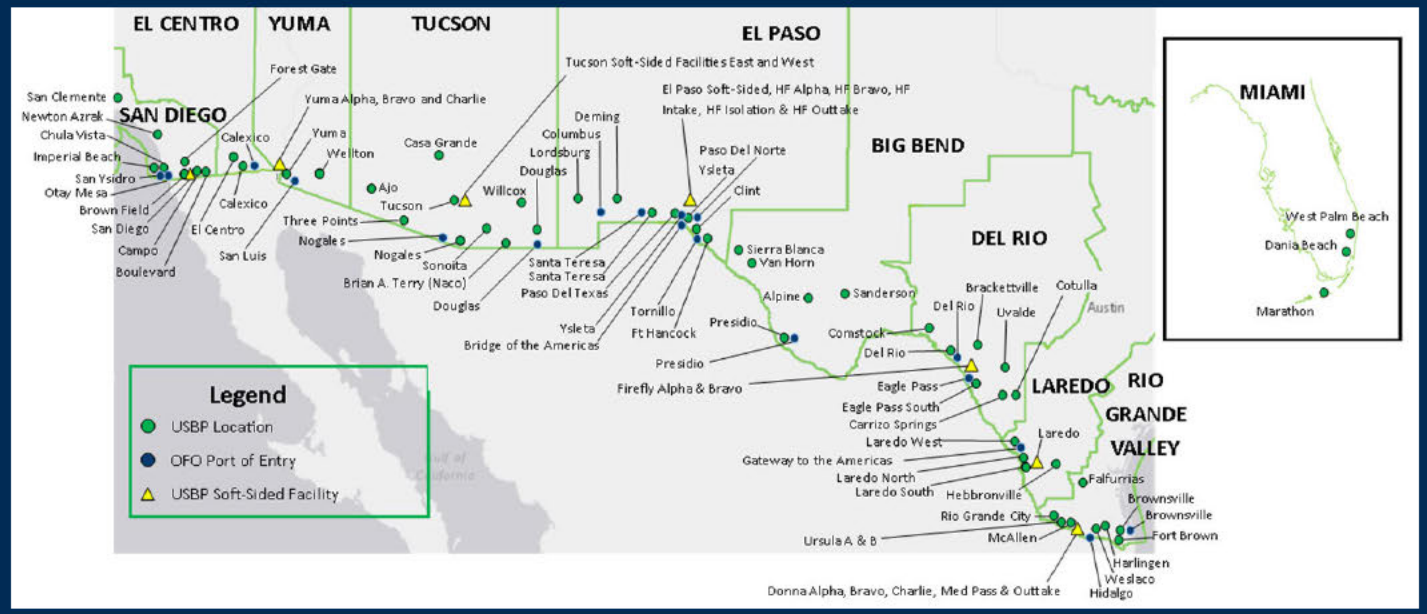
Pediatricians and Supervising Physicians consulted (as required)

Medical Encounter Performed by CBP Medical Services Personnel

Medical Summary for Continuity of Care

Our Capabilities | By the Numbers

As of 7/31/2024,
93 Active Medical Units at
82 Locations including:



At Peak Flow, in one September 2023 week* CBP…

Performed **49,241** medical interviews

Performed **10,614** medical encounters

Initiated **483** hospital referrals

Now, in one July 2024 week**, CBP…

Performed **9,948** medical interviews

Performed **4,071** medical encounters

Initiated **200** hospital referrals

*Based on CBP Electronic Medical Record Data – Sept. 17-23, 2023
**from July 21–27, 2024

Our Capabilities | Medical Service Contractor Structure

The Office of the Chief Medical Officer employs contracted medical services personnel to provide care to persons in CBP lawful custody.

Advanced Practice Providers (APPs)

- Nurse Practitioners
- Physician Assistants

Support Personnel

- EMT/B
- Paramedics
- CNA
- CMA
- LVNs

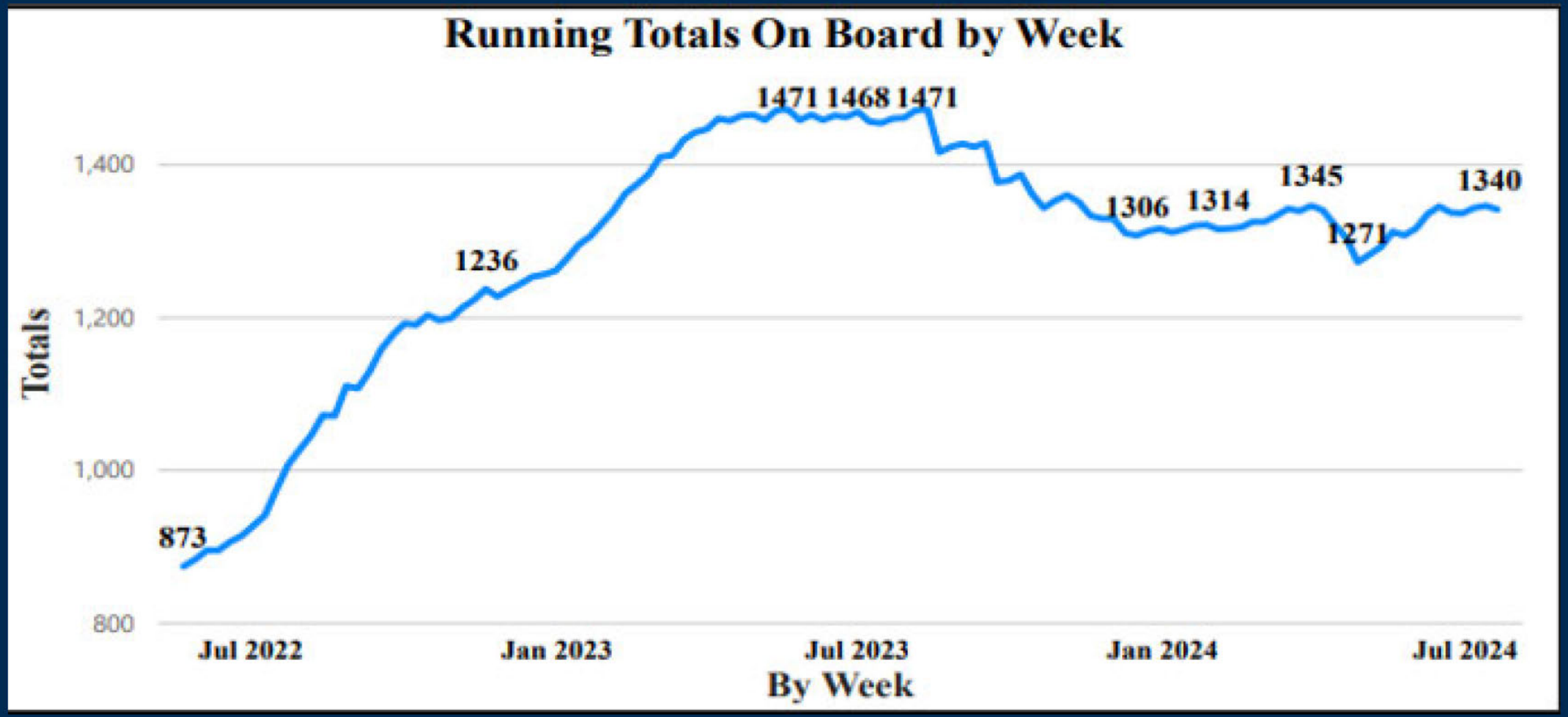
Advisory Staff

- Patient Safety Risk Monitor
- Supervising Physicians
- Pediatric Advisors

Program Manager by Region

- Program Manager
- Deputy Program Manager

MSC Staffing|



MSC Staffing|

Qlik ... Analyze Sheet | Narrate Storytelling | Medical Unit Live Staff | Ask Insight Advisor

Insight Advisor | ListItemsFromID.active Active | Bookmarks | Sheets

Medical Unit Staffing Live

Providers	EMT	Medical Support	Non Clinical Staff	Total Signed In	Last Refreshed:
72	80	63	0	215	Jul 10, 2024 11:01:07 Eastern Updated hourly

Total Staff Signed In Per Medical Unit

Component	Sector / Field Office	Station / Port of Entry	Substation (USBP Only)	Provider	Required Providers		Support	Required Support
OFO	ELP	BOA		1	1		1	1
OFO	ELP	COL		0	0		1	1
OFO	ELP	PDN		1	1		1	1
OFO	ELP	PRE		0	0		1	1
OFO	ELP	STR		0	0		1	1
OFO	ELP	TRN		0	0		1	1
OFO	ELP	YSL		1	1		1	1
OFO	LAR	BRO		1	1		2	4
OFO	LAR	DLR		0	0		1	1
OFO	LAR	EGP		0	1		1	2
OFO	LAR	HID		1	1		4	3
OFO	LAR	LAR		0	1		2	2
OFO	SAN	CAL		1	1		1	1
OFO	SAN	OTM		1	1		0	1
OFO	SAN	SYS		0	1		0	2
OFO	TUC	DOU		0	0		1	1
OFO	TUC	NOG		0	1		1	1
OFO	TUC	SLU		1	1		1	1
USBP	BBT	APT		1	1		1	1
USBP	BBT	PRS		1	1		2	1
USBP	BBT	SBT		1	1		1	1

MSC Staffing|

Operational Area	Provider Shifts Required Per Week	Support Shifts Required Per Week	Provider Shifts Filled Last Week	Support Shifts Filled Last Week	Total Shifts Filled Last Week	MPF Provider Weekly Fill Rate	MPF Support Weekly Fill Rate	MPF Total Weekly Fill Rate	Total Health Interactions Completed in Last 7 Days	Provider Workload Status: Average # of MIs Completed by 1 Provider Per Shift in Last 7 Days	Support Workload Status: Average # of MIs Completed by 1 Support Person in Last 7 Days	MPF Operational Status
San Diego, CA	154	322	137.00	301.25	438.25	88.96%	93.56%	92.07%	18608	16.64	61.77	Green
El Centro, CA Yuma, AZ	119	273	80	266.50	346.25	67.02%	97.62%	88.33%	6027	20.11	22.62	Green
Tucson, AZ	308	504	182.50	338.25	520.75	59.25%	67.11%	64.13%	18265	21.35	54.00	Green
El Paso, TX	336	567	180.50	411.50	625.00	53.72%	72.57%	69.21%	15561	23.42	37.82	Green
Big Bend, TX	42	84	35.00	73.50	108.50	83.33%	87.50%	86.11%	300	1.71	4.08	Green
Del Rio, TX	252	434	104.00	318.50	422.50	41.27%	73.39%	61.59%	9137	14.64	28.69	Green
Laredo, TX	112	196	66.00	189.75	255.75	58.93%	96.81%	83.04%	3403	13.61	17.93	Green
Rio Grande Valley, TX	378	686	350.50	661.75	1,012.25	92.72%	96.47%	95.14%	13357	9.56	20.18	Green
Miami, FL	7	14	7.00	12.00	19.00	100.00%	85.71%	90.48%	55	6.43	4.50	Green

Our Capabilities | Our Scope of Care

Customs and Border Protection has limited capabilities in the medical care we can provide to persons in custody.

The care **we provide**	The care we provide in a **limited capacity**	The care we **can not provide**
• Health interviews/screenings • Medical assessments • Medical encounters • Medication prescriptions and distributions • Medical summaries • Hospital referrals • Elevated In-Custody Medical Risk (ECMR) monitoring, processing, and alerts	• Basic care • Wound care • Very limited point of care testing capabilities • Pharmaceuticals	• Cardiac testing • IV therapy • Oxygen • Imaging or laboratory capabilities • Durable medical equipment • Suicide watch/monitoring

Our Capabilities | Elevated In-Custody Medical Risk (ECMR)

ECMR OVERIVEW

CBP employs an **Elevated in-Custody Medical Risk monitoring and processing system** to proactively identify, monitor, and expedite the processing of persons in CBP custody who may be at elevated risk for deterioration while in our custody.

ECMR CATEGORIZATION

- Persons in custody who have medical needs or diagnoses that **exceed the capabilities** of the medical unit are given a **red determination**
- Persons with a red determination are **not automatically referred** to a hospital unless their condition can not be treated in the CBP facilities

ENHANCED MEDICAL MONITORING

- Monitoring checks include (at minimum) obtaining vital signs and a review of symptoms
- Worsening medical status in a person with ECMR requires:
  - Immediate physician consultation and/or
  - Immediate hospital referral

EXPEDITED PROCESSING

- Due to CBP's limited scope of care capabilities, CBP will expedite the processing of individuals with a red determination to expedite moving these individual out of CBP custody

Our Capabilities | Public Health at the Southwest Border

Infectious Disease Intelligence & Analysis

- Support public health incident investigations for local health officials
- Conduct ongoing surveillance of infectious disease case rates within facilities

Public Health Situational Awareness

- Monitor global infectious disease trends and outbreaks
- Develop situational awareness reporting on public health and infectious disease concerns
- Empower CBP personnel and providers with knowledge to identify and respond to health threats

Medical Countermeasures

- Ensure facilities have adequate inventory for emergency response
- Coordinate regular emergency response preparedness exercises to ensure facilities are prepared for incidents such as anthrax attacks

Our Capabilities | Isolation Procedures in CBP Facilities

CDC RING | CBP follows the standard CDC RING (Recognize, Isolate, Notify, Give Support) protocol format at all facilities where persons are held in custody.

RECOGNIZE

- Providers are trained to recognize isolatable conditions, such as tuberculosis or measles
- Providers receive guidance from CBP on recognizing emerging health threats

ISOLATE

- Individuals immediately receive a surgical mask and are moved to a designated isolation space
- Asymptomatic close contacts are given masks

NOTIFY

- Local public health authorities, and in some cases, the CDC are notified
- The receiving healthcare facility is notified prior to transport of the individual (if needed)

GIVE SUPPORT

- Individuals in isolation receive enhanced medical monitoring
- CBP coordinates with local health officials to transport individuals to a local health facility (if needed)

Updated isolation guidance and quick reference guides were provided to facilities in 2024.

Our Capabilities | Behavioral Health Interventions

- CBP has limited capabilities to engage in interventions with migrants with behavioral health concerns.
- Many cases requiring behavioral health intervention require an outside care referral, per ECMR policy.
- Facilities triage and refer out individuals requiring immediate attention per ECMR policy, such as suicidal ideation, suicide attempt, etc.
- CBP does **not** have the capability to provide 24/7 monitoring for individuals at risk of harming themselves.

All agents are required to complete annual training on Medical Care of Individuals in CBP Custody to recognize, respond, and refer persons in medical distress, including behavioral health distress.

CBP Electronic Medical Record (EMR) (Current)

- FY2020, Congress passed the Consolidated Appropriations Act which required all DHS components who hold person in custody to create or procure an electronic medical record keeping system. The CBP EMR was created using an existing WebEOC platform and approved by the DHS CMO.
- Multiple enhancements have subsequently been made to the current CBP EMR, but it lacks the ability to provide clinical decision support features, which is an EMR/EHR industry standard. The current EMR would require an integration package to provide this function.

Upgrading to Cloud Based Service

24/7 Technical Support

CBP Systems Interoperability

6 Major Release Updates
33 Minor Release Updates

DRAFT- *This document is incomplete without accompanying discussion.*

Enhancing the EMR System

EMR enhancements to improve documentation and medical quality data collection include

Enhanced Diagnosis Options & Automatic ECMR Selection
Expanded diagnoses pick list and automated ECMR status based on selected diagnosis, ensuring immediate identification of high-risk PIC to promote quality care.

Documentation of Supervising Physician Consultation
Implemented mandatory consultations with supervising physicians or pediatric advisors based on PIC status to promote appropriate clinical oversight.

Whiteboard for EMM tracking
Introduced whiteboard feature for EMM tracking, enhancing visibility to promote timely interventions for these PIC.

New Clinical Note Function
Improved clinical note function to enable precise tracking of patient interactions and quality of care.

Enhanced Staffing Tracking
Utilized sign-in data to monitor staffing compliance, enabling real-time tracking and better visibility.

Automated importing of Medical Summary Information
Automated 2501 Form for information sharing with HHS and ICE to improve interagency coordination and continuity of care.

Electronic Health Records (HER) Replacement Initiative

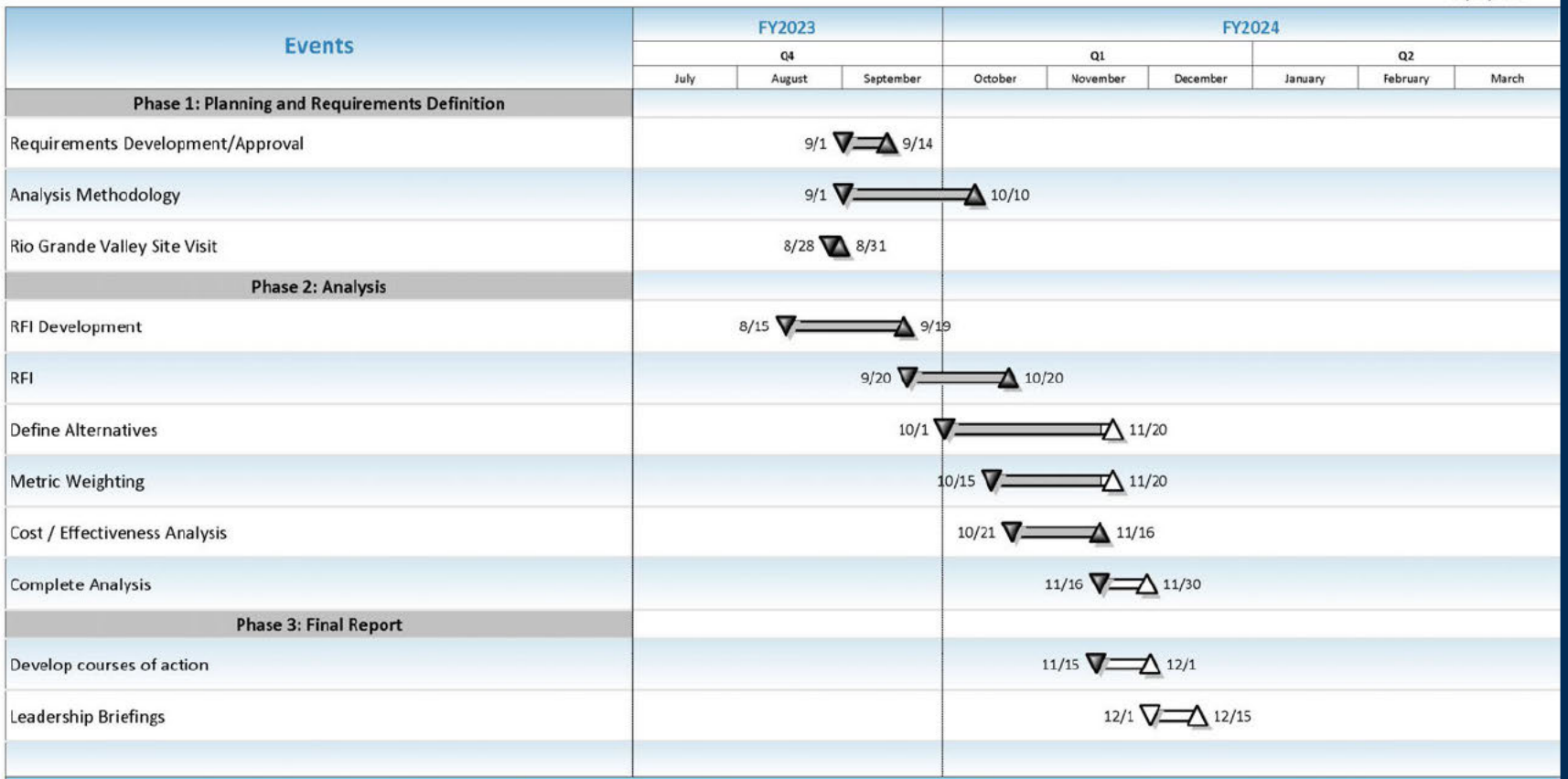
- An EHR Alternative Analysis was conducted to evaluate the effectiveness of the current CBP EMR versus a new Commercial Off the Shelf (COTS) product.
- CBP received information from 20 potential vendors, who were scored and categorized.
- The decision was made to proceed with procurement of a COTS product to replace the CBP EMR and improve medical capabilities.

Estimated Cost in FY 25 is $5.89M	**86% Effectiveness Score**

Market Analysis Schedule

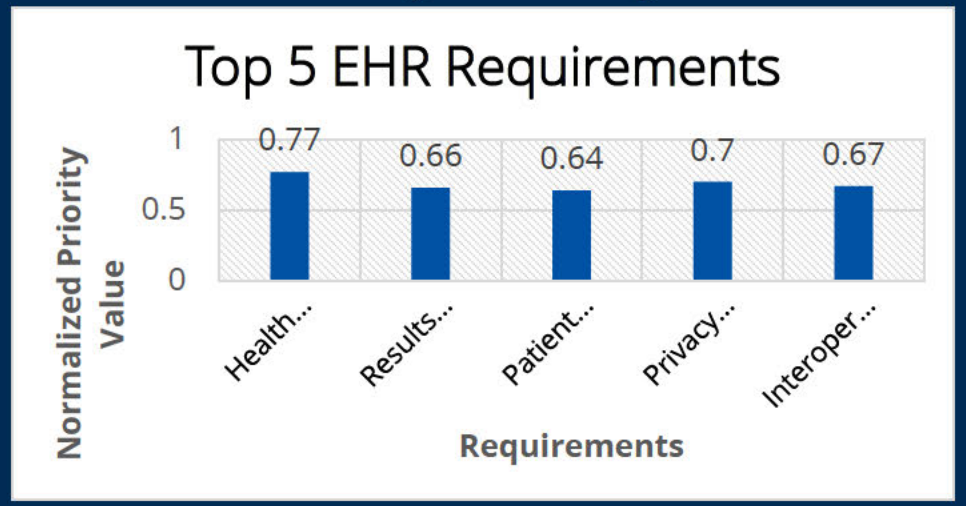
Electronic Health Records Program High Level Schedule

11/16/2023

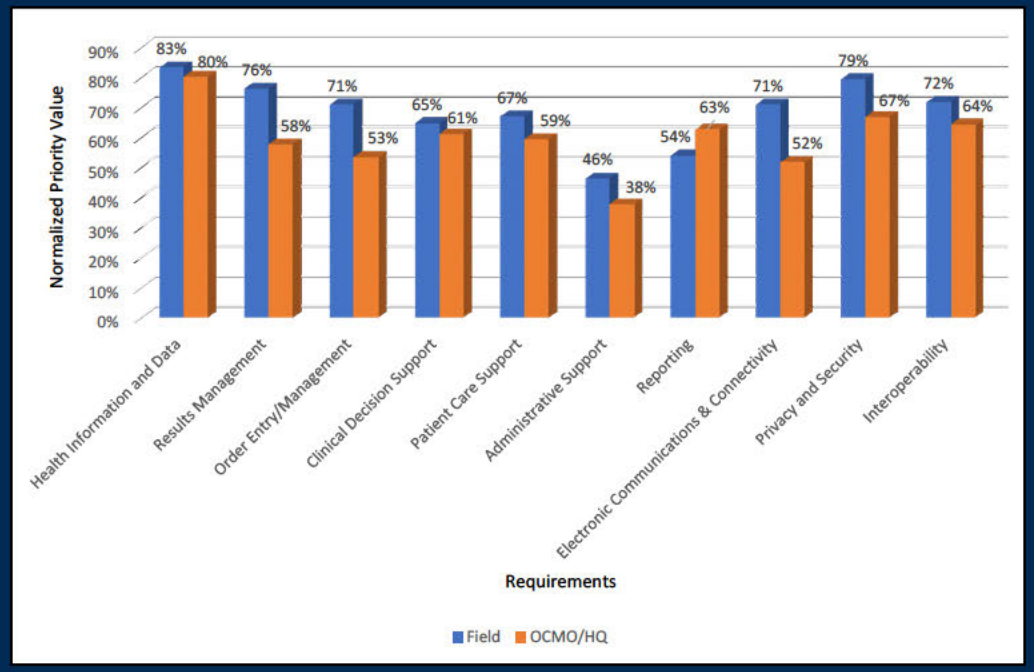


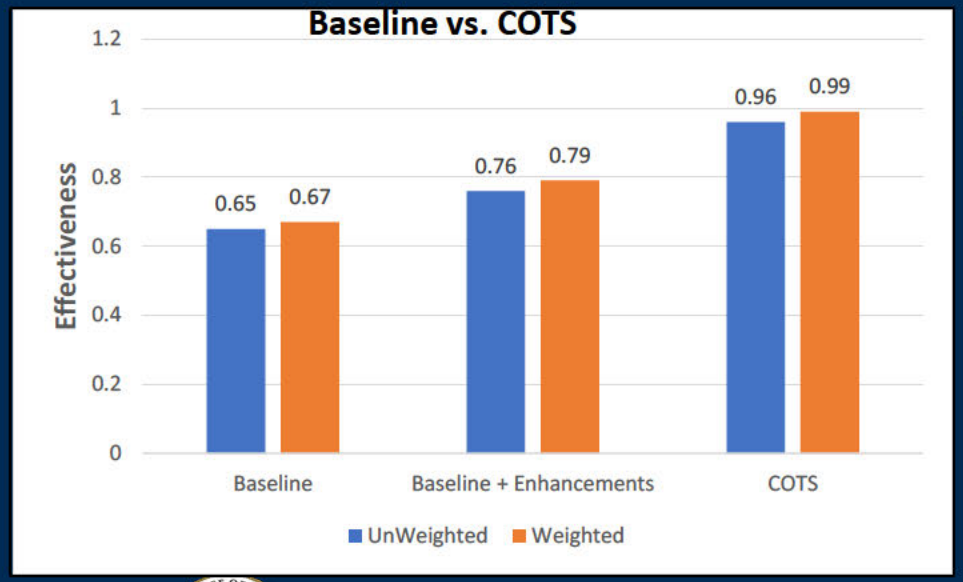
Concept Diagram for Federated Model of DHS Medical Record Systems

Sensitivity Analysis



- Results informed by 25 stakeholder survey responses
- Based on relative importance of operational requirements to stakeholders





- COTS alternatives had 20% higher eff ectiveness than the Baseline + Enhance ments alternative

- A comparison of the survey data illustrates the level of importance between Field Users and OCMO/HQ Personnel
  - Field Users: Nurse Practitioners, Medical Assistants, EMTs, Physician Assistants, Registered Nurses
  - OCMO/HQ: Management, Physicians, Medical Officers and Program Managers
- The data is extracted from 25 survey responses and is raw/unweighted

Overview of DHS CMO Findings & Recommendations

The CBP Office of the Chief Medical Officer (OCMO) has taken actions to improve the quality of medical care provided in response to the May 2023 pediatric death in custody and the June 2023 DHS CMO Memorandum.

Five Focused Medical Improvement Areas:

1. Contract Management and Operations
2. Medical Risk Reduction
3. Enhanced Medical Monitoring
4. Clinical Care Communication and Documentation
5. USBP Isolation Unit Operations

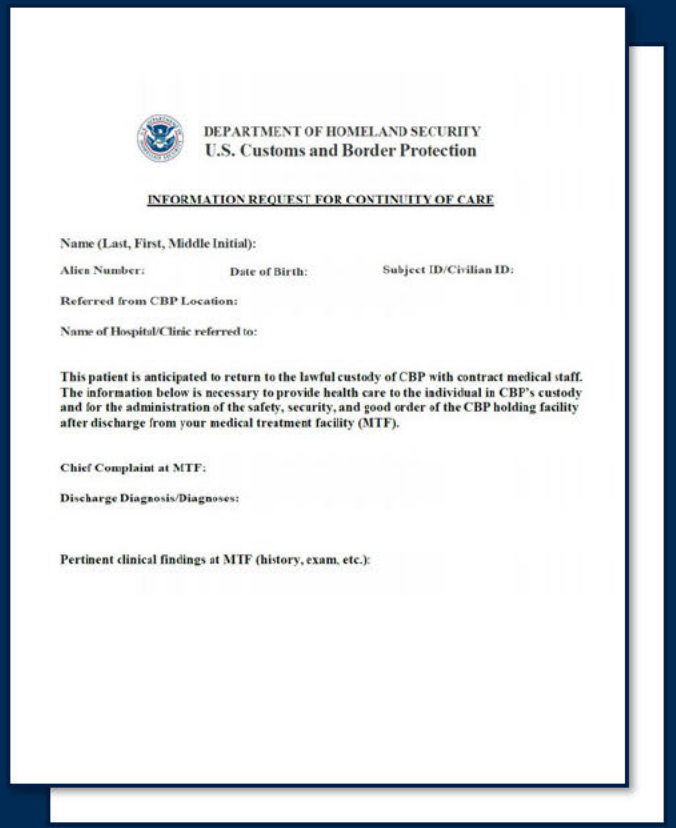
Enhancement across these five medical improvement areas have enriched **quality management**, improved **risk identification** and **informed leadership decision-making.**

How We Work With Hospitals

Medical Information Requests & HIPAA Considerations

CBP Medical Information Request Form

- Where possible, CBP will provide a referral form along with the individual if they have already been seen by a contracted CBP medical services provider.
- Upon patient discharge, hospitals provide CBP with a summary of care using the CBP **Medical Information Request Form.**
  - This can be a clinical summary printed from the EMR.
- Facilities that do not provide this form **may not be reimbursed for services** through MedPar.



DEPARTMENT OF HOMELAND SECURITY
U.S. Customs and Border Protection

INFORMATION REQUEST FOR CONTINUITY OF CARE

Name (Last, First, Middle Initial):

Alien Number: Date of Birth: Subject ID/Civilian ID:

Referred from CBP Location:

Name of Hospitol/Clinic referred to:

This patient is anticipated to return to the lawful custody of CBP with contract medical staff. The information below is necessary to provide health care to the individual in CBP's custody and for the administration of the safety, security, and good order of the CBP holding facility after discharge from your medical treatment facility (MTF).

Chief Complaint at MTF:

Discharge Diagnosis/Diagnoses:

Pertinent clinical findings at MTF (history, exam, etc.):

HIPAA EXCEPTION

- Covered entities may disclose requested health information to CBP pursuant to the Health Insurance Portability and Accountability act of 1996 (HIPAA), **without the authorization or agreement of the patient.**
- This health information is **necessary for CBP to provide health care to patients in custody** and for the safety, security, and good order of the CBP holding facilities. (See 45 CFR 164.512 (k)(5)).

Overview of Response and Improvements

Since May 2023, CBP OCMO has taken specific improvement actions.

Death In Custody Immediate Response

May 2023

- Pediatric death in custody occurs on May 17th.
- CBP ceased Harlingen Station Isolation Unit Operations.
- DHS deploys United States Public Health Service (USPHS) uniformed clinicians to locations across the Southwest Border.

Immediate Improvements

June 2023

- DHS issues memo detailing necessary medical process improvements.
- OCMO modifies Medical Services Contract (MSC) oversight to more effectively mitigate risks.

Near Term Enhancements

July 2023 – February 2024

- OCMO implemented improvements for Medical Risk Reduction, Contract Management and Operations, Enhanced Medical Monitoring, Clinical Care Communication and Documentation, and USBP Isolation Unit Operations.

Modifying the Medical Services Contractor (MSC) SOW

CBP has taken additional steps to improve oversight of the MSC, modifying the Statement of Work (SOW) with additional requirements for the competitive procurement award expected in 2024.

	1. Assessment for Elevated In Custody Medical Risk	2. Physician Consultation for Red ECMR Status	3. Documentation of Enhanced Medical Monitoring Actions
KEY CHANGES	• Requires use of standardized protocols to identify and document individuals with elevated medical in-custody risk.	▪ Requires documented consultation with a physician for any individual classified with a red ECMR status or diagnosed with a condition requiring isolation.	▪ Requires detailed documentation of all medical monitoring actions performed during an individual's time in custody and communication with CBP staff.
IMPACT	➢ Enables **proactive risk identification and management** for medical risk in custody.	➢ Ensures **timely medical interventions**, ensuring care decisions are well-informed.	➢ Supports **oversight of medical care quality** and **continuity of care** for those at risk.

Implementing the ECMR Protocol

ECMR status is automatically determined by the CBP Electronic Medical Record based on the age, pregnancy status, and diagnosis identified during the medical assessment.

ECMR Status	Definition	Risk	Treatment*
Yellow	PIC with well-controlled medical conditions able to be managed while in CBP Custody	Low	• As needed based on condition
Orange	PIC with medical needs that require treatment, but can be managed in CBP Custody	Moderate	• Treatment as required by the condition • Enhanced medical monitoring every 12 hours
Red	PIC with medical needs that exceed the capabilities of the medical unit	High	• Consultation with Supervising Physician or Pediatric Advisor • Evaluation for isolation based on condition • Enhanced medical monitoring every 4 hours • Verbal notification to CBP and use of red wristband to notify others within the facility of condition • Expedited CBP enforcement processing to reduce time the PIC spends in CBP custody

Looking Ahead

In addition to ensuring the improvements made in the past six months are enduring and continue to uphold the high standard of care to all migrants CBP encounters, OCMO priorities for the next six months:

- **Border Health System Operations**
  - Implementing automated monitoring systems that communicate with CBP custodial systems.
- **Deployment of enhanced medical services contract oversight team**
  - CBP-employed, OCMO-assigned leads in select USBP SWB Sectors
- **Replacement of the current CBP Electronic Health Record System**
  - Joint endeavor with OIT, OA

Thank You

Alexander L. Eastman, MD, MPH, FACS, FAEMS
Acting Chief Medical Officer
[redacted]

Key Document Q

From: [redacted]
Sent: Tuesday, August 20, 2024 9:39 AM
To: [redacted]
Subject: RE: Follow-up to 39027 Signed Response from CBP - Chairman DURBIN

[redacted]

Please see the cleared response below regarding the station cameras – thanks[redacted]:

1. System upgrade: Following the two death-in-custody incidents in 2023 at the Harlingen, TX US Border Patrol Facility, the video surveillance system (VSS) was updated with the installation of the AirShip™ Fly-Away Kit, Video Surveillance System, installed by the USBP BORTAC team. .
    a. Description: The Airship Fly-Away Kit shall be a self-contained, rugged, portable solution featuring a federated, scalable, secure video and data management platform, comprised of edge hardware and software, core and cloud hardware and software, and downstream data visualization software offerings optimized to support the unique requirements of CBP. The platform shall be radio and sensor agnostic.

2. Status (USBP, Harlingen Station):
    a. As of August 19, 2024, the AirShip™ system is fully operational.
    b. The Harlingen Station has experience little to no lapse in coverage for the migrant holding and processing areas. (A power outage for the facility caused a temporary lapse in video coverage.)
    c. The quality of the video (resolution, color, clarity, night vision capability) are adequate to meet the basic needs of the USBP Station in the migrant holding and processing areas.
    d. Video records for 30+ days are available for download locally.
    e. This system is only accessible locally although can be upgraded for cloud storage through Wi-Fi connection.

3. Camera outage tracking:
    a. Tracking and reporting of system outages are currently being updated to include outages for: cameras, recording devices (DVR/NVR), network/encoders, monitors/laptops/CPU.

b. Any component outage over 24 hours will be reported to the CBP WATCH as a Serious Incident Report (SIR).
c. Current reporting format track camera and DVR/failure, of which weekly reports are archived.
d. Current outage report does not identify failure in video recording capability and is being modified to include this criteria.

Key Document R

From: [redacted]
To: [redacted]
Cc: [redacted]

Subject: RE: Follow-up to 39027 Signed Response from CBP - Chairman DURBIN
Date: Tuesday, September 24, 2024 9:56:11 AM

[redacted]

I wanted to share responses to your additional questions:

1. We have reviewed the Sentinel Event policy. Are there any additional policies/procedures accompanying that policy?
    a. Additionally, we want to confirm that all the guidance the Committee has been sent is the most updated guidance.

    The Sentinel Event policy that was previously shared is the most updated guidance and there are no additional policies that accompany what was provided.

2. How is the fill rate determined under the current Loyal Source contract?
    a. We know this was covered in the briefing on August 1*st*, but we would appreciate a written response.

    In relation to the Loyal Source (LSGS) contract staffing, OCMO undertakes an evidence-based analysis of Medical Priority Facility (MPF) workload to determine the staffing requirements of each MPF. The required number of shifts is determined by the number of shifts/days at each location multiplied by the staffing requirement/shift. The number of shifts filled each week is provided to OCMO as a deliverable from LSGS. The fill rate is the ratio of the number of shifts filled by the contractor and the required number of shifts and is expressed as a percentage.

3. We did receive medical guidance on the 2500 form, but not the form itself. Can we be provided with the form as soon as possible?

    The current CBP Form 2500 is being presented in .pdf format for reference, but the form is officially part of the CBP enforcement systems (e3 Detention Module and Unified Secondary-USEC) so it may appear in a different format when reviewing records. A revised CBP 2500 is expected at the beginning of FY25 that will include additional questions that will identify chronic conditions and assist Health & Human Services (HHS) Office of Refugee Resettlement (ORR) in determining placement of Unaccompanied Children (UC).

Please let me know if you have any other questions.

Thanks,

[redacted]

Key Document S

This document is incomplete without accompanying discussion.

Office of Health Security

OHS is the principal medical, workforce health and safety, and public health authority for DHS.

Briefing for Senate Judiciary – Majority

September 27, 2024

Evolution of the DHS Chief Medical Officer

Since the inception of the Department of Homeland Security (DHS), health security has been foundational to the execution of DHS's mission. However, DHS's previous structure prevented organizational efficiencies and did not allow for adequate and appropriate oversight of DHS health activities. OHS best positions the Department for a proactive and agile response to the evolving health security landscape.

DHS ORIGINS

2002

The Homeland Security Act of 2002 established the Department of Homeland Security .

CHIEF MEDICAL OFFICER POSITION

2006 - 2007

In 2006, the DHS Chief Medical Officer (CMO) was established in the Post Katrina Emergency Reform Act with "primary responsibility within the Department for medical issues related to natural disasters, acts of terrorism, and other manmade disasters." In 2007, the Office of Health Affairs (OHA) was created and the role of the CMO was elevated to lead the new office as the Assistant Secretary for Health Affairs.

THE REORGANIZATION OF OHA

2017

A DHS reorganization reassigned the CMO to a predominantly advisory role in the Department, now reporting to the Assistant Secretary for Countering Weapons of Mass Destruction. OHA's workforce health functions were transferred to the DHS Management Directorate's Office of the Chief Human Capital Officer.

POST OHA: CWMD ACT (2018-2022)

2018

Congress amended the Homeland Security Act though the Countering Weapons of Mass Destruction Act of 2018 (CWMD Act). The CWMD Act officially codified the 2017 reorganization.

THE OFFICE OF HEALTH SECURITY

JULY 2022

To capitalize on the lessons learned from unprecedented health security events including the COVID-19 pandemic, Congress authorized a limited DHS reorganization to unite the Workforce Health and Safety Division from OCHCO and the Medical Operations Directorate from CWMD into the Office of Health Security, led by the DHS CMO who concurrently serves as the Director of OHS.

WHERE WE ARE TODAY

*The creation of OHS has vastly **improved our effectiveness,** created **efficiencies**, and has ensured new appropriate **oversight.** OHS continues to mature and position the office for continued **optimal mission delivery** through **leadership and collaboration.***

OHS's Mission & Lines of Effort

OHS achieves its mission by leading and supporting the DHS enterprise through five lines of effort to deliver broader, more holistic value to the DHS workforce, individuals in DHS's care and custody, and the Nation.

Our Mission

We strengthen the Nation's health security through leadership and partnership, a safer and healthier DHS workforce, and optimal care for those entrusted to us.

Our Role

Led by the Chief Medical Officer, OHS is the principal medical, workforce health and safety, and public health authority for DHS. OHS leads and coordinates efforts to prepare for an ever-expanding, dynamic, and complex health security landscape.

OHS Serves

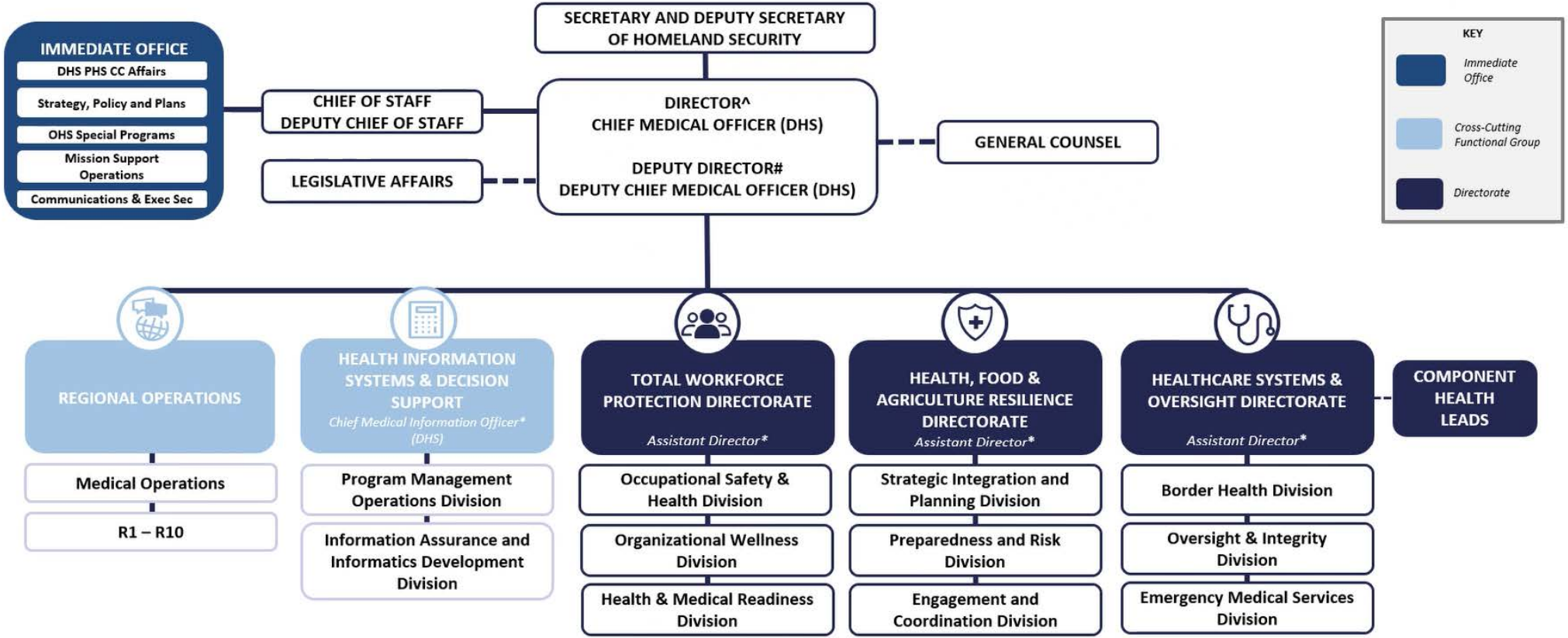
- DHS Workforce
- The Nation's Health Security
- Individuals in DHS's Care & Custody

By Providing

1. ***Healthcare Systems & Oversight***
   Train, unify, integrate, and standardize quality healthcare for individuals in our care while ensuring appropriate oversight
2. ***Health, Food, & Agriculture Resilience***
   Enhance preparedness and response efforts for events that threaten the health, food, and agriculture sectors
3. ***Total Workforce Protection***
   Innovate, implement and oversee DHS workforce, health, safety and medical programs
4. ***Health Information Systems & Decision Support***
   Manage DHS medical and public health data to drive decision-making, oversight and enable effective healthcare delivery and readiness
5. ***Regional Operations***
   Provide specialized direct technical assistance to FSLTT partners through a regionalized network of interdisciplinary subject matter experts

OHS's Organizational Structure

Each directorate serves a unique function within the office, working closely with our partners as DHS's principal health security advisor and an interagency collaborator in response to the changing health security landscape.



^ Assistant Secretary Equivalent
# Principal Deputy Assistant Secretary Equivalent
* Deputy Assistant Secretary Equivalent

Spotlight: OHS's Special Programs

OHS Special Programs is an incubator for new programs – prioritizing them within the Immediate Office for development. Once matured, these programs are realigned into a permanent positioning within a Directorate or Unit.

Serving as an **incubator for new programs,** the OHS Special Programs structure **enables growth** and **allows for close leadership guidance** as new programs respond to the **evolving health security landscape.**

Spotlight on OHS Special Programs

What is OHS Special Programs?

OHS Special Programs is a unit within the Immediate Office which serves as the **incubator for new programs.** Leadership leverage this proximity to **confirm appropriate staffing, define goals and objectives,** and **set the direction for the program.** Once each program is adequately established and ready for implementation, **program management will move to the appropriate OHS Directorate or Unit.**

CASE STUDY: Child Well-Being (CWB) Program

- The CWB Program is a new program established by the FY22 Appropriations Act to enhance the well-being of children in DHS's care.
- Currently, OHS is building the team of federal program management cohort, has recently procured our services contract (SEP 2024), and is implementing the program with a high level of support from OHS and CBP leadership.
- In FY25, the CWB Program will transfer to the Border Health Division within the Healthcare Systems and Oversight Directorate.

Child Well-Being Program Locations Map

OHS will deploy Child Well-Being Specialists across all USBP Sectors along the Southwest Border.

The scope of the Child Well-Being Program covers the entire Southwest Border in steady-state, crisis, surge, and mass migration conditions.

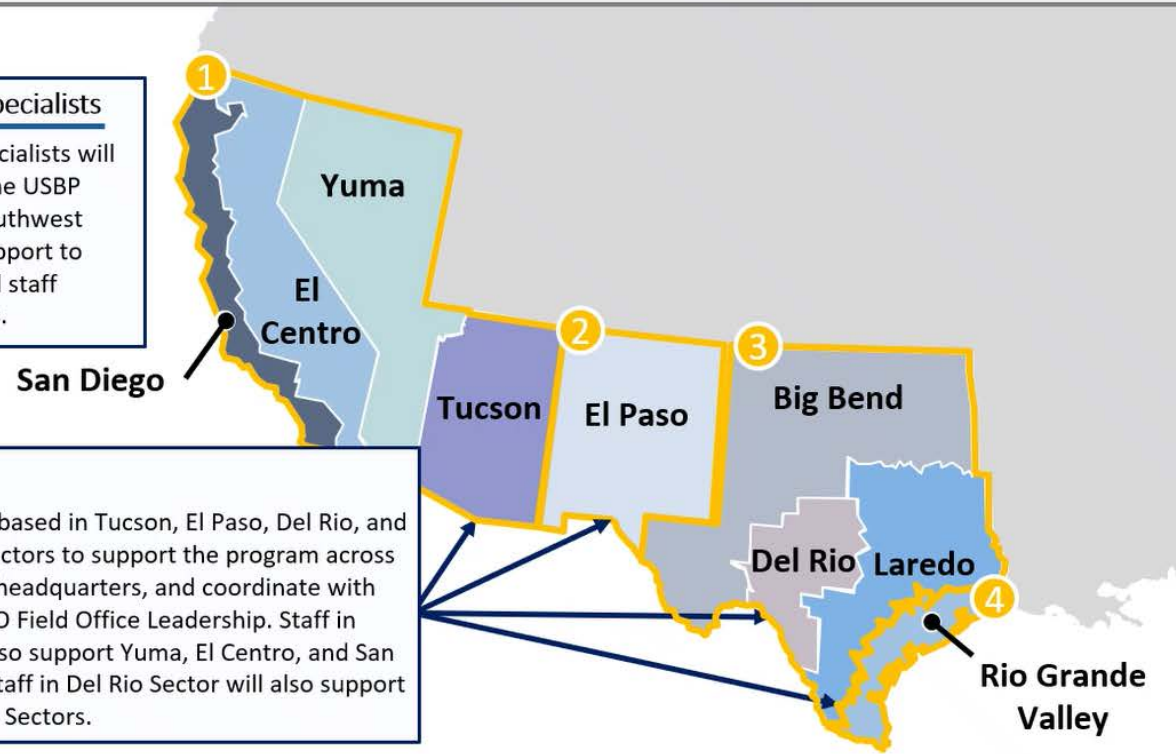
CWB Specialists will deploy to each U.S. Border Patrol Sector along the Southwest Border, serving at USBP facilities with UCs and families. Additionally, CWB federal staff will be located at DHS Headquarters and various locations along the Southwest Border to support the program and coordinate with CBP.

Child Well-Being Specialists

Contracted CWB Specialists will be available to all nine USBP Sectors along the Southwest Border, providing support to children, Agents, and staff within USBP facilities.

Regional Leads

Federal Staff will be based in Tucson, El Paso, Del Rio, and Rio Grande Valley Sectors to support the program across the field, liaise with headquarters, and coordinate with USBP Sector and OFO Field Office Leadership. Staff in Tucson Sector will also support Yuma, El Centro, and San Diego Sectors, and staff in Del Rio Sector will also support Big Bend and Laredo Sectors.



Headquarters Office

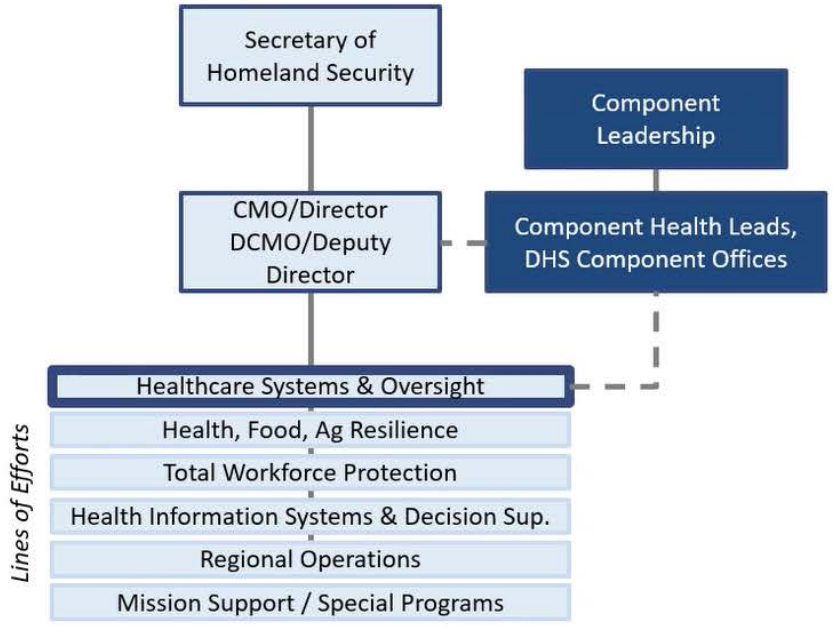
The Child Well-Being Program will have a Headquarters Office dedicated to planning and administrative support, under the Office of Health Security.

KEY — *Outline of the four regions each Federal Regional Lead will support*

How OHS Conducts Appropriate Oversight

OHS enhances DHS's ability to consistently deliver the highest quality medical care and health practices to DHS employees, those in our care and custody, and all others who we serve.

Indirect Oversight Model



What is Different?

Components and Offices retain administrative and operational control of CHLs. OHS provides indirect oversight of CHLs through input into CHL performance plans/appraisals, serving on relevant hiring panels, providing medical contract reviews, setting department-wide policy, and reviewing all policies/procedures related to medical care, public health and workforce health and safety.

What are the Benefits?

- ✓ Enables a "One DHS Health" approach
- ✓ Establishes a centralized policy-making process
- ✓ Promotes efficiencies by harnessing the availability of specialized expertise to all Components and Offices
- ✓ Encourages compliance with Departmental standards and protocols

As an oversight authority for medical quality management, OHS supports CBP/OPR on their investigations. OHS also coordinates with other DHS HQ oversight authorities such as CRCL, including through the DHS Detention Investigations Leadership Group (DILG).

The Indirect Oversight Model is currently implemented at OHS and elsewhere in DHS (e.g., Chief Procurement Officer) and is the preferred model based on engagement with DHS Components.

Medical Improvement Actions and Coordination with CBP (May 2023 Pediatric Death)

- The OHS team, led by the DHS Chief Medical Officer (A), visited Harlingen TX in the days following the death as part of the Department's standard medical quality management processes and oversight.
- The DHS Chief Medical Officer (A) issued an analysis of findings and medical improvement actions to CBP following the pediatric death in custody (May 2023). The memorandum focused on five medical improvement areas:
  1. Contract Management and Operations
  2. Medical Risk Reduction
  3. Enhanced Medical Monitoring
  4. Clinical Care Communication and Documentation
  5. USBP Isolation Unit Operations
- OHS has coordinated with CBP's Office of the Chief Medical Officer on enhancement across these five medical improvement areas that enrich quality management, improve risk identification and inform leadership decision-making.
- OHS coordination and oversight with CBP is frequent and enduring.

OHS Program Highlight: Medical Information Exchange (MIX) Portfolio

The Medical Information Exchange (MIX) system is DHS's solution for better integration of electronic health record (EHR) systems – through a federated model.

Overview

The Medical Information eXchange (MIX) – which is a portfolio of programs – will be the next-generation information technology backbone for a DHS-wide EHR to create **interoperability across Components'** individual EHR systems and fill gaps in medical information systems in DHS.

Collaboration with CBP

- Pursuant to DHS Delegation 26000, OHS is responsible for oversight of all DHS-wide EHR programs and activities.
- OHS has coordinated closely with CBP since 2020 on the development of the current CBP Electronic Health Record (EMR). In recognition of evolving requirements related to EMR capabilities, OHS continues to work with CBP on the design, development, and procurement of current and future technological capabilities related to collection, storage, and management of patient records.
- Clinical Decision Support: While low-level alerts such as medical interactions are widely available in commercial off-the-shelf platforms, enhanced support such as that available in hospital settings requires significant resources to establish and maintain – particularly in the unique operating environment of CBP.
- OHS has participated in the prior CBP Request for Information (RFI) and will be participating in the Request for Proposal (RFP) process.

Intended Impact

MIX will fulfill the mandate as a platform to **enable information sharing and analysis across the extended medical and public health community.** This system will assist OHS in oversight responsibilities to further facilitate outbreak response, disease surveillance, and national health security and provide data-driven decision support.