Minority Staff Report

# THE FAILURE TO PROVIDE ADEQUATE CARE TO VULNERABLE INDIVIDUALS IN CBP CUSTODY


U.S. SENATE COMMITTEE ON THE
JUDICIARY
Ranking Member Dick Durbin

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## Executive Summary

### Objective

After the death of Anadith Reyes Álvarez in May 2023, then-Chair of the Senate Judiciary Committee, Senator Richard J. Durbin directed his staff to investigate the role and performance of Department of Homeland Security (DHS) U.S. Customs and Border Protection (CBP) and CBP's medical services contractor, Loyal Source Government Services, in providing medical care to detainees. The objective of the Committee's investigation was to evaluate the provision of medical care in CBP facilities. Chair Durbin's staff analyzed the breakdowns in medical care and oversight that allowed for the preventable death of eight-year-old Anadith in CBP custody, and identified steps CBP has taken and should take to prevent a similar tragedy from occurring in the future. At the time of publication of this report, Senator Durbin is Ranking Member of the Senate Judiciary Committee.

### Background

Anadith Reyes Álvarez, an eight-year-old girl with sickle cell disease and congenital heart disease, died on May 17, 2023 in CBP custody following several days of illness.[1] Prior to Anadith's death and recent whistleblower allegations, media and agency oversight offices had raised alarms about CBP's failure to provide adequate medical care to detained immigrants in the agency's custody.[2] This was, in part, because Anadith was not the first child to die in CBP custody. In 2018, two children died within a month of each other.[3] The Committee's investigation revealed longstanding failures in the provision of medical care in CBP custody. Despite efforts to draw attention to CBP's inability to provide adequate medical care, including by CBP's Office of Chief Medical Officer (OCMO), many concerns were not sufficiently addressed, leading to the conditions that caused Anadith's death in 2023.[4]

Under any administration, desperate individuals will seek safety in the United States. However, the number of individuals approaching the border during the Biden Administration decreased dramatically in 2024 due to policies put in place by President Biden and the Mexican government.[5] Despite these lower numbers, individuals have spent long periods of time in CBP custody where they rely entirely on CBP for medical care.

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[1] *Update: Death in Custody of 8-Year-Old in Harlingen, Texas*, U.S. CUSTOMS AND BORDER PROT. (May 21, 2023), https://www.cbp.gov/newsroom/national-media-release/update-death-custody-8-year-old-harlingen-texas.

[2] Sheri Fink and Caitlin Dickerson, *Border Patrol Facilities Put Detainees With Medical Conditions at Risk*, THE NEW YORK TIMES (Mar. 5, 2019), https://www.nytimes.com/2019/03/05/us/border-patrol-deaths-migrant-children.html

[3] Miriam Jordan, *8-Year Old Migrant Child From Guatemala Dies in U.S. Custody*, THE NEW YORK TIMES (Dec. 25, 2018), https://www.nytimes.com/2018/12/25/us/guatemalan-boy-dies-border-patrol.html; Amir Vera, *Autopsy determines 7-year-old Guatemalan girl died from sepsis while in US custody*, CNN (Mar. 30, 2019), https://www.cnn.com/2019/03/29/us/guatemala-jakelin-caal-maquin-autopsy/index.html.

[4] *Child's death in immigration custody was preventable, independent monitor concludes*, NATIONAL CENTER FOR YOUTH LAW (Jul. 20, 2023), https://youthlaw.org/news/childs-death-immigration-custody-was-preventable-independent-monitor-concludes.

[5] Salvador Hernandez and Ruben Vives, *Unlawful border crossings dropped to four-year low in November, new data show*, LOS ANGELES TIMES (Dec. 31, 2024), https://www.latimes.com/california/story/2024-12-31/year-end-border-

Under the current administration, the provision of adequate medical care in CBP facilities will be an urgent issue. President Donald Trump already has begun enacting sweeping policies restricting immigration that aim to shut down the border, even to those lawfully seeking asylum. If medical care in CBP custody worsens, more individuals and children may die.

**Sources and Methods**

As part of this investigation, the Committee reviewed investigations and reports from agency oversight offices, Congress, nongovernmental organizations, whistleblowers, the *Flores* Juvenile Care Monitor,[6] and other stakeholders that identified numerous factors contributing to poor medical care in CBP facilities, including CBP's failure to provide rigorous oversight of its medical services contractor. The Committee reviewed policies in place prior to and after Anadith's death and considered other steps CBP has taken to improve medical care in its facilities. The Committee obtained information directly from CBP and Loyal Source. Initial information requests were made to CBP and Loyal Source on December 14, 2023. Loyal Source promptly complied with the Committee's investigation requests. CBP did not finish its document production to the Committee until October 16, 2024, prolonging the investigation.

**Key Findings**

The Committee's investigation of CBP's medical care concluded that the substandard care Anadith received in CBP custody was not aberrant but consistent with other examples of poor care in CBP custody. The report makes five key findings:

I. ***Children Are Held Too Long in CBP Custody, Putting Them at Risk.*** CBP guidelines state that detained individuals generally should not be held for longer than 72 hours in a CBP facility, and the law requires that unaccompanied minors generally be released from CBP custody in under 72 hours.[7] The Committee's review found that many children in

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crossings-lowest-seen-in-biden-administration; Mary Beth Sheridan, *How Mexico is helping Biden and Harris at the U.S. border,* THE WASHINGTON POST (Sept. 4, 2024), https://www.washingtonpost.com/world/2024/09/14/mexico-migrant-border-merry-go-round/.

[6] CBP Settlement Agreement, *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. No. 1254-1, at *17 (C.D. Cal., May 21, 2022) (describing authority of Juvenile Care Monitor to monitor CBP's compliance with the Settlement Agreement in Rio Grande Valley and El Paso Border Patrol Sectors).

[7] *National Standards on Transport, Escort, Detention, and Search (TEDS)*, U.S. CUSTOMS AND BORDER PROT. (Oct. 2015), https://www.cbp.gov/sites/default/files/assets/documents/2020-Feb/cbp-teds-policy-october2015.pdf (requires that "[e]very effort must be made to hold detainees for the least amount of time required for their processing, transfer, release, or repatriation as appropriate and as operationally feasible," and that people "should generally not be held for longer than 72 hours"); 8 U.S.C.. § 1232(b)(3) ("Except in the case of exceptional circumstances, any department or agency of the Federal Government that has an unaccompanied alien child in custody shall transfer the custody of such child to the Secretary of Health and Human Services not later than 72 hours after determining that such child is an unaccompanied alien child."); Amna Nawaz, *Hundreds of children have been held by Border Patrol for more than 10 days. The legal limit is 72 hours*, PBS NEWS (Mar. 17, 2021), https://www.pbs.org/newshour/nation/hundreds-of-children-have-been-held-by-border-patrol-for-more-than-10-days-the-legal-limit-is-72-hours.

CBP custody are held for far longer than 72 hours. For example, in October 2024, 832 children were in CBP custody for over seven days and 56 children were in custody for over 14 days.[8] Incredibly, during the same month, a 7-year-old child and 14-year-old child were held for 22 days.[9] Despite her medical vulnerabilities and tender age, at the time Anadith died, she had spent nine days in CBP custody with her family, far above the 72-hour maximum. The Committee's review found that prolonged periods in custody place children, like Anadith, at greater risk of harm.[10]

**II.** ***CBP Facilities Are Chronically Understaffed.*** Though the failure to staff CBP facilities with adequate medical personnel is well documented, CBP and Loyal Source disagree about the gravity of the problem and its root causes. CBP takes the position that Loyal Source has consistently neglected to provide sufficient medical staff at CBP facilities. Loyal Source disagrees, taking the position that it has consistently met the staffing requirements under its contract, but because CBP's background check process is lengthy, Loyal Source has not been able to quickly complete the hiring process and move newly hired staff into vacant positions. CBP and Loyal Source have not been able to work together effectively to resolve these challenges, leaving individuals in CBP custody without adequate care.

**III.** ***Staff Have Not Properly Used Medical Records Systems to Track Critical Information About Medically Vulnerable Individuals.*** Accurate and comprehensive medical records are necessary to identify and care for individuals with elevated medical risks. In earlier phases of the implementation of CBP's current Electronic Medical Records (EMR) system, CBP and Loyal Source identified technical challenges with the system. Though many of those issues have been addressed, OCMO leadership recommends implementing a new EMR system. The Committee has found past challenges with the EMR system noteworthy; however, key issues have been resolved and the U.S. Office of Special Counsel (OSC) currently is investigating whistleblower reports that Acting OCMO Chief Medical Officer (CMO), Dr. Alexander Eastman, improperly attempted to replace the EMR. Because of these developments, OCMO should continue to explore alternatives to replacing the EMR system.[11] In addition, systemic issues cannot be resolved by implementing a new EMR system. CBP and Loyal Source staff, for example, have not always properly recorded medical records in CBP's current EMR system nor checked the EMR system when treating a patient. Anadith's case is a tragic example. Her medical history was documented in the EMR system when her family was first taken into custody

[8] Decl. of Diane de Gramont in Supp. of Pls.' Reply in Supp. of Mot. to Modify the 2022 CBP Settlement, *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. No. 1538, at *4 (C.D. Cal., Jan. 14, 2025) (citing data provided by CBP).
[9] *Id*.
[10] *See infra* Part VII.G.
[11] According to reporting, Dr. Eastman was removed as CBP's Acting Chief Medical Officer in December 2024. *CBP Acting Chief Medical Officer Removed Following Whistleblower Disclosures*, GOVERNMENT ACCOUNTABILITY PROJECT (Dec. 20, 2024), https://whistleblower.org/press-release/cbp-acting-chief-medical-officer-removed-following-whistleblower-disclosures/; Nick Schwellenbach, *CBP Replaces Top Doctor Accused of Misconduct*, POGO (Dec. 19, 2024), https://www.pogo.org/investigations/cbp-replaces-top-doctor-accused-of-misconduct.

and transported to the Donna Centralized Processing Facility.[12] Loyal Source staff and U.S. Border Patrol personnel at Harlingen Station who interacted with the girl and her mother, however, claimed to be unaware Anadith had sickle cell anemia or a history of congenital heart disease.[13] This is because the medical staff member who treated Anadith in the hours before her death apparently never reviewed her records in the EMR system.[14] In the hours preceding her death, medical staff denied Anadith life-saving care.[15] In fact, agents were reportedly dismissive of Anadith's mother's pleas for help and Anadith's worsening symptoms.[16] In an interview with CBS, Anadith's mother, Mabel Alvarez, recounted what a dismissive CBP agent told Anadith: "Tell me how you can't breathe, because a girl that can't breathe would be passing out and you're not passing out, you're fine."[17]

**IV.** ***Medical Personnel Are Not Always Empowered to Seek Emergency Medical Services Without Approval from Nonmedical Personnel.*** One of the factors that contributed to Anadith's death was medical services personnel's failure to seek higher-level care when Anadith's health was failing, including securing transport to a hospital or calling emergency services. The Committee has determined that the process for obtaining emergency care is not consistent across CBP facilities, and despite CBP policies stating that medical services personnel should contact emergency services, Loyal Source medical personnel do not always feel empowered to seek emergency services without approval by nonmedical CBP personnel at CBP facilities.[18]

**V.** ***Contracted Medical Personnel Need Consistent Oversight by CBP to Ensure the Successful Implementation of Guidance to Improve Medical Care for Vulnerable Individuals, Including Children.*** Guidance related to the medical treatment of children and other vulnerable individuals, such as pregnant individuals, creates requirements for Loyal Source staff. It remains unclear, however, how CBP or DHS entities like the DHS Office of Health Security (OHS) and the DHS Office of the Immigration Detention Ombudsman (OIDO), conduct meaningful oversight to ensure Loyal Source medical services staff comply with the guidance. Since the development and implementation of the Elevated In-Custody Medical Risk (ECMR) guidance, for example, there does not appear to be consistent internal monitoring of implementation of the guidance, including Loyal Source's performance. It also is unclear how internal monitoring by CBP takes place to ensure medical services staff are consistently conducting health interviews,

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[12] *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. 1326, at *34 (C.D. Cal., Jan. 30, 2023), https://youthlaw.org/sites/default/files/2023-07/2023.01.30%20-%20Flores%20Juvenile%20Care%20Monitor%20Report.pdf.

[13] *Update: Death in Custody of 8-Year-Old in Harlingen, Texas,* U.S. CUSTOMS AND BORDER PROT. (Jun. 1, 2023), https://www.cbp.gov/newsroom/speeches-and-statements/june-1-2023-update-death-custody-8-year-old-harlingen-texas.

[14] *Id.*

[15] *Id.*

[16] Camilo Montoya-Galvez, *Official concedes 8-year-old who died in U.S. custody could have been saved as devastated family recalls final days*, CBS NEWS (Jul. 20, 2023), https://www.cbsnews.com/news/anadith-danay-reyes-alvarez-8-year-old-migrant-died-border-patrol-custody-family/.

[17] *Id.*

[18] *See infra* Part VII.C.

medical assessments, and medical encounters, and reviewing the medical history of individuals, including children, to ensure they are receiving proper treatment.

**Recommendations**

The report contains seven recommendations for strengthening mechanisms for holding CBP and contractor Loyal Source accountable, improving the delivery of medical care, and reducing risk to medically vulnerable individuals in CBP custody.

## REPORT

### I. Overview of CBP Medical Care

The medical personnel responsible for Anadith's care at the time she died were employees of Loyal Source, a company contracted by CBP to provide medical care to individuals in CBP custody.[19] CBP and Loyal Source whistleblowers have alleged that CBP's Office of Acquisitions failed to hold Loyal Source accountable for deficient medical care over a number of years.[20] Whistleblowers and oversight offices, such as the DHS Office of Inspector General (OIG) and DHS Office of Civil Rights and Civil Liberties (CRCL), have attributed inadequate medical care in CBP facilities to, among other factors, understaffing, an inadequate electronic medical records system, and a lack of clarity related to roles and responsibilities in the delivery of medical care. In addition to inadequate medical care, oversight entities have highlighted dangers associated with longer stays in CBP custody.[21] The length of time in custody may exacerbate existing medical care needs, create additional challenges for medical staff attending to the needs of large numbers of migrants, and create dangerous and untenable conditions in CBP facilities that were not designed for long-term detention.[22]

Under the 2022 *Flores* Settlement Agreement, Texas immigration detention facilities in the Rio Grande Valley and El Paso Border Patrol Sectors became subject to enhanced medical

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[19] Nick Miroff, *Medical provider vying for border contract faces scrutiny after girl's death*, THE WASHINGTON POST (Nov. 19, 2023), https://www.washingtonpost.com/immigration/2023/11/19/border-loyal-source-medical-care-migrants/.

[20] *Id.*

[21] Results of Unannounced Inspections of CBP Holding Facilities in the San Diego Area, OFF. OF INSPECTOR GEN., U.S. DEP'T OF HOMELAND SEC. 4-6, 9 (Nov. 15, 2023), https://www.oig.dhs.gov/sites/default/files/assets/2023-11/OIG-24-07-Nov23.pdf.

[22] *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. 1381, at *14 (C.D. Cal., Dec. 13, 2024), https://youthlaw.org/sites/default/files/2024-12/December%202024%20Juvenile%20Care%20Final%20Monitor%20Report%20by%20Andrea%20S.%20Ordin%2C%20Dr.%20Nancy%20Ewen%20Wang%2C%20Dr.%20Paul%20Wise_0.pdf.
(". . . holding children at elevated medical risk in custody for what appears to be increasingly longer times will inevitably place additional stress on the ability of the CBP medical system to ensure the well-being of children at elevated medical risk while in custody.").

care requirements for children.[23] These include providing adequate medical care to vulnerable children in CBP custody, referring children to local health systems for higher level care, using risk management principles, contracting with medical personnel to provide enhanced medical support, and conducting health intake interviews and assessments.[24] Children in DHS custody, including CBP custody, continue to be subject to the original *Flores* Settlement Agreement which permits plaintiffs' counsel to visit facilities and speak with children.[25] The 2022 Settlement Agreement required the appointment of a Juvenile Care Monitor to monitor CBP's compliance with its requirements, and allowed the Juvenile Care Monitor to access CBP documents and records, conduct unannounced visits, and speak with detained children and families as well as CBP employees of CBP contractors.[26]

Loyal Source remained relatively free from public scrutiny until it became the subject of whistleblower allegations and reporting alleging CBP failed to engage in adequate oversight over Loyal Source. Whistleblower Troy Hendrickson stated that Loyal Source spent millions of federal funds while providing subpar healthcare.[27] He alleged that if concerns had been addressed by CBP, Anadith might not have died. Hendrickson stated that, among other failures, Loyal Source was understaffed by 40 percent, migrant electronic health records were improperly maintained, and billing mistakes resulted in overpayments of millions of dollars to Loyal Source.[28] More recent whistleblower allegations from current and former employees of CBP and Loyal Source detail concerns about the circumstances surrounding Anadith's death and the delivery of medical care in CBP facilities, including staffing shortages, inadequate oversight of Loyal Source, and failures to anticipate medical care needs during surges at the border.[29]

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[23] CBP Settlement Agreement, *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. No. 1254-1, at *7-10 (C.D. Cal., May 21, 2022).
[24] *Id*.
[25] *See* Stipulated Settlement Agreement, *Flores v. Reno*, No. 85-4544-RJK (Px), at ¶12 (C.D. Cal. Jan. 17, 1997), https://www.acf.hhs.gov/sites/default/files/documents/orr/Flores-Settlement-Agreement.pdf ("Facilities will provide access to toilets and sinks, drinking water and food as appropriate, medical assistance if the minor is in need of emergency services… Every effort must be taken to ensure that the safety and well-being of the minors detained in these facilities are satisfactorily provided for by the staff").
[26] CBP Settlement Agreement, *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. No. 1254-1 (C.D. Cal., May 21, 2022). A new U.S. Dep't of Health and Human Services (HHS) rule governing the treatment of unaccompanied children in Office of Refugee Resettlement custody went into effect on July 1, 2024. The district court overseeing *Flores* ruled that *Flores* was "conditionally and partially terminat[ed]" as to HHS, but the terms of the *Flores* agreement continue to apply with "full force and effect" to DHS. *See Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. No. 1447, at *20-21 (C.D. Cal., June 28, 2024); *See also Updates on Protections for Unaccompanied Children*, NATIONAL CENTER FOR YOUTH LAW (July 2024), https://youthlaw.org/sites/default/files/attachments/2024-07/NCYL-July2024-UpdatesOnProtectionsForUnaccompaniedChildren.pdf.
[27] *Protected Whistleblower Disclosures Regarding the Performance and Oversight Failures of the Medical Services Contract of U.S. Customs and Border Protection with Loyal Source Government Services*, GOVERNMENT ACCOUNTABILITY PROJECT (Nov. 20, 2023), https://whistleblower.org/wp-content/uploads/2023/11/11-30-2023-Hendrickson-Congressional-Disclosure.pdf.
[28] *Protected Whistleblower Disclosures Regarding the Performance and Oversight Failures of the Medical Services Contract of U.S. Customs and Border Protection with Loyal Source Government Services*, GOVERNMENT ACCOUNTABILITY PROJECT (Nov. 20, 2023), https://whistleblower.org/wp-content/uploads/2023/11/11-30-2023-Hendrickson-Congressional-Disclosure.pdf; Rafael Bernal, *Whistleblower report alleges shoddy medical care for detained migrants*, THE HILL (Nov. 30, 2023), https://thehill.com/homenews/administration/4336206-cbp-whistleblower-report-medical-care-detained-migrants/.
[29] *Protected Whistleblowers' Disclosures Regarding Failure of CBP Leadership and CBP Office of Acquisition to Oversee its Medical Services Contract with Loyal Source Government Services and Ongoing Wrongdoing by Acting*

## II. Deaths of Children in CBP Custody

Prior to Anadith's death and recent whistleblower allegations, media and agency oversight offices raised alarms about CBP's failure to provide adequate medical care.[30] This was, in part, because Anadith was not the first child to die in CBP custody. In 2018, a seven-year-old girl, Jakelin Caal Maquin, and an eight-year-old boy, Felipe Gomez Alonso, died within a month of each other,[31] spurring public outrage, a series of investigations, and extensive scrutiny of CBP conditions and policies.

After the deaths of children in 2018, CBP stated it was aware the agency's infrastructure was inadequate. The CBP commissioner acknowledged CBP facilities were built in the 1980s and 1990s to temporarily house single adult males and were not built for holding children or families.[32] He likened a CBP facility to a "police station" where a person is detained for a short period of time before they are sent to a jail or a facility built to house individuals for longer periods of time.[33]

Though DHS implemented some enhancements in early 2018 to medical screenings, children continued to die in CBP custody—both in CBP holding cells and at hospitals after spending time in holding cells.[34] In May 2019, a 16-year-old boy, Carlos Gregario Hernandez Vasques, died after spending six days in CBP custody, suffering from flu symptoms, including a fever, and reportedly failing to receive any welfare checks as his health rapidly deteriorated.[35] Anadith's tragic death in 2023 brought renewed scrutiny and calls for accountability, reigniting a number of congressional and federal investigations into CBP medical care.[36]

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*CBP Chief Medical Officer*, GOVERNMENT ACCOUNTABILITY PROJECT (Feb. 16, 2024), https://whistleblower.org/wp-content/uploads/2024/02/02-16-2024-CBP-Medical-Services-Whistleblower-Disclosure.pdf.

[30] Miriam Jordan, *8-Year Old Migrant Child From Guatemala Dies in U.S. Custody*, THE NEW YORK TIMES (Dec. 25, 2018), https://www.nytimes.com/2018/12/25/us/guatemalan-boy-dies-border-patrol.html; Amir Vera, *Autopsy determines 7-year-old Guatemalan girl died from sepsis while in US custody*, CNN (Mar. 30, 2019), https://www.cnn.com/2019/03/29/us/guatemala-jakelin-caal-maquin-autopsy/index.html.

[31] *Id.*

[32] Miriam Jordan, *8-Year Old Migrant Child From Guatemala Dies in U.S. Custody*, THE NEW YORK TIMES (Dec. 25, 2018), https://www.nytimes.com/2018/12/25/us/guatemalan-boy-dies-border-patrol.html.

[33] *Id*.

[34] Robert Moore, Susan Schmidt, and Maryam Jameel, *Inside the Cell Where a Sick 16-Year-Old Boy Died in Border Patrol Care*, PROPUBLICA (Dec. 5, 2019), https://www.propublica.org/article/inside-the-cell-where-a-sick-16-year-old-boy-died-in-border-patrol-care.

[35] *Id*.

[36] *Durbin Presses for Further Investigation into Systemic Failures at Customs and Border Protection Resulting in Years of Deficient Medical Care*, U.S. SENATE COMMITTEE ON THE JUDICIARY (Dec. 14, 2023), https://www.judiciary.senate.gov/press/releases/durbin-presses-for-further-investigation-into-systemic-failures-at-customs-and-border-protection-resulting-in-years-of-deficient-medical-care; *Oversight Democrats Request GAO Conduct Review of Medically Necessary Procedures for ICE, CBP Detainees*, U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON OVERSIGHT AND ACCOUNTABILITY DEMOCRATS (May 10, 2024), https://oversightdemocrats.house.gov/news/press-releases/oversight-democrats-request-gao-conduct-review-medically-necessary-procedures.

## III. Longstanding Deficiencies in Medical Care in CBP Facilities

Several years before Anadith's death, a 2020 DHS OIG report found that CBP stations were ill-equipped to address influxes of migrants. During its investigation, OIG visited 14 Border Patrol stations. In 12 of the 14 facilities, detainees had been there for longer than the permitted 72 hours, and a substantial number had been there for over a month.[37] Of 9,400 detainees, 3,750 had been held longer than 72 hours when OIG conducted its inspection.[38] OIG identified overcrowding as playing a role in exacerbating the health care crisis at these stations, since many immigrants were held in close quarters with one another. The report found that when CBP stations attempted to address overcrowding by isolating and quarantining sick individuals, this further exacerbated overcrowding for those who were not sick, increasing their susceptibility to any disease or ailment and starting the cycle anew.[39] When OIG conducted its investigation, processes in place at the time only required CBP staff to visually inspect migrants for signs of injury, illness, or other physical or mental health concerns, and to ask migrants about needed prescription medications.[40] The flaw in this approach, according to the investigation, was that the guidelines for CBP stations did not require the sites to have on-site medical staff.[41] As a result, only 10 out of 14 of the stations that investigators visited had medical personnel addressing health care issues.[42] In the other four, medical assessments were performed by CBP agents or emergency medical technicians.[43]

The report also detailed how Border Patrol facilities did not meet CBP's own National Standards on Transport, Escort, Detention, and Search (TEDS) regarding treatment of children in CBP custody. The standards require special protections for children in detention, including requirements for food, clothing, and conditions of detention.[44] According to the report, some children in custody for more than 48 hours lacked access to a shower or a change of clothing.[45] And in a few facilities, children did not get a hot meal until OIG arrived at the facility.[46]

Later reports from agency oversight offices also raised alarms about CBP's failure to provide adequate medical care. A July 2020 Government Accountability Office (GAO) report noted that CBP had not consistently implemented enhanced medical care policies and procedures for those in their custody, including children, at southwest border facilities.[47] The report recommended that CBP develop certain oversight mechanisms, including "documentation of expected practices, metrics and corresponding performance targets, and roles and responsibilities

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[37] *Capping Report: CBP Struggled to Provide Adequate Detention Conditions During 2019 Migrant Surge*, 13, OFF. OF INSPECTOR GEN., U.S. DEP'T OF HOMELAND SEC. (Jun. 12, 2020), https://www.oig.dhs.gov/sites/default/files/assets/2020-06/OIG-20-38-Jun20.pdf.
[38] *Id.*
[39] *Id.* at 17.
[40] *Id.* at 14.
[41] *Id.*
[42] *Id.*
[43] *Id.*
[44] *Id.* at 18-19.
[45] *Id.*
[46] *Id.*
[47] *Southwest Border: CBP Needs to Increase Oversight of Funds, Medical Care, and Reporting of Deaths*, U.S. GOVERNMENT ACCOUNTABILITY OFFICE (Jul. 2020), https://www.gao.gov/assets/gao-20-536.pdf.

for taking corrective action."[48] In response, CBP incorporated medical quality management requirements into its medical support contract, established a Contracting Officer's Representative position for medical services, and developed a protocol for conducting management inspections of medical care at CBP facilities.[49] GAO also recommended that CBP ensure that CBP contracting officers for its medical services blanket purchase agreement (BPA) perform and document annual reviews—a requirement under the Federal Acquisition Regulation.[50] According to GAO, CBP's Procurement Directorate Border Enforcement Contracting Division provided individual training regarding how to respond to the GAO recommendations and provided a BPA review checklist that lists required elements of an annual review and reminded staff to preserve the documentation.[51] These actions were intended to help CBP better ensure that annual reviews of its medical services agreement are performed and properly documented, thereby providing contracting officers with opportunities to identify additional savings and ensure that the agreement continues to be the best option to meet CBP's need for contracted medical services. An OIG management alert issued later in 2020 recommended CBP take immediate steps to ensure its medical services contract did not lapse and a medical services contractor remained in place.[52]

In July 2021, OIG issued a report analyzing CBP's standards of care for migrants in its custody to determine if CBP policies adequately safeguarded detained migrants experiencing medical emergencies or illnesses.[53] The report found CBP could not demonstrate it consistently complied with agency policies at the time to conduct health interviews and "regular and frequent" welfare checks to identify people who were experiencing serious medical conditions.[54] The report also determined CBP could not ensure policies were followed, because it failed to conduct sufficient oversight, policies and procedures were not clear, and CBP officers and agents were not adequately trained to identify individuals who needed medical attention.[55] OIG recommended CBP update its procedures to clearly define at-risk individuals, establish times for welfare checks, ensure rescreening of migrants if their detention exceeded 72 hours in CBP custody, and ensure all juveniles in CBP custody complete medical assessments.[56] OIG also recommended the CBP Chief Medical Officer work with U.S. Border Patrol and the Office of Field Operations to strengthen oversight and quality assurance plans and to review and assess medical screening, welfare checks, and the recording of supporting documentation.[57] Finally, OIG recommended CBP develop trainings on changes to policies and procedures and on

[48] *Id.* at 47.
[49] *Id.* at 77.
[50] *Id.* at 55.
[51] *Id.* at 54.
[52] *Management Alert – CBP Needs to Award a Medical Services Contract Quickly to Ensure no Gap in Services 6*, OFF. OF INSPECTOR GEN., U.S. DEP'T OF HOMELAND SEC. (Sept. 3, 2020), https://www.oig.dhs.gov/sites/default/files/assets/Mga/2020/oig-20-70-sep20-mgmtalert.pdf.
[53] *CBP Needs to Strengthen Its Oversight and Policy to Better Care for Migrants Needing Medical Attention*, OFF. OF INSPECTOR GEN., U.S. DEP'T OF HOMELAND SEC. (Jul. 20, 2021), https://www.oig.dhs.gov/sites/default/files/assets/2021-07/OIG-21-48-Jul21.pdf.
[54] *Id.* at 5.
[55] *Id*. at 4.
[56] *Id*. at 8.
[57] *Id*.

identifying medical emergencies.[58] CBP concurred with OIG's recommendations and indicated it would update its policies and procedures.

A 2022 Ombudsman Alert issued by the DHS Immigration Detention Ombudsman (OIDO) raised concerns that there was a "critical shortage of medical services at CBP facilities" that "could jeopardize the health and safety of noncitizens in CBP custody."[59] In June 2023, OIDO issued a more in-depth analysis of the Loyal Source medical contract with CBP, voicing concerns that the medical staffing levels at Tucson medical units did not meet contract requirements.[60]

## IV. Investigations into the Circumstances of Anadith's Death

The circumstances that resulted in Anadith's death were unfortunately not an aberration, but indicative of systemic problems with the provision of medical care in CBP facilities and CBP's broader failure to properly oversee that care. A pediatrician appointed by a federal court to monitor CBP's compliance with the June 2022 settlement agreement in *Flores v. Garland* issued multiple reports highlighting serious concerns with medical care of children in CBP facilities in the Rio Grande Valley and El Paso Border Patrol Sectors.[61] A report issued in July 2023 stated CBP procedures and policies in place at the time of Anadith's death were "catastrophically inadequate to prevent the deterioration in [Anadith's] condition and ultimately, her tragic death."[62] According to the report, "these failures occurred at multiple levels and should not be viewed as rare anomalies but rather as systemic weaknesses that if not remedied, are likely to result in future harm to children in CBP custody."[63]

After an investigation of the circumstances surrounding Anadith's death, CBP's Office of Professional Responsibility (OPR) found numerous breakdowns in Anadith's care, including

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[58] *Id*.
[59] *Ombudsman Alert: Critical Medical Understaffing on the Border* 1, OFFICE OF THE IMMIGRATION DETENTION OMBUDSMAN (Jul. 12, 2022), https://www.dhs.gov/sites/default/files/2022-07/OIDO%20Ombudsman%20Alert%20CBP%20Medical%20Contract%20Final_508.pdf.
[60] *OIDO Review: CBP Medical Support Contract for Southwest Border and Tucson,* OFFICE OF THE IMMIGRATION DETENTION OMBUDSMAN (Jun. 16, 2023), https://www.dhs.gov/sites/default/files/2023-07/OIDO%20Review%20-%20CBP%20Medical%20Support%20Contract%20for%20Southwest%20Border%20and%20Tucson.pdf, (finding, in addition to inadequate staffing levels, Loyal Source had incorrectly billed for overtime and double time hours).
[61] *See e.g., Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. 1381 (C.D. Cal., Dec. 13, 2024), https://youthlaw.org/sites/default/files/2024-12/December%202024%20Juvenile%20Care%20Final%20Monitor%20Report%20by%20Andrea%20S.%20Ordin%2C%20Dr.%20Nancy%20Ewen%20Wang%2C%20Dr.%20Paul%20Wise_0.pdf; *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. 1352 (C.D. Cal., July 18, 2023), https://youthlaw.org/sites/default/files/2023-07/2023.07.18_Flores%20Juvenile%20Care%20Monitor%20Report.pdf; *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. 1326 (C.D. Cal., Jan 30, 2023), https://youthlaw.org/sites/default/files/2023-07/2023.01.30%20-%20Flores%20Juvenile%20Care%20Monitor%20Report.pdf; *see also* Plaintiffs' Mem. in Support of Motion to Modify 2022 CBP Settlement, *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. 1526-1, at *2-3 (C.D. Cal., Dec. 20, 2024) (requesting the court extend the Settlement for 2.5 years given CBP's noncompliance with its terms).
[62] *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. 1352, at *35 (C.D. Cal., July 18, 2023), https://youthlaw.org/sites/default/files/2023-07/2023.07.18_Flores%20Juvenile%20Care%20Monitor%20Report.pdf.
[63] *Id*. at *41.

Loyal Source staff's professed lack of awareness that Anadith had sickle cell disease and a history of congenital heart disease; medical personnel's failure to consult with on-call physicians, including an on-call pediatrician; and medical personnel's failure to document multiple medical encounters with Anadith.[64] In addition, the camera system at the facility was not functioning and the outage was not reported to OPR.[65] OPR found that Mabel Álvarez, Anadith's mother, took necessary steps to alert Loyal Source staff of her daughter's medical conditions only hours after they were placed in CBP custody. When Anadith's health declined, Ms. Álvarez repeatedly requested that Anadith be taken to a hospital.[66] Medical staff only called an ambulance after Anadith suffered a seizure and was unresponsive.[67]

Acting Commissioner Troy Miller requested a review of CBP's medical care by DHS OHS. DHS OHS conducted in-person site visits to multiple facilities in the Rio Grande Valley Sector and made recommendations for correcting inadequate medical care in CBP facilities. In a June 8, 2023 memorandum, Herbert O. Wolfe, the Acting Chief Medical Officer (CMO) and Acting Director of OHS, provided an overview of the numerous failures to provide adequate medical care in CBP facilities and recommended changes.[68] The recommendations, according to the memo, were "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."[69]

OHS's observations and recommendations for improving medical care in CBP custody addressed several critical deficiencies. First, the observation that families were being held in custody longer than the established 72-hour standard revealed that CBP lacked a clear process for identifying and managing medically at-risk individuals, including children.[70] As a result, these individuals were not prioritized for expedited processing to reduce their time in custody. The second major issue concerned the management of the CBP Medical Services Contract (MSC) with Loyal Source, which was found to contribute to unsafe conditions and increase the likelihood of preventable harm.[71] There was no verification that sentinel event reviews—reviews taking place after an unexpected death or serious injury to a patient—were being conducted or documented.[72] Furthermore, CBP lacked awareness of the supervising physicians' involvement and had no clear standard operating procedures (SOPs) in place for clinical care.[73] The third

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[64] *June 1, 2023 Update: Death in Custody of 8-Year-Old in Harlingen, Texas,* U.S. CUSTOMS AND BORDER PROT. (Jun. 1, 2023), https://www.cbp.gov/newsroom/speeches-and-statements/june-1-2023-update-death-custody-8-year-old-harlingen-texas.
[65] *Id.*
[66] *Id.*
[67] *Id.* Anadith's family alleges both neglect and discrimination contributed to her death. Anadith's mother has alleged medical staff ignored her pleas and treated her family poorly, in part, because her family is Black. Camilo Montoya-Galvez, *Official concedes 8-year-old who died in U.S. custody could have been saved as devastated family recalls final days,* CBS NEWS, (Jul. 20, 2023), https://www.cbsnews.com/news/anadith-danay-reyes-alvarez-8-year-old-migrant-died-border-patrol-custody-family/.
[68] 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* (Jun. 8, 2023), Appendix, Key Document I.
[69] *Id.* at ¶ 2.
[70] *Id.* at ¶ 3.
[71] *Id.* at ¶ 5.
[72] *Id.*
[73] *Id.*

observation noted deficiencies in enhanced medical monitoring (EMM), especially for individuals in isolation. The lack of objective criteria, clinical protocols, and proper use of the EMR system resulted in inadequate monitoring and documentation of care.[74] Some individuals in isolation had little to no documentation of their medical care, and the EMR system was not used effectively to track patient information or ensure continuity of care. Fourth, communication and documentation of clinical care were inconsistent.[75] Critical medical history and information were not shared between health care providers during shift changes, and there was no documented communication between medical and custodial personnel regarding at-risk individuals. Additionally, the EMR system lacked functionality to produce comprehensive care summaries, making it difficult to ensure continuity of care.[76] The fifth observation focused on the inadequacies of the USBP Harlingen Isolation Unit, where medical care was insufficient and lacked sufficient oversight by CBP.[77] There was a notable absence of medical engagement and accountability for the individuals placed in isolation.

To address these issues, OHS made five recommendations related to: 1) medical risk reduction, 2) contract management and operations, 3) enhanced medical monitoring, 4) clinical care communication and documentation, and 5) isolation unit operations. First, medically at-risk individuals should be identified quickly, and their time in custody should be minimized by prioritizing their processing in collaboration with medical service providers.[78] Second, CBP must improve the management of the MSC by reviewing and updating its oversight of clinical operations, including the establishment of a sentinel event review process.[79] Third, EMM protocols should be clarified, ensuring regular medical assessments are documented in the EMR system for individuals in isolation, with consultations conducted by supervising physicians or pediatric advisors as needed.[80] Fourth, OHS recommended updating the EMR system to enable comprehensive documentation of clinical history, medical findings, and care provided, while improving communication between health care providers and custodial staff during shift changes.[81] Finally, OHS recommended the Harlingen Isolation Unit be closed, with operations transitioned to the Donna Processing Center, which is better equipped to handle isolation care.[82] Additionally, CBP should develop new standards and procedures for isolation units in consultation with OHS to ensure safe, effective, and humane medical care.[83]

## V. Overview of Entities Involved in Provision and Oversight of Medical Care in CBP Custody

[74] *Id*. at ¶ 7.
[75] *Id.* at ¶ 9.
[76] *Id*.
[77] *Id.* at ¶ 11.
[78] *Id.* at ¶ 4.
[79] *Id.* at ¶ 6.
[80] *Id.* at ¶ 8.
[81] *Id.* at ¶ 10.
[82] *Id.* at ¶ 12.
[83] *Id.*

### A. Role of Loyal Source as CBP's Sole Contractor for Medical Services

Currently, Loyal Source, a private company, contracts with CBP to provide onsite medical care at CBP facilities. CBP entered into a $421 million contract with Loyal Source on September 30, 2020,[84] and has since renewed the contract. Loyal Source staff are responsible for day-to-day medical care, including intake screenings when an individual enters CBP custody, treatment of minor medical issues, responses to acute medical care needs and emergency medical situations, dispensing medication, referrals to local hospitals, and follow-up care after an individual is discharged from a hospital and returned to CBP custody.[85]

The number of CBP facilities where medical care is provided has grown exponentially. Loyal Source provided medical care in only three medical units in 2015; it now provides medical care in approximately 93 medical units at 82 locations.[86] The number of Loyal Source personnel also has increased significantly, from 60 medical personnel in 2015 to more than 1,000 medical personnel in 2023.[87] According to snapshots of the medical services workforce provided by CBP, in July 2022, 873 contracted personnel were working in CBP facilities; a year later, in July 2023, 1,471 personnel were working in CBP facilities; in July 2024, slightly fewer—1,340 personnel—were working in CBP facilities.[88]

Contracted medical staff in CBP facilities include advanced practice providers, including nurse practitioners and physician assistants; support personnel, including EMTs, paramedics, certified nursing assistants, certified medical assistants, and licensed vocational nurses; advisory staff, including patient safety risk monitors, supervising physicians, and pediatric advisors; and program managers by region, including a program manager and a deputy program manager.[89]

### B. Role of CBP Office of Acquisitions

Though Loyal Source medical services staff provide care within the facilities, CBP personnel also play key roles in the delivery of medical care. Through its Office of Acquisitions, CBP manages the medical services contract with Loyal Source, making decisions about what work Loyal Source is required to perform under the contact.[90] The Office of Acquisitions resides

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[84] *Delivery Order V797D30203-70B03C20F00001383*, GOVTRIBE (last visited Jan. 6, 2024), https://govtribe.com/award/federal-contract-award/delivery-order-v797d30203-70b03c20f00001383.

[85] TEDS, TEDS MEDICAL CARE OF INDIVIDUALS IN CUSTODY POWERPOINT, Appendix, Key Document A; *see also* OFF. OF THE IMMIGRATION DET. OMBUDSMAN, OMBUDSMAN ALERT: CRITICAL MEDICAL UNDERSTAFFING ON THE BORDER 1, (Jul. 12, 2022), https://www.dhs.gov/sites/default/files/2022-07/OIDO%20Ombudsman%20Alert%20CBP%20Medical%20Contract%20Final_508.pdf.

[86] U.S. Customs and Border Protection, Office of the Chief Medical Officer, Border Health System Briefing to Senate Judiciary Staff (Aug. 1, 2024).

[87] Loyal Source Government Services Briefing to Senate Judiciary Staff (Dec. 5, 2023).

[88] U.S. Customs and Border Protection, Office of the Chief Medical Officer, Border Health System Briefing to Senate Judiciary Staff (Aug. 1, 2024).

[89] *Id.*

[90] Federal Acquisition Regulation (FAR) Section 1.602-2 (stating the responsibility of the Contract Officer "is to ensur[e] performance of all necessary actions for effective contracting, ensur[e] compliance with the terms of the contract, and safeguar[d] the interests of the United States in its contractual relationships."); FAR Section 1.604 of the FAR (stating a COR's role is to "assis[t] in the technical monitoring or administration of a contract.").

within the Enterprise Services support office.[91] It is responsible for providing expertise and oversight in procuring "mission-essential" services, among other responsibilities.[92] The Contract Officer in the Border Enforcement Contracting Division of the CBP Office of Acquisitions manages the Loyal Source contract, with a Contract Officer Representative.

### C. Role of CBP Office of Chief Medical Officer (OCMO) and Response to Anadith's Death

CBP's Office of Chief Medical Officer (OCMO) plays an oversight and management role in the delivery of medical care. Within CBP's organizational structure, CBP medical services and OCMO fall under CBP's Chief Operating Officer and Operations Support.[93] DHS describes OCMO's role as providing "medical direction, coordination, and oversight of medical support to CBP personnel, operations, and persons in custody."[94] The Chief Medical Officer is the "principal adviser regarding medical issues and emerging health matters, priorities, and policies of critical importance to CBP" and is "CBP's lead medical representative to external partners."[95] According to materials provided by OCMO to the Committee, OCMO's stated mission is to "vigilantly safeguard those entrusted to our care, while countering health security threats at our nation's border."[96] OCMO develops guidance and spearheads the development of systems—such as the EMR system used to maintain medical records—to guide the delivery of medical care, though Loyal Source staff provides the care.

Data provided to the Committee by OCMO showed fluctuations of medical services in CBP facilities based on the flow of individuals into these facilities.[97] For example, there were larger numbers of screenings, medical encounters, and hospital visits between September 17 and 23, 2023, when a large number of individuals were entering CBP custody, compared with July 21 and 27, 2024, when the numbers were fewer:

- Medical personnel completed 49,241 medical interviews during the September 2023 period, compared to 9,948 medical interviews during the July 2024 period.
- There were 10,614 medical encounters during the September 2023 period, compared to 4,071 medical encounters during the July 2024 period; and

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[91] *Customs and Border Protection: Actions Needed to Enhance Acquisition Management and Knowledge Sharing 7-8*, U.S. GOVERNMENT ACCOUNTABILITY OFFICE, (Apr. 2023), https://www.gao.gov/assets/gao-23-105472.pdf.
[92] *Id.* at 8.
[93] *Budget Overview: Fiscal Year 2025, Congressional Justification 261-62*, U.S. CUSTOMS AND BORDER PROT., U.S. DEP'T OF HOMELAND SEC. (stating the role of Operations Support as providing oversight and guidance regarding medical programs and that the Office of the Chief Medical Officer falls within Operations Support), https://www.dhs.gov/sites/default/files/2024-04/2024_0314_us_customs_and_border_protection.pdf; *CBP Organization Chart*, U.S CUSTOMS AND BORDER PROT. (last visited Dec. 11, 2024) (providing a chart of CBP's operational make-up), https://www.cbp.gov/document/publications/cbp-organization-chart.
[94] *Budget Overview: Fiscal Year 2025, Congressional Justification 324*, U.S. CUSTOMS AND BORDER PROT., U.S. DEP'T OF HOMELAND SEC., https://www.dhs.gov/sites/default/files/2024-04/2024_0314_us_customs_and_border_protection.pdf.
[95] *Id.*
[96] U.S. Customs and Border Protection, Office of the Chief Medical Officer, Border Health System Briefing to Senate Judiciary Staff (Aug. 1, 2024).
[97] *Id.*

- There were 483 hospital referrals during the September 2023 period, compared to 200 hospital referrals during the July 2024 period.

OCMO has shared with the Committee the immediate steps DHS took in response to Anadith's death, including closing Harlingen Station's Isolation Unit Operations—where she was transferred for her fever and flu symptoms—and deploying U.S. Public Health Service (USPHS) uniformed clinicians to locations across the southwest border to provide oversight and medical guidance.[98] DHS also issued a memo detailing medical process improvements to implement and modified the Medical Services Contract.[99] Between July 2023 and February 2024, OCMO stated that it implemented improvements to its enhanced medical monitoring, clinical care communication and documentation, and isolation unit operations.[100]

In addition to these improvements, OCMO has plans to implement "Border Health System Operations," which, according to OCMO, are automated monitoring systems that communicate with CBP's custodial records systems.[101] OCMO also plans to deploy an enhanced medical services contract oversight team which will include OCMO-assigned leads in select Border Patrol sectors.[102]

### D. Role of DHS Office of Health Security

DHS OHS describes itself as the "principal medical, workforce health and safety public health authority for DHS." In a briefing with the Committee, OHS stated that its role is, in part, to standardize quality health care for individuals in DHS care, while ensuring oversight of that care.[103] According to OHS, prior to 2022, DHS's organizational structure did not allow for adequate and appropriate oversight of medical and health-related DHS "activities."[104] In July 2022, in response to the COVID-19 pandemic's "unprecedented health security events," Congress authorized a DHS reorganization to create OHS.[105] According to the Acting DHS Chief Medical Officer (CMO), who also serves as the Director of OHS, OHS now has a much-improved ability to conduct oversight and proactively respond to health concerns.[106] Relevant to CBP medical care, OHS states that it has authority to "[o]versee all medical, public health, and workforce health and safety activities of the Department of Homeland Security" and to "[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

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[98] *See Id.*; *see also* Nick Miroff, *CBP reassigns chief medical officer after child's death in border custody,* THE WASHINGTON POST (Jun. 15, 2023), https://www.washingtonpost.com/nation/2023/06/15/border-patrol-medical-care-child-death/

[99] 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* (Jun. 8, 2023), Appendix, Key Document I.

[100] U.S. Customs and Border Protection, Office of the Chief Medical Officer, Border Health System Briefing to Senate Judiciary Staff (Aug. 1, 2024).

[101] *Id.*

[102] *Id.*

[103] U.S. Department of Homeland Security, Office of Health Security Briefing to Senate Judiciary Staff (Sept. 27, 2024)

[104] *Id.*

[105] *Id.*

[106] *Id.*

substandard healthcare against the Department or any of its Components, employees, detailees, or contractors."[107]

OHS provides oversight according to what it calls an "indirect oversight model," where OHS does not exert administrative and operational control over DHS Component Health Leads such as OCMO.[108] OHS's indirect oversight includes providing input into performance plans and appraisals, serving on relevant hiring panels, providing medical contract reviews, setting department-wide policy, and reviewing all policies and procedures related to medical care.[109] In addition, OHS supports CBP OPR investigations and coordinates with other DHS oversight authorities such as CRCL.

One of OHS's initiatives relevant to CBP medical care is the Child Well-Being Program. This program, established through the FY2022 Appropriations Act, is intended to improve the well-being of children in DHS's care. The program currently is being "incubated" within the OHS Special Programs unit and, in 2025, will be transferred to the Border Health Division within the Healthcare Systems and Oversight Directorate. [110] According to OHS, the program will provide field-licensed clinical social workers in all nine CBP sectors to provide advice to caregivers already stationed at CBP facilities.

## VI. Policies Governing Medical Care in CBP Custody

### A. Overview of the Medical Care Process in CBP Custody

A Medical Process Guide, updated in June 2023, provides an overview of the general process for providing medical care in CBP facilities. Upon entering a CBP facility, CBP medical services personnel complete an *initial health interview*. In cases where medical services staff is not available, CBP staff will conduct the interview.[111] Information obtained in the initial interview is recorded in a CBP 2500 Form.[112] Agency guidance states that the person conducting the interview must utilize appropriate translation services pursuant to CBP Language Access Directive 2130-031.[113] The guidance also states that an additional interview is required if a person was in transport for more than 12 hours or the person's medical condition changed during

[107] *See* 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* (Jun. 8, 2023), Appendix, Key Document I (referencing oversight authority pursuant to DHS Delegation 26000, *Delegation to the Chief Medical Officer/Director of the Office of Health Security*. (section II.C.2.) (December 14, 2022)).
[108] U.S. Department of Homeland Security, Office of Health Security Briefing to Senate Judiciary Staff (Sept. 27, 2024).
[109] *Id*.
[110] *Id.*
[111] U.S. CUSTOMS AND BORDER PROT., OFF. CHIEF MEDICAL OFFICER, U.S. DEP'T OF HOMELAND SEC., MEDICAL PROCESS GUIDANCE 3 (June 2023), Appendix, Key Document I.
[112] *Id. at 3.*
[113] *Id. at 3.*

transport. CBP must notify medical services personnel if a person meets those requirements.[114] During the health intake interview, medical services personnel ask if the person has: 1) a history of medical or mental health issues; 2) if the person is taking any medications—either prescription or over-the-counter; 3) if the person has any allergies to food or medicine; 4) if the person is a drug user; 5) if female, if a person is pregnant and how many months pregnant; 6) if female, if the person is nursing; 7) if the person is currently injured or in significant pain; 8) if the person has a skin rash; 9) if the person has a contagious disease; 10) if the person is considering hurting themself or others; 11) if the person feels feverish or has a fever; 12) if the person has a cough or difficulty breathing; and 13) if the person has nausea, vomiting, or diarrhea.[115]

If a person is a juvenile, pregnant, or answered yes to any of the health interview questions, they will then undergo a *medical assessment* conducted by CBP medical services personnel. According to CBP, a person also will receive a medical assessment even if they do not answer yes to any of the health interview questions but are identified as having a potential injury, illness, medication requirement, or medical issue.[116] During a medical assessment, a second health intake interview is conducted and documented in the EMR system. Medical assessments are conducted as appropriate, but according to CBP guidance, must be repeated and documented for juveniles every fifth day in CBP custody.[117] CBP guidance states that in instances where medical services personnel are not available and a medical assessment must take place, a person in custody can be referred to a local health system for the assessment.[118] The guidance states that only a nurse practitioner or physician assistant can record information collected in the medical assessment in the EMR system.

If medical services staff determine that a person needs additional medical care at any point while in CBP custody, they will undergo a *medical encounter*. In the course of determining whether additional medical care is required, pediatricians and supervising physicians will be consulted "as required."[119] After the medical encounter is performed, a medical summary will be compiled for continuity of care. If it is determined that a person in custody has an elevated in-custody medical risk, medical personnel take additional steps.[120]

CBP provided the Committee with a framework for the care contracted medical personnel should provide. The care that contracted medical personnel *always* should provide includes: 1) health interviews and screenings; 2) medical assessments; 3) medical encounters, 4) medication prescriptions and distributions; 5) medical summaries; 6) hospital referral; and 7) elevated in-custody medical risk monitoring, processing, and alerts.[121] Medical personnel will provide

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[114] *Id. at 4.*
[115] Loyal Source Health Evaluation SOP (Apr. 17, 2023), Appendix, Key Document H.
[116] U.S. CUSTOMS AND BORDER PATROL, OFF. CHIEF MEDICAL OFFICER, U.S. DEP'T OF HOMELAND SEC., MEDICAL PROCESS GUIDANCE (June 2023), Appendix, Key Document I (stating medical assessments are not necessary if a concern is identified during initial intake; the issue may then be addressed during a medical encounter without a medical assessment).
[117] *Id*. at 5-6.
[118] *Id.*
[119] *Id.* at 6.
[120] *See infra* Part VI.B.
[121] U.S. Customs and Border Protection, Office of the Chief Medical Officer, Border Health System Briefing to Senate Judiciary Staff (Aug. 1, 2024).

additional medical care in a "limited capacity," including: 1) basic care; 2) wound care; 3) very limited point of care testing capabilities; and 4) pharmaceuticals.[122] According to OCMO, *in no cases* can medical services personnel provide: 1) cardiac testing; 2) IV therapy; 3) oxygen; 4) imaging of laboratory capabilities; 4) durable medical equipment; or 5) suicide watch and monitoring.[123]

The CBP TEDS standards also generally have guided the treatment of individuals in CBP custody since the standards were established in 2015.[124] The TEDS standards govern different phases of medical care, including screening, documenting, and treating injuries, illnesses, or physical or mental health issues upon an individual's entry into a CBP holding cell.[125] The standards also address when advanced medical care is needed and should be requested. According to the TEDS standards, "at-risk" individuals include those who require additional care and oversight, such as infants, juveniles, or elderly individuals; minors with an acute injury; individuals with a chronic illness; and individuals with medical or mental health conditions.[126]

After Anadith's death, CBP developed additional guidance for medical care, including treatment of individuals with enhanced medical risk. According to Loyal Source, it incorporated some of CBP's guidance in its own internal policies that are distributed to Loyal Source staff. According to OCMO, though OCMO reviews Loyal Source guidance, it does not edit or otherwise control the guidance that Loyal Source disseminates to its staff.[127]

### B. Policies Regarding Elevated Medical Risk and Transferring to Hospitals

After Anadith's death, in October 2023, CBP issued guidance to address the treatment of individuals, like Anadith, who are at higher risk of harm in CBP custody because of a medical condition. CBP defines Elevated In-Custody Medical Risk (ECMR) as "an acute or chronic medical condition(s) which may elevate risk of deterioration while in custody or pose risk to the congregate population."[128] According to OCMO, the ECMR monitoring and processing is

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[122] *Id.*
[123] *Id.*
[124] *National Standards on Transport, Escort, Detention, and Search (TEDS)*, U.S. CUSTOMS AND BORDER PROT. (Oct. 2015), https://www.cbp.gov/sites/default/files/assets/documents/2020-Feb/cbp-teds-policy-october2015.pdf ("the Foreword from then acting Commissioner Kerlikowske describes it as 'an agency-wise policy that sets forth the first nationwide standards which govern CBP's interaction with detained individuals. This policy continues our commitment to the safety, security and care of those in our custody . . . incorporates best practices developed in the field, and reflects key legal and regulatory requirements.").
[125] *National Standards on Transport, Escort, Detention, and Search (TEDS)*, U.S. CUSTOMS AND BORDER PROT. (Oct. 2015), https://www.cbp.gov/sites/default/files/assets/documents/2020-Feb/cbp-teds-policy-october2015.pdf
[126] TEDS, TEDS MEDICAL CARE OF INDIVIDUALS IN CUSTODY POWERPOINT 5, Appendix, Key Document A ("at-risk individuals also include pregnant women or post-partum mothers, individuals who have defined mental, physical, or developmental disabilities, and individuals of any age with a known or reported contagious disease, illness, and/or injury and/or who have been isolated/quarantined within a CBP facility.")
[127] U.S. Customs and Border Protection, Office of the Chief Medical Officer, Border Health System Briefing to Senate Judiciary Staff (Aug. 1, 2024).
[128] TEDS, TEDS MEDICAL CARE OF INDIVIDUALS IN CUSTODY POWERPOINT 4, Appendix, Key Document A ("CBP officers now receive trainings that include identifying those at higher risk and applying a multi-tiered approach to those experiencing medical distress. The trainings describe the "3 Rs"—recognize, respond and refer—in response to medical distress"); U.S. CUSTOMS AND BORDER PROTECTION, OFFICE OF THE CHIEF MEDICAL OFFICER, MEDICAL

designed to proactively identify, monitor, and expedite the processing of individuals like Anadith.[129]

The new ECMR guidance categorizes people by levels of medical risk and assigns treatment corresponding to their classification. If medical personnel determine a person has medical needs or a diagnosis that exceeds the capabilities of the medical unit, that individual is given a "red determination" and tagged with a red wristband on their left wrist. Once a person is given a red determination, clinical medical staff must consult with the supervising physician or pediatric advisor and note the interaction in the EMR system and monitor the individual every four hours, at a minimum, obtaining vital signs and a review of symptoms.[130] According to CBP guidance, after a medical encounter is recorded, a pop-up will appear in the EMR system to inform the clinical staff of the patient's "At Risk" categorization in the EMR system and provide further instructions. The ECMR category color also is visible in the EMR system.[131]

According to the ECMR guidance, any worsening medical status of a person with a red determination requires: 1) immediate physician consultation and/or 2) immediate hospital referral. If the person cannot be cared for within the limited scope of care provided by medical staff, CBP will "expedite" the processing of this individual out of CBP custody. CBP guidance also requires CBP officers and agents to report "any changes in conditions" of an individual in custody to medical services staff.[132]

This guidance also applies to juveniles in detention and lists considerations and specific clinical conditions that would fall under a red determination classification for juveniles.

### C. Guidance Governing Treatment of Children

Current policies in place governing the treatment of children in CBP custody include the CBP Infant Detainee Assessment SOP; the CBP Medical Process Guidance issued in June 2023 (addressing requirements for tender age juveniles (12 and under) and noncitizen unaccompanied children); the updated ECMR guidance, issued in October 2023; and TEDS. As previously mentioned, juveniles in CBP custody receive health intake interviews upon entering a CBP facility and receive a medical assessment with a second intake interview every five days.[133]

According to CBP guidance, however, there may be cases where operational dynamics or "lack of medical resources" make medical assessments of all juveniles "not feasible."[134] In these cases, the guidance states that medical assessments on "non-tender age juveniles may be

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PROCESS GUIDANCE, ANNEX A: ELEVATED IN-CUSTODY MEDICAL RISK (ECMR) (Oct. 2023), Appendix, Key Document L.

[129] U.S. Customs and Border Protection, Office of the Chief Medical Officer, Border Health System Briefing to Senate Judiciary Staff (Aug. 1, 2024).

[130] U.S. CUSTOMS AND BORDER PROTECTION, OFFICE OF THE CHIEF MEDICAL OFFICER, MEDICAL PROCESS GUIDANCE, ANNEX A: ELEVATED IN-CUSTODY MEDICAL RISK (ECMR) 4 (Oct. 2023), Appendix, Key Document L.

[131] *Id.* at 5.

[132] *Id.* at 4-5 (guidance provides no specific information regarding how the agency will "expedite" processing).

[133] U.S. CUSTOMS AND BORDER PROTECTION, OFFICE OF THE CHIEF MEDICAL OFFICER, MEDICAL PROCESS GUIDANCE 3-4, 6 (Jun. 2023), Appendix, Key Document J.

[134] *Id.* at 5.

temporarily paused to focus limited medical resources on tender age juveniles and persons with identified medical issues."[135] The guidance states that this pause requires written approval by facility leadership and should cease as soon as "operationally possible."[136] The guidance states that there are "no exceptions to the requirement of tender-age juveniles receiving a medical assessment and if there are no medical services staff at the CBP facility, the child should be referred to a local healthcare facility for a medical assessment."[137]

According to a CBP training on the requirements of TEDS, juveniles may not refuse a medical assessment or a referral to a higher level of care, if warranted.[138] Younger children, especially infants, should "generate a higher index of suspicion for illness or injury, and have a lower threshold for referral."[139] The training states that CBP should be "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."[140]

Between July 2020 and March 2023, CBP responded to GAO recommendations to develop training focused on "trauma-informed recognition of medical distress" that addresses differences in recognizing medical distress in children compared to adults and discusses steps CBP employees should take to respond to children experiencing medical distress in CBP custody.[141] Guidance shared with the Committee addresses medical distress and specifies that if a person shows signs of medical distress at any time in CBP custody, medical personnel should be contacted and can decide if additional treatment is indicated. CBP officials, according to CBP training, are instructed to "err on the side of safety."[142]

The ECMR guidance describes juveniles who fall into the "ECMR RED" category and states that juveniles who fall into this category generally include those with acute or chronic medical conditions that: 1) require medication to maintain daily function; 2) require intensive management by a subspecialist; 3) require durable medical equipment, specialty diet, intensive occupational therapy, physical therapy, or rehab to maintain daily function; or 4) impact daily function. The category also generally includes: 1) juveniles with significant developmental delays and/or who require special needs care; 2) infants less than 12 weeks old; 3) juveniles placed in medical isolation or quarantine (see below for more detail); and 4) juveniles with congenital syndromes and anomalies, especially those which require assistance with activities of daily living, such as cerebral palsy.[143]

The guidance also lists specific conditions that fall into the ECMR RED category, including: 1) congenital heart disease (especially if surgical repair was required, attempted, or

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[135] *Id.*
[136] *Id.*
[137] *Id.* at 6.
[138] TEDS, TEDS MEDICAL CARE OF INDIVIDUALS IN CUSTODY POWERPOINT 26, Appendix, Key Document A.
[139] *Id.*
[140] *Id.*
[141] *Southwest Border: CBP Needs to Increase Oversight of Funds, Medical Care, and Reporting of Deaths*, U.S. GOVERNMENT ACCOUNTABILITY OFFICE (Jul. 14, 2020), (https://www.gao.gov/products/gao-20-536.
[142] TEDS, TEDS MEDICAL CARE OF INDIVIDUALS IN CUSTODY POWERPOINT 25-29, Appendix, Key Document A.
[143] U.S. CUSTOMS AND BORDER PROTECTION, OFFICE OF THE CHIEF MEDICAL OFFICER, MEDICAL PROCESS GUIDANCE 6 (Jun. 2023), Appendix, Key Document J.

recommended); 2) sickle cell disease; 3) infectious disease (including possible or confirmed measles, malaria, Dengue, COVID-19, influenza, and varicella) or the presence of a fever in children less than 12 weeks old; 4) oropharyngeal conditions; 5) structural lung disease; 6) hematologic conditions; 7) endocrine conditions; 8) neurologic conditions (including epilepsy, seizure disorder, and cerebral palsy); and 9) children subject to sexual assault allegations.[144]

Even if symptoms of a condition listed are not present during a medical encounter, CBP encourages medical providers "to consult with pediatric advisors and/or supervising physicians when they are concerned about medical status of a juvenile in their care even in the absence of an identifiable medical diagnosis/condition."[145] This is important given that the Juvenile Care Monitor's December report noted that "ongoing reassessment" of the enhanced medical monitoring system should continue to determine "whether the list of conditions triggering entry into the EMM program should evolve."[146]

When a determination is made to send a person to a hospital, CBP will provide a referral form to an individual if they have already been seen by a medical services provider in CBP custody.[147] Upon discharge from the hospital, the hospital provides CBP with a summary of care using the CBP Medical Information Request Form, which can be a clinical summary printed from the EMR system.[148]

### D. Policies Regarding Pregnant Individuals in CBP Custody

Before 2017, CBP did not hold pregnant people in custody absent exceptional circumstances. After the policy changed during the Trump Administration, reports emerged of pregnant individuals receiving poor medical care in CBP custody.[149] After Senator Durbin and others called on DHS OIG to investigate CBP practices,[150] OIG found that CBP failed to supply adequate care to pregnant, postpartum, and/or nursing individuals in their custody.[151] This was followed by a November 2021 CBP policy statement, which enumerated the medical services

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[144] U.S. CUSTOMS AND BORDER PROTECTION, OFFICE OF THE CHIEF MEDICAL OFFICER, MEDICAL PROCESS GUIDANCE, ANNEX A: ELEVATED IN-CUSTODY MEDICAL RISK (ECMR) 6 (Oct. 2023), Appendix, Key Document L.
[145] TEDS, TEDS MEDICAL CARE OF INDIVIDUALS IN CUSTODY POWERPOINT, Appendix, Key Document A.
[146] *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. 1381, at *16 (C.D. Cal., Dec. 13, 2024), https://youthlaw.org/sites/default/files/2024-12/December%202024%20Juvenile%20Care%20Final%20Monitor%20Report%20by%20Andrea%20S.%20Ordin%2C%20Dr.%20Nancy%20Ewen%20Wang%2C%20Dr.%20Paul%20Wise_0.pdf.
[147] U.S. Customs and Border Protection, Office of the Chief Medical Officer, Border Health System Briefing to Senate Judiciary Staff (Aug. 1, 2024).
[148] *Id.*
[149] Zack Budryk, *Guatemalan woman who gave birth in Border Patrol Station says request for help were ignored*, THE HILL, (Apr. 9, 2020), https://thehill.com/latino/491944-guatemalan-woman-who-gave-birth-in-border-patrol-station-says-requests-for-help-were/.
[150] Letter from Sens. Blumenthal, Markey, Hirono, Carper, Durbin, Warren, Harris, Van Hollen, Booker, Duckworth, Gillibrand, Klobuchar, and Merkley to Joseph V. Cuffari, Inspector Gen., Off. of Inspector Gen., U.S. Dep't of Homeland Sec. (Apr. 8, 2020), https://www.blumenthal.senate.gov/imo/media/doc/2020.04.08%20DHS%20OIG%20Letter%20re%20CBP%20Mistreating%20Pregnant%20Detainees.pdf.
[151] *Review of the February 16, 2020 Childbirth at the Chula Vista Border Patrol Station,* OFF. OF INSPECTOR GEN., U.S. DEP'T OF HOMELAND SEC. (Jul. 20, 2021), https://www.oig.dhs.gov/sites/default/files/assets/2021-07/OIG-21-49-Jul21.pdf.

and safeguards ostensibly available to pregnant, postpartum, and/or nursing people in CBP custody.[152]

As previously stated, any individual who indicates they are pregnant during the initial health intake interview receives a health assessment.[153] In response to information gathered at intake interviews and medical assessments, a pregnant person also may receive a "medical encounter," where a medical professional evaluates any potential health concerns, taking "additional steps as appropriate, including treatment or referral and medical disposition."[154] Pregnant women above 20 weeks of gestation are given a red determination under the new ECMR guidance.[155]

According to CBP guidance, any detained pregnant, postpartum, and/or nursing individual "should be placed in the least restrictive setting possible."[156] Furthermore, breastfeeding people should be afforded privacy while nursing.[157] According to CBP, everyone in the agency's custody (including those who are pregnant, postpartum, and/or nursing) should not be forced to "stand for long periods of time" and should be provided sufficient room to sit, rest, and sleep.[158] Agency policy also requires personnel to conduct welfare checks on pregnant. postpartum, and/or nursing individuals every 15 minutes.[159]

### E. Loyal Source Health Evaluation Standard Operation Procedures

The purpose of the Health Evaluation SOP, according to Loyal Source, is to inform Loyal Source staff of required medical evaluations, interim medical care processes, and exit assessments; identify documentation requirements for patients in the Medical Units; outline the Medical Unit Scope of Care; and provide clarification regarding EMR system use and documentation.[160] The SOP applies to all medical services providers and staff working in CBP medical units.[161]

The SOP provides for an intake health interview with 13 scripted questions, a skin and scabies assessment, a lice assessment, any required medical assessment or medical encounter after the initial intake health interview, and enhanced medical monitoring "as directed" by a

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[152] *Policy Statement and Required Actions Regarding Pregnant, Postpartum, Nursing Individuals, and Infants in Custody*, U.S. CUSTOMS AND BORDER PROT., U.S. DEP'T OF HOMELAND SEC. (Nov. 23, 2021) [hereinafter CBP 2021 Policy Statement] https://www.cbp.gov/sites/default/files/assets/documents/2022-Jul/2022-Policy%20Statement-%20and-Required-Action-Pregnant-Postpartum-Nursing-Individuals-and-Infants-%20%28signed%29_0.pdf.
[153] TEDS, TEDs MEDICAL CARE OF INDIVIDUALS IN CUSTODY POWERPOINT 12, Appendix, Key Document A.
[154] *Id.* at 4.
[155] U.S. CUSTOMS AND BORDER PROTECTION, OFFICE OF THE CHIEF MEDICAL OFFICER, MEDICAL PROCESS GUIDANCE, ANNEX A: ELEVATED IN-CUSTODY MEDICAL RISK (ECMR) 10 (Oct. 2023), Appendix, Key Document L.
[156] U.S. CUSTOMS AND BORDER PATROL, OFF. CHIEF MEDICAL OFFICER, U.S. DEP'T OF HOMELAND SEC., MEDICAL PROCESS GUIDANCE (Jun. 2023), Appendix, Key Document J.
[157] *Id.*
[158] *Id.*
[159] U.S. CUSTOMS AND BORDER PROT., U.S. DEP'T OF HOMELAND SEC., POLICY STATEMENT AND REQUIRED ACTIONS REGARDING PREGNANT, POSTPARTUM, NURSING INDIVIDUALS, AND INFANTS IN CUSTODY (Nov. 23, 2021) https://www.cbp.gov/sites/default/files/assets/documents/2022-Jul/2022-Policy%20Statement-%20and-Required-Action-Pregnant-Postpartum-Nursing-Individuals-and-Infants-%20%28signed%29_0.pdf.
[160] Loyal Source Health Evaluation SOP (Apr. 17, 2023), Appendix, Key Document H.
[161] *Id.*

medical provider during specific upticks in prevalence of communicable disease.[162] The SOP specifies that juvenile patients less than 12 years of age and third trimester pregnant patients always require medical assessments, while juveniles between the ages of 12 and 18 should receive assessments when operationally feasible. Patients who require encounters include patients who answer "yes" to any of the last seven of the 13 questions, are currently taking medication, and/or have a medical complaint. The SOP also describes protocols for provision of interim health care and exit health interviews and assessments.[163]

The SOP clarifies that the Loyal Source "scope of care" is limited to 1) public health assessments; 2) limited acute/chronic care; and 3) basic first aid and life support. The SOP describes public health assessments as assessments where nurse practitioners, physician assistants, and trained support staff (e.g., EMTs or paramedics) can identify diseases that pose a public health threat, including the presence of lice and scabies.

The SOP states that CBP medical units do not have access to routine laboratory, radiology, diagnostic, or confirmatory tools and any illnesses or injuries that require advanced diagnostic tools should be referred to an emergency room or urgent care facility.[164] The SOP states that the following are outside the scope of Loyal Source care: 1) injections; 2) IVs; 3) suturing; 4) incision and draining; 5) prescribing narcotics or scheduled medications; 6) nebulizer treatments; and 7) oxygen therapy.[165]

The guidance requires that Loyal Source staff respond to "life, limb or eyesight" emergencies and provide basic life support.[166] Loyal Source staff also must call 911 and keep the patient stable following basic life support until the emergency response team arrives.[167]

CBP guidance and Loyal Source guidance appear to conflict with respect to pregnant patients in one respect. According to CBP guidance, all individuals who indicate they are pregnant should receive a health assessment. However, according to Loyal Source's Health Evaluation SOP,[168] patients in their third trimester are required to have a health assessment, but patients in their first and second trimester are provided medical assessments only if they request them.

## VII. Systemic Problems in the Delivery of Medical Care that Led to Anadith's Death

[162] *Id.*
[163] *Id.*
[164] *Id.*
[165] *Id.*
[166] *Id.*
[167] *Id.*
[168] *Id*.

### A. Understaffing

Understaffing has been a critical issue affecting the delivery of medical care in CBP facilities. According to reports by an oversight office and agency and disclosures by a federal whistleblower, Loyal Source consistently failed to meet the staffing requirements in the company's agreement with CBP.[169]

Loyal Source is required "to staff different facilities 24 hours a day."[170] The importance of Loyal Source's role in providing consistent 24-hour care was underscored in 2020, when DHS OIG released a Management Alert warning of potential lapses in medical care due to CBP's delay in awarding a new medical services contract.[171] OIG noted that interrupting Loyal Source's services would have devastating impacts across facilities and jeopardize the health and safety of migrants in CBP custody.[172]

OIDO discovered "significant understaffing" at CBP facilities after analyzing weekly staffing reports provided by Loyal Source to CBP and after site visits and inspections at CBP detention facilities in 2021 and 2022, which coincided with whistleblower reporting.[173] OIDO also discovered staff in some locations worked overtime shifts for up to two weeks to compensate for staffing shortages.[174] While OIDO's report redacted the percentage of shifts Loyal Source filled, it stated the numbers indicated a "critical staffing shortage."[175]

Whistleblower disclosures also illustrated the understaffing issue. In February 2024, confidential whistleblowers employed by Loyal Source who provided medical care at multiple CBP facilities throughout California, Arizona, New Mexico, and Texas, stated Loyal Source frequently failed to staff entire shifts and failed to schedule available workers to fill vacant shifts. The whistleblowers stated that understaffing caused delays in required medical checks, which sometimes resulted in lengthier detention of noncitizens in CBP custody, or deterioration of their

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[169] *OIDO Review: CBP Medical Support Contract for Southwest Border and Tucson,* OFFICE OF THE IMMIGRATION DETENTION OMBUDSMAN (Jun. 16, 2023), https://www.dhs.gov/sites/default/files/2023-07/OIDO%20Review%20-%20CBP%20Medical%20Support%20Contract%20for%20Southwest%20Border%20and%20Tucson.pdf; *Protected Whistleblower Disclosures Regarding the Performance and Oversight Failures of the Medical Services Contract of U.S. Customs and Border Protection with Loyal Source Government Services*, GOVERNMENT ACCOUNTABILITY PROJECT, (Nov. 20, 2023), https://whistleblower.org/wp-content/uploads/2023/11/11-30-2023-Hendrickson-Congressional-Disclosure.pdf; *Protected Whistleblowers' Disclosures Regarding Failure of CBP Leadership and CBP Office of Acquisition to Oversee its Medical Services Contract with Loyal Source Government Services and Ongoing Wrongdoing by Acting CBP Chief Medical Officer*, GOVERNMENT ACCOUNTABILITY PROJECT, (Feb. 16, 2024), https://whistleblower.org/wp-content/uploads/2024/02/02-16-2024-CBP-Medical-Services-Whistleblower-Disclosure.pdf.

[170] *Ombudsman Alert: Critical Understaffing on the Border*, OFFICE OF THE IMMIGRATION DETENTION OMBUDSMAN, (Jul. 12, 2022), https://www.dhs.gov/sites/default/files/2022-07/OIDO%20Ombudsman%20Alert%20CBP%20Medical%20Contract%20Final_508.pdf.

[171] *Management Alert – CBP Needs to Award a Medical Services Contract Quickly to Ensure no Gap in Services 6*, OFF. OF INSPECTOR GEN., U.S. DEP'T OF HOMELAND SEC, (Sept. 3, 2020), https://www.oig.dhs.gov/sites/default/files/assets/Mga/2020/oig-20-70-sep20-mgmtalert.pdf.

[172] *Id.*

[173] *Ombudsman Alert: Critical Understaffing on the Border*, OFFICE OF THE IMMIGRATION DETENTION OMBUDSMAN, (Jul. 12, 2022), https://www.dhs.gov/sites/default/files/2022-07/OIDO%20Ombudsman%20Alert%20CBP%20Medical%20Contract%20Final_508.pdf.

[174] *Id.*

[175] *Id.*

medical conditions.[176] Troy Hendrickson, a whistleblower who worked as a contract officer representative for CBP's medical services contract in 2021, reported 40 percent staffing deficits and "entire shifts where no [medical] provider" was "available at all."[177] In January 2022, Hendrickson urged the CBP Office of Acquisitions to issue a "Letter of Concern" to Loyal Source for "not meeting contract performance scheduling"; however, a cure notice was not issued until after the Anadith's death.[178] Further highlighting the alarming shortage of workers, in late 2023, a Loyal Source employee said he was "often the only medical-care provider at stations in Texas, New Mexico and Arizona where 200 to 300 migrants sometimes arrive during a single shift."[179]

In response to allegations of understaffing at CBP facilities, Loyal Source stated that it does not have a responsibility to fully staff all CBP facilities. This is because its contract with CBP only requires it to fill a certain percentage of positions outlined in OCMO's Med Plan Laydown, also referred to as the staffing plan.[180] The staffing plan, which the Committee reviewed, lists 82 CBP facilities along the southwest border and details required provider and support staff shifts by location.[181] Several facilities require no provider. Though all facilities but one require support staff, the majority of the facilities required only one support staff.

It is important to note that the staffing plan can change depending on migration patterns, prioritizing staffing for some facilities over others. The number of staff required at a facility, therefore, is often in flux. In September 2020, when Loyal Source signed a new contract with CBP, it agreed to maintain "a 95 percent adherence to provider and support schedules at contracted locations."[182] Though the 95 percent adherence rate might sound high, the number of vacancies still may be significant, as "certain locations may tolerate a lower (for instance, 90 percent) adherence" based on the discretion of the CBP contracting officer representative and/or

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[176] *Protected Whistleblowers' Disclosures Regarding Failure of CBP Leadership and CBP Office of Acquisition to Oversee its Medical Services Contract with Loyal Source Government Services and Ongoing Wrongdoing by Acting CBP Chief Medical Officer*, GOVERNMENT ACCOUNTABILITY PROJECT, (Feb. 16, 2024), https://whistleblower.org/wp-content/uploads/2024/02/02-16-2024-CBP-Medical-Services-Whistleblower-Disclosure.pdf.

[177] *Protected Whistleblower Disclosures Regarding the Performance and Oversight Failures of the Medical Services Contract of U.S. Customs and Border Protection with Loyal Source Government Services*, GOVERNMENT ACCOUNTABILITY PROJECT, (Nov. 20, 2023), https://whistleblower.org/wp-content/uploads/2023/11/11-30-2023-Hendrickson-Congressional-Disclosure.pdf.

[178] *Protected Whistleblower Disclosures Regarding the Performance and Oversight Failures of the Medical Services Contract of U.S. Customs and Border Protection with Loyal Source Government Services*, GOVERNMENT ACCOUNTABILITY PROJECT, (Nov. 20, 2023), https://whistleblower.org/wp-content/uploads/2023/11/11-30-2023-Hendrickson-Congressional-Disclosure.pdf.

[179] Nick Miroff, *Medical provider vying for border contract faces scrutiny after girl's death* (Nov. 19, 2023), THE WASHINGTON POST, https://www.washingtonpost.com/immigration/2023/11/19/border-loyal-source-medical-care-migrants/.

[180] *OIDO Review: CBP Medical Support Contract for Southwest Border and Tucson,* OFFICE OF THE IMMIGRATION DETENTION OMBUDSMAN (Jun. 16, 2023), https://www.dhs.gov/sites/default/files/2023-07/OIDO%20Review%20-%20CBP%20Medical%20Support%20Contract%20for%20Southwest%20Border%20and%20Tucson.pdf.

[181] CBP Medical Staffing Positions, Appendix, Key Document O.

[182] *Ombudsman Alert: Critical Understaffing on the Border*, OFFICE OF THE IMMIGRATION DETENTION OMBUDSMAN, (Jul. 12, 2022), https://www.dhs.gov/sites/default/files/2022-07/OIDO%20Ombudsman%20Alert%20CBP%20Medical%20Contract%20Final_508.pdf.

the U.S. Border Patrol National Medical Program Manager.[183] In addition, because some facilities are considered medical "priority" facilities where medical staff is determined to be more critical, they are prioritized for staffing.[184] The Statement of Work for the medical support contract provides few metrics or details regarding how the amended percentage fill rate would be determined, only stating that the new percentage fill rate would be "based on constraints and operational shifts."[185]

### B. Inadequate Electronic Medical Records System and Maintenance of Records

Another issue in the delivery of medical care is the maintenance of medical records within CBP facilities; specifically, CBP's failure to document or adequately assess medical encounters and other important medical information within the EMR system. These issues became apparent after Anadith's death.

OPR found numerous breakdowns in Anadith's care related to the documentation and sharing of critical medical information. Despite Anadith's mother providing records related to her daughter's chronic heart condition to medical staff, Loyal Source staff and U.S. Border Patrol personnel at Harlingen Station who interacted with the girl and her mother claimed to be unaware Anadith had sickle cell anemia and a history of congenital heart disease.[186] However, Anadith's medical history was documented in the EMR system when her family was first taken into custody and transported to the Donna Centralized Processing Facility.[187] If true, medical personnel at Harlingen Station apparently chose not to review Anadith's medical history in the EMR system after Anadith and her family were transferred to Harlingen Station, a transfer that was prompted by Anadith testing positive for influenza and requiring isolation. The nurse practitioner who visited with Anadith a total of *four times* in the hours leading up to her death failed to access her electronic medical records where her condition was clearly documented.[188] On top of this failure, OPR found the nurse practitioner treating Anadith immediately prior to her death "declined to review [] papers" brought by another contracted medical staff member from the family.[189] Finally, OPR found Loyal Source medical personnel failed to consult with on-call physicians and document all medical encounters with Anadith.[190]

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[183] *OIDO Review: CBP Medical Support Contract for Southwest Border and Tucson,* OFFICE OF THE IMMIGRATION DETENTION OMBUDSMAN (Jun. 16, 2023), https://www.dhs.gov/sites/default/files/2023-07/OIDO%20Review%20-%20CBP%20Medical%20Support%20Contract%20for%20Southwest%20Border%20and%20Tucson.pdf.
[184] *See* Sept. 24, 2024 response from CBP, Appendix, Key Document R.
[185] *OIDO Review: CBP Medical Support Contract for Southwest Border and Tucson 12,* OFFICE OF THE IMMIGRATION DETENTION OMBUDSMAN (Jun. 16, 2023), https://www.dhs.gov/sites/default/files/2023-07/OIDO%20Review%20-%20CBP%20Medical%20Support%20Contract%20for%20Southwest%20Border%20and%20Tucson.pdf.
[186] *Update: Death in Custody of 8-Year-Old in Harlingen, Texas,* U.S. CUSTOMS AND BORDER PROT. (Jun. 1, 2023), https://www.cbp.gov/newsroom/speeches-and-statements/june-1-2023-update-death-custody-8-year-old-harlingen-texas.
[187] *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. 1326, at *34 (C.D. Cal., Jan. 30, 2023), https://youthlaw.org/sites/default/files/2023-07/2023.01.30%20-%20Flores%20Juvenile%20Care%20Monitor%20Report.pdf.
[188] *Update: Death in Custody of 8-Year-Old in Harlingen, Texas,* U.S. CUSTOMS AND BORDER PROT. (Jun. 1, 2023), https://www.cbp.gov/newsroom/speeches-and-statements/june-1-2023-update-death-custody-8-year-old-harlingen-texas.
[189] *Id.*
[190] *Id.*

In the July 18, 2023, *Flores* Report, Juvenile Care Monitor Dr. Paul H. Wise stressed the necessity of documenting detained children's medical history and conditions in the EMR system.[191] The report underscored the critical need for accurate and comprehensive medical records to ensure appropriate care for children at elevated medical risk. It noted that in Anadith's case, "there was no documentation that the presence of a child at greatly elevated medical risk had been conveyed to BP [Border Patrol] agents responsible for custodial care" or any documentation that an on-call physician was consulted or "that a transfer to a local facility was contemplated."[192]

In a June 8, 2023 memo by Acting CMO Herbert O. Wolfe to Acting CBP Commissioner Troy Miller, Wolfe voiced concern about the "ad hoc system" in place at the time, with limited capacity to handle medical records, poor staff communication, and unclear procedures for seeking help from external physicians.[193] Wolfe stated that CBP should produce a medical care manual within 90 days to "ensure information sharing and accountability at shift change for medically at-risk individuals in CBP custody" and that all encounters must be electronically documented.[194]

The failure to document medical encounters in the EMR system has been a widespread issue amongst Loyal Source staff. Loyal Source whistleblowers stated that, in some cases, Loyal Source providers chose not to use the EMR system "citing ignorance of the system, understaffing, and overwhelming numbers of noncitizens to process through it."[195] Whistleblower Troy Hendrickson's congressional disclosure outlines similar medical documentation and communication issues by Loyal Source staff. He stated that staff often refused to use the CBP-provided EMR system, resorting instead to paper records due to internet outages or management directives during surges of migrants.[196] In his view, this reliance on paper records led to risks of information deficiencies and hindered the ability of medical providers to appropriately treat individuals in their care.[197]

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[191] *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. 1326, at *34 (C.D. Cal., Jan. 30, 2023), https://youthlaw.org/sites/default/files/2023-07/2023.01.30%20-%20Flores%20Juvenile%20Care%20Monitor%20Report.pdf.

[192] *Id.* at 37.

[193] 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* (Jun. 8, 2023), Appendix, Key Document I.

[194] *Id.*

[195] *Protected Whistleblowers' Disclosures Regarding Failure of CBP Leadership and CBP Office of Acquisition to Oversee its Medical Services Contract with Loyal Source Government Services and Ongoing Wrongdoing by Acting CBP Chief Medical Officer*, GOVERNMENT ACCOUNTABILITY PROJECT, (Feb. 16, 2024), https://whistleblower.org/wp-content/uploads/2024/02/02-16-2024-CBP-Medical-Services-Whistleblower-Disclosure.pdf.

[196] *Protected Whistleblower Disclosures Regarding the Performance and Oversight Failures of the Medical Services Contract of U.S. Customs and Border Protection with Loyal Source Government Services*, GOVERNMENT ACCOUNTABILITY PROJECT, 29 (Nov. 20, 2023), https://whistleblower.org/wp-content/uploads/2023/11/11-30-2023-Hendrickson-Congressional-Disclosure.pdf.

[197] *Id.*

In January 2024, Acting CMO Dr. Eastman also highlighted systemic problems with the EMR system in a letter to James W. McCament, Interim CBP Chief Operating Officer. The memo reported multiple instances where incomplete or inaccurate documentation occurred due to staffing failures and noncompliance with contract requirements.[198]

The Fiscal Year 2020 Consolidated Appropriations Act authorized $30 million for CBP's "development of an agency-wide electronic health records system."[199] When first implemented, the electronic system was just CBP's health intake in paper form made virtual and put on a web platform.[200] The system proved inadequate, however, as migration patterns increased and CBP's needs changed.[201] For instance, OCMO stated that the system struggled with intaking external medical records and assisting with clinical assessments.[202]

Though reporting shows Loyal Source staff failed to adequately document medical care in the EMR system, Loyal Source also had concerns related to the usability of the EMR system. Loyal Source staff repeatedly shared concerns about the functionality of the EMR system with CBP. Documents provided to the Committee show that Loyal Source emailed CBP multiple times in early 2021 about concerns with the EMR system, including the system freezing and deleting inputted data, delays in printing clearance forms, poor internet service, and the inability to access charts from previous months for history of treatment.[203] Loyal Source claimed "these small hindrances" become more problematic "when multiplied by the hundreds of bodies moving in and out of the station daily."[204]

CBP attempted to address the concerns shared by Loyal Source staff by rolling out updates to the EMR system, referring Loyal Source staff to the IT Help Desk, and offering to discuss their concerns further.[205] After Anadith's death, CBP initiated a review of its medical record-keeping system to implement updates and determine if they would be "better served by replacing this system with a different system, such as a commercial medical records system."[206] According to OCMO, CBP has since then made 39 updates to the EMR system, which include enhanced diagnosis options, enhanced staff tracking, and automated importing of medical information.[207] Despite these updates, former Acting CMO, Dr. Eastman shared with the Committee that the EMR system still "lacks the ability to provide clinical decision support

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[198] *Id.*
[199] *Consolidated Appropriations Act, 2020, H.R.1158*, 116th Cong. (2019), https://www.congress.gov/bill/116th-congress/house-bill/1158/text.
[200] U.S. Customs and Border Protection, Office of the Chief Medical Officer, Border Health System Briefing to Senate Judiciary Staff (Aug. 1, 2024); U.S. Customs and Border Protection, Alien Health Interview Questionnaire, Form 2500, Appendix, Key Document C.
[201] *Id.*
[202] *Id.*
[203] Loyal Source Communications, (Feb. 11, 2021), Appendix, Key Document G.
[204] Loyal Source communications, (Jan. 29, 2021), Appendix, Key Document E.
[205] Loyal Source communications, (Jan 11, 2021), Appendix, Key Document D; Loyal Source Communications, (Feb. 9, 2021), Appendix, Key Document F.
[206] Nick Miroff, *Inquiry after girl's death reports unsafe medical care in U.S. border facilities,* THE WASHINGTON POST (Jun. 22, 2023), https://www.washingtonpost.com/immigration/2023/06/22/medical-care-unsafe-border-facilities-migrants/.
[207] U.S. CUSTOMS AND BORDER PROTECTION, OFFICE OF THE CHIEF MEDICAL OFFICER, BORDER HEALTH SYSTEM BRIEFING TO SENATE JUDICIARY STAFF (AUG. 1, 2024).

features, which is an industry standard," is currently approximately 60 percent effective, and does not meet the needs of CBP.[208] Dr. Eastman, stated that he would like the agency to move forward with a new system and has interviewed potential vendors.[209]

The tragic circumstances surrounding Anadith's death underscore significant flaws in the maintenance and utilization of medical records within CBP facilities, particularly regarding the documentation of medical encounters and reviewing of medical history. The breakdowns in communication and documentation identified by OPR and the *Flores* Juvenile Care Monitor, as well as the systemic issues reported by whistleblowers and CBP officials, highlight the critical need for a more reliable and comprehensive approach to documenting medical care. Though former Acting CMO, Dr. Eastman, believed an updated EMR system with a higher level of effectiveness would help meet the agency's needs, this proposed solution cannot provide a substitute for consistent adequate medical care, including referencing relevant medical records, provided by responsible medical personnel.

### C. Unclear and Inadequate Guidance for Treating Medically Vulnerable Children

In the January 2023 *Flores* Juvenile Care Monitor Report, Dr. Wise, stated that "the admission of a young child with sickle cell disease and a fever to the Harlingen Station should have triggered a close consultation with an on-call pediatrician or an evaluation at a local hospital."[210] Neither of these ever happened. Instead, Anadith remained in CBP custody as her health continued to deteriorate.[211] Compounding the problem, at this time, CBP did not have adequate agency guidance describing how to identify and consistently monitor children in custody who were considered medically at-risk.

In the July 2023 Juvenile Care Monitor Report, Dr. Wise identified several critical areas where guidelines for treating medically vulnerable individuals, assessing chronic medical conditions, and providing elevated levels of care were lacking or unclear. One major issue was the lack of enhanced monitoring of children at elevated medical risk. Dr. Wise noted that "medical monitoring of [Anadith's] condition was not augmented in response to her elevated medical risk."[212] When she died, it was not normal procedure for medical staff in CBP facilities to consistently assess vital signs of at-risk individuals in holding cells or isolation facilities, leading to missed signs of health deterioration. Dr. Wise also revealed a gap in guidance on the overall care of at-risk children, observing "considerable variation in how children with serious chronic disorders are managed by medical personnel."[213] For instance, there was a lack of standardized protocols requiring consultation with pediatric advisors for children with serious medical issues or a "standard practice for informing BP [Border Patrol] personnel that a child at

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[208] *Id.*
[209] *Id.*
[210] *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. 1352, at *40 (C.D. Cal., July 18, 2023), https://youthlaw.org/sites/default/files/2023-07/2023.07.18_Flores%20Juvenile%20Care%20Monitor%20Report.pdf.
[211] *Id.*
[212] *Id.*
[213] *Id.*

elevated medical risk has entered custody."[214] It appears that consultations with external doctors rarely happened, as the list of on-call doctors posted in the Harlingen, Texas station where Anadith was held had inaccurate and out-of-date information.[215]

Another area of concern was the process for referral to local medical facilities. Despite Anadith's condition, her mother's repeated pleas for an ambulance, and "the series of treatments required to manage" her condition, "contracted medical personnel did not transfer her to a hospital for higher-level care."[216] The Juvenile Care Monitor observed that medical providers faced constraints when deciding to transfer children to local hospitals, often due to logistical and workforce concerns from Border Patrol personnel.[217] In late June 2023, the *Los Angeles Times* reported on an internal OIDO report in which Border Patrol complained about the overuse of hospitalization at the Donna Processing Facility, the same facility Anadith and her family where were first held before being transferred to Harlingen.[218] Border Patrol agents believed medical personnel would transfer migrants to a hospital for conditions the agents believed could be treated on the spot, and it was burdening Border Patrol resources "needed for more emergent cases."[219] According to the Juvenile Care Monitor, considering logistical constraints when deciding to refer a sick child to a hospital is "both inappropriate and dangerous," since this decision "should be based on medical criteria alone as determined by the appropriate medical personnel."[220]

While it is not clear that transport constraints played a role in Anadith's death, it raises questions about potential constraints on referrals for outside care for those at elevated risk. It is important that medical staff feel empowered to make independent decisions regarding the referral of children to local health facilities based solely on medical considerations, and not on the concerns of non-medical personnel. Committee staff spoke with medical services staff at the San Diego soft-sided CBP facility, who stated that they do not contact emergency services, even in an urgent situation, without receiving consent from CBP.[221] This directly contradicts agency guidance stating that an individual in acute medical distress, for example, may require an immediate hospital referral.[222]

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[214] *Id.*
[215] Nick Miroff, *Inquiry after girl's death reports unsafe medical care in U.S. border facilities,* THE WASHINGTON POST (Jun. 22, 2023), https://www.washingtonpost.com/immigration/2023/06/22/medical-care-unsafe-border-facilities-migrants/.
[216] *June 1, 2023 Update: Death in Custody of 8-Year-Old in Harlingen, Texas,* U.S. CUSTOMS AND BORDER PROT. (Jun. 1, 2023), https://www.cbp.gov/newsroom/speeches-and-statements/june-1-2023-update-death-custody-8-year-old-harlingen-texas.
[217] *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. 1326, at *41 (C.D. Cal., Jan. 30, 2023), https://youthlaw.org/sites/default/files/2023-07/2023.01.30%20-%20Flores%20Juvenile%20Care%20Monitor%20Report.pdf.
[218] Hamed Aleaziz, *Border Patrol officials complained of 'overuse of hospitalization' as 8-year-old died*, LOS ANGELES TIMES (Jun. 28, 2023), https://www.latimes.com/politics/story/2023-06-28/8-year-old-border-patrol-death-fever-hospital.
[219] *Id.*
[220] *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. 1326, at *41 (C.D. Cal., Jan. 30, 2023), https://youthlaw.org/sites/default/files/2023-07/2023.01.30%20-%20Flores%20Juvenile%20Care%20Monitor%20Report.pdf.
[221] U.S. Customs and Border Protection Site Visit Briefing (Aug. 28, 2024).
[222] U.S. CUSTOMS AND BORDER PROTECTION, OFFICE OF THE CHIEF MEDICAL OFFICER, MEDICAL PROCESS GUIDANCE, ANNEX A: ELEVATED IN-CUSTODY MEDICAL RISK (ECMR) 4, Appendix, Key Document L.

Dr. Wise reiterated to Committee staff that though CBP treats the transfer of an individual to a hospital as a medical decision and helps facilitate the transfer, in reality, the request by contracted medical personnel to send a detained individual to the hospital is more a negotiation with CBP than an immediate approval.[223] According to the December 2024 Juvenile Care Monitor Report, some medical staff still reported resistance from CBP personnel when electing to transfer patients for outside care.[224] It is in the best interest of CBP, and the individuals in CBP care and custody, for CBP to defer to medical providers regarding referrals and ensure that any child or adult in medical distress receives the care they require without delay.

### D. Overcrowding

Overcrowding—a longstanding concern at CBP facilities—can strain resources and significantly impact the provision of medical care to detained individuals. According to the January 2023 Juvenile Care Monitor Report, the El Paso sector had recently experienced substantial overcrowding in family holding areas, with conditions frequently exceeding the maximum capacity of the facility.[225] The overcrowding in this sector led to inadequate hygiene conditions, insufficient medical care, and limited caregiver coverage. Sleeping mats were placed close together, and the noise levels, combined with the lack of privacy and personal space, contributed to "elevated levels of psychological distress and emotional volatility among children in custody."[226] When the Juvenile Care Monitor returned to El Paso in July 2023, the overcrowding was no longer present.[227] However, the Juvenile Care Monitor stressed the importance of continuing to closely monitor occupancy, as overcrowding can have detrimental effects on "cleanliness, hygiene, medical care, and caregiver coverage."[228]

According to DHS OIG, in May 2023, the San Diego sector also experienced issues with overcrowding in its facilities. Of the 1,187 detainees in custody across five facilities, 56 percent were held longer than the 72-hour limit specified by the TEDS standards.[229] The San Diego Area Detention (SAD) facility was at 171 percent capacity, with 853 detainees in a facility designed

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[223] Senate Judiciary Staff Meeting with Dr. Wise and Dr. Nancy Ewen Wang, (Oct. 7, 2024) (Dr. Wang was appointed Medical Advisor to the Juvenile Care Monitor, Andrea Ordin, JD in 2024).
[224] *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. 1381, at *17 (C.D. Cal., Dec. 13, 2024), https://youthlaw.org/sites/default/files/2024-12/December%202024%20Juvenile%20Care%20Final%20Monitor%20Report%20by%20Andrea%20S.%20Ordin%2C%20Dr.%20Nancy%20Ewen%20Wang%2C%20Dr.%20Paul%20Wise_0.pdf
[225] *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. 1326, at *21-41 (C.D. Cal., Jan. 30, 2023), https://youthlaw.org/sites/default/files/2023-07/2023.01.30%20-%20Flores%20Juvenile%20Care%20Monitor%20Report.pdf.
[226] *Id*. at 18.
[227] *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. 1352, at *32 (C.D. Cal., July 18, 2023), https://youthlaw.org/sites/default/files/2023-07/2023.07.18_Flores%20Juvenile%20Care%20Monitor%20Report.pdf.
[228] *Id.* at 15.
[229] *Results of Unannounced Inspections of CBP Holding Facilities in the San Diego Area 4*, U.S. DEP'T OF HOMELAND SECURITY OFFICE OF INSPECTOR GENERAL, (Nov. 15, 2023), https://www.oig.dhs.gov/sites/default/files/assets/2023-11/OIG-24-07-Nov23.pdf.

for 500.[230] At SAD, 64 percent of detained individuals were held in custody for over 72 hours.[231] Delays in processing and transferring detainees to federal partners, coupled with prolonged times in custody due to the Enhanced Expedited Removal (EER) process, exacerbated overcrowding.[232] One egregious example is the case of one detained individual, who spent over 34 days in custody "waiting for USCIS or DOJ to adjudicate their fear claims."[233]

OIG identified some steps the agency has taken to address overcrowding, including increasing communication with USCIS, increasing staffing, closely cooperating with ICE Enforcement and Removal Operations (ERO), using virtual processing to increase processing capacity, and enhancing collaboration with non-governmental organizations to support newly released noncitizens.[234] Because the number of individuals in CBP custody is now significantly lower than at certain points in the past few years,[235] overcrowding is currently not as significant of a concern. CBP should continue to work with its agency partners, however, to expedite the processing of individuals in the agency's custody and avoid overcrowding to minimize medical risks.

### E. Failure to Conduct Adequate Oversight of Loyal Source

After Anadith's death, amid renewed calls to hold both CBP and Loyal Source responsible for failures to take steps to address systemic issues in the provision of medical care, the poor relationship among the Office of Acquisitions, OCMO, and Loyal Source became public. Troy Hendrickson, in his whistleblower report to Congress, described how efforts to hold Loyal Source accountable were consistently thwarted by the Office of Acquisitions, despite documented concerns about deficiencies in the company's performance.[236]

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[230] *Id.*
[231] *Id.*
[232] *Id.* at 6.
[233] *Id.*
[234] *Id.* at 9.
[235] Adam Isacson, *Five Migration and Security Trends at the U.S.-Mexico Border*, WOLA: ADVOCACY FOR HUMAN RIGHTS IN THE AMERICAS (Nov. 12, 2024), https://www.wola.org/analysis/five-migration-and-security-trends-at-the-u-s-mexico-border/#:~:text=1.,Data%20table ("2,135,005 people entered CBP's custody at the U.S.-Mexico border between October 2023 and September 2024[—]combining people who came to the official border crossings plus people apprehended by CBP's Border Patrol component . . . That was the smallest number since 2021, and 14 percent fewer people than in fiscal 2023."); John Gramlich, *Migrant encounters at U.S.-Mexico border have fallen sharply in 2024*, PEW RESEARCH CENTER, (Oct. 1, 2024), https://www.pewresearch.org/short-reads/2024/10/01/migrant-encounters-at-u-s-mexico-border-have-fallen-sharply-in-2024/#:~:text=By%20John%20Gramlich,recorded%20in%20a%20single%20month.
[236] *Protected Whistleblower Disclosures Regarding the Performance and Oversight Failures of the Medical Services Contract of U.S. Customs and Border Protection with Loyal Source Government Services*, GOVERNMENT ACCOUNTABILITY PROJECT, (Nov. 20, 2023), https://whistleblower.org/wp-content/uploads/2023/11/11-30-2023-Hendrickson-Congressional-Disclosure.pdf; *Protected Whistleblowers' Disclosures Regarding Failure of CBP Leadership and CBP Office of Acquisition to Oversee its Medical Services Contract with Loyal Source Government Services and Ongoing Wrongdoing by Acting CBP Chief Medical Officer*, GOVERNMENT ACCOUNTABILITY PROJECT, 7 (Feb. 16, 2024), https://whistleblower.org/wp-content/uploads/2024/02/02-16-2024-CBP-Medical-Services-Whistleblower-Disclosure.pdf (describing how OCMO leadership raised concerns with CBP leadership, including then Executive Assistant Commissioner of Operations Support Manuel Padilla, and Deputy Executive Assistant Commissioner of Operations Support Mark Koumans).

In his dual role as a detailee at OCMO and a Contract Officer Representative with the Office of Acquisitions, Hendrickson documented Loyal Source's underperformance and failures to adhere to medical standards.[237] Beginning in January 2022, he alerted the Office of Acquisitions and the Office of Chief Counsel of Loyal Source's shortcomings, including that Loyal Source was not staffing any providers on certain shifts at facilities. This included attempts to convince his supervisors at CBP to issue Loyal Source a warning or "cure notice" regarding what he believed to be Loyal Source's failure to comply with the contract to provide medical services at CBP facilities.[238]

Later that year, in September 2022, CBP attempted to award its medical services contract to a different firm, Vighter.[239] Loyal Source and other companies protested that bid.[240] Despite the GAO ruling in CBP's favor and denying Loyal Source's protest, Loyal Source has continued to file additional protests.[241] In 2023, tensions boiled over when the Acquisitions Office refused to follow OCMO's recommendation to give Loyal Source a poor rating in a Contract Performance Assessment Report (CPAR) regarding Loyal Source's performance between September 30, 2021, and March 29, 2023. OCMO submitted a recommended CPAR rating to the Office of Acquisitions Contracting Officer on August 23, 2023. According to a letter from Acting CMO Eastman, a team of OCMO experts arrived at an "accurate, legally defensible, and unbiased CPAR rating."[242] On January 18, 2024, months after submitting the CPAR, OCMO learned that the Office of Acquisitions Contracting Officer had altered the poor rating and officially filed the CPAR without notifying OCMO of the changes.

The CPAR with OCMO's recommendations stated that Loyal Source should not be recommended for similar assignments under the contract in the future. It 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."[243]

The Office of Acquisitions changed the language in the CPAR to read: "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."[244]

In addition to reversing this recommendation, the Office of Acquisitions made changes to multiple evaluation areas within the CPAR. In the version of the CPAR with the poor rating, for

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[237] *Protected Whistleblower Disclosures Regarding the Performance and Oversight Failures of the Medical Services Contract of U.S. Customs and Border Protection with Loyal Source Government Services*, GOVERNMENT ACCOUNTABILITY PROJECT, (Nov. 20, 2023), https://whistleblower.org/wp-content/uploads/2023/11/11-30-2023-Hendrickson-Congressional-Disclosure.pdf.
[238] *Id*. at 7.
[239] Nick Miroff, *Medical provider vying for border contract faces scrutiny after girl's death* (Nov. 19, 2023), THE WASHINGTON POST, https://www.washingtonpost.com/immigration/2023/11/19/border-loyal-source-medical-care-migrants/.
[240] *Id*.
[241] *Id*.
[242] Contractor Performance Assessment Report Rating Inconsistencies, Response from Dr. Eastman, Acting CMO, to James W. McCament, Chief Operating Officer (Feb. 12, 2024), Appendix, Key Document N.
[243] *Id*.
[244] *Id*.

example, Loyal Source received a "Marginal" rating in several categories, including: 1) Quality, 2) Schedule, 3) Cost Control, 4) Management, and 5) Regulatory Compliance. The Office of Acquisitions changed the rating from "Marginal" to "Satisfactory" in each of these categories, overriding OCMO's recommendations.

On March 30, 2023, CBP awarded a contract to Loyal Source through June 29, 2023, and the agency subsequently extended the contract through November 29, 2023.[245] CBP then issued Loyal Source another bridge contract, which has been extended to January 29, 2025.[246]

On August 10, 2023, the Office of Acquisitions sent a cure notice to Loyal Source detailing a number of deficiencies related to its performance under the contract, including: 1) the failure to maintain a certain shift "fill rate" of medical personnel at CBP facilities;[247] 2) incorrect and absent reporting of medical interactions; 3) the failure to adopt certain updated program guidance and to develop ongoing professional performance evaluation standards; and 4) the failure to escalate care and consult physicians.[248]

On March 29, 2024, CBP submitted a Final CPAR of Loyal Source in the Contract Performance Assessment Reporting System (CPARS) with unfavorable performance ratings. Loyal Source sued the United States in October 2024 alleging, among other claims, that CBP's evaluation of Loyal Source's performance was arbitrary and capricious in violation of the Federal Acquisition Regulation (FAR).[249] Although significant portions of the complaint are redacted, Loyal Source refutes CBP's statement that "performance deficiencies" may have contributed to Anadith's death. Loyal Source argues that its contracted medical staff did not breach any standard of care or fail to comply with its contractual obligations preceding Anadith's death.[250] Loyal Source claims that its personnel took "reasonable" action, and CBP, instead, was responsible for detaining Anadith and her family beyond the 72-hour time limit outlined in CBP's TEDS standards.[251] Loyal Source also contends that no "significant medical issues or concerns" were present when Anadith was evaluated by its staff, and that CBP should not use "post hoc" medical judgment "to supplant the medical judgement of the onsite professionals."[252] Loyal Source demands that CBP rescind the Final CPARS and reevaluate Loyal Source's performance.[253]

According to whistleblower reports, the Office of Acquisitions failed to issue negative ratings in CPARs or a cure notice for years prior to the August 2023 notice due to the belief that a negative performance review of Loyal Source would mean that Loyal Source could not provide

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[245] Compl., *Loyal Source Government Services v. United States*, 7 (Fed. Cl. No. 24-01426) (Sept. 24, 2024).
[246] USASPENDING.gov, Award Profile Contract Summary, Award Recipient: Loyal Source Government Services LLC, https://www.usaspending.gov/award/CONT_AWD_70B03C24F00000046_7014_36F79722D0185_3600.
[247] The cure notice states that staff shift fill rates have not reached 95 percent required by the Statement of Work (SOW) for all sites (there is an allowance of 5% for absenteeism). CBP "Cure Notice" to Loyal Source Government Services, (Aug. 10, 2023), Appendix, Key Document K.
[248] *Id.*
[249] Compl., *Loyal Source Government Services v. United States*, 14 (Fed. Cl. No. 24-01426) (Sept. 24, 2024).
[250] *Id*. at 14-20.
[251] *Id*. at 17.
[252] *Id*. at 18.
[253] *Id*. at 3, 4.

medical care in CBP facilities.[254] CBP did not believe it possible to wind down its contract with Loyal Source. As a result, the CBP Office of Acquisitions failed to conduct meaningful oversight and continued to give Loyal Source a passing grade to ensure there was a medical service provider in place.[255]

In June 2024, OCMO stated that it has prioritized the development of an enhanced medical services contract oversight team that will consist of CBP employees and have OCMO-assigned team leads in certain Border Patrol Sectors on the southwest border.[256] While this development is encouraging, it remains unclear how exactly the oversight team will hold Loyal Source accountable under the existing contract in ways that will differ from past practices.

According to OCMO, modifications to the medical services contractor statement of work for the next contract award will include several key changes, including: 1) standardized protocols to identify and document individuals with elevated in-custody risk; 2) requirements to consult physicians for any individuals classified with a red ECMR status or diagnosed with a condition requiring isolation; and 3) detailed documentation of medical monitoring actions performed during an individual's time in custody and communication with CBP staff.[257] It is critical that these accountability mechanisms are built into the contract with CBP's medical services provider.

### F. Failure to Ensure Video Cameras Are Functioning at CBP Facilities

The failure to capture video of medical contractor staff interacting with Anadith and her family at the Harlingen station has complicated the investigation of her death. Some questions may never be answered without video evidence.

CBP provided updates to the Committee with respect to its video camera systems, stating that certain steps have been taken to address video cameras failing to function at CBP facilities.[258] It informed the Committee that after two deaths in custody in 2023 at the Harlingen facility, the video surveillance system at the facility was updated with the installation of the AirShip™ Fly-Away Kit Video Surveillance System.[259]

CBP stated that the new video system at Harlingen only became fully operational on August 19, 2024. Since then, according to CBP, Harlingen has experienced "little to no lapse in coverage" except for a temporary outage caused by a power outage.[260] CBP states that the quality of the video, including the resolution, color, clarity, and night vision capability are "adequate to

[254] Briefing with confidential whistleblower.
[255] *Id*.
[256] U.S. Customs and Border Protection, Office of the Chief Medical Officer, Border Health System Briefing to Senate Judiciary Staff (Aug. 1, 2024).
[257] *Id*.
[258] CBP response to Committee (Aug. 20, 2024), Appendix, Key Document Q.
[259] CBP described this system to the Committee as 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." In addition, it is "radio and sensor agnostic." CBP response to Committee (Aug. 20, 2024), Appendix, Key Document Q.
[260] *Id.*

meet the basic needs of the USBP Station in the migrant holding and processing areas,"[261] and that records for more than 30 days can be downloaded locally. CBP has stated that the system is only available locally but can be upgraded for cloud storage.[262]

CBP currently is tracking and reporting system outages, including outages for "cameras, recording devices (DVR/NVR), network/encoders, [and] monitors/laptops/CPU."[263] According to CBP policy, any outage over 24 hours should be reported as a significant incident to CBP Watch.[264] Currently, weekly outage reports for camera and DVR/failure are archived.[265] The current outage report, however, does not identify failures in video recording capabilities. CBP has stated that it plans to modify the report to include reporting on video recording failures in the future.[266]

### G. Lengthy Stays in CBP Custody and Open-Air Detention Sites Create Urgency

CBP guidelines state that detained individuals generally should not be held longer than 72 hours in a CBP facility,[267] and the law generally requires unaccompanied minors be released from CBP custody in under 72 hours.[268] During periods of time when border crossings have been high, individuals have been held for much longer.[269] DHS officials stated in July 2023 that some individuals had been held in facilities for over 10 days and sometimes up to 30 days.[270]

Pursuant to court order, CBP provides monthly data indicating length of detention for children in CBP custody to plaintiffs' counsel in *Flores v. Garland*.[271] Recently, CBP revealed that the data it has been providing each month to plaintifffs' counsel and the Juvenile Care Monitors was inaccurate and seriously undercounted the number of days that children were held

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[261] *Id.*
[262] *Id.*
[263] *Id.*
[264] *CBP Privacy Impact Assessment for the CBP Web Emergency Operations Center* 3, U.S. CUSTOMS AND BORDER PROTECTION, (Sept. 13. 2021) (CBP Watch is "the primary point of contact for significant incident reporting from all CBP operational component and offices . . ."), https://www.dhs.gov/sites/default/files/publications/privacy-pia-cbp-065-webeoc-september2021.pdf
[265] *Id.*
[266] *Id*.
[267] *National Standards on Transport, Escort, Detention, and Search (TEDS)*, U.S. CUSTOMS AND BORDER PROT. (Oct. 2015), https://www.cbp.gov/sites/default/files/assets/documents/2020-Feb/cbp-teds-policy-october2015.pdf
[268] 8 U.S.C.A. § 1232(b)(3) ("Except in the case of exceptional circumstances, any department or agency of the Federal Government that has an unaccompanied alien child in custody shall transfer the custody of such child to the Secretary of Health and Human Services not later than 72 hours after determining that such child is an unaccompanied alien child.")
[269] Amna Nawaz, *Hundreds of children have been held by Border Patrol for more than 10 days. The legal limit is 72 hours*, PBS NEWS (Mar. 17, 2021), https://www.pbs.org/newshour/nation/hundreds-of-children-have-been-held-by-border-patrol-for-more-than-10-days-the-legal-limit-is-72-hours.
[270] Priscilla Alvarez, *Adult Migrants Are Held in Border Facilities Amid Biden Administration Policy Changes, Sources Say*, CNN (Jul. 18, 2023), https://www.cnn.com/2023/07/18/politics/migrants-border-facilities-biden-policies/index.html.
[271] Decl. of Diane de Gramont in Supp. of Pls.' Reply in Supp. of Mot. to Modify the 2022 CBP Settlement, *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. No. 1538, at *1 (C.D. Cal., Jan. 14, 2025).

in CBP custody.[272] CBP attributed this discrepancy to a failure to include children transferred from CBP to HHS custody in recent months. As a result of this error, CBP failed to accurately report the number of unaccompanied children who were in CBP custody over 72 hours between July and October 2024. *Flores* counsel currently only have updated data for October 2024.[273] The discrepancies in the data are significant. The original October data provided by CBP indicated that two unaccompanied children were in custody over 72 hours. The corrected data indicated that 37 unaccompanied children were in custody over 72 hours. The discrepancies also extended to children in family units. The original October data provided by CBP indicated that 1,203 children in family units were in custody over 72 hours. The corrected data indicated that 2,452 children in family units were in custody over 72 hours in October.[274] This means CBP undercounted by *more than half* the number of children in family units who were in CBP custody for over 72 hours in October 2024.

Prior to these recent admissions by CBP, the most recent *Flores* Juvenile Care Monitor Report raised concerns that data provided by CBP underestimates the number of children that have been in custody over 72 hours.[275] The Report stated that "[e]stimates of the portion of apprehended children in families who are reported to have times [in custody] greater than 72 hours appear to be lower than expected given the reported number of family apprehensions over the same time period."[276] The Juvenile Care Monitor plans to make public clarifications regarding the data prior to the end of the Juvenile Care Monitor term.[277] These concerns were justified, given the recent corrections CBP has made to its October 2024 data.

Corrected data for additional months no doubt will raise even greater concerns regarding lengthy detention and related risk for medically vulnerable individuals, including children. Current data is concerning, nonetheless. According to data, Between October 2023 and October 2024, CBP frequently held unaccompanied children and families in custody for between 72 (three days) and 168 hours (seven days).[278] In December 2023, the highest number of children fell into this category, with 3,457 children held for between 72 and 168 hours.[279] Over 1,000 children in families were held between 72 and 168 hours in November 2023, December 2023, March 2024, April 2024 and June 2024.[280] In June of 2024, 551 families with children were held in custody for more than 168 hours.[281] In August 2024, 360 children in families were in custody for over 168 hours. Incredibly, data indicated children have been held in CBP custody for weeks.[282] A family was held in CBP custody for 20 days in June 2024. In June, July, August,

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[272] *Id*. at *2.
[273] *Id*. at *1
[274] *Id*. at *2.
[275] *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. 1381, at *4 (C.D. Cal., Dec. 13, 2024), https://youthlaw.org/sites/default/files/2024-12/December%202024%20Juvenile%20Care%20Final%20Monitor%20Report%20by%20Andrea%20S.%20Ordin%2C%20Dr.%20Nancy%20Ewen%20Wang%2C%20Dr.%20Paul%20Wise_0.pdf.
[276] *Id*. at 22.
[277] *Id*.
[278] Government data analyzed by the National Center for Youth Law (on file with the Senate Judiciary Committee). The National Center for Youth Law
[279] *Id*.
[280] *Id*.
[281] *Id*.
[282] *Id*.

September and October of 2024, families were held in custody for over 17 days.[283] Unaccompanied children, though fewer in number, also are held for long periods.[284] In August 2024, an unaccompanied child was held for 11 days; in September 2024, an unaccompanied child was held for 20 days.[285]

The detention of children for lengthy periods of time soared under the previous Trump administration. DHS OIG found that over 30 percent of the 2,669 children held in Rio Grande Valley facilities at the time of the OIG's inspection were held for longer than 72 hours.[286] In 2019, detention of unaccompanied children and children with families reportedly reached 300,000; 40 percent of those children were held for longer than 72 hours.[287]

The growth of CBP Open Air Detention Sites (OADs) has created a greater need for adequate medical care. Since 2022, migrants have been detained in certain open-air areas on U.S. side of the border until CBP has capacity to process them at CBP detention facilities.[288] Recently, the *Flores* court established that migrants held in seven OADS—four west of the San Ysidro Port of Entry and three in the desert town of Jacumba, California—were in CBP custody. Because the court determined these migrants are in CBP's legal custody, it held children must receive a range of protections under the *Flores* Settlement Agreement."[289] In its decision, the court cited observations by nonprofit volunteers who witnessed "dozens to hundreds of migrants camping in the OADS, including children."[290] The court described the extreme conditions at these sites: during the summer, "temperatures can be over 110 degrees and, in the winter, temperatures can drop to around 20 degrees," with children being held "anywhere from several hours to several days."[291] In addition, according to court filings, "children and their families are forced to take shelter in porta potties, dumpsters, or tarps filled with trash to escape the cold, wind, and rain."[292]

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[283] *Id*.
[284] *Id*.
[285] *Id*.
[286] *Management Alert – DHS Needs to Address Dangerous Overcrowding and Prolonged Detention of Children and Adults in the Rio Grande Valley* 5, OFF. OF INSPECTOR GEN., U.S. DEP'T OF HOMELAND SEC. (July 2, 2019), https://www.oig.dhs.gov/sites/default/files/assets/Mga/2019/oig-19-51-jul19.pdf.
[287] Anna Flagg and Andrew Rodriguez Calderon, *500,000 Kids, 30 Million Hours: Trump's Vast Expansion of Child Detention*, THE MARSHALL PROJECT (Sept. 30, 2020), https://www.themarshallproject.org/2020/10/30/500-000-kids-30-million-hours-trump-s-vast-expansion-of-child-detention.
[288] Order, Motion to Enforce, *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. 1406, at *3 (C.D. Cal. Apr. 3, 2024), https://youthlaw.org/sites/default/files/2024-04/ORDER%20-%20Motion%20to%20Enforce%20%28OADS%29.pdf.
[289] *Major victory for children held in Open Air Detention Sites*, NATIONAL CENTER FOR YOUTH LAW, (Apr. 4, 2024), https://youthlaw.org/news/major-victory-children-held-open-air-detention-sites.
[290] *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. 1406, at *3 (C.D. Cal. Apr. 3, 2024), https://youthlaw.org/sites/default/files/2024-04/ORDER%20-%20Motion%20to%20Enforce%20%28OADS%29.pdf.
[291] *Id.* at 7.
[292] *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. 1392, at *1 (C.D. Cal. Feb. 29, 2024), https://www.aila.org/aila-files/28990AF2-3F1A-4AA5-B1A5-40708C0E8085/Motion-to-Enforce-OADS.pdf.

Additional concerns regarding the OADS include that individuals in these open-air areas lack "access to adequate food and water, sanitation, and medical services,"[293] and "migrants, including children, suffer[] from significant injuries or other serious medical issues,"[294] including accounts of "seizures, symptoms of smoke inhalation, severe kidney pain to the point of vomiting, diabetic emergencies, and people going into labor."[295] Other accounts relate to lack of food, with the *Flores* court noting that "CBP hands out one bottle of water and one pack of crackers to each migrant each day," well below the "minimum standard that juveniles should receive a meal every six hours, at least two of which must be hot."[296] Additionally, CBP does not provide "first aid or medical care at OADS," and instead, "rel[ies] on humanitarian volunteers to provide first aid."[297] When detained individuals call for emergency care, ambulances sometimes refuse to respond because of the remote location of the OADS.[298] This is compounded by the fact that, according to reports, CBP agents actively compromise access to medical care by regulating access by medical volunteers and "have at times barred medical volunteers from the sites." Furthermore, there have been reports that CBP agents threaten "people seeking medical assistance with a loss of the right to seek asylum."[299]

CBP has stated that it has a policy to ensure "at-risk or medically fragile individuals, including, but not limited to, individuals with a chronic illness; infants or elderly; minors with an acute injury, medical or mental health condition; pregnant women or postpartum mothers with complications; and individuals with a disabling mental disorder" are processed expeditiously so as to "minimize the length of time in CBP custody." The agency also has stated that it takes numerous factors into consideration when determining how quickly an individual should be processed. These factors include: 1) the impact of custodial conditions, 2) the length of time the individual has been in custody; 3) the number of individuals in custody; 4) medical issues impacting the individuals in custody; 5) whether the individuals are likely to be in custody for more than 72 hours; and 6) whether the facility is over capacity.[300]

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[293] *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. 1406, at *3 (C.D. Cal. Apr. 3, 2024), https://youthlaw.org/sites/default/files/2024-04/ORDER%20-%20Motion%20to%20Enforce%20%28OADS%29.pdf.
[294] *Id.* at 7.
[295] *Id.*
[296] *Id.* at 11.
[297] *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. 1406, at *6 (C.D. Cal. Apr. 3, 2024), https://youthlaw.org/sites/default/files/2024-04/ORDER%20-%20Motion%20to%20Enforce%20%28OADS%29.pdf.
[298] *Id*.
[299] *Id.* at 7.
[300] *Short Term Detention: Fiscal Year 2023 Report to Congress 3*, U.S. CUSTOMS AND BORDER PROT., U.S. DEP'T HOMELAND SEC. (Jan. 11, 2023), https://www.dhs.gov/sites/default/files/2024-03/2024_0111_cbp_short_term_detention.pdf.

## VIII. Recommendations

### A. Reduce Time in Custody and Strengthen Protections for Medically Vulnerable Populations

CBP must take immediate steps to shorten the time individuals remain in custody, particularly those with medical vulnerabilities, as its facilities are not designed for long-term detention. Though existing policies state that individuals with enhanced medical risk should be processed expeditiously, it is not clear what steps the agency takes to ensure expedited processing. CBP should develop and enforce clear guidelines that prioritize the prompt release of medically vulnerable individuals, including those undergoing credible fear interviews, while safeguarding their access to legal counsel.[301] There should be rigorous oversight of CBP's adherence to policies that prioritize these releases, including monitoring through the medical records system and consistent reporting to CRCL and OIDO.

Additionally, CBP must strengthen its policies for pregnant, postpartum, and nursing individuals, who continue to face prolonged detentions and inadequate medical care despite a 2021 policy meant to protect them.[302] Many of these individuals remain in custody for more than 72 hours, even in facilities lacking adequate medical personnel and basic necessities, which increases the risk of miscarriages and other serious health complications.[303] To address this, CBP should issue a new directive clearly stating that, barring extraordinary circumstances, these individuals should not be detained for longer than the minimum time necessary to process them. A new directive to this effect would align with existing ICE policy, which discourages the detention of pregnant, postpartum, and nursing individuals in most instances.[304]

Lastly, data provided to the Committee by OCMO demonstrated a far greater need for medical services during periods when large numbers of migrants approached the southern border. This data provided valuable information about agency medical needs during peak flows and the need for CBP to be prepared for fluctuations in the volume of migrants entering CBP facilities. During the current slowdown of migrants entering the United States, CBP has an opportunity to improve processes in anticipation of future influxes.

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[301] Though not explored in this report, the Committee is aware of serious concerns regarding access to counsel during credible fear interviews. NATIONAL IMMIGRATION LAW CENTER, SEEKING SAFETY FROM DARKNESS: RECOMMENDATIONS TO THE BIDEN ADMINISTRATION TO SAFEGUARD ASYLUM RIGHTS IN CBP CUSTODY (2024), https://www.nilc.org/resources/seeking-safety-from-darkness-recommendations-to-the-biden-administration-to-safeguard-asylum-rights-in-cbp-custody/.

[302] Letter from ACLU Foundation San Diego and Imperial Counties to Joseph V. Cuffari, Off. Of Inspector General, U.S. Dep't of Homeland Sec. (Jan. 22, 2020), https://www.aclu-sdic.org/sites/default/files/2020-01-22-oig-complaint-1-final-1_0.pdf.

[303] *Id*. ("[A] July 2019 DHS OIG report found that, of 8,000 individuals detained by Border Patrol in the Rio Grande Valley, 3,400 (42.5 percent) were held in excess of 72 hours.").

[304] U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT, ICE Directive No. 11032.4, *Identification and Monitoring of Pregnant, Postpartum, or Nursing Individuals* (Jul. 1, 2021).

### B. Ensure Staffing Needs are Met and Increase Access to Physicians

Without adequate or reliable staffing of medical personnel, CBP will not be able to provide adequate medical care to those in its custody.[305] To address this issue, CBP must ensure greater accountability for its medical services contractor, Loyal Source. In addition, CBP should streamline the hiring and clearance process to reduce delays in staffing. This could involve allocating more resources to expedite background checks and other temporary staffing solutions.

CBP and OCMO should also continue to seek input from OHS when negotiating their medical services contract to ensure they are requesting the appropriate level of providers to treat detained individuals and increase access to physicians when needed. Specifically, CBP should look to broaden its network of external physicians. With the new ECMR guidance, physician consultations are sometimes a required step, depending on a detained individual's level of distress. CBP should monitor the accessibility of physicians when they are requested for consults to ensure that physicians are easily accessible at every facility, especially during peak hours or at high-risk locations.

Finally, CBP should implement a robust monitoring system to track the effectiveness of staffing levels and physician access. Key metrics, such as the ratio of medical staff to detainees, response times to medical emergencies, and wait times for physician consultations, should be regularly collected and reported to oversight bodies like OHS. Based on this data, CBP can continuously refine its staffing models and consultation processes to ensure the highest possible standard of care for individuals in custody.

### C. Continue to Improve Existing EMR System; Ensure Contracted Medical Staff Assess Medical Records in the EMR System and Share Health Information After Release from CBP Custody

OCMO leadership has recommended CBP acquire a new EMR system to ensure medical services personnel are better able to communicate medical needs, prioritize methods for sharing medical records among health providers, and ensure that hospital records are efficiently conveyed to CBP medical personnel. OCMO staff who have contributed to the development of the existing EMR system have described extensive improvements they have made to the system and expressed concern that the pursuit of a new system is wasteful and unnecessary. The Committee recommends OCMO explore alternatives to an off-the-shelf EMR system that will not require extensive customization and integration.[306] This could include continuing to improve its existing EMR system by integrating new ECMR guidance regarding documenting children at elevated risk. It is concerning that the December 2024 Juvenile Care Monitor Report noted that

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[305] U.S. CUSTOMS AND BORDER PROT., CBP Directive No. 2210-004, *Enhanced Medical Support Efforts* (Dec. 30. 2019).

[306] *Protected Whistleblowers' Disclosures Regarding Failure of CBP Leadership and CBP Office of Acquisition to Oversee its Medical Services Contract with Loyal Source Government Services and Ongoing Wrongdoing by Acting CBP Chief Medical Officer*, GOVERNMENT ACCOUNTABILITY PROJECT 25 (Feb. 16, 2024), https://whistleblower.org/wp-content/uploads/2024/02/02-16-2024-CBP-Medical-Services-Whistleblower-Disclosure.pdf.

"two children who were worthy of elevated risk had not been accurately flagged" by the EMR.[307]

OCMO's improvements to the EMR system must be matched by a firm commitment to ensuring contracted medical staff complete the necessary medical documentation in the EMR system and assess that information when treating individuals in their care. OCMO must ensure that medical services staff carefully assess every individual's medical records. If the records of an individual with enhanced medical needs like Anadith are not carefully assessed and taken into consideration during treatment, even the most sophisticated medical records system cannot save the person's life.

OCMO must establish a system for monitoring medical services staff's review and assessment of medical records during treatment of all detained individuals, with special attention to individuals with heightened medical needs. The most recent *Flores* Juvenile Care Monitor Report noted improvements regarding OCMO's monitoring abilities,[308] but expressed concerns that these monitoring mechanisms "are still being implemented or have had only minimal operational experience in actual facility settings" and their effectiveness is still in question.[309] In addition, it is critical that CBP consistently provide medical records to individuals upon their release from CBP custody to ensure successful continuity of care after every individual's release.

### D. Ensure Medical Services Staff are Empowered to Seek Higher-Level Care When Appropriate

Medical services contractors should feel empowered to contact emergency services and seek hospital care for individuals in CBP custody. To the extent CBP must assign agents to accompany individuals to hospitals, there may be logistical hurdles in ensuring an individual is quickly transferred to a hospital. CBP should ensure its policies clearly state that logistical challenges should never impact a decision to seek higher levels of care or slow the process for transferring a person to a hospital. In addition, CBP should evaluate policies to ensure: 1) the ability of a parent or trusted adult to accompany a child to the hospital; and 2) phone communication between health providers and a parent or trusted adult who cannot accompany a child. This will ensure that health providers in local facilities have full and timely access to all medical information, which may prove critical to the care of the child being referred for care.

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[307] *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. 1381, at *12 (C.D. Cal., Dec. 13, 2024), https://youthlaw.org/sites/default/files/2024-12/December%202024%20Juvenile%20Care%20Final%20Monitor%20Report%20by%20Andrea%20S.%20Ordin%2C%20Dr.%20Nancy%20Ewen%20Wang%2C%20Dr.%20Paul%20Wise_0.pdf.

[308] *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. 1522, at *14, 28 (C.D. Cal. Dec. 12, 2024), https://youthlaw.org/sites/default/files/2024-12/December%202024%20Juvenile%20Care%20Final%20Monitor%20Report%20by%20Andrea%20S.%20Ordin%2C%20Dr.%20Nancy%20Ewen%20Wang%2C%20Dr.%20Paul%20Wise_0.pdf (stating that the "quality assurance mechanism" includes "the review of electronic medical records of cases that meet specific diagnostic or procedural criteria, such as children entered into the Enhanced Medical Monitoring system; the review of sentinel events that provide special insight into system components likely to have a major impact on patient outcomes, such as urgent transport of a child from a CBP facility to a local hospital; and monitoring of real-time, electronic dashboards of the medical status of children in CBP custody.").

[309] *Id*. at *29-30.

### E. Enhance Transparency of Medical Care Oversight

To ensure the delivery of adequate medical care in CBP facilities, stronger oversight and greater transparency are essential. DHS must enhance its internal oversight mechanisms, particularly how it monitors the performance of medical services contractors such as Loyal Source. OCMO, which currently oversees medical care in CBP facilities, is hindered by a lack of staffing and effective processes, and a restructuring is necessary. One solution may be to move OCMO under the DHS Office of Health Security (OHS), which would enable better coordination and streamline oversight efforts. This realignment would allow OHS to take an active role in reviewing medical contracts and ensuring that standards of care are consistently met across all CBP facilities. It also would lessen the likelihood that the Office of Acquisitions interferes or undermines OCMO reform efforts.

Modifications to the medical services contract should include more specific requirements for tracking and monitoring the implementation of protocols such as the ECMR guidelines. A granular approach to data collection and consistent oversight should be implemented, particularly for vulnerable populations such as minors. This will enable the use of documented evidence to assess contractor performance and support future Contract Performance Assessment Reports.

Transparency is key to maintaining public trust and holding CBP accountable for the care provided in its facilities. To this end, CBP should make medical service contracts publicly available and regularly report on the amount of time individuals, particularly children in family units and unaccompanied minors, spend in custody. Reporting should not only include average times in custody, but also present more comprehensive data, such as the mean and outer time limits by nationality, to provide a clearer picture of custody durations.

Additionally, CBP must prioritize the installation and proper maintenance of video cameras in all facilities. These video recordings are critical for documenting and verifying the treatment of migrants, particularly in cases where medical care has been called into question. Clear video footage, much like the body-worn camera footage already available on CBP's website, would greatly enhance accountability. Furthermore, CBP should improve its reporting on camera outages, making these reports public and identifying facilities that require camera upgrades. These efforts would significantly bolster transparency and ensure that CBP upholds its responsibility to provide safe, effective, and humane medical care to those in its custody.

### F. Discontinue the Use of Isolation Units Except When a Medical Quarantine is Needed

CBP should discontinue the use of isolation units in all instances where a communicable disease does not render quarantine a medical necessity. If isolation is required because of a contagious illness, individuals in these rooms should have access to warm clothes and blankets and sufficient access to showers, toilets, and a phone. Additionally, individuals should be permitted to spend time outside of isolation units for several hours each day. Children also

should have full access to caregivers and families should not be held in small isolation units. These recommendations are in line with reports by the Juvenile Care Monitor.[310]

### G. Ensure Robust Monitoring of Medical Care in CBP Facilities by Medical Experts

External monitoring of medical care in CBP facilities should continue. Under the *Flores* settlement, monitoring of CBP medical care by medical experts has been concentrated in the Rio Grande Valley (RGV) and El Paso sectors. However, this *Flores* monitoring will formally conclude at the end of January 2025. Independent oversight of conditions in CBP facilities, however, is crucial. Whether under a Juvenile Care Monitor appointed by a court or another independent monitor, independent monitoring of medical care should continue and expand to additional CBP sectors. Such monitoring should prioritize assessing the quality of care provided to vulnerable groups, including children and individuals with chronic health conditions, and should help identify systemic problems within CBP facilities that require attention and improvement, such as overcrowding and medical recordkeeping. If OCMO proceeds to conduct oversight over its own activities and medical services contractor without external monitoring, it should put a concrete monitoring plan in place and share that plan with Congress.

[310] *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. 1412, at *9, 30 (C.D. Cal. May 6, 2024), https://youthlaw.org/sites/default/files/2024-05/Flores%20Monitor%20Report%20-%20May%202024.pdf; *Flores v. Garland*, No. CV 85-4544-DMG (AGRx), Doc. 1522, at *12, 16 (C.D. Cal. Dec. 12, 2024), https://youthlaw.org/sites/default/files/2024-12/December%202024%20Juvenile%20Care%20Final%20Monitor%20Report%20by%20Andrea%20S.%20Ordin%2C%20Dr.%20Nancy%20Ewen%20Wang%2C%20Dr.%20Paul%20Wise_0.pdf ("The use of small isolation rooms requires immediate reconsideration . . . the size of these rooms is inappropriate for holding families for any significant length of time.").

## Appendix: Key Documents

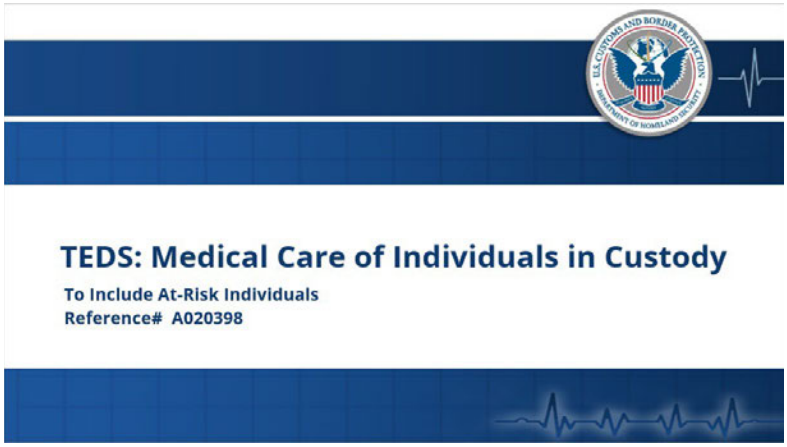
| Document | Description |
|---|---|
| **A** | TEDS: Medical Care of Individuals in Custody PowerPoint |
| **B** | TEDS: Duration, Conditions, and Monitoring of Individuals in CBP Custody PowerPoint |
| **C** | U.S. Customs and Border Protection, Alien Initial Health Interview Questionnaire, Form 2500 |
| **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

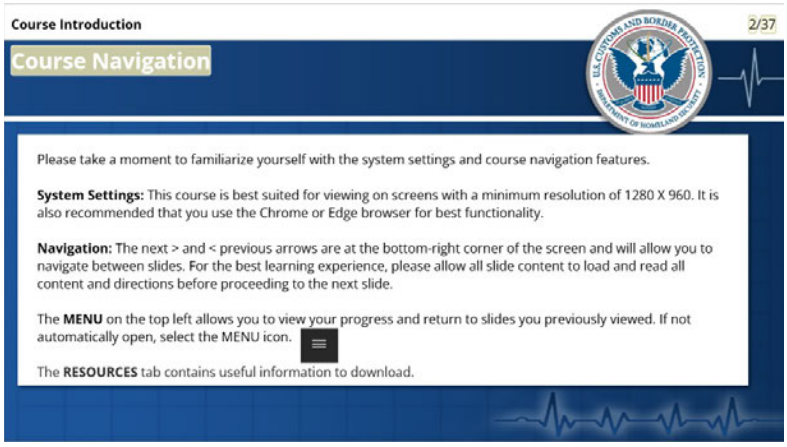
## 1. Introduction

### *1.1 TEDS: Medical Care of Individuals in Custody*

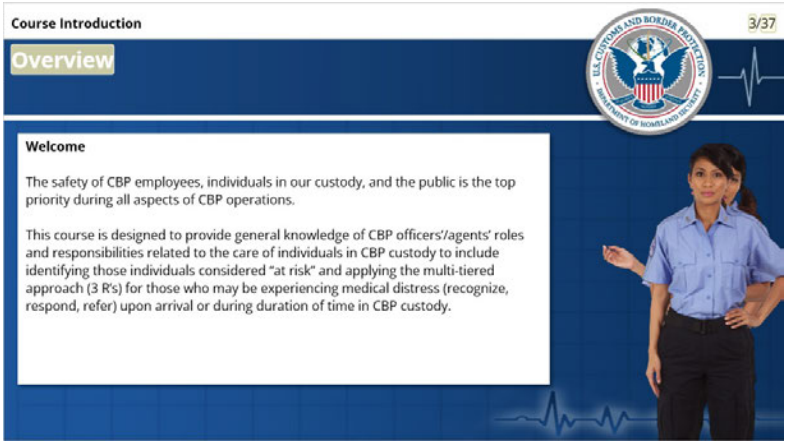



**Notes:**

### *1.2 Course Navigation*



## *1.3 Overview*

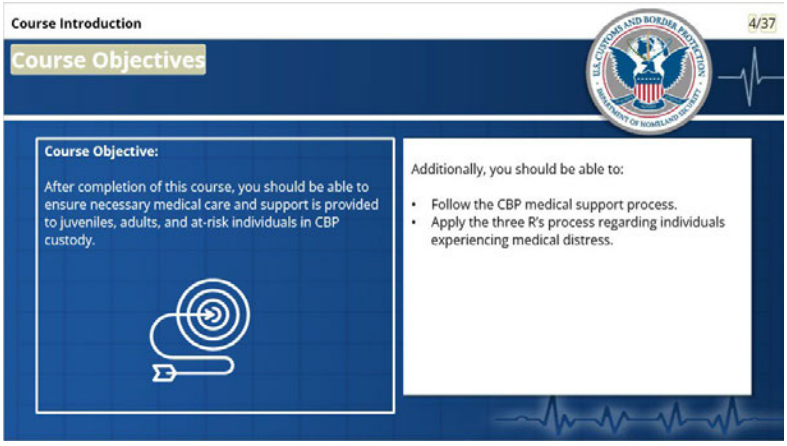



**Notes:**

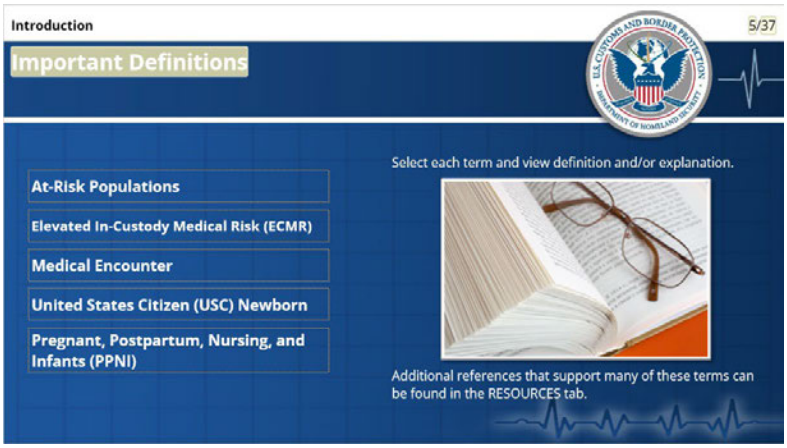
Audio Narration:

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*

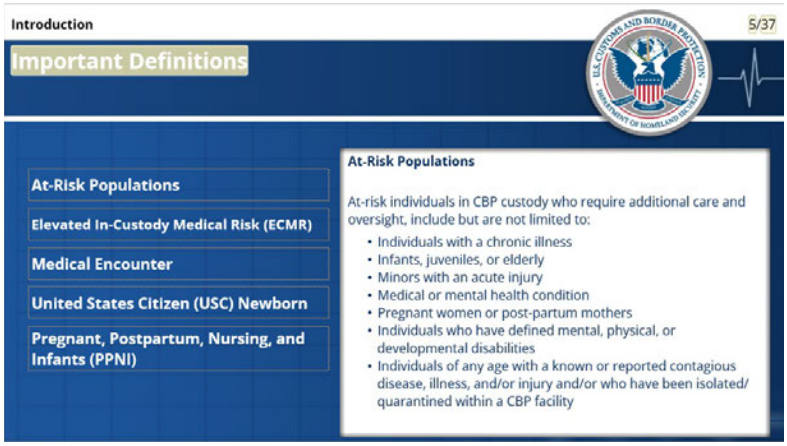



## *1.5 Important Definitions*

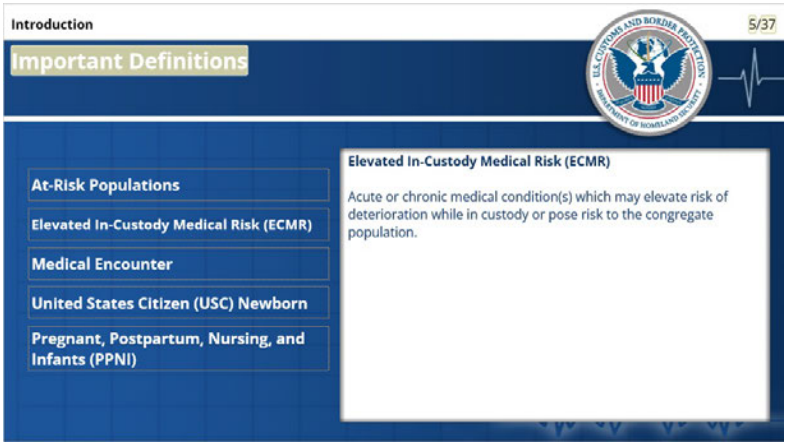



**Notes:**

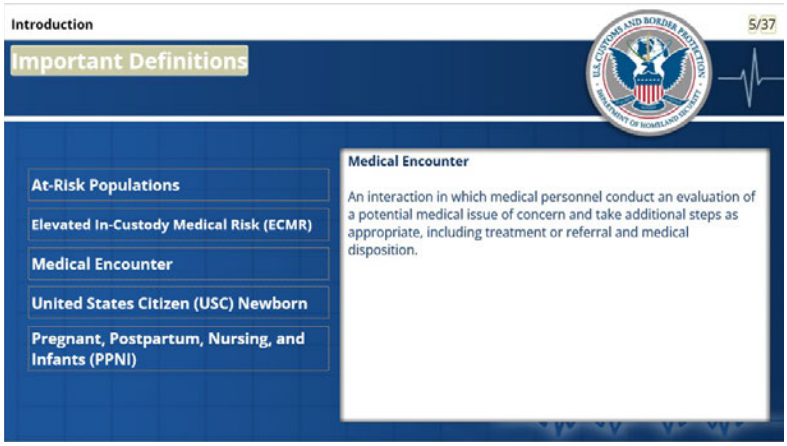
## At Risk Populations (Slide Layer)



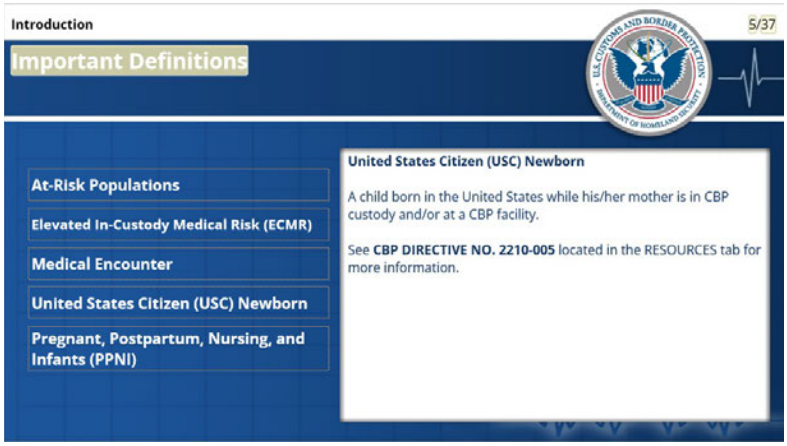

## ECMR (Slide Layer)



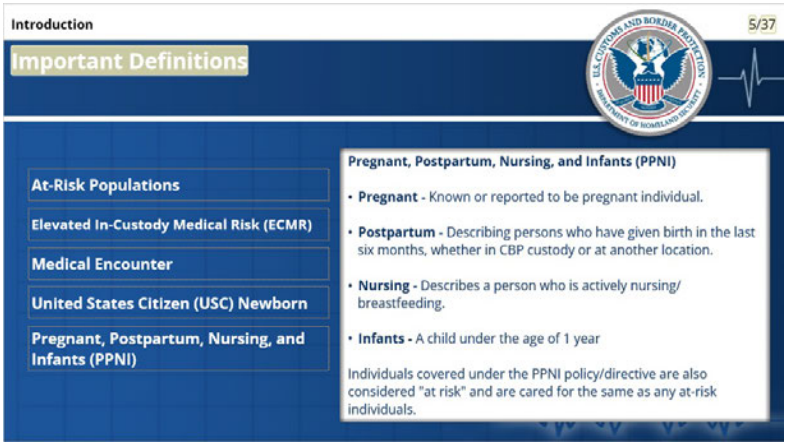

## Medical Encounter (Slide Layer)



## USC Newborns (Slide Layer)

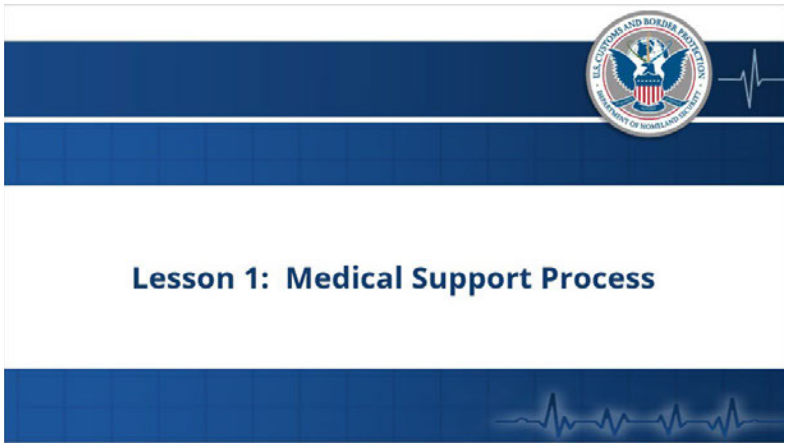



## PPNI (Slide Layer)

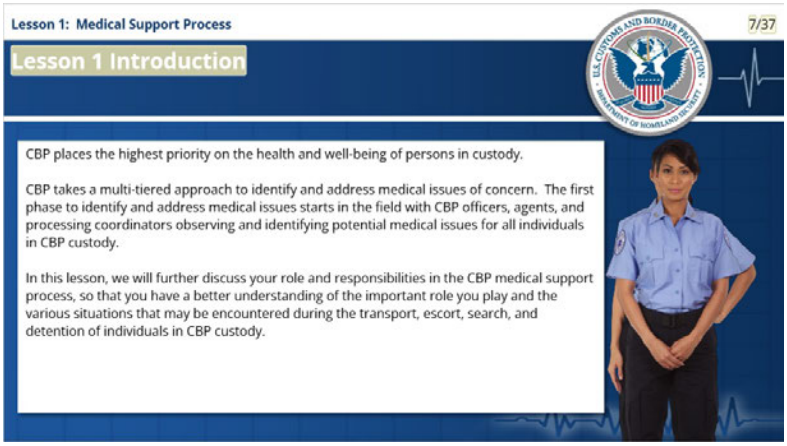


# 2. Lesson 1:  Medical Support Process

## *2.1 Lesson 1:  Medical Support Process*




## *2.2 Lesson 1 Introduction*



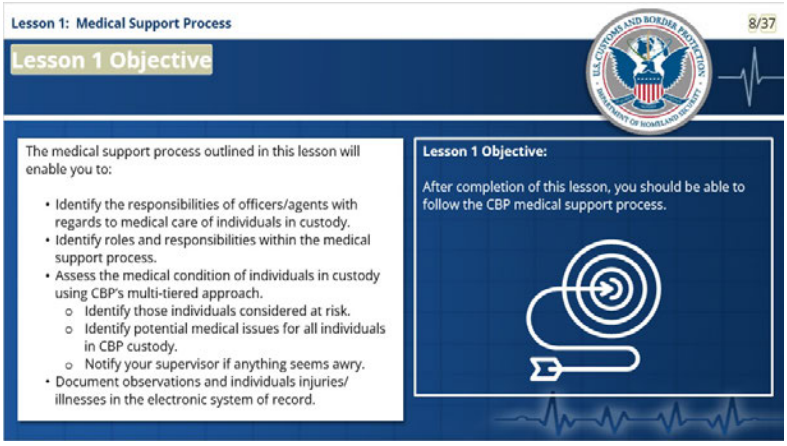

**Notes:**

**Audio Narration:**

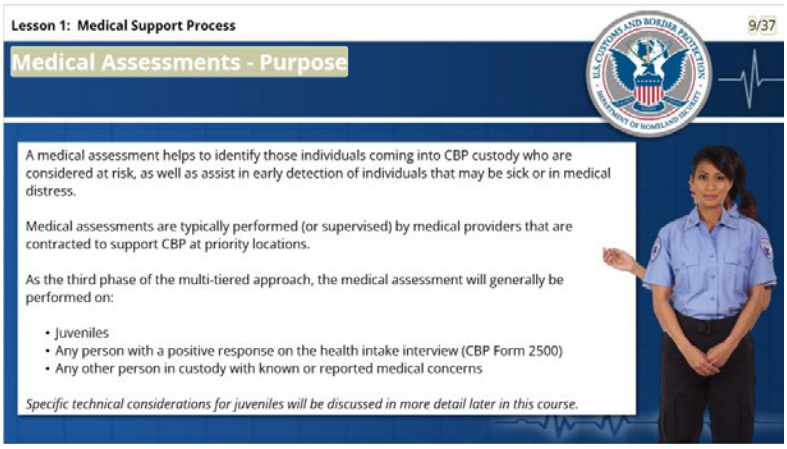
CBP takes a multi-tiered approach to identify and address medical issues of concern.  The first phase to identify and address medical issues starts in the field with CBP officers, agents, and processing coordinators observing and identifying potential medical issues for all individuals in CBP custody.

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:

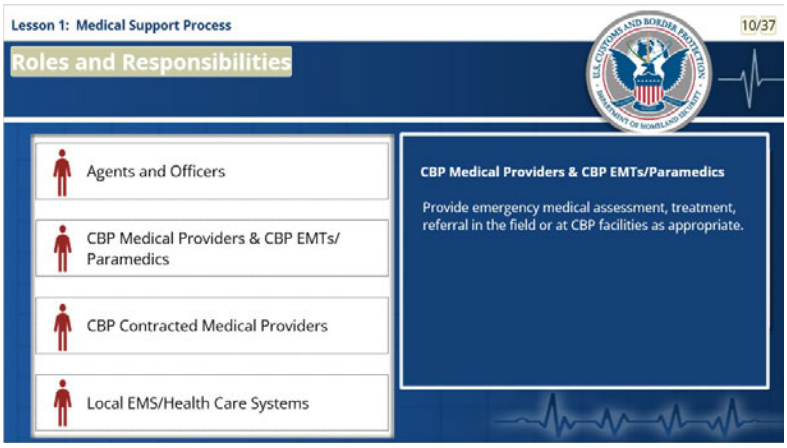
A medical assessment helps to identify those individuals coming into CBP custody who are considered at risk, as well, as assist in early detection of individuals that may be sick or in medical distress.

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

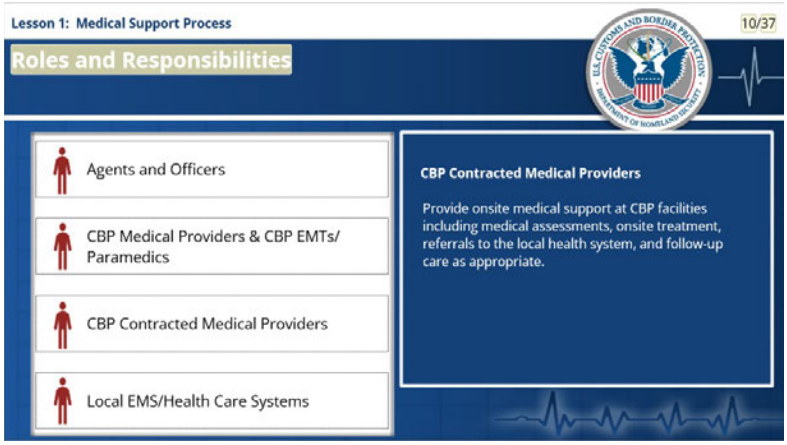
As the third phase of the multi-tiered approach you reviewed in lesson one, the medical assessment will generally be performed on juveniles, any person with a positive response on the health intake interview (CBP Form 2500), or any other person in custody with known or reported medical concerns.

## *2.5 Roles and Responsibilities*

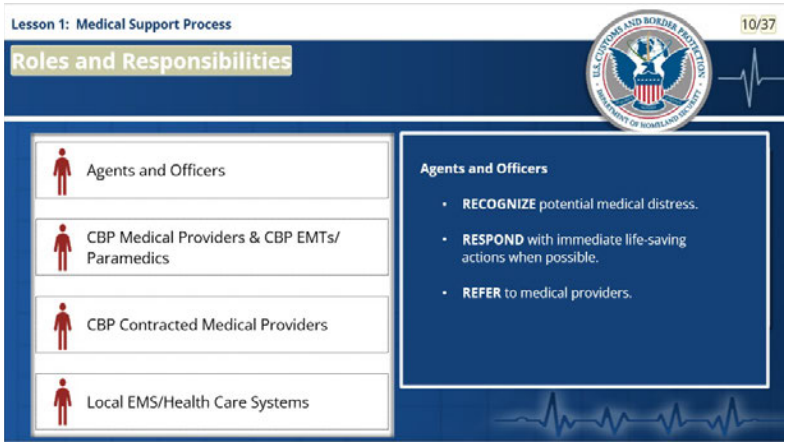

### CBP Medical Providers (Slide Layer)




### Contracted Medical Providers (Slide Layer)

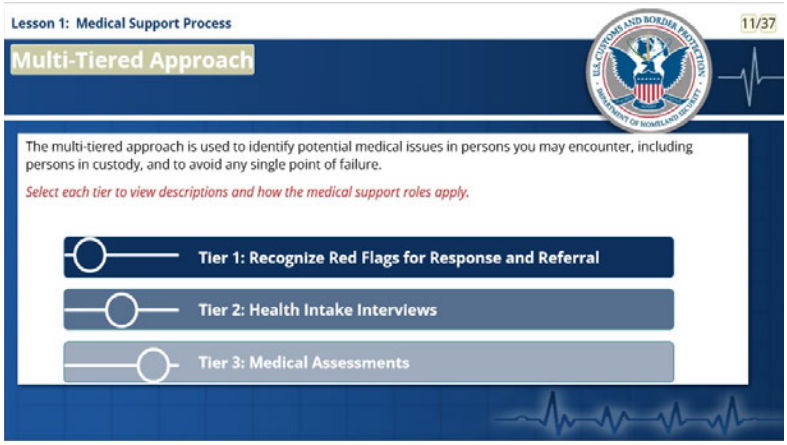


## Agents and Officers (Slide Layer)

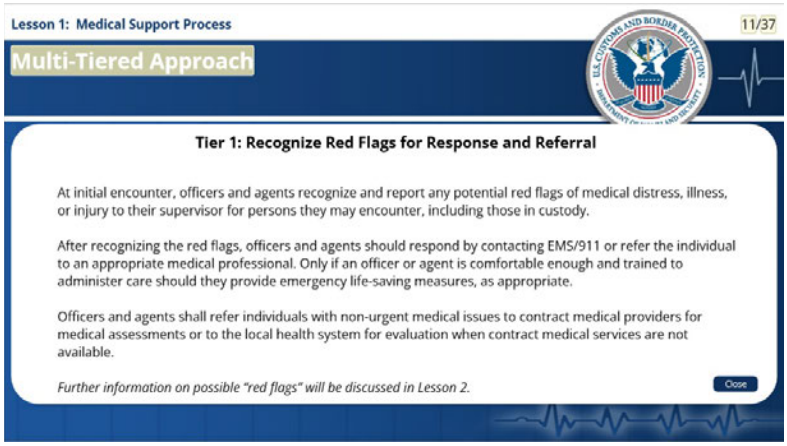



## Local EMS Health Care Systems (Slide Layer)

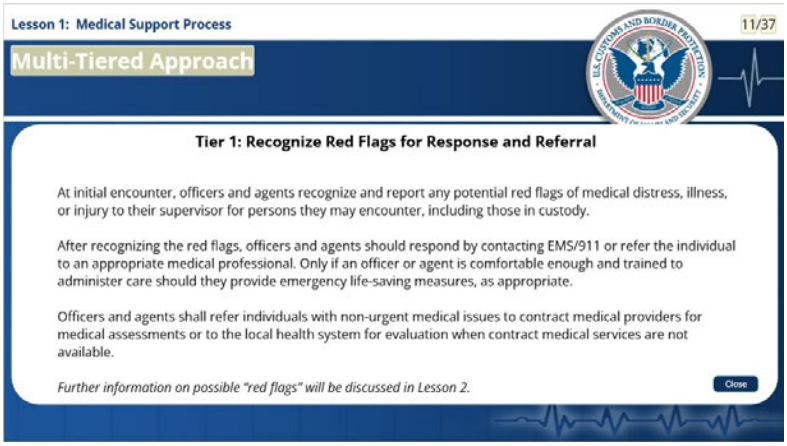

## *2.6 Multi-Tiered Approach*



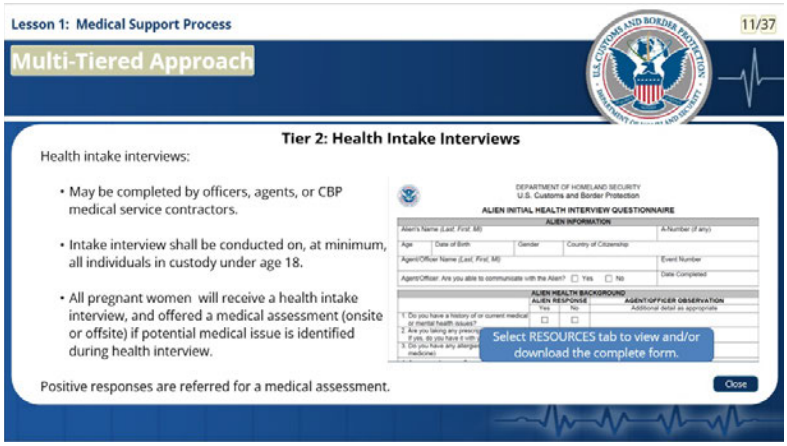
## Tier 1 (Slide Layer)



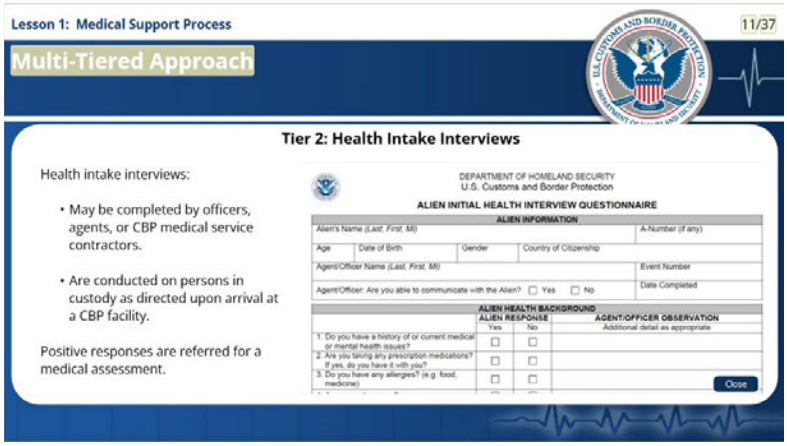

## Tier 1 - Close (Slide Layer)



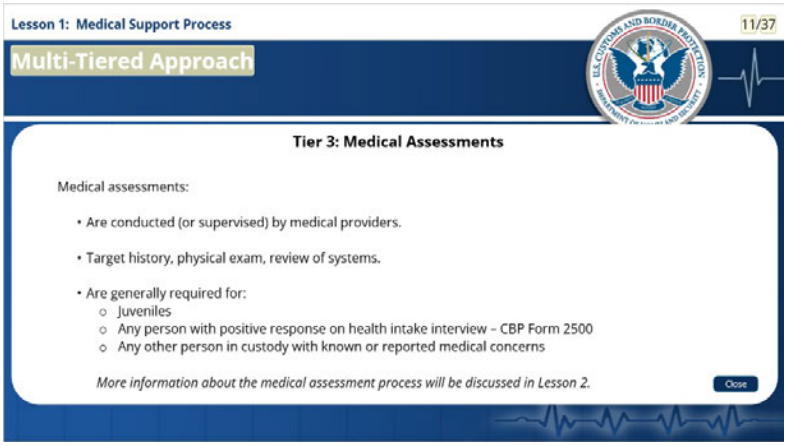

## Tier 2 (Slide Layer)



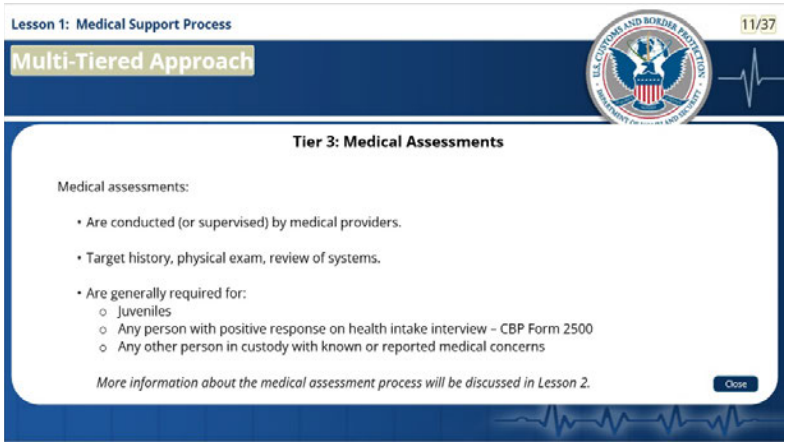
## Tier 2 - Close (Slide Layer)



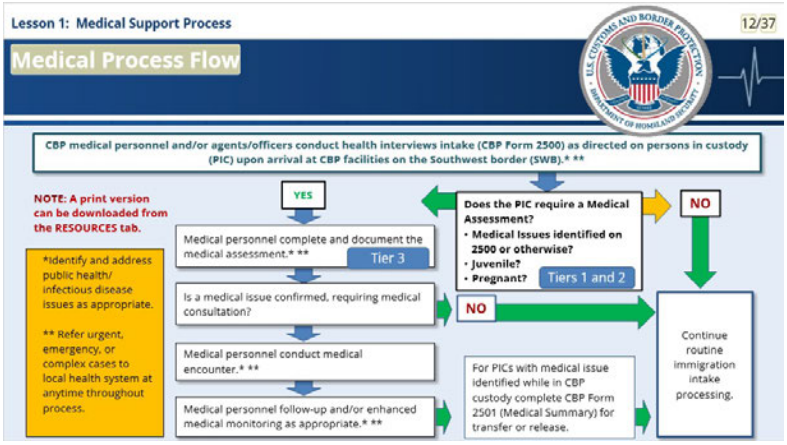

## Tier 3 (Slide Layer)




## 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. |

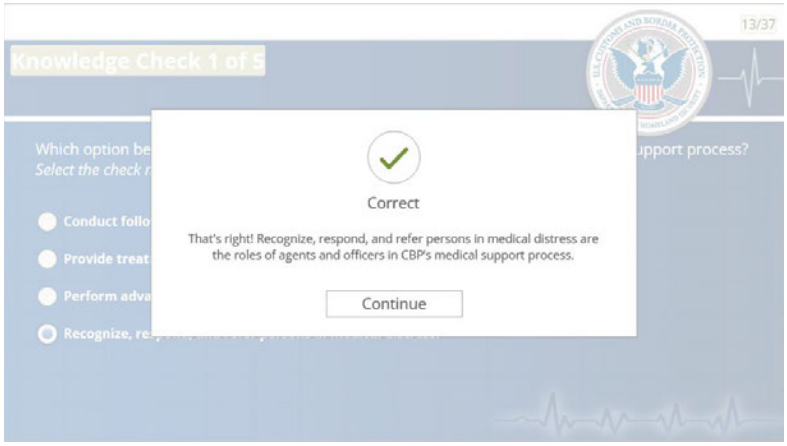
**Feedback when correct:**

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

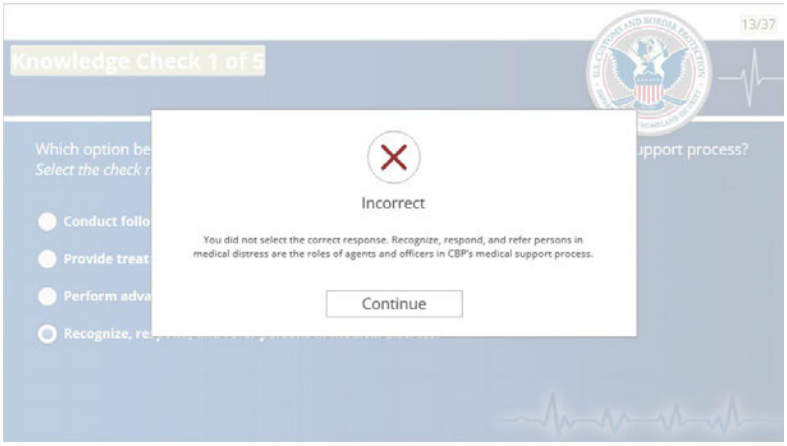
**Feedback when incorrect:**

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)**

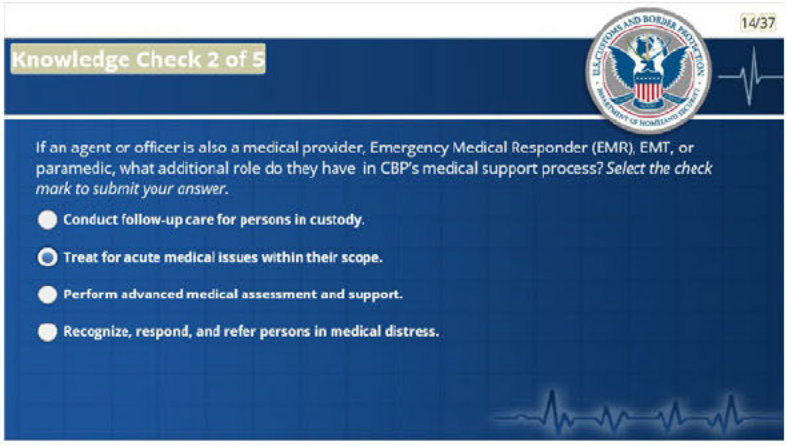



**Incorrect (Slide Layer)**




## *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. |

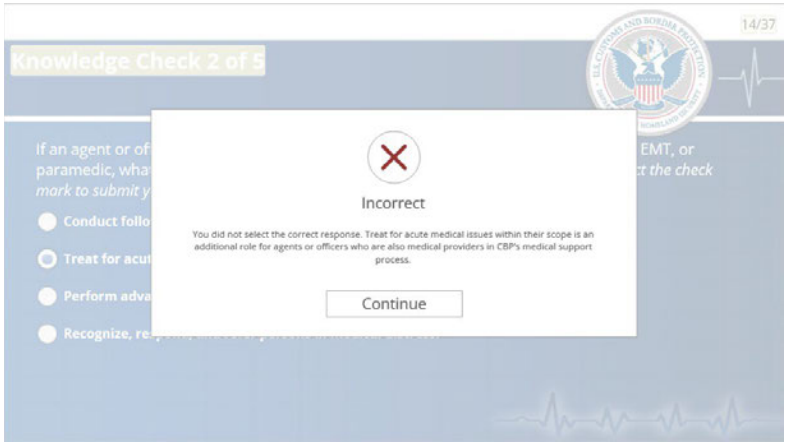
**Feedback when correct:**

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.

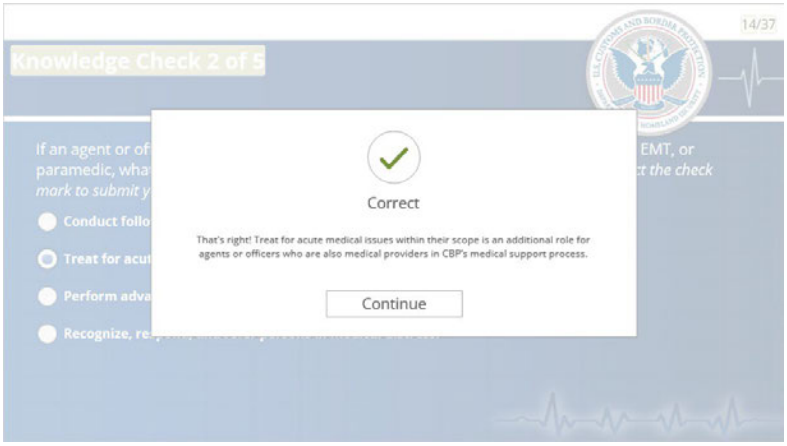
**Feedback when incorrect:**

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)**

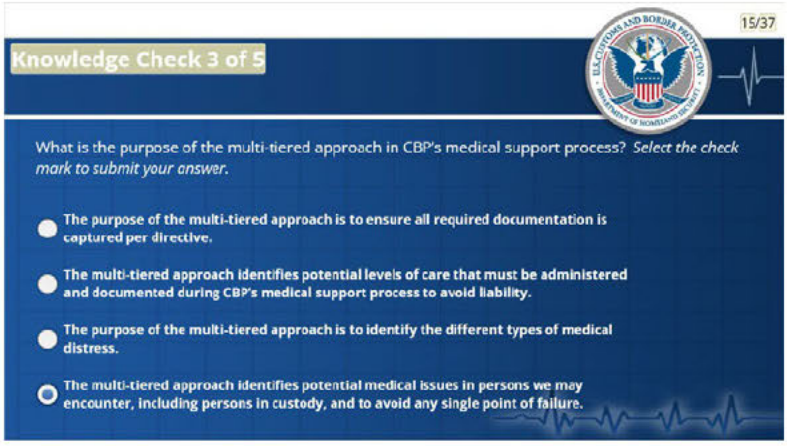



**Correct (Slide Layer)**




## *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.

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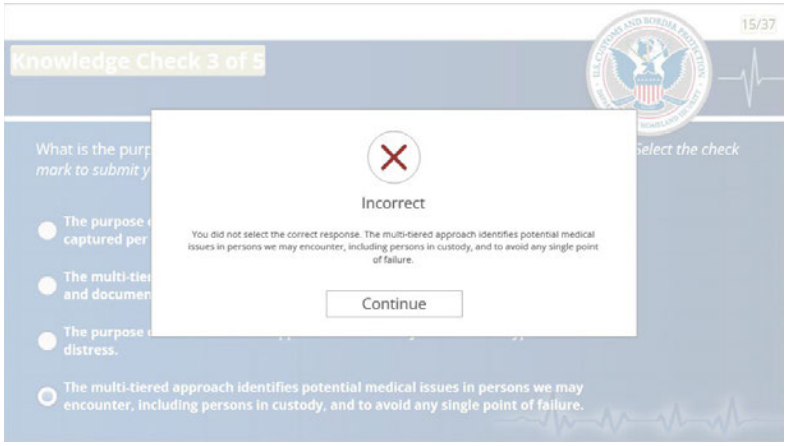
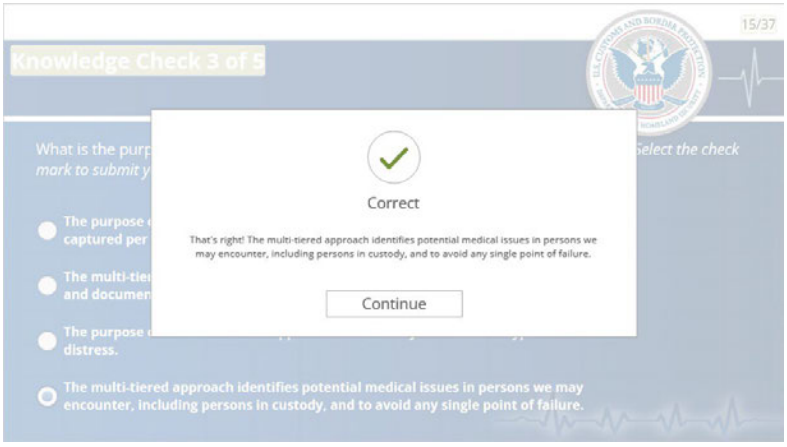
**Incorrect (Slide Layer)**




**Correct (Slide Layer)**




## *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. |

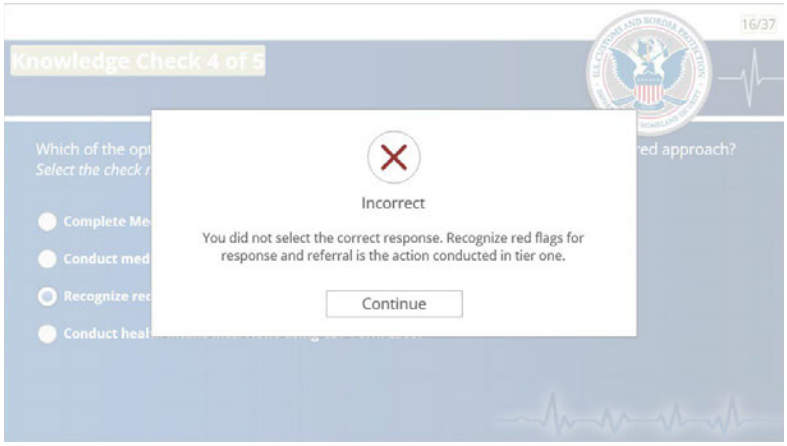
**Feedback when correct:**

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

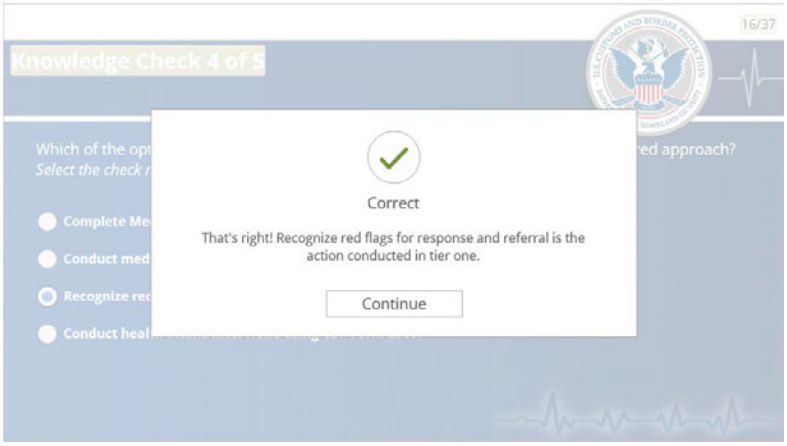
**Feedback when incorrect:**

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

**Incorrect (Slide Layer)**

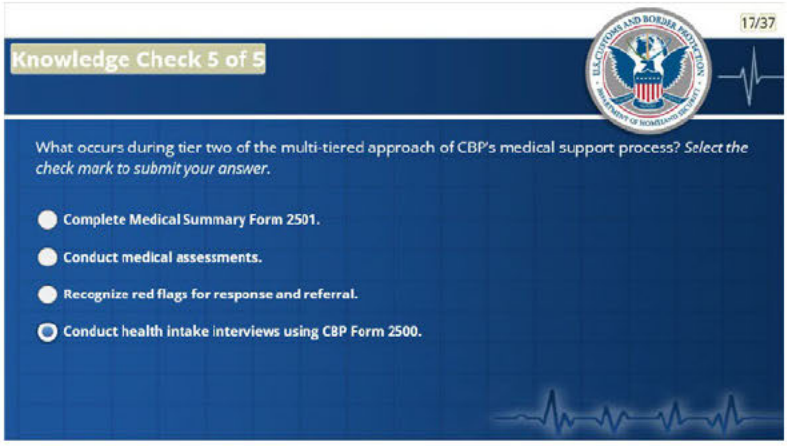



**Correct (Slide Layer)**




## *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:**

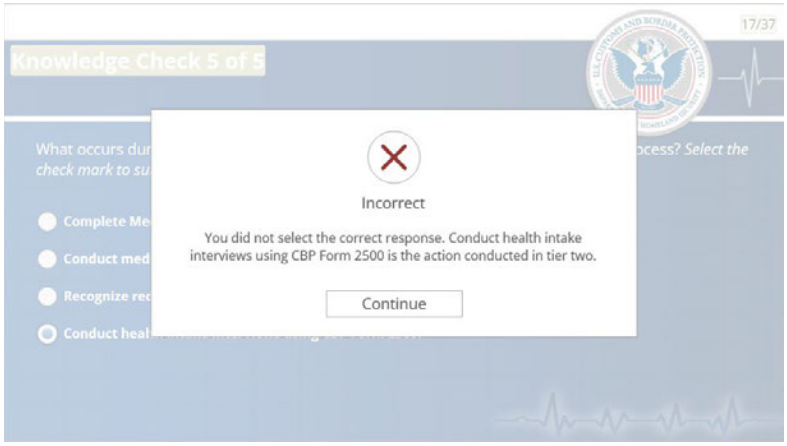
That's right! Conduct health intake interviews using CBP Form 2500 is the action conducted in tier two.

**Feedback when incorrect:**

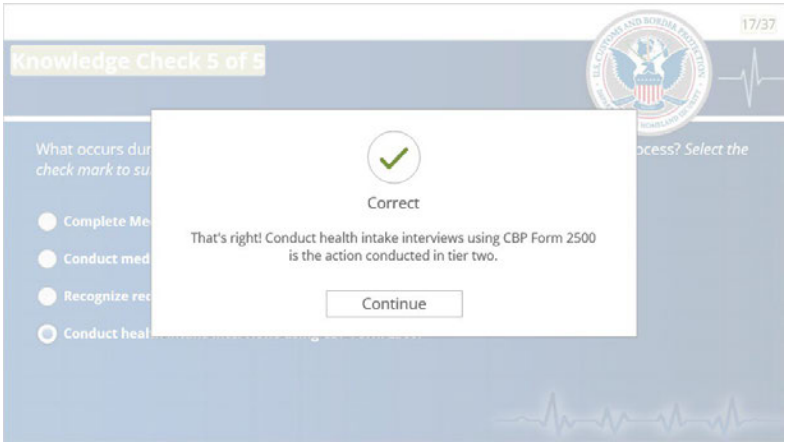
You did not select the correct response. Conduct health intake interviews using CBP Form 2500 is the action conducted in tier two.

**Notes:**

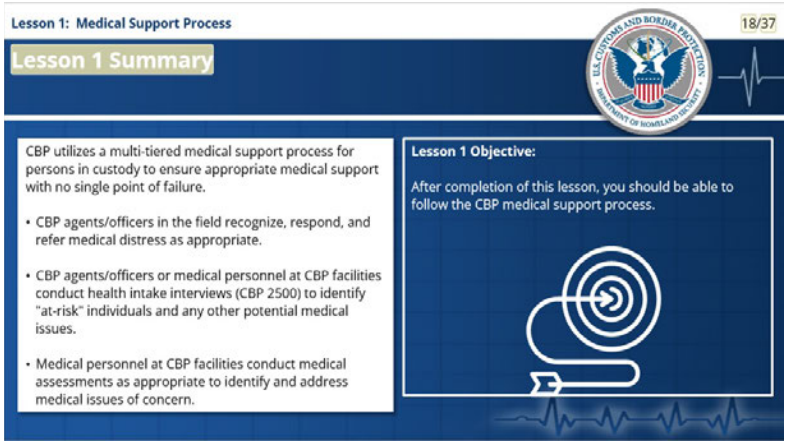
## Incorrect (Slide Layer)




## Correct (Slide Layer)




## *2.13 Lesson 1 Summary*



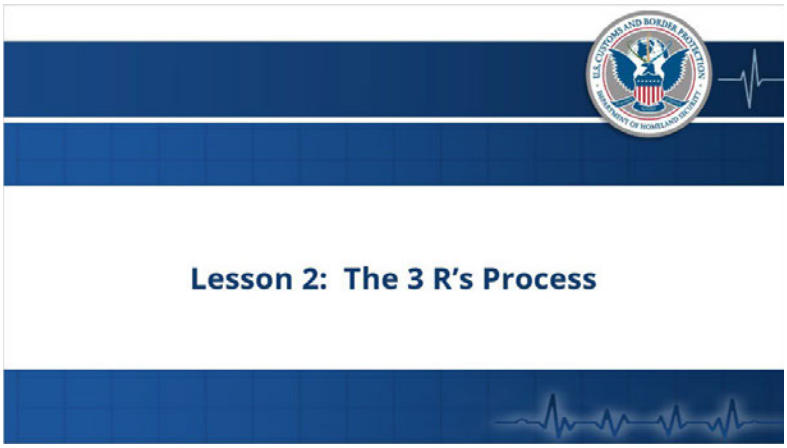
**Notes:**

Audio Narration:

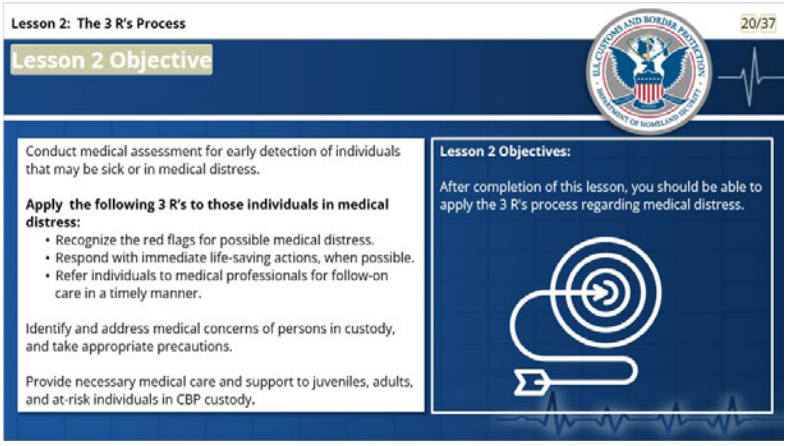
As we conclude this lesson, where we reviewed the medical support process, remember that – although others may have direct responsibilities in responding to an individual needing medical attention, your ethical responsibility as a CBP employee remains.  You play a key role in recognizing and ensuring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

# 3. Lesson 2:  The 3 R's Process

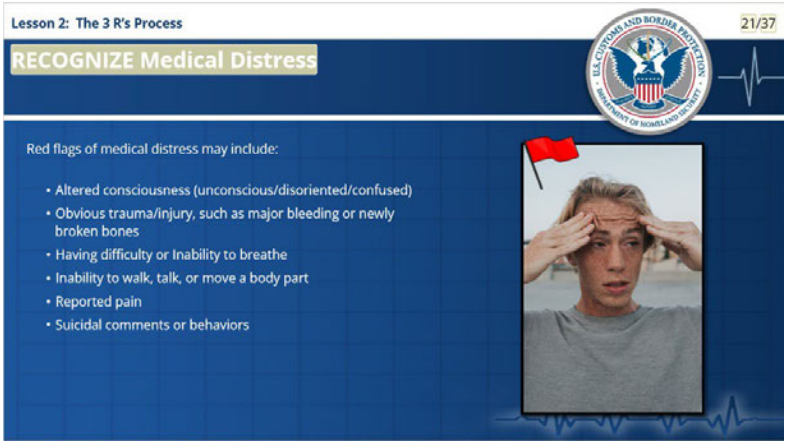
## *3.1 The 3 R's Process*




## *3.2 Lesson 2 Objective*



## *3.3 RECOGNIZE Medical Distress*



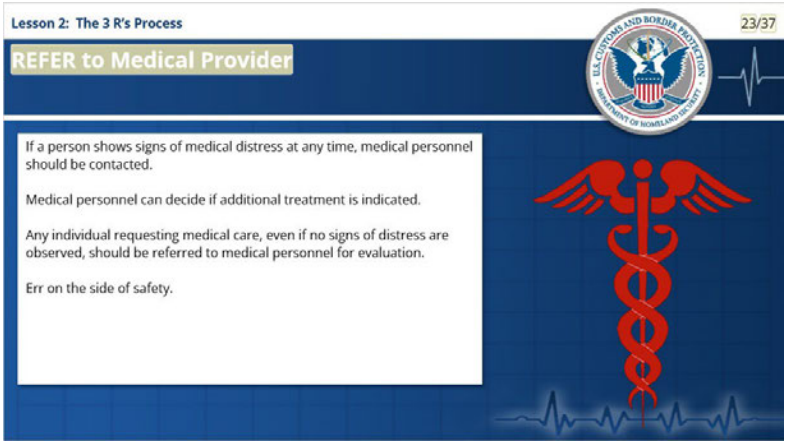

**Notes:**

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*

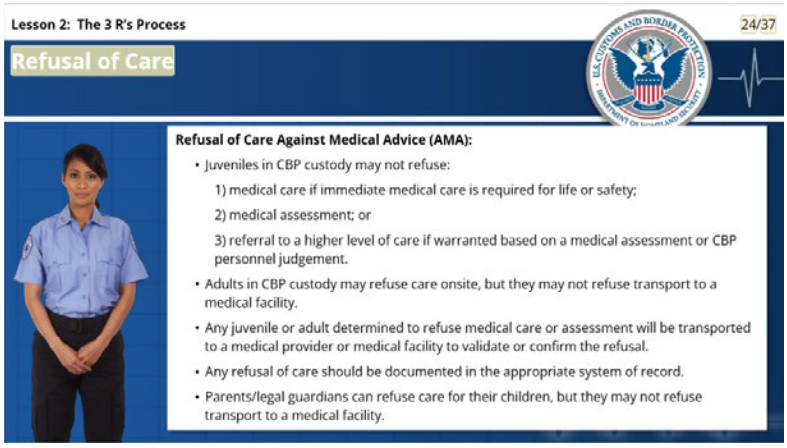



**Notes:**

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:

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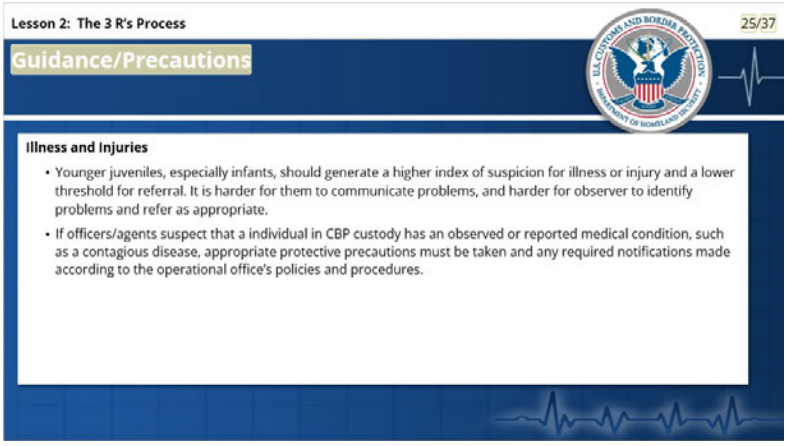
Juveniles in CBP custody may not refuse medical care, if it's required for life or safety. They do not have the right to refuse that.
They cannot refuse a medical assessment and they cannot refuse referral to a higher level of care, if warranted, based on your judgment in the field.
Adults, on the other 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*

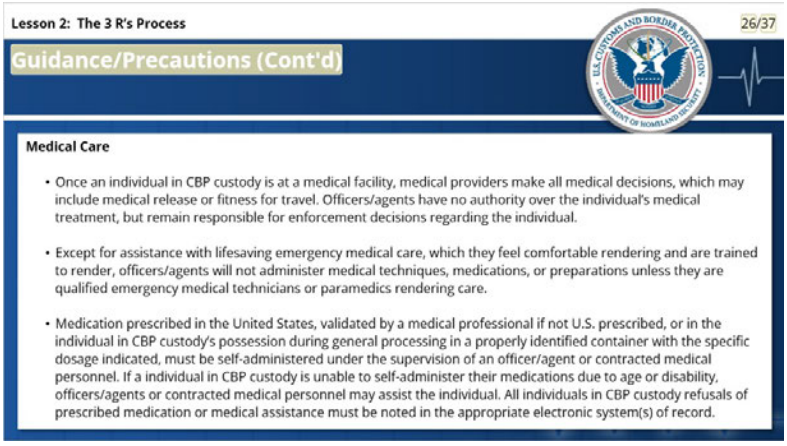



**Notes:**

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)*

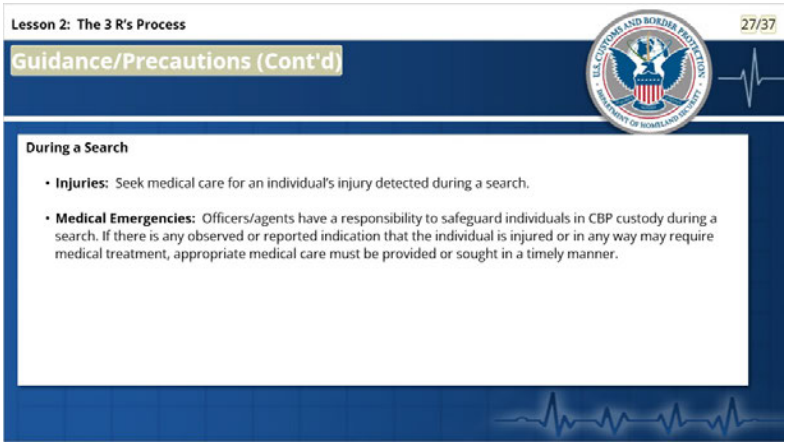



**Notes:**

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.
It can be harder for them to communicate problems. It can also be harder for the observer to identify problems, and referring as appropriate.

## *3.9 Guidance/Precautions (Cont'd)*




**Notes:**

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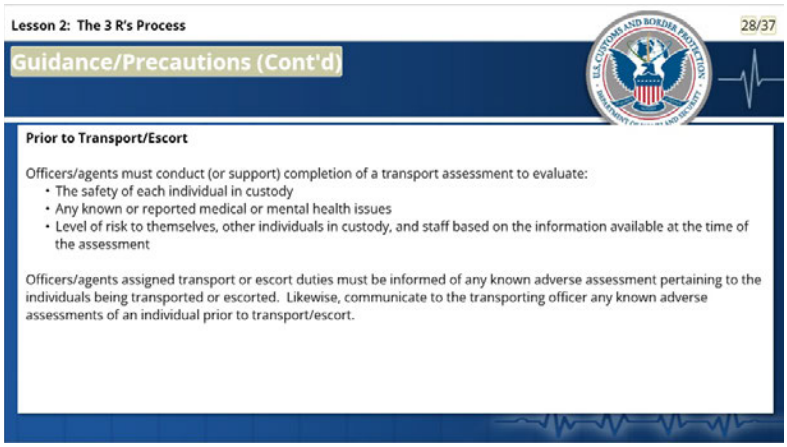
Audio Narration:

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.
It can be harder for them to communicate problems. It can also be harder for the observer to identify problems, and referring as appropriate.

## *3.10 Guidance/Precautions (Cont'd)*

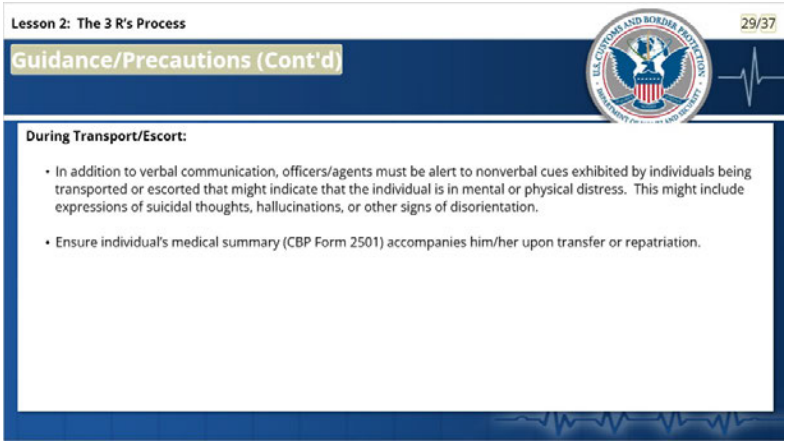



**Notes:**

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.
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.

## *3.11 Guidance/Precautions (Cont'd)*

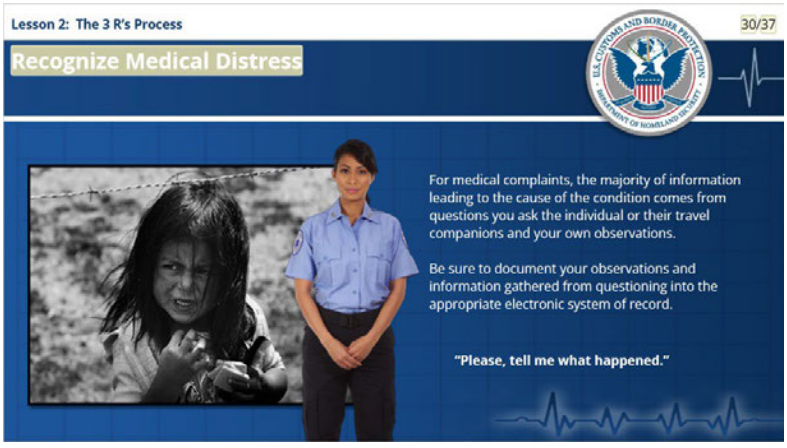



**Notes:**

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.
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.

## *3.12 Recognize Medical Distress*

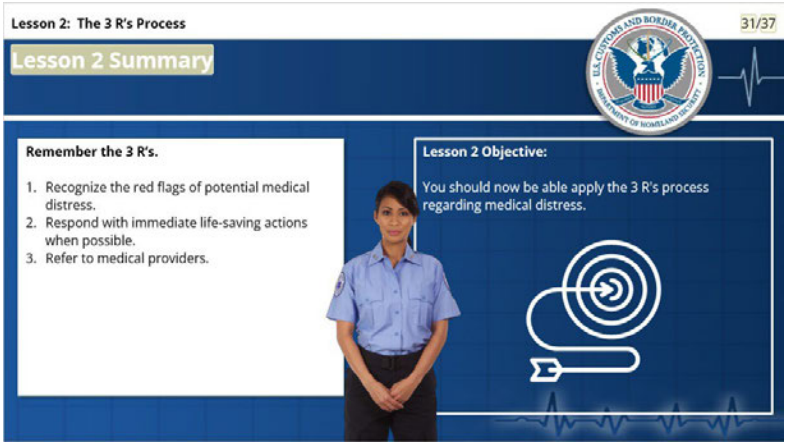



**Notes:**

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.

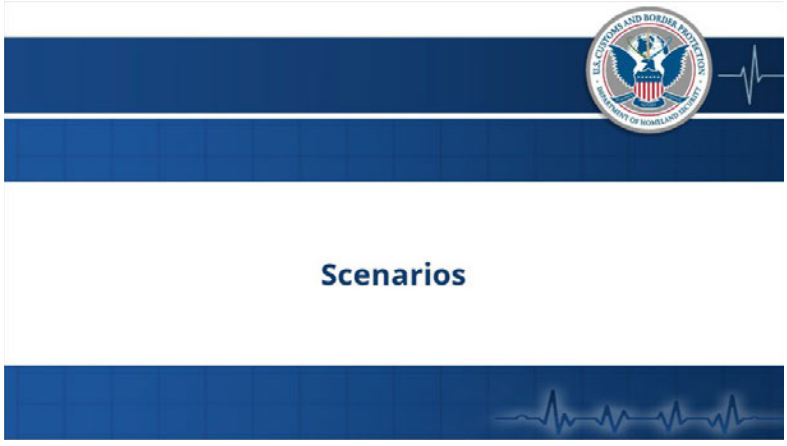
### *3.13 Lesson 2 Summary*




**Notes:**

## 4. Scenarios

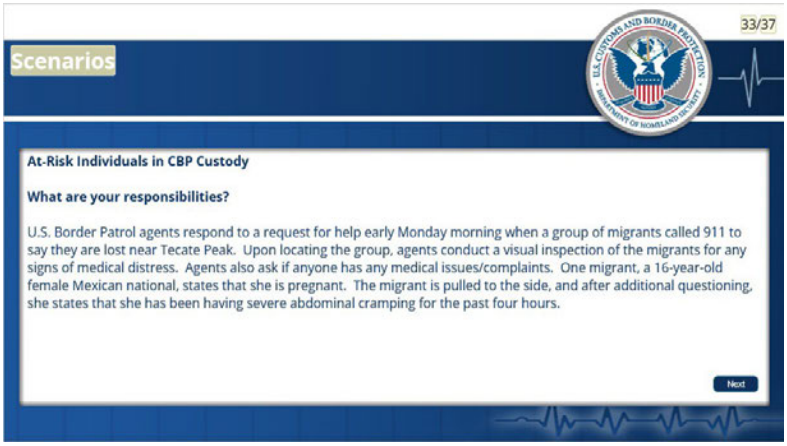
### *4.1 Scenarios*



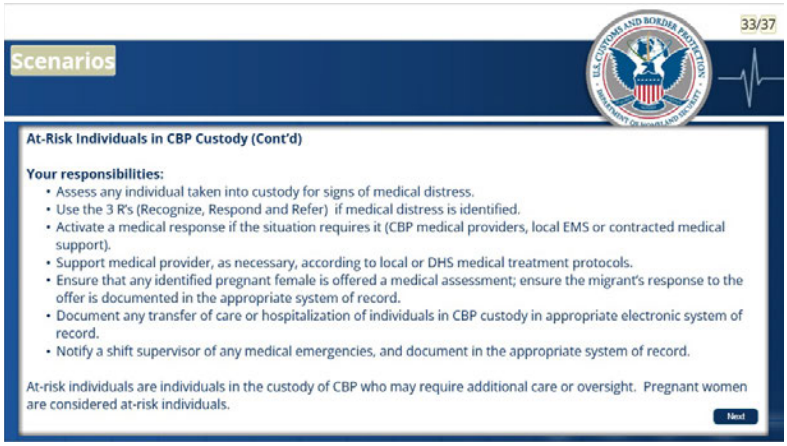
## *4.2 Scenarios*


**Notes:**

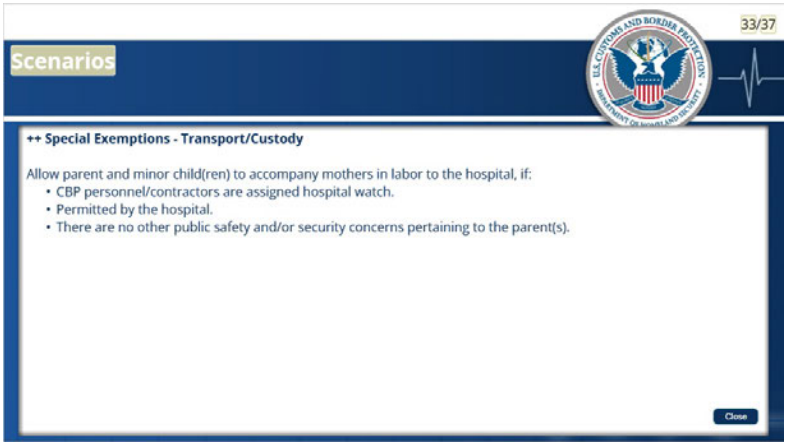
### At-Risk Individuals in CBP Custody (Slide Layer)



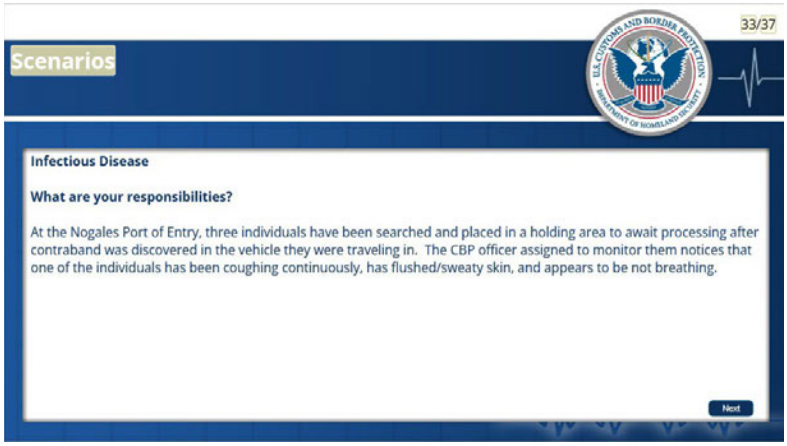
## At-Risk Responsibilities (Slide Layer)



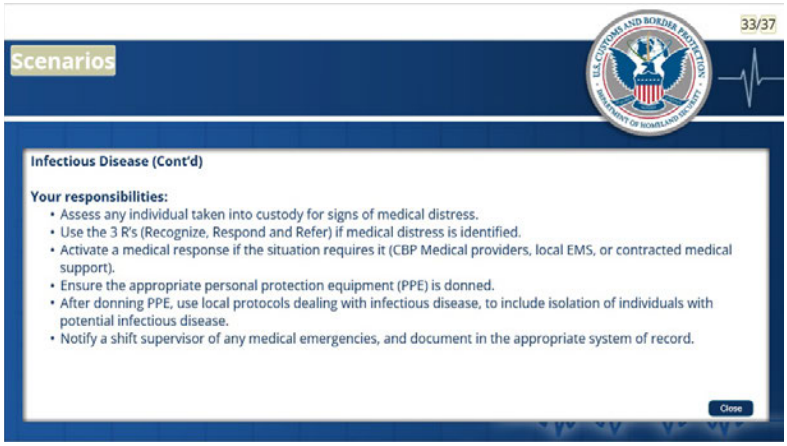

## At-Risk Responsibilities - Copy (Slide Layer)



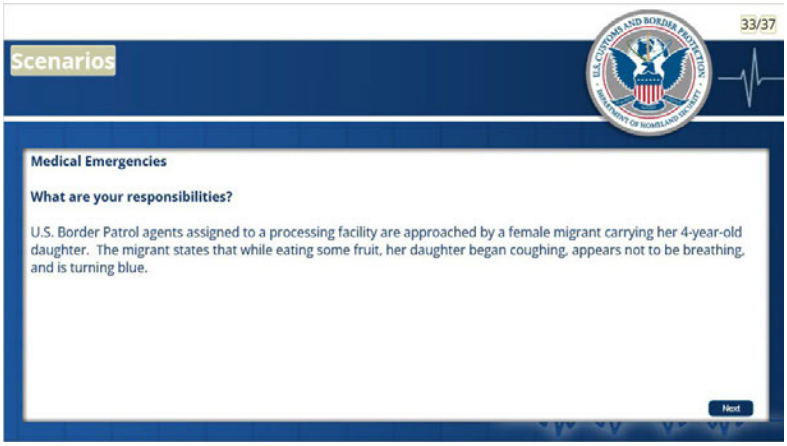

## Infectious Disease (Slide Layer)



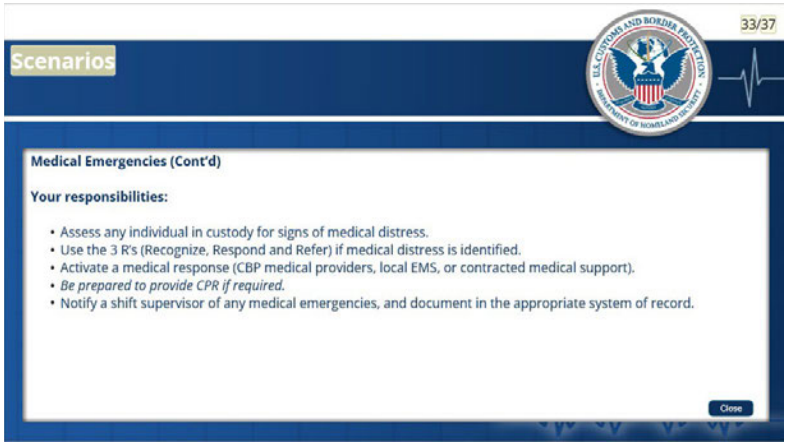
## Infectious Disease Responsibilities (Slide Layer)




## Medical Emergencies (Slide Layer)



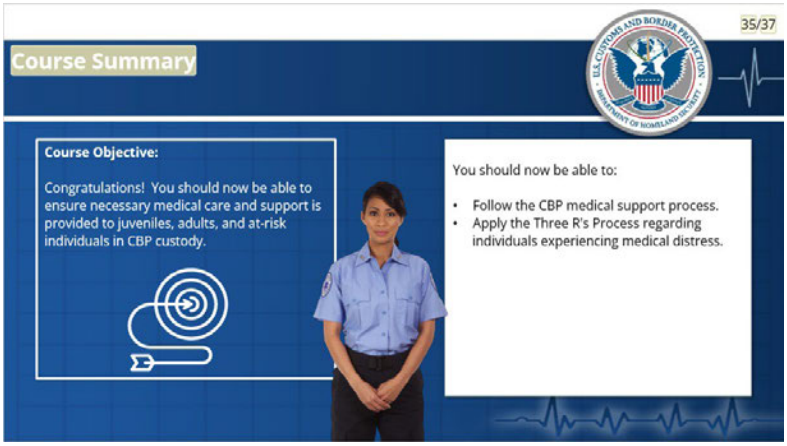

## Medical Emergencies (Cont'd) (Slide Layer)



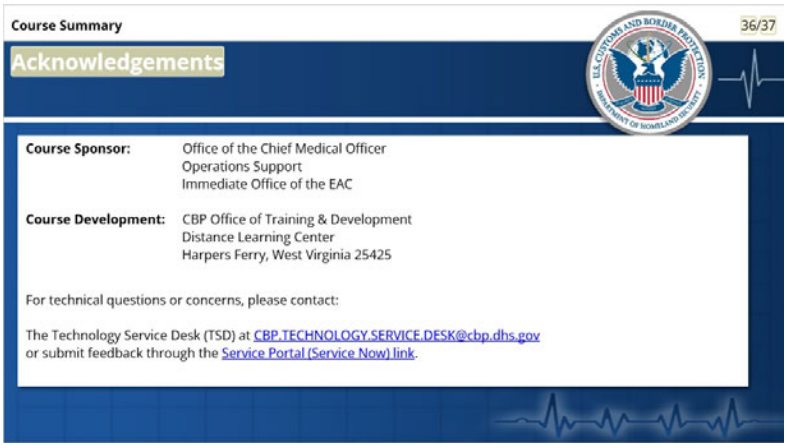
# 5. Course Summary

## *5.1 Course Summary*


## *5.2 Course Summary*

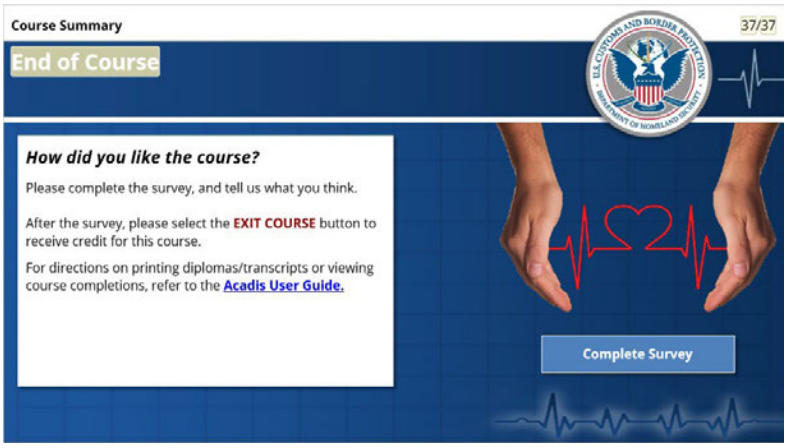


## *5.3 Acknowledgements*




**Notes:**

## *5.4 End of Course*

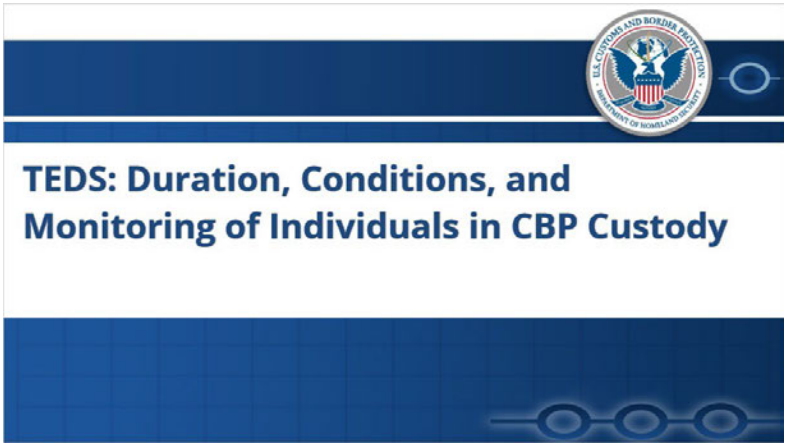


# Key Document B

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

## 1. Course Introduction

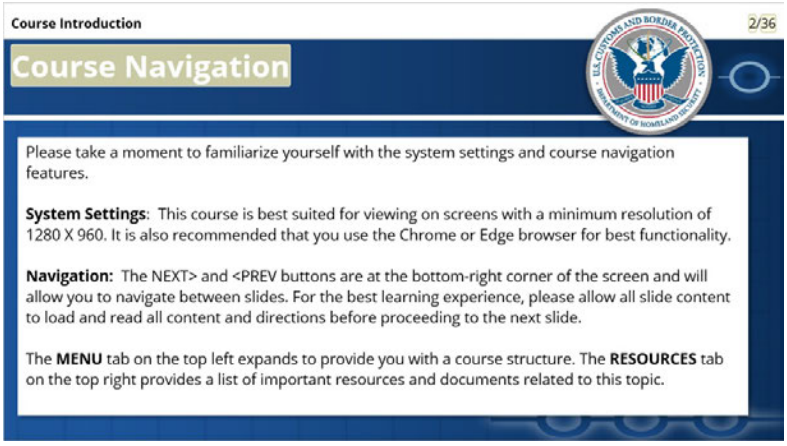
### *1.1 TEDS: Duration, Conditions, and Monitoring of Individuals in CBP Custody*



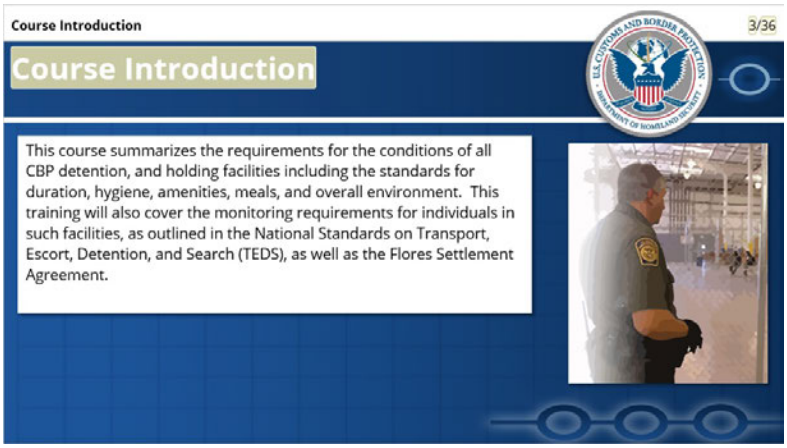

**Audio:**

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.

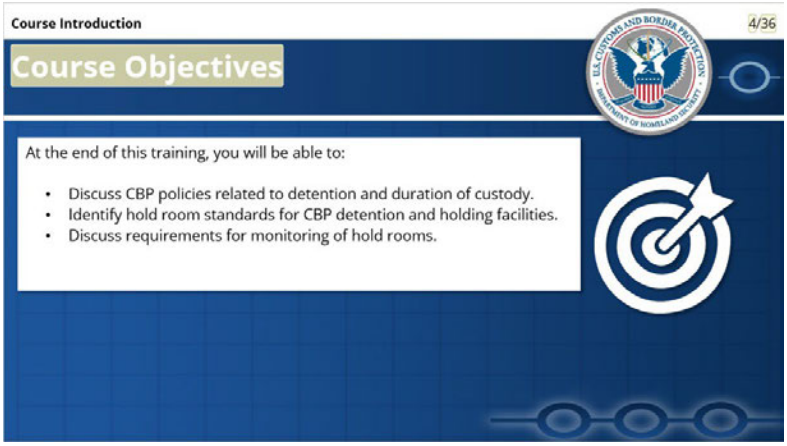
## *1.2 Course Navigation*




## *1.3 Course Introduction*



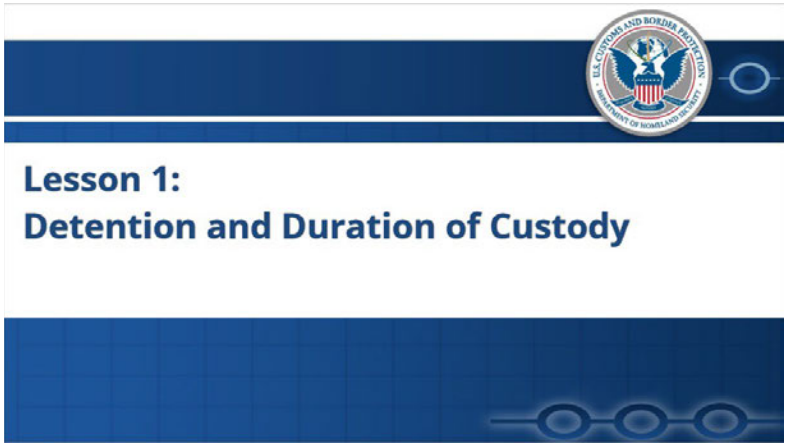

## *1.4 Course Objectives*



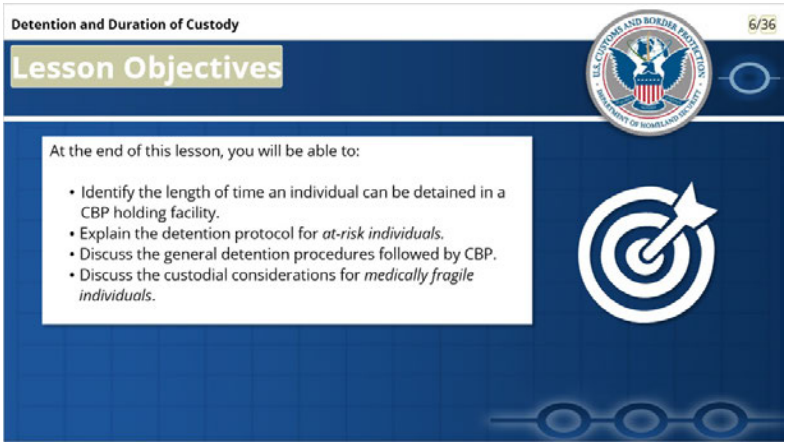
## 2. Detention and Duration of Custody

### *2.1 Lesson 1:*

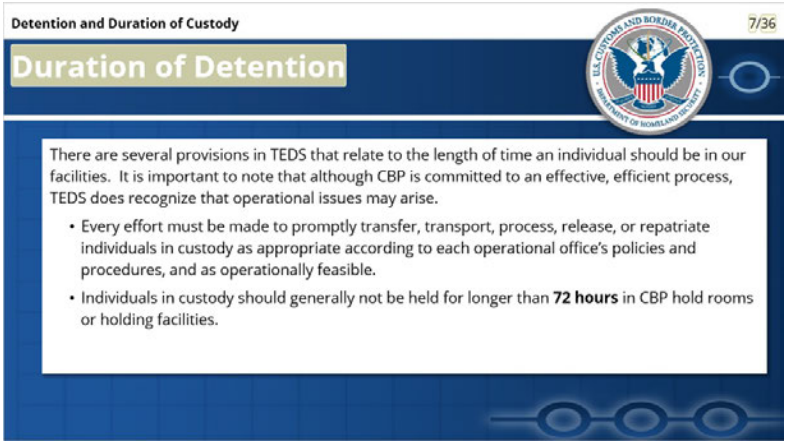
### *Detention and Duration of Custody*



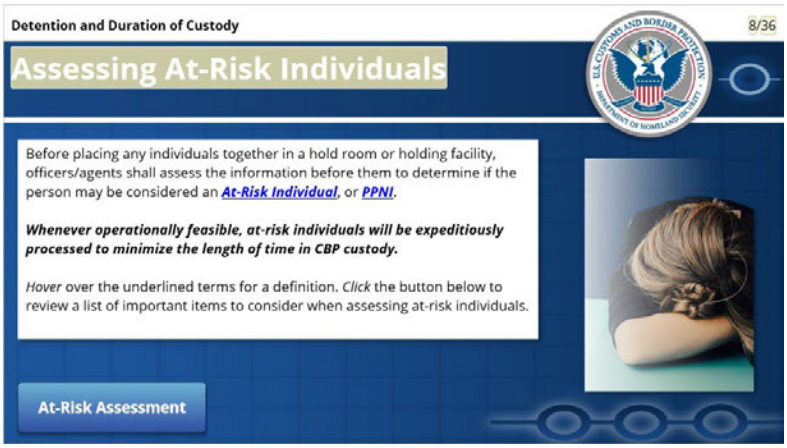

### *2.2 Lesson Objectives*



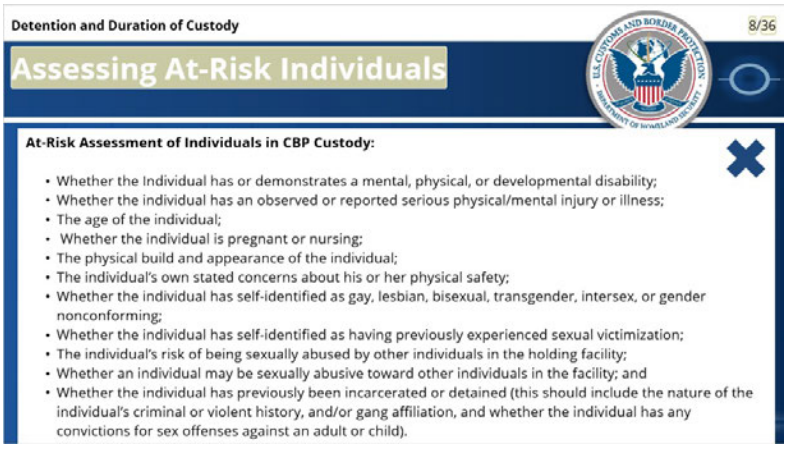
## *2.3 Duration of Detention*



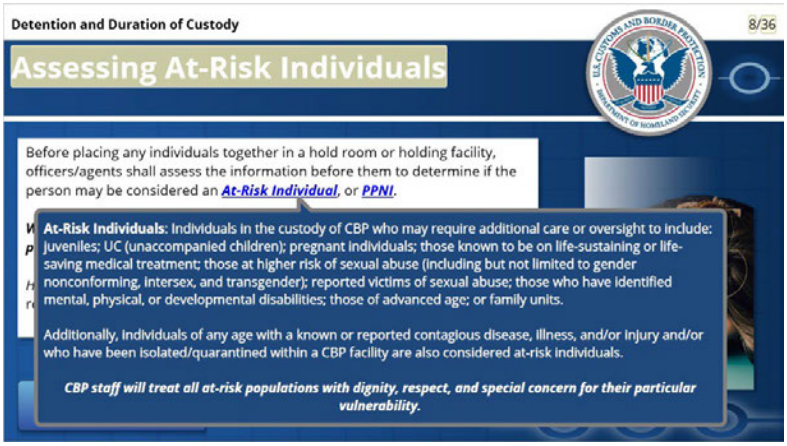

## *2.4 Assessing At-Risk Individuals*



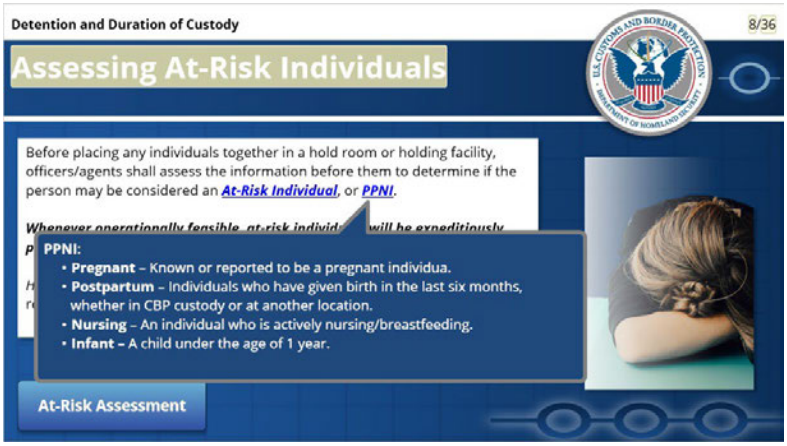

### Assessment (Slide Layer)



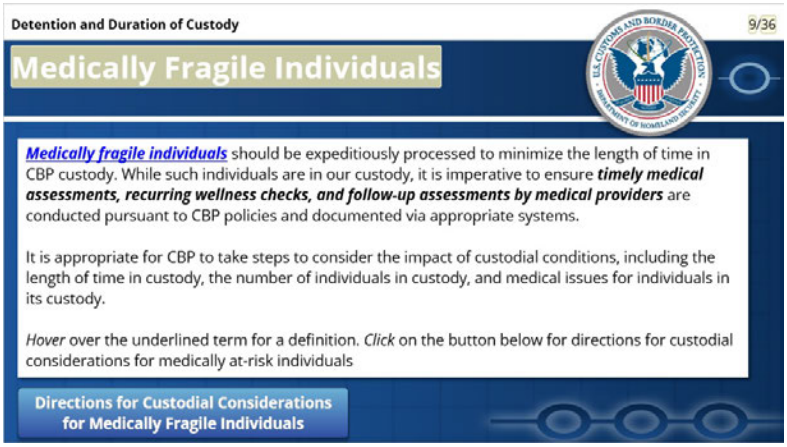
## At-Risk Individuals (Slide Layer)



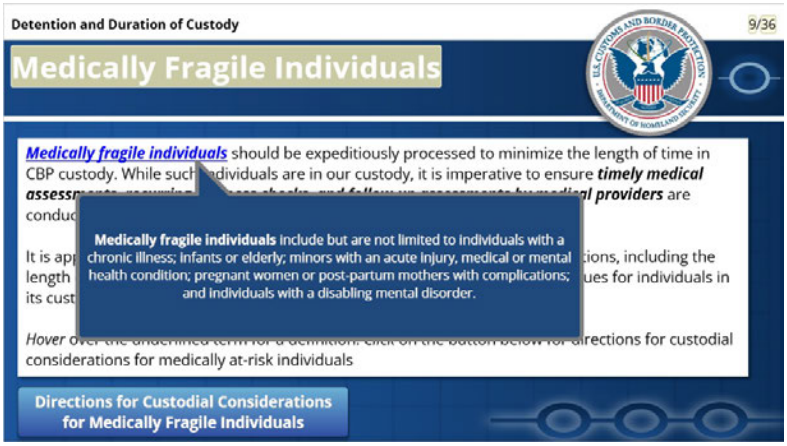

## PPNI (Slide Layer)



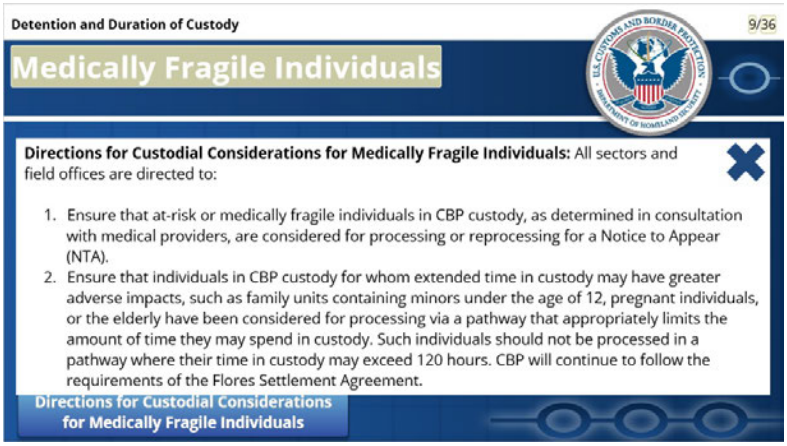

## *2.5 Medically Fragile Individuals*



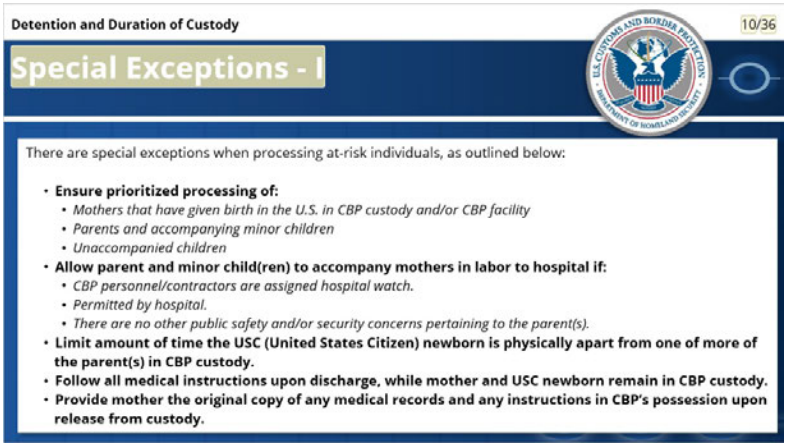
## Medically Fragile (Slide Layer)



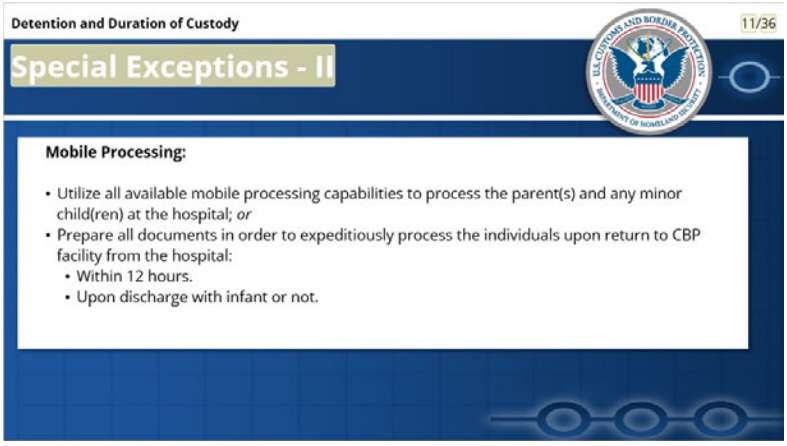

## Directions (Slide Layer)



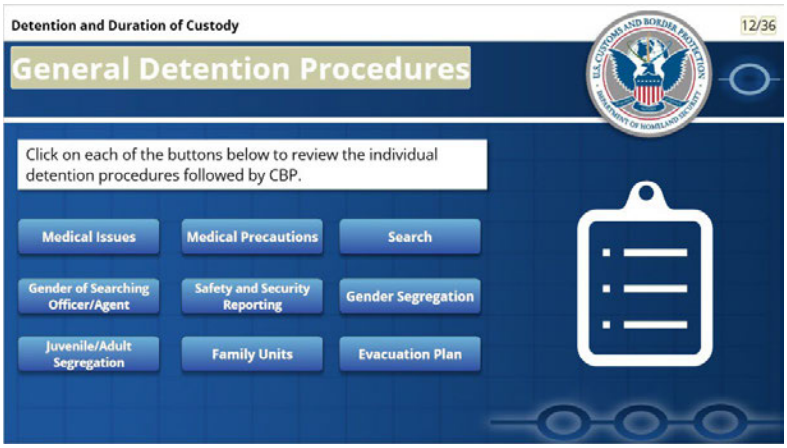

## *2.6 Special Exceptions - I*



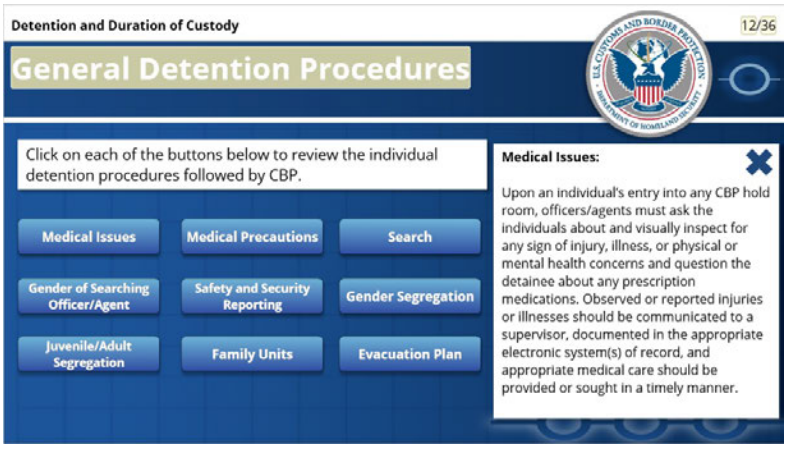
## *2.7 Special Exceptions - II*



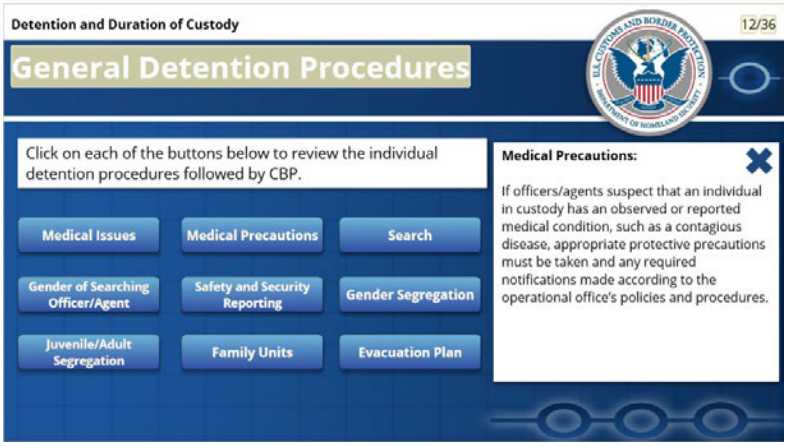

## *2.8 General Detention Procedures*



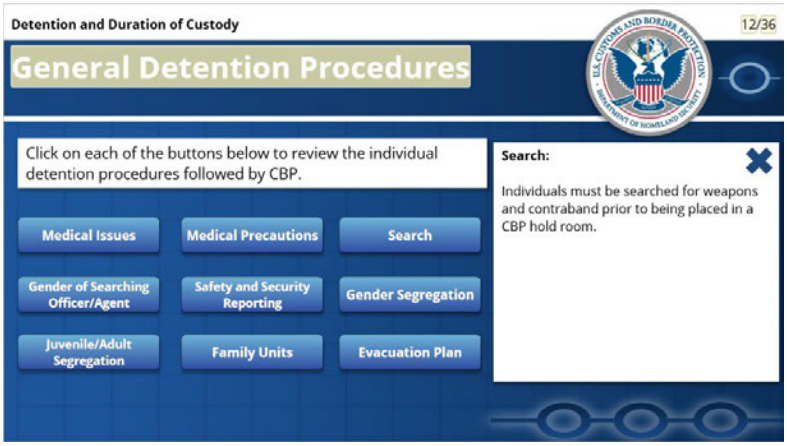

### Medical Issues (Slide Layer)



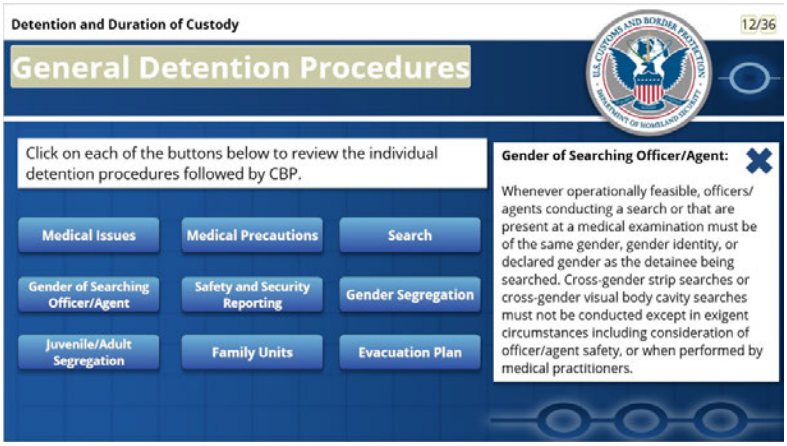
## Medical Precautions (Slide Layer)



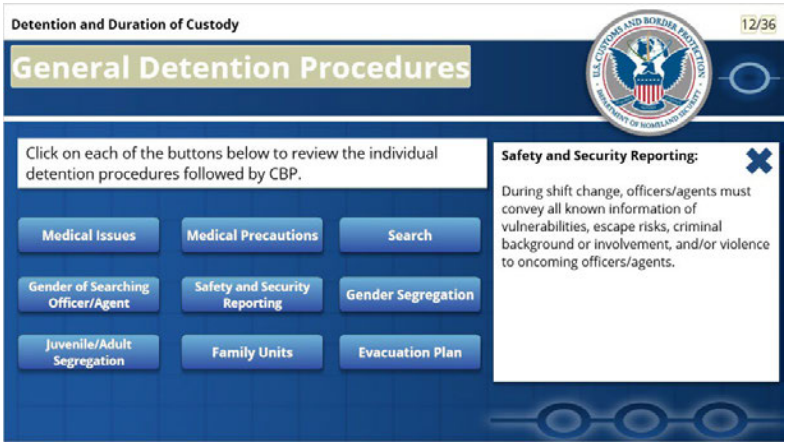

## Search (Slide Layer)



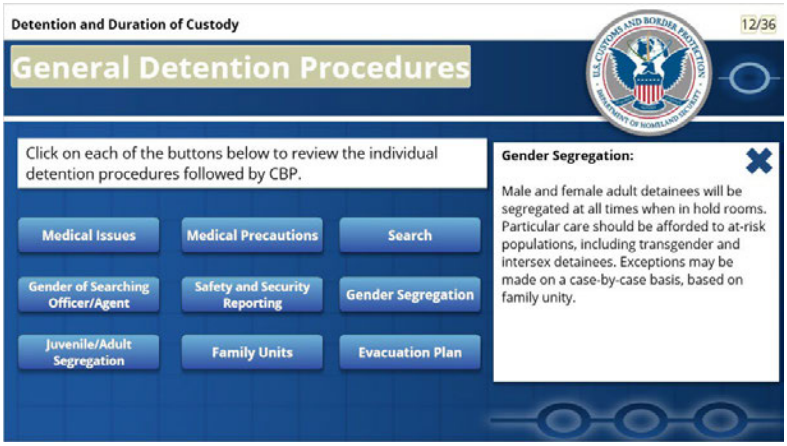

## Gender Search (Slide Layer)



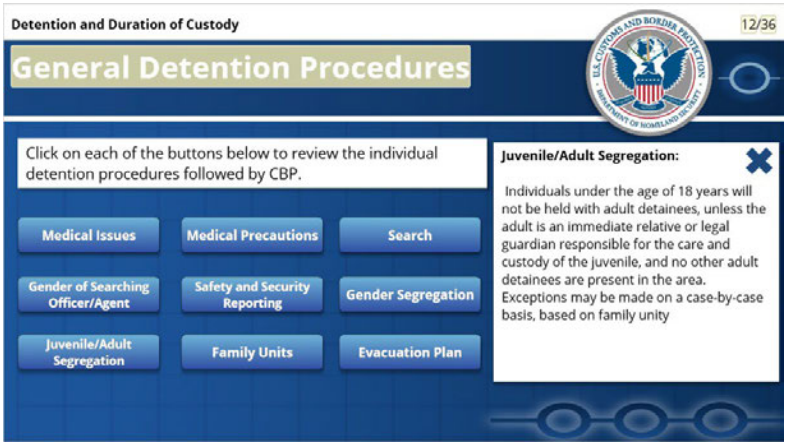
## Safety and Security Reporting (Slide Layer)



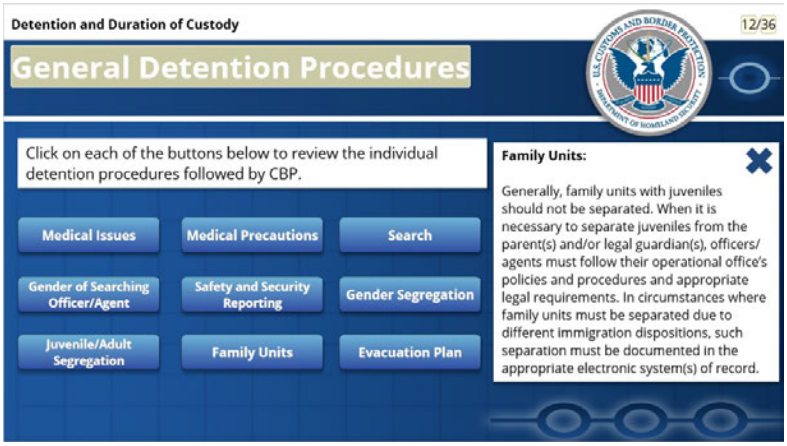

## Gender Segregation (Slide Layer)



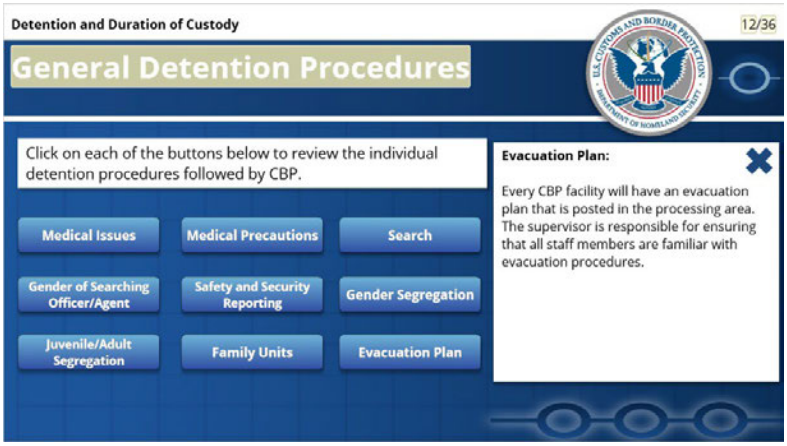

## Juvenile Segregation (Slide Layer)



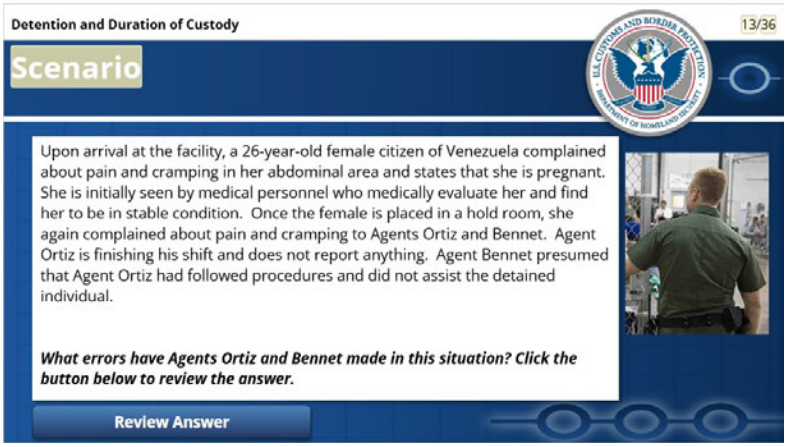
## Family Units (Slide Layer)



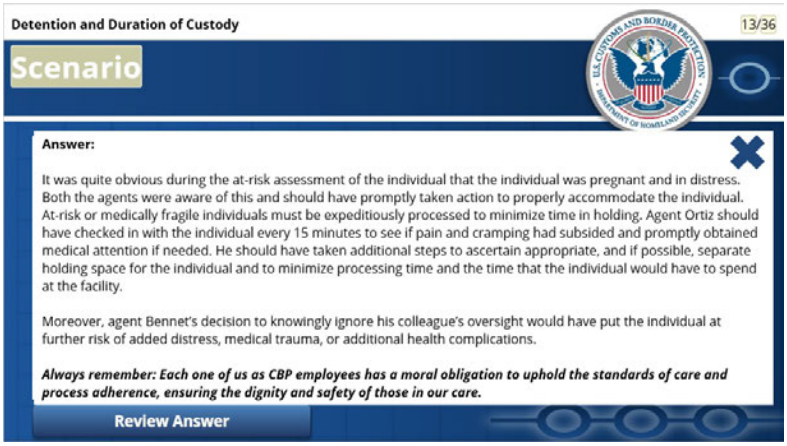

## Evacuation Plans (Slide Layer)



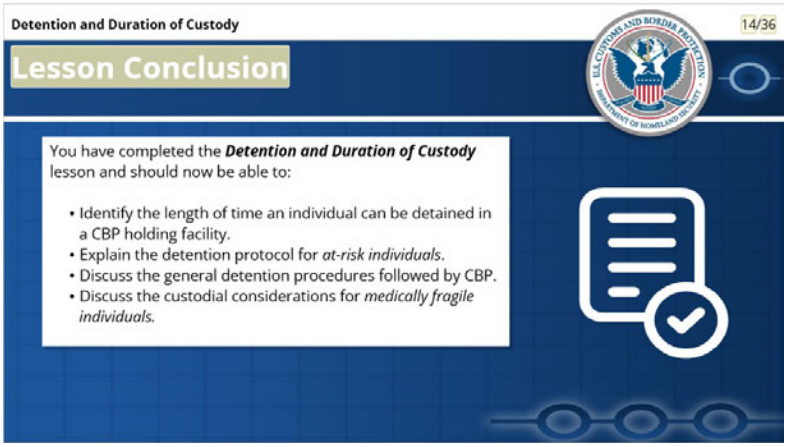

## *2.9 Scenario*



## Answer (Slide Layer)



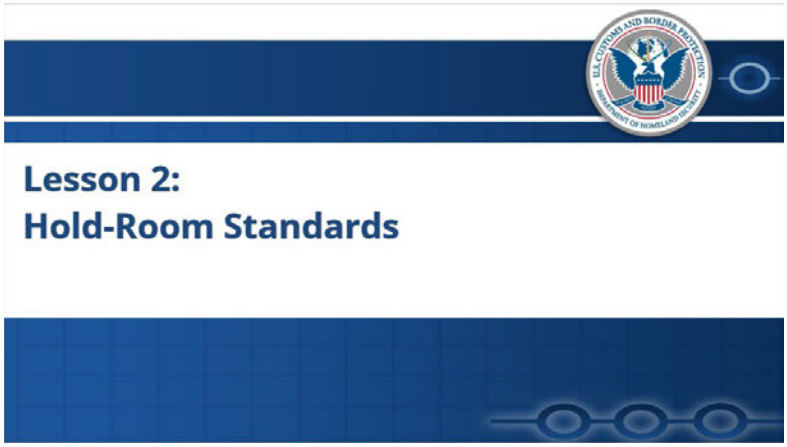

## *2.10 Lesson Conclusion*



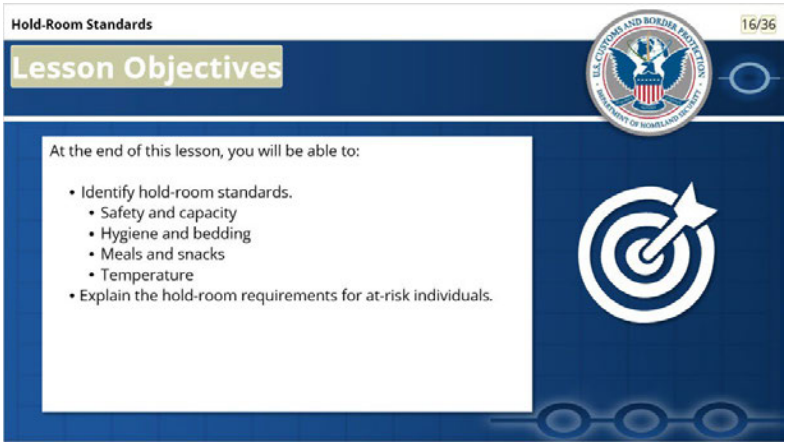
# 3. Hold-Room Standards

## *3.1 Lesson 2:*

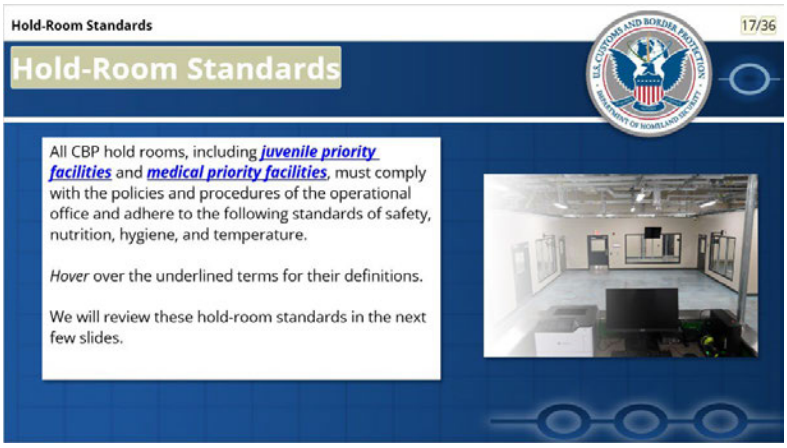
## *Hold-Room Standards*



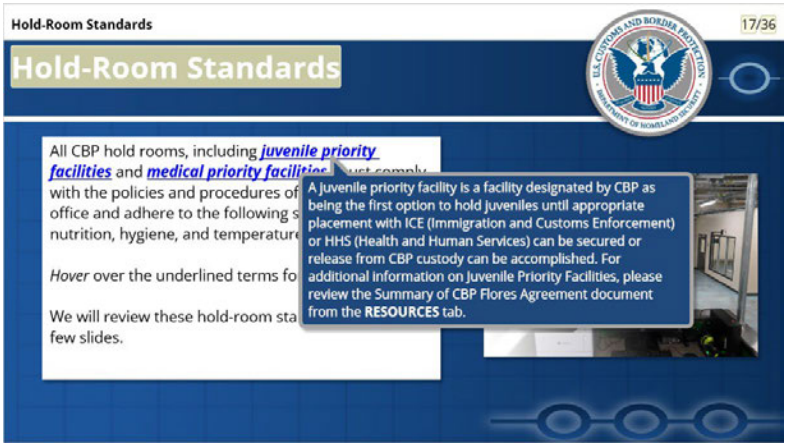

## *3.2 Lesson Objectives*



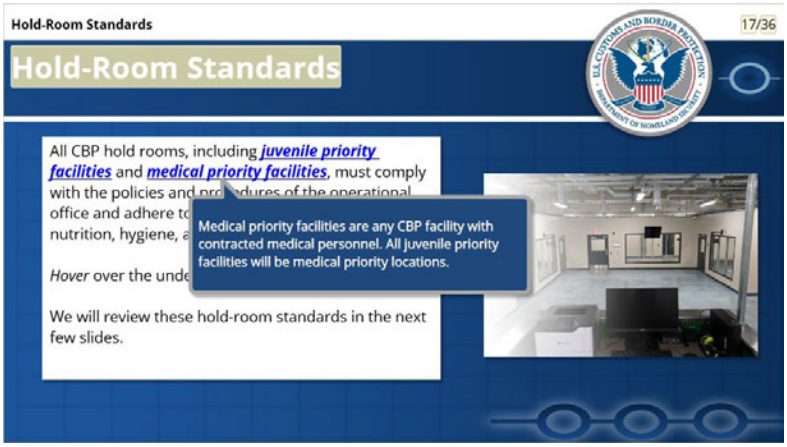
## *3.3 Hold-Room Standards*




### Juvenile Priority Facility (Slide Layer)

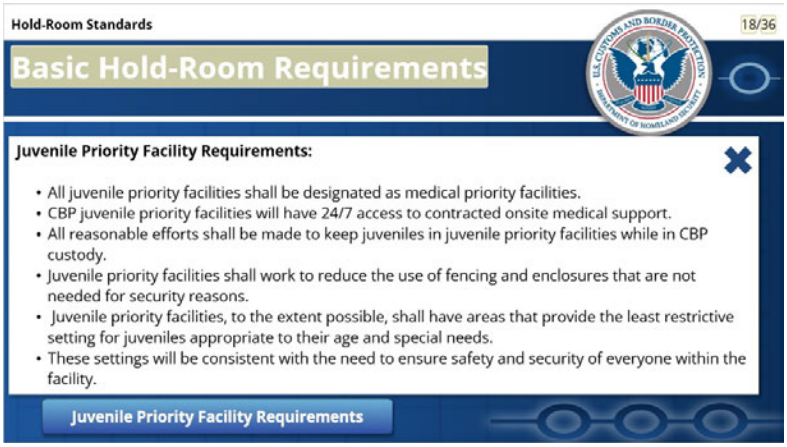



### Medical Priority Facility (Slide Layer)

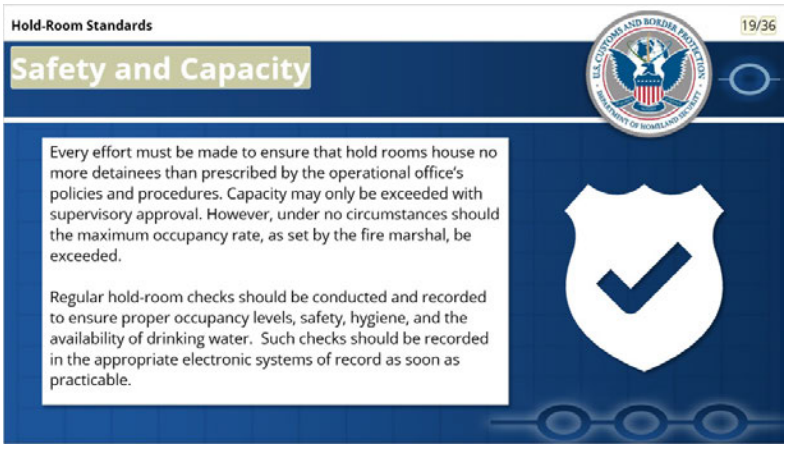


## *3.4 Basic Hold-Room Requirements*

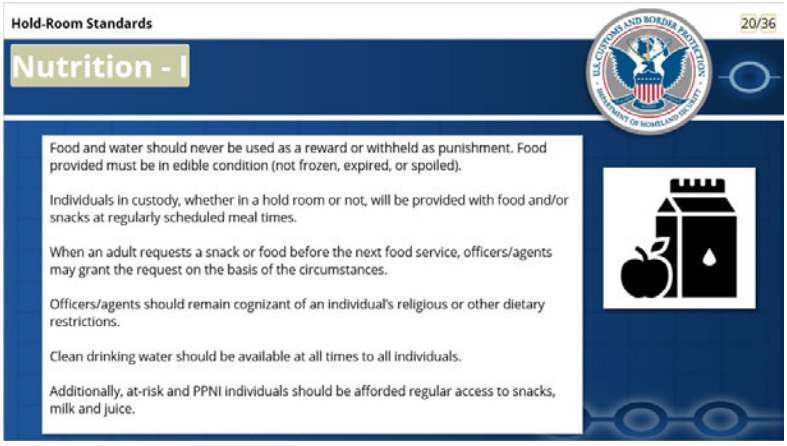

### Juveniles (Slide Layer)



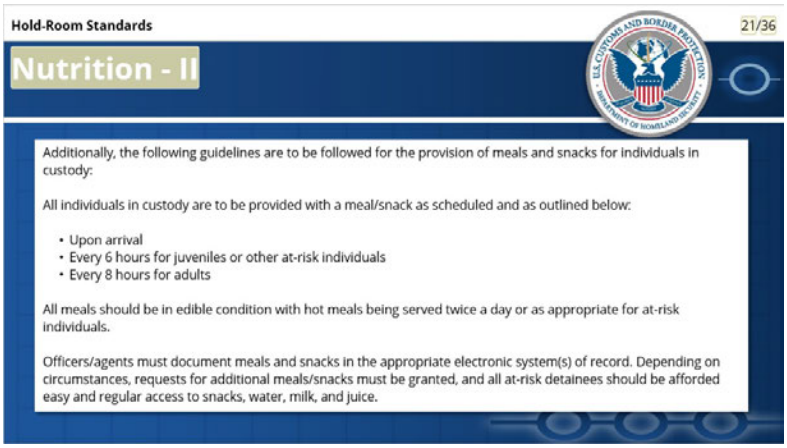

## *3.5 Safety and Capacity*



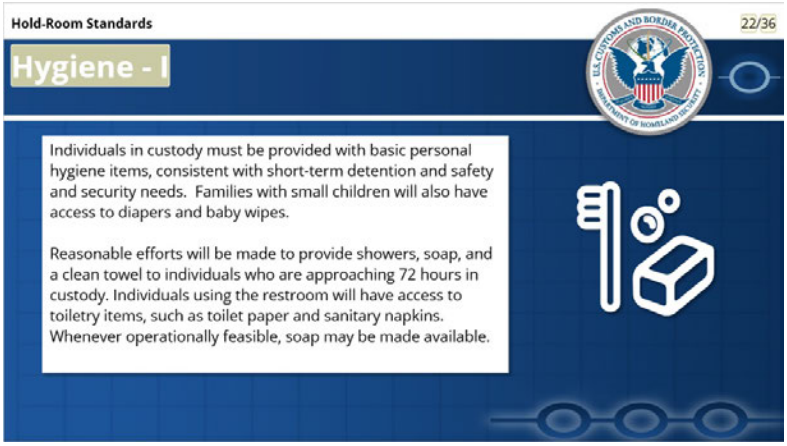
## *3.6 Nutrition - I*



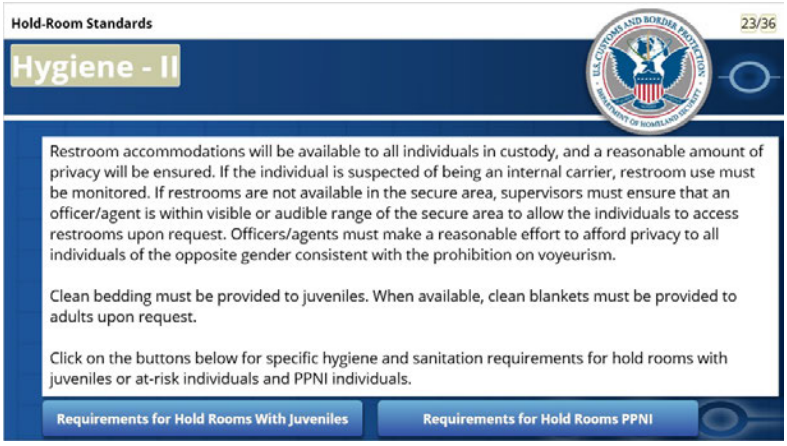

## *3.7 Nutrition - II*



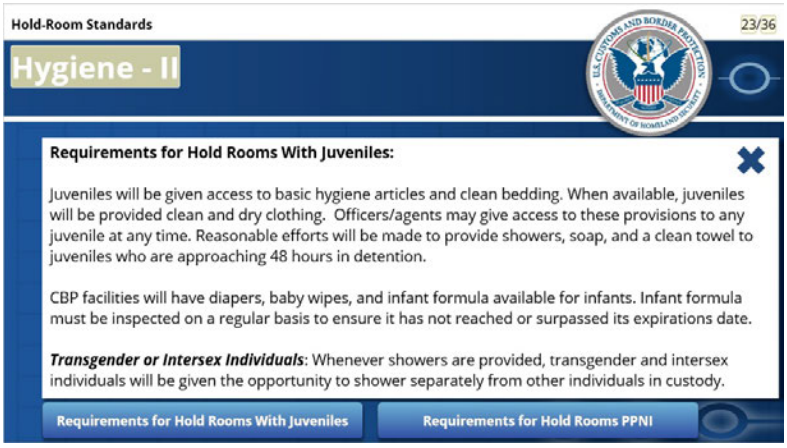

## *3.8 Hygiene - I*



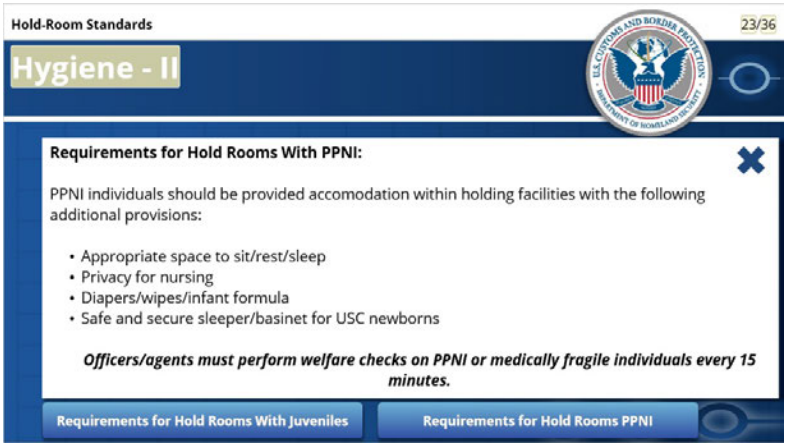
## *3.9 Hygiene - II*



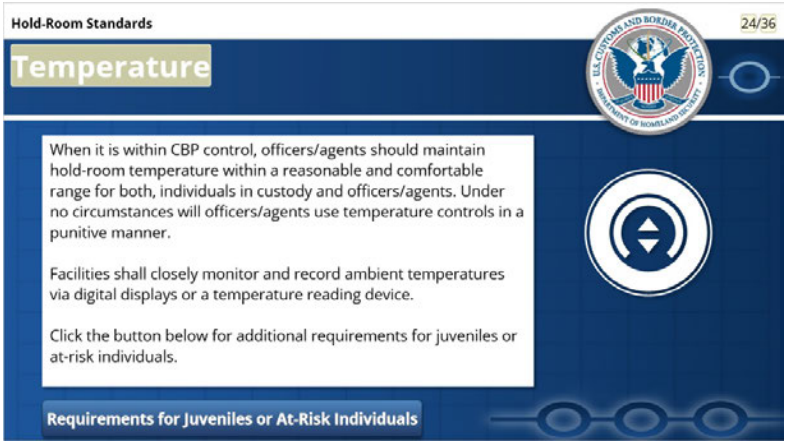

### Juveniles (Slide Layer)



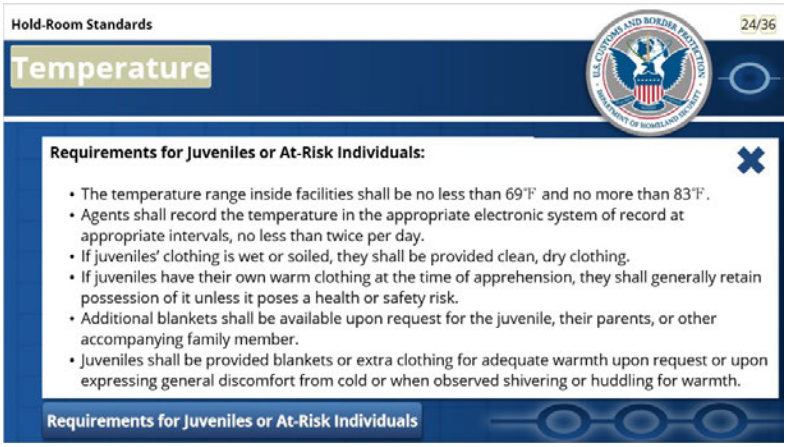

### PPNI (Slide Layer)



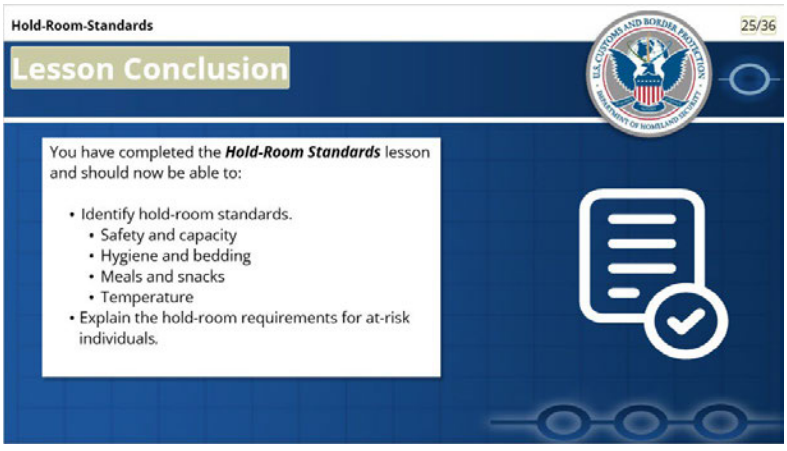
## *3.10 Temperature*




### Juveniles (Slide Layer)



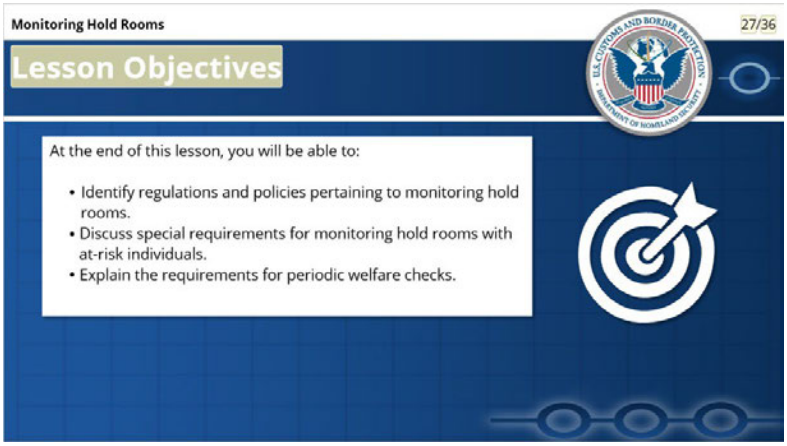

## *3.11 Lesson Conclusion*



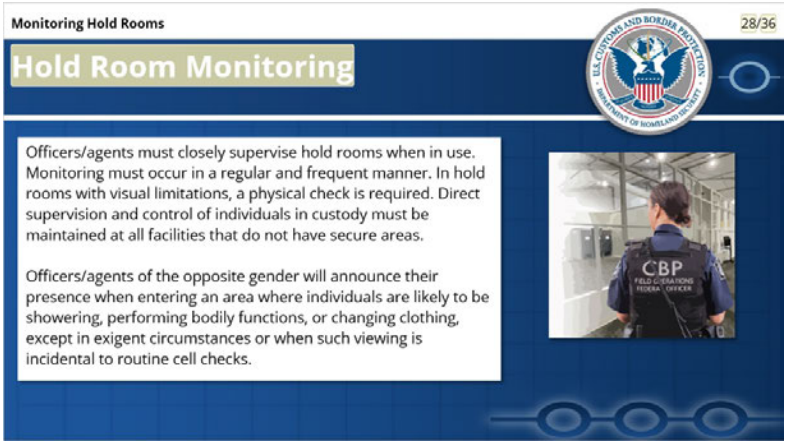
# 4. Monitoring Hold Rooms

## *4.1 Lesson 3:*

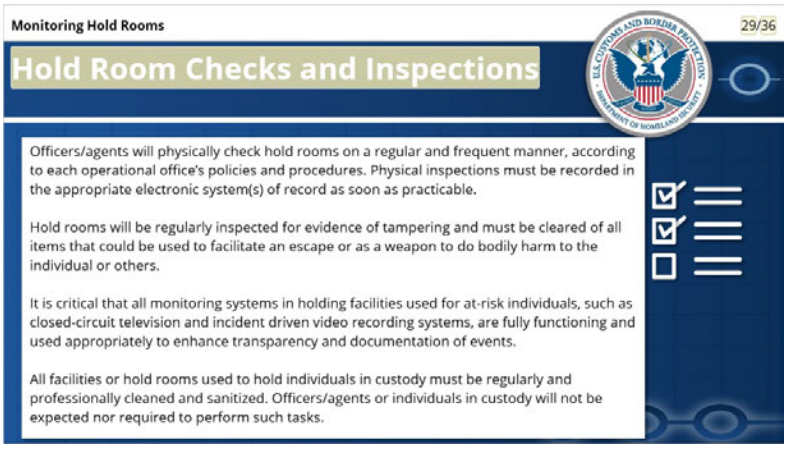

## *4.2 Lesson Objectives*



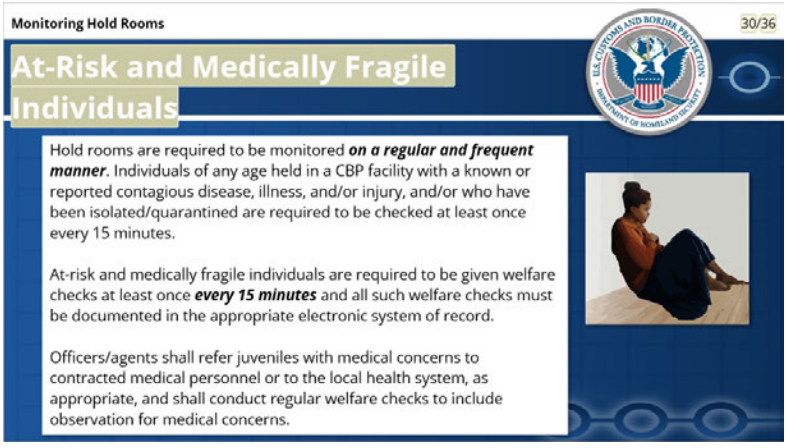
## *4.3 Hold Room Monitoring*



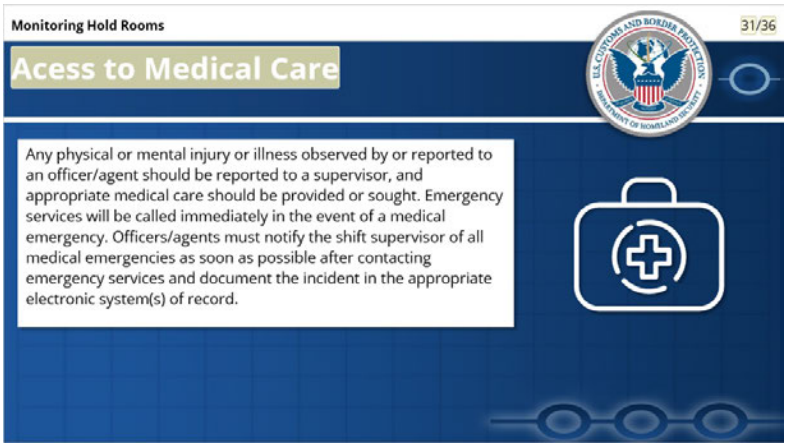

## *4.4 Hold Room Checks and Inspections*



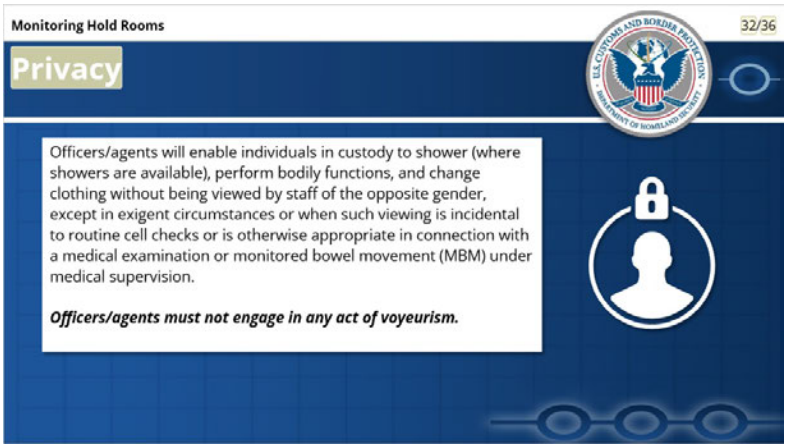

## *4.5 At-Risk and Medically Fragile Individuals*



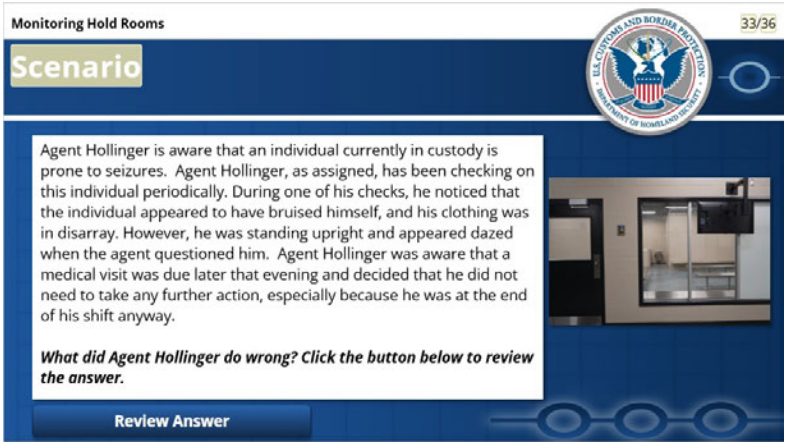
## *4.6 Acess to Medical Care*



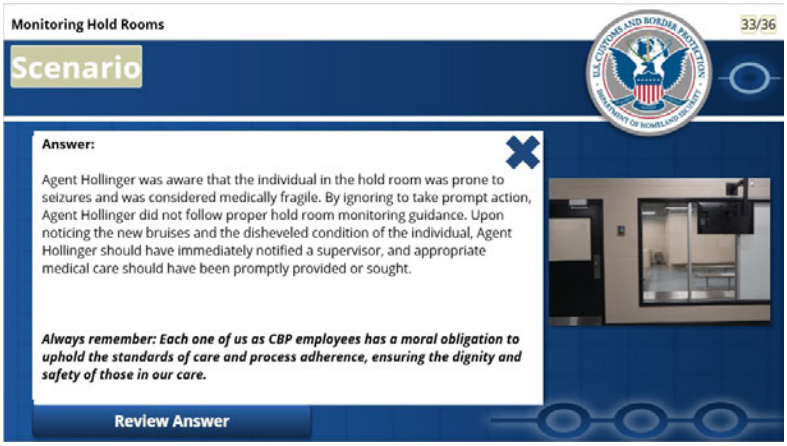

## *4.7 Privacy*



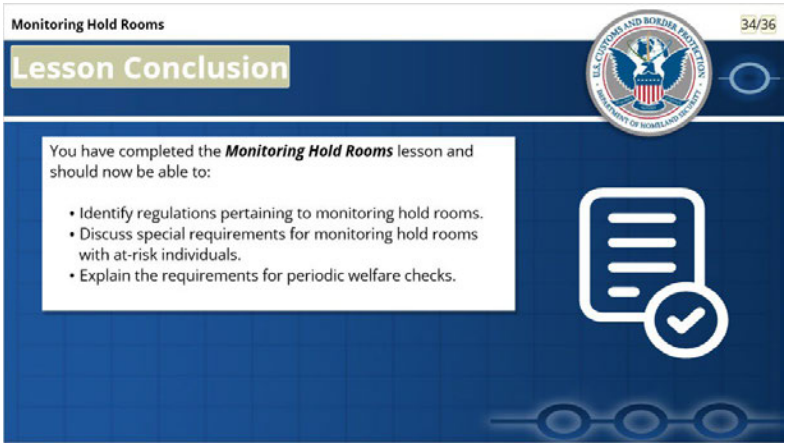

## *4.8 Scenario*



## Answer (Slide Layer)

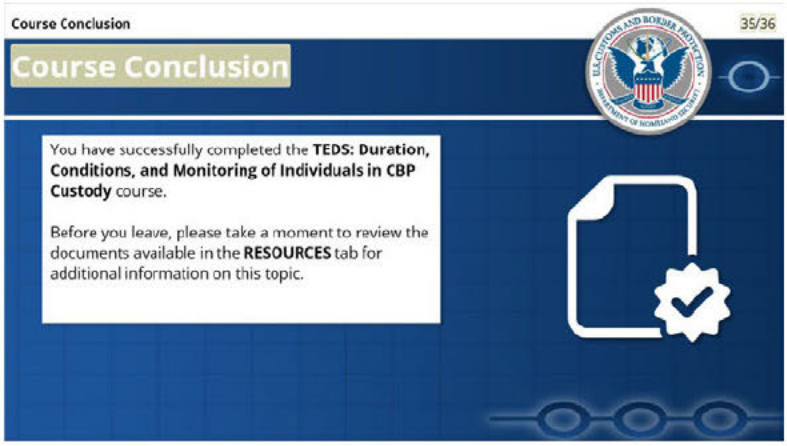



## *4.9 Lesson Conclusion*



# 5. Course Conclusion

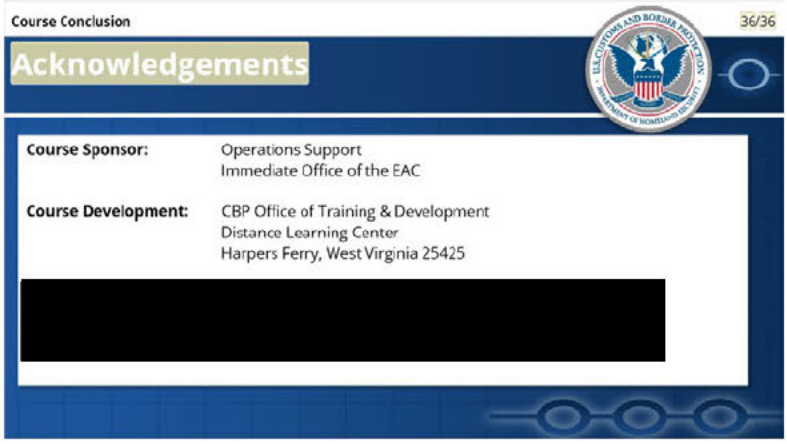
## *5.1 Course Conclusion*




### 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.

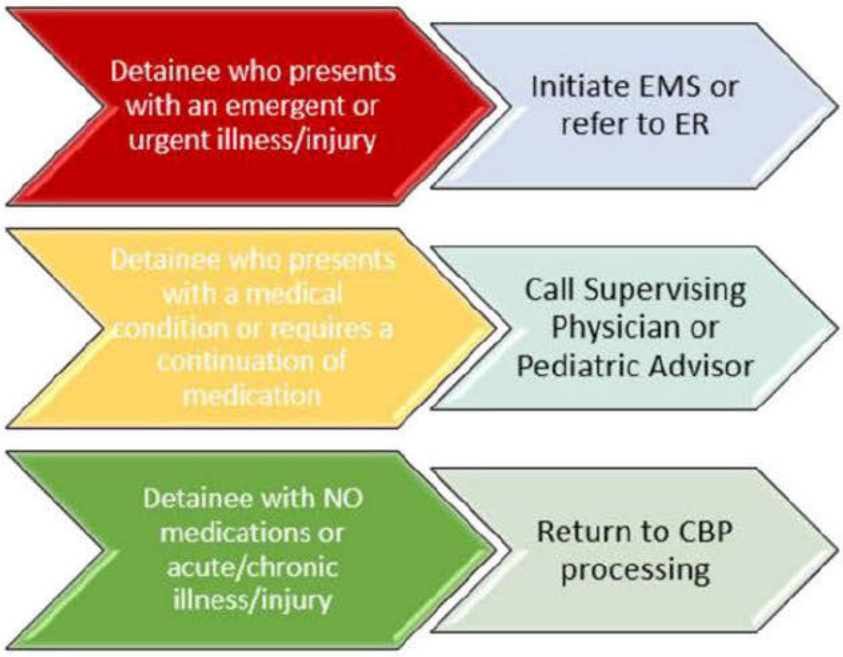
3. Medical Assessment should consist of:

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**

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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.

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[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**

*WARNING: This document is FOR OFFICIAL USE ONLY (FOUO). It contains information that may be exempt from public release under the Freedom of Information Act (5 U.S.C. 552). It is to be controlled, stored, handled, transmitted, distributed, and disposed of in accordance with U.S. Department of Homeland Security (DHS) policy relating to FOUO information and is not to be released to the public or other personnel who do not have a valid "need-to-know" without prior approval of an authorized DHS official.*

# 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

## Table of Contents

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

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

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

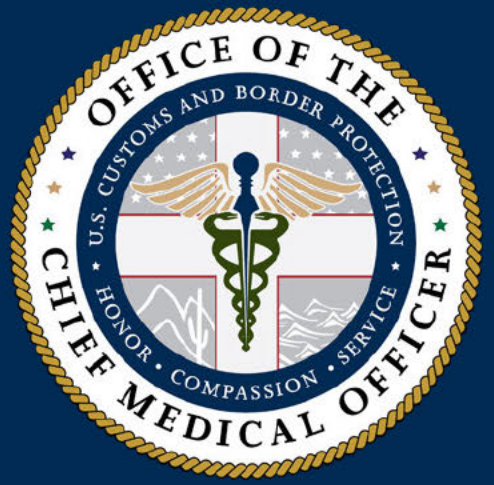
# Key Document P

# 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:*

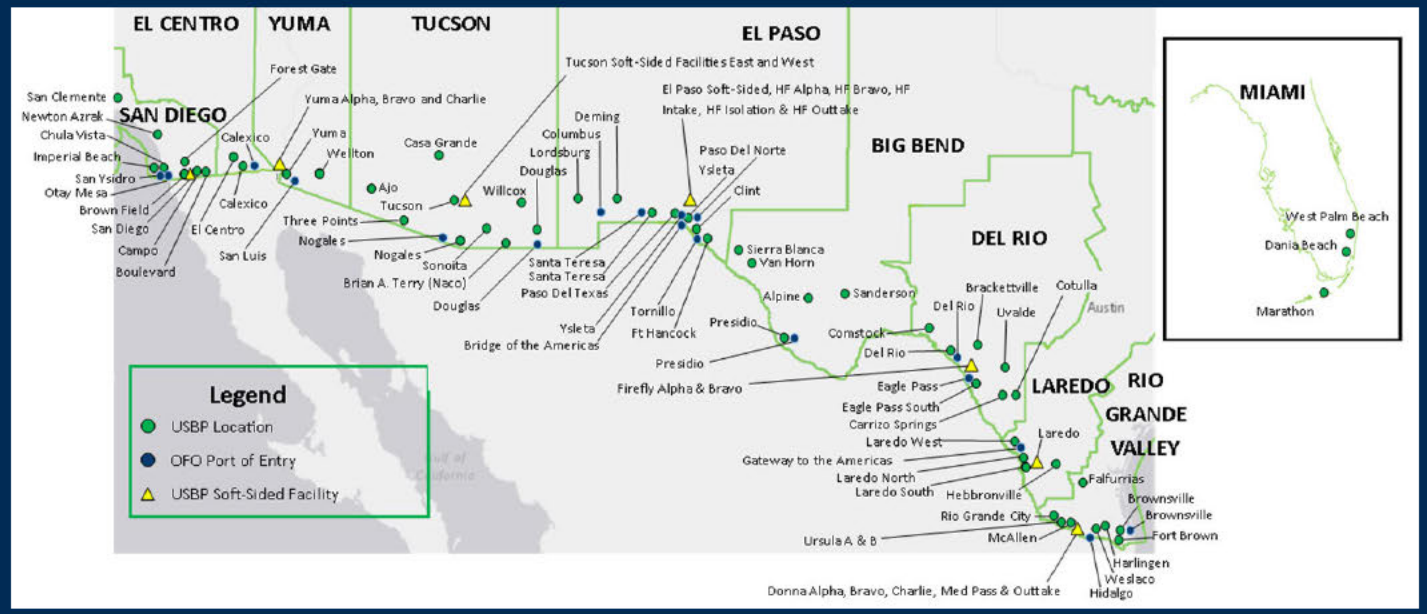
*Pediatricians and Supervising Physicians consulted (as required)*

**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

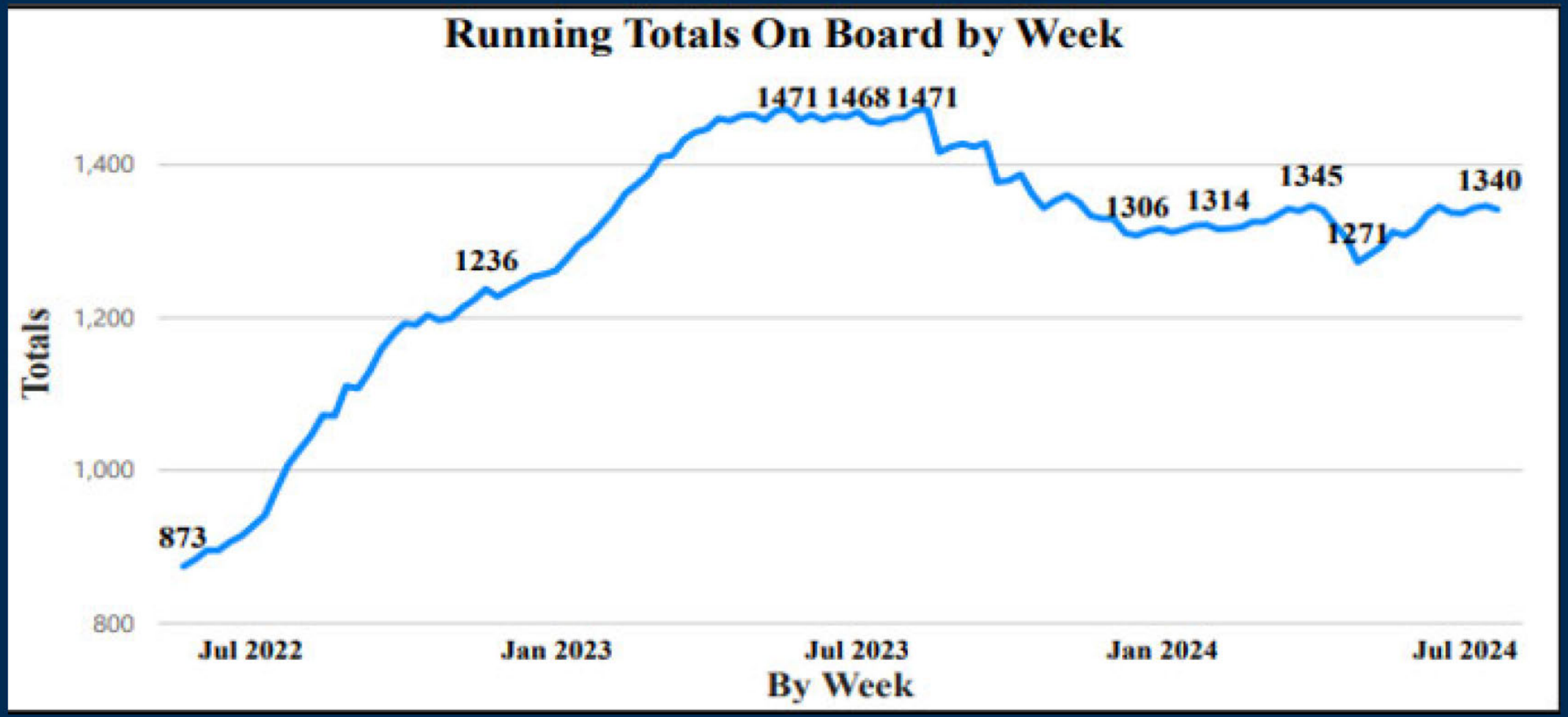
**Advisory Staff**

- 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<br>• Medical assessments<br>• Medical encounters<br>• Medication prescriptions and distributions<br>• Medical summaries<br>• Hospital referrals<br>• Elevated In-Custody Medical Risk (ECMR) monitoring, processing, and alerts | • Basic care<br>• Wound care<br>• Very limited point of care testing capabilities<br>• Pharmaceuticals | • Cardiac testing<br>• IV therapy<br>• Oxygen<br>• Imaging or laboratory capabilities<br>• Durable medical equipment<br>• 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

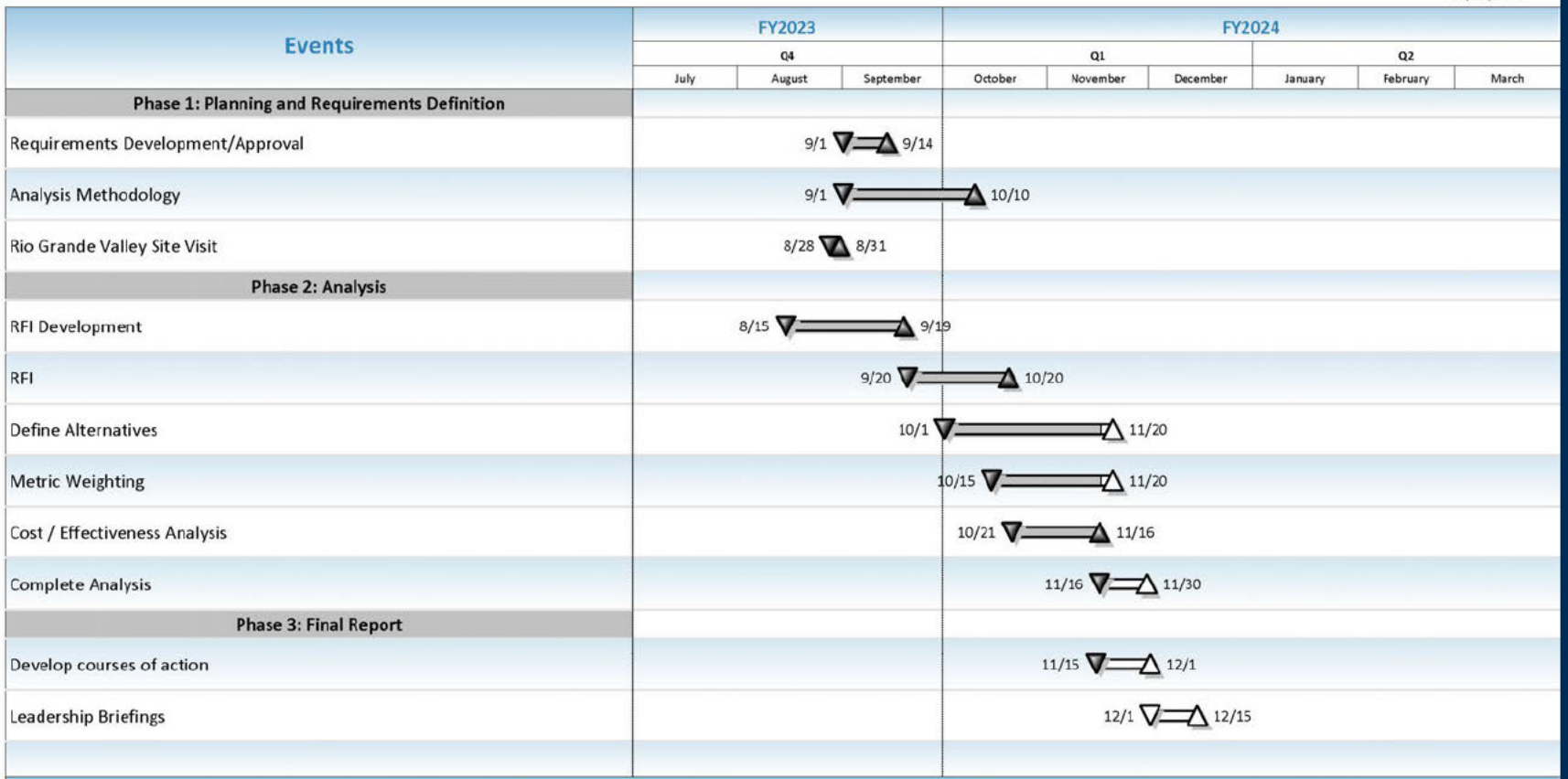
- An EHR Alternative Analysis was conducted to evaluate the effectiveness of the current CBP EMR versus a new Commercial Off the Shelf (COTS) product.
- CBP received information from 20 potential vendors, who were scored and categorized.
- The decision was made to proceed with procurement of a COTS product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

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

# Market Analysis Schedule

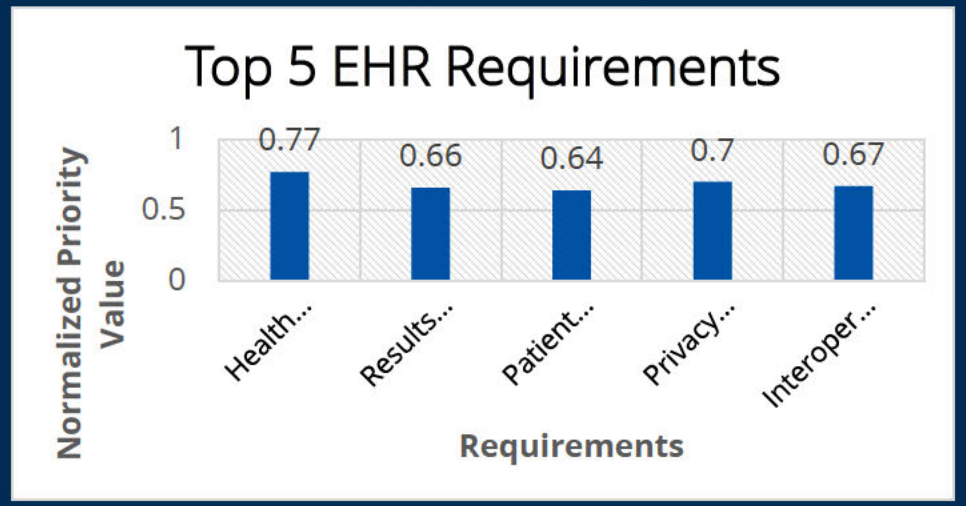
## Electronic Health Records Program High Level Schedule

11/16/2023

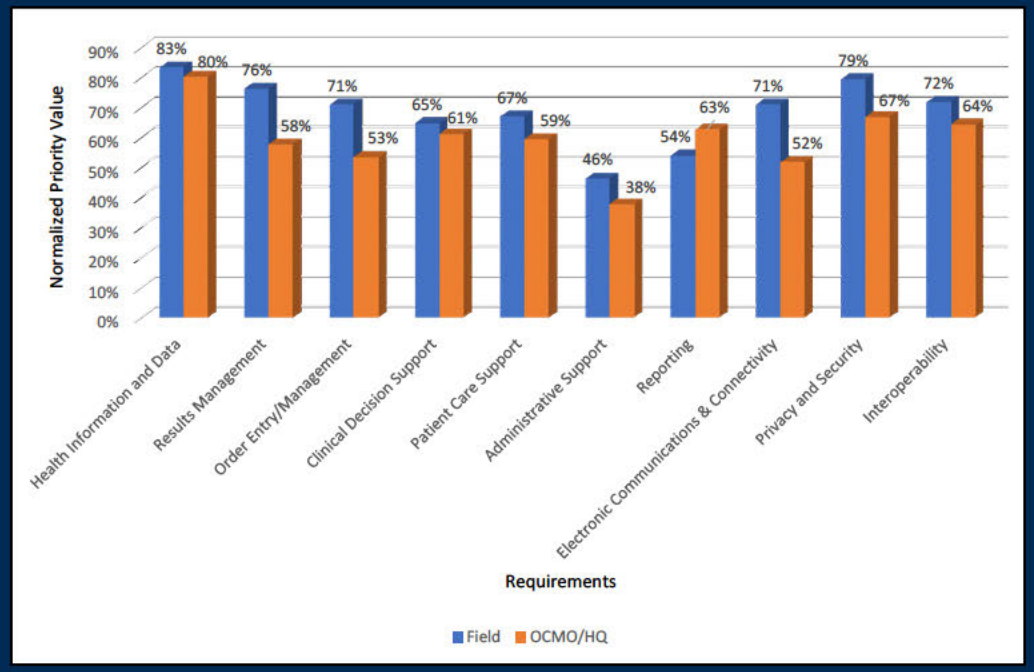


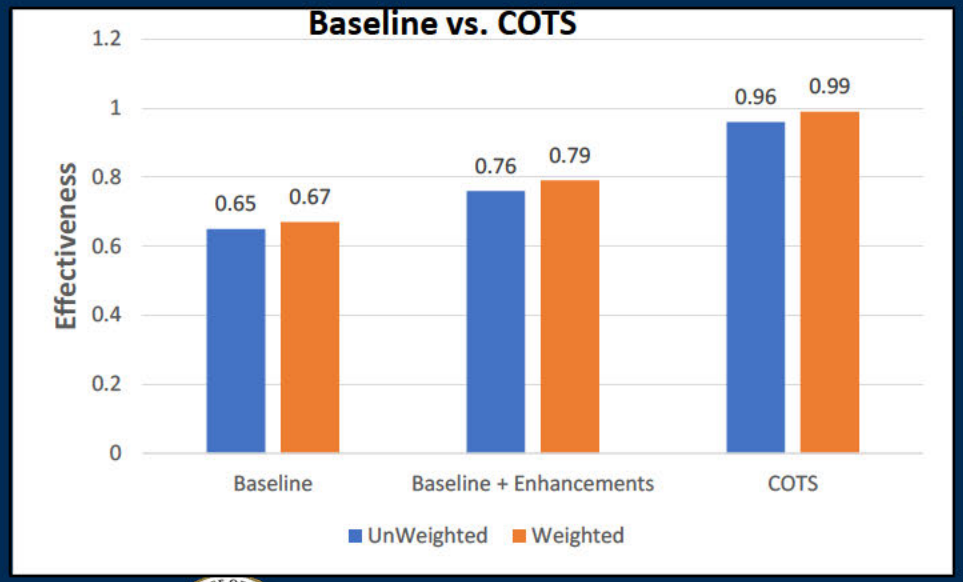
# Concept Diagram for Federated Model of DHS Medical Record Systems

# 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

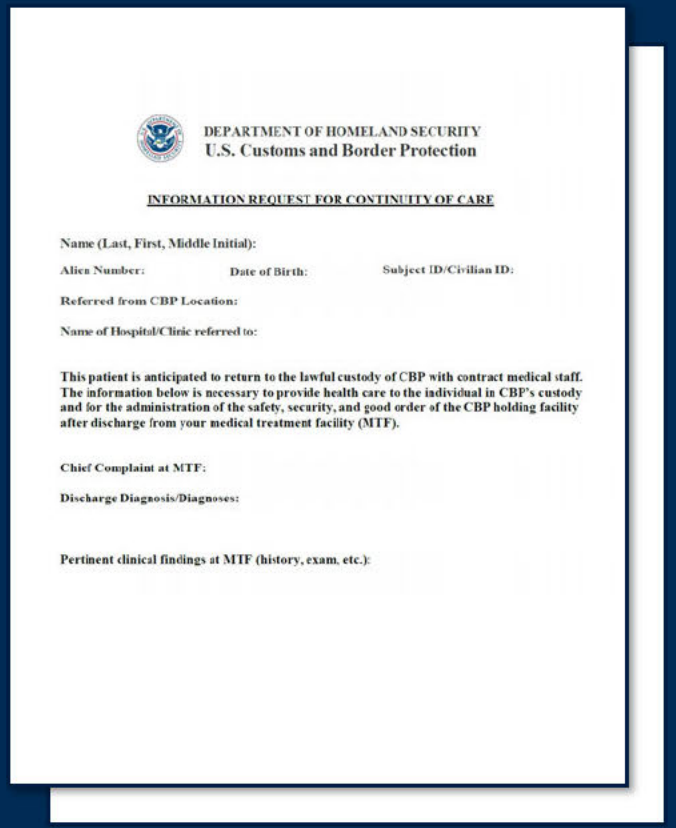
Enhancement across these five medical improvement areas have enriched **quality management**, improved **risk identification** and **informed leadership decision-making.**

# 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<br>• 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<br>• Evaluation for isolation based on condition<br>• Enhanced medical monitoring every 4 hours<br>• Verbal notification to CBP and use of red wristband to notify others within the facility of condition<br>• 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.

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# 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**

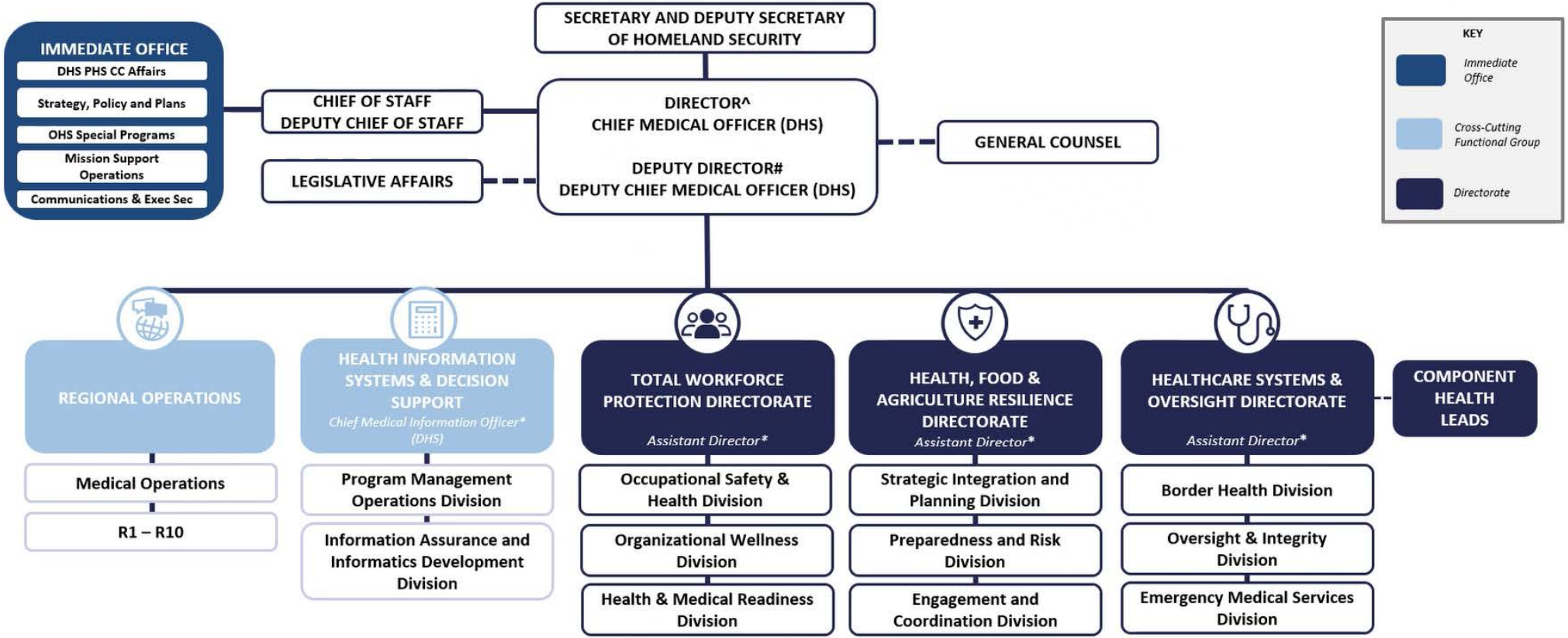
- DHS Workforce
- The Nation's Health Security
- Individuals in DHS's Care & Custody

**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.**

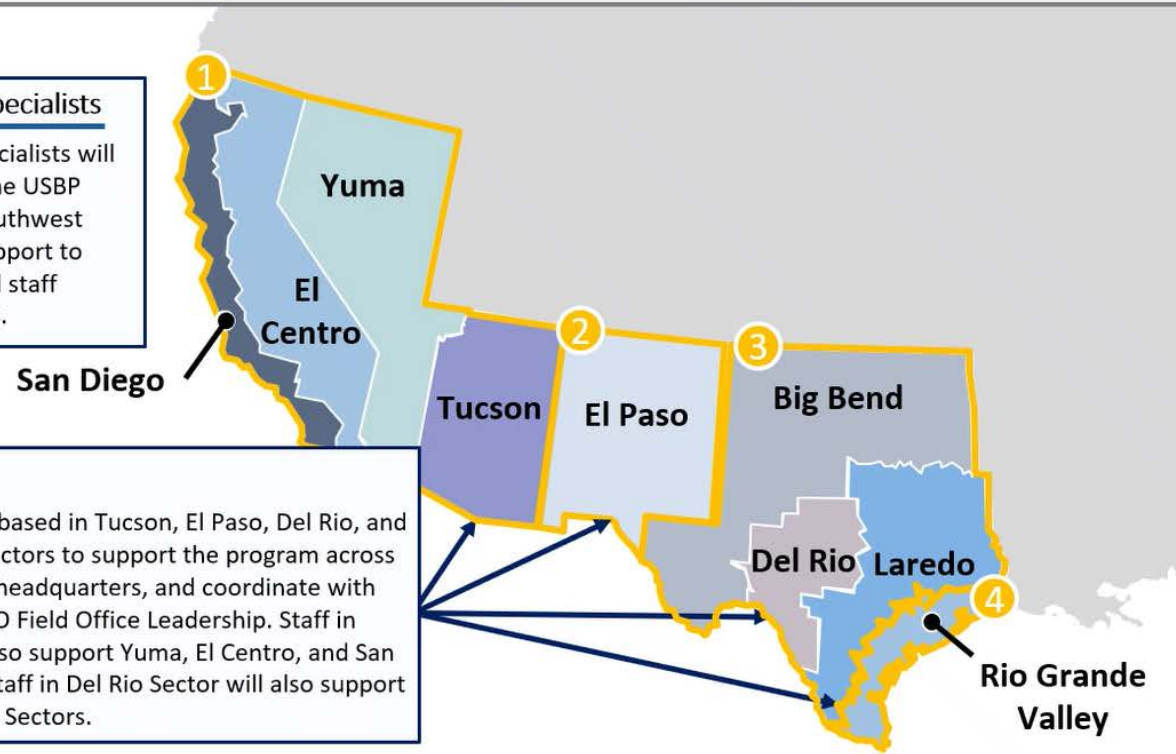
CWB Specialists will deploy to each U.S. Border Patrol Sector along the Southwest Border, serving at USBP facilities with UCs and families. Additionally, CWB federal staff will be located at DHS Headquarters and various locations along the Southwest Border to support the program and coordinate with CBP.

## 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.

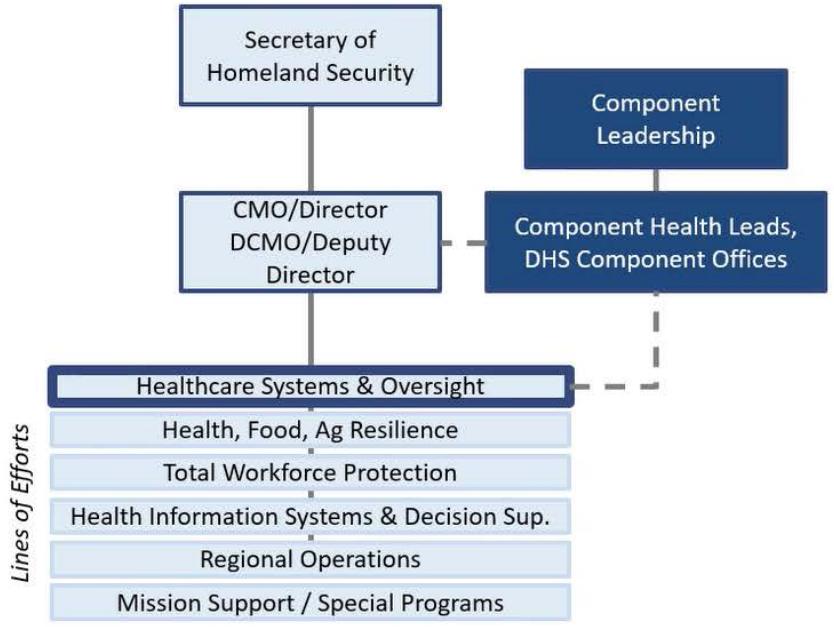


*KEY* — *Outline of the four regions each Federal Regional Lead will support*

# 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.