OFFICE OF INSPECTOR GENERAL

Many Factors Hinder ICE's Ability to Maintain Adequate Medical Staffing at Detention Facilities

Homeland Security

October 29, 2021

OIG-22-03

OFFICE OF INSPECTOR GENERAL
Department of Homeland Security

Washington, DC 20528 / www.oig.dhs.gov

October 29, 2021

MEMORANDUM FOR: Tae D. Johnson
Acting Director
U.S. Immigration and Customs Enforcement

FROM: Joseph V. Cuffari, Ph.D.
Inspector General

JOSEPH V CUFFARI
Digitally signed by JOSEPH V CUFFARI
Date: 2021.10.29 09:49:34 -04'00'

SUBJECT: *Many Factors Hinder ICE's Ability To Maintain Adequate Medical Staffing at Detention Facilities*

Attached for your action is our final report, *Many Factors Hinder ICE's Ability To Maintain Adequate Medical Staffing at Detention Facilities*. We incorporated the formal comments provided by your office.

The report contains five recommendations aimed at evaluating options for enhancing resources for medical staffing and ensuring medical staff assist with relevant detention contract negotiations. Your office concurred with all five recommendations. Based on information provided in your response to the draft report, we consider all five recommendations open and resolved. Once your office has fully implemented the recommendations, please submit a formal closeout letter to us within 30 days so that we may close the recommendations. The memorandum should be accompanied by evidence of completion of agreed-upon corrective actions.

Please send your response or closure request to OIGSREFollowup@oig.dhs.gov.

Consistent with our responsibility under the *Inspector General Act*, we will provide copies of our report to congressional committees with oversight and appropriation responsibility over the Department of Homeland Security. We will post the report on our website for public dissemination.

Please call me with any questions, or your staff may contact Thomas Kait, Deputy Inspector General for Inspections and Evaluations, at 202-981-6000.

Attachment

DHS OIG Highlights

Many Factors Hinder ICE's Ability to Maintain Adequate Medical Staffing at Detention Facilities

October 29, 2021

Why We Did This Evaluation

We conducted this evaluation to assess the causes and impact of medical vacancies at U.S. Immigration and Customs Enforcement (ICE) detention facilities and determine whether existing medical staffing plans and vacancies at detention facilities hinder ICE detainees' access to adequate medical care.

What We Recommend

We made five recommendations for ICE to evaluate options for enhancing resources for medical staffing and ensuring medical staff assist with relevant detention contract negotiations.

For Further Information:
Contact our Office of Public Affairs at (202) 981-6000, or email us at DHS-OIG.OfficePublicAffairs@oig.dhs.gov

What We Found

ICE relies on a patchwork of detention facilities, governed by a variety of contracts and payment agreements, to house detainees. Regardless of how medical care is provided, facilities face challenges recruiting, hiring, and retaining medical staff. Specifically, remote locations, competing opportunities, difficulty offering competitive pay rates, and cumbersome hiring processes adversely affect ICE's ability to attract qualified staff. However, it is difficult to measure medical vacancy rates; facility requirements are fluid, and strategies for ensuring adequate coverage vary widely. In addition, ICE has limited options to impose consequences if contractors do not meet staffing contract terms. Challenges ICE faces in recruiting medical staff require resource-intensive mitigation.

Many of the challenges ICE faces hiring medical staff also affect ICE's access to offsite specialty care. Remote locations and reluctance among some medical specialists to treat detainees reduce access to specialty care. ICE's options are also constrained by its reimbursement system, because compensation rates are outside ICE's control.

Medical vacancies may increase the risk of inadequate care, but the full effects of medical vacancies are difficult to evaluate. The unusual circumstances presented by COVID-19 limited our ability to assess the costs and effects of medical vacancies during the period of our review.

ICE Response

ICE concurred with all five of our recommendations, which are resolved and open, noting that efforts were underway to improve pay rates, hiring processes, and contract oversight.

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Abbreviations

COR	Contracting Officer Representative
COVID-19	Corona virus disease of 2019
CRCL	Office of Civil Rights and Civil Liberties
ERO	Enforcement and Removal Operations
FMC	Field Medical Coordinator
GAO	U.S. Government Accountability Office
GS	General Schedule
HROC	Human Resources Operations Center
ICE	U.S. Immigration and Customs Enforcement
IHSC	ICE Health Service Corps
ODO	Office of Detention Operations
OPR	Office of Professional Responsibility
PBNDS	Performance-Based National Detention Standards
PHS	Public Health Service
U.S.C.	United States Code
USMS	U.S. Marshals Service
VA	Veterans Administration

Introduction

U.S. Immigration and Customs Enforcement (ICE) houses immigrant detainees in nearly 200 facilities nationwide. ICE manages these facilities directly or through contracts with state or local governments, private contractors, and other Federal agencies. ICE detention standards require all facilities to provide detainees with access to adequate medical care. ICE Health Service Corps (IHSC) provides direct onsite medical services in approximately 20 facilities and oversees medical care at the remaining facilities. Several Department of Homeland Security entities monitor compliance with medical care standards included in ICE's detention standards and facility contracts, such as access to care, timeliness of care, and adherence to existing medical staffing models. Reports by these oversight entities of vacancies at IHSC-run and contract facilities have raised concerns about ICE's ability to provide adequate health care to detainees. Our objective was to assess the causes and impact of medical vacancies at ICE detention facilities and determine whether existing medical staffing plans and vacancies at detention facilities hinder ICE detainees' access to adequate medical care.

Background

ICE Enforcement and Removal Operations (ERO) is responsible for long-term detention of inadmissible family units[1] and single adults[2] nationwide. ERO oversees immigration detention facilities, which are intended for the purpose of holding, processing, and preparing detainees for removal from the United States.[3] Immigration detention is to ensure detainees' presence for immigration proceedings and deportation; it is civil in nature and assumed to be non-punitive.[4] Appendix C shows the populations of detention facilities used by ICE ERO in fiscal year 2019, before the coronavirus disease of 2019 (COVID-19) limited the use of detention.

Contracts and agreements with more than 200 facilities holding ICE detainees require adherence to ICE detention standards, which include the *2019 National Detention Standards*, *2011 Performance-Based National Detention Standards* (PBNDS) (revised in 2016), the *2008 PBNDS*, the *2000 National Detention*

[1] When U.S. Customs and Border Protection apprehends an individual known or reasonably believed to be younger than 18 years with his or her parent or legal guardian, the child and parent or guardian are classified as a family unit.
[2] Individuals known or reasonably believed to be 18 years of age or older who are not part of a family unit are classified as "single adults."
[3] For a discussion of immigration detention, see *Immigration Detention: ICE Should Enhance Its Use of Facility Oversight Data and Management of Detainee Complaints*, GAO-20-596, August 2020, p. 5; see also https://www.ice.gov/about-ice/ero.
[4] *Zadvydas v. Davis*, 533 U.S. 678, 690 (2001).

Standards for Non-Dedicated Facilities, or the *2020 Family Residential Standards*. The treatment of detainees may also be governed by state and Federal law, court rulings, and agency policies. Detention standards aim to establish consistent conditions of confinement, program operations, and management expectations within ICE's detention system. These standards set requirements for detainee healthcare, including behavioral health.

Detention standards set expectations for medical care detainees receive. For example, the 2011 PBNDS (revised in 2016) and the *2020 Family Residential Standards* require that detainees receive "medically necessary and appropriate medical, dental and mental health care and pharmaceutical services." The detention standards require initial health screenings, preventative care, diagnosis, health education, and treatment. To meet those standards, facilities generally provide some level of medical care on site and use providers in the surrounding community for specialty care beyond the scope of the facility.

Provision of Care at ICE Facilities

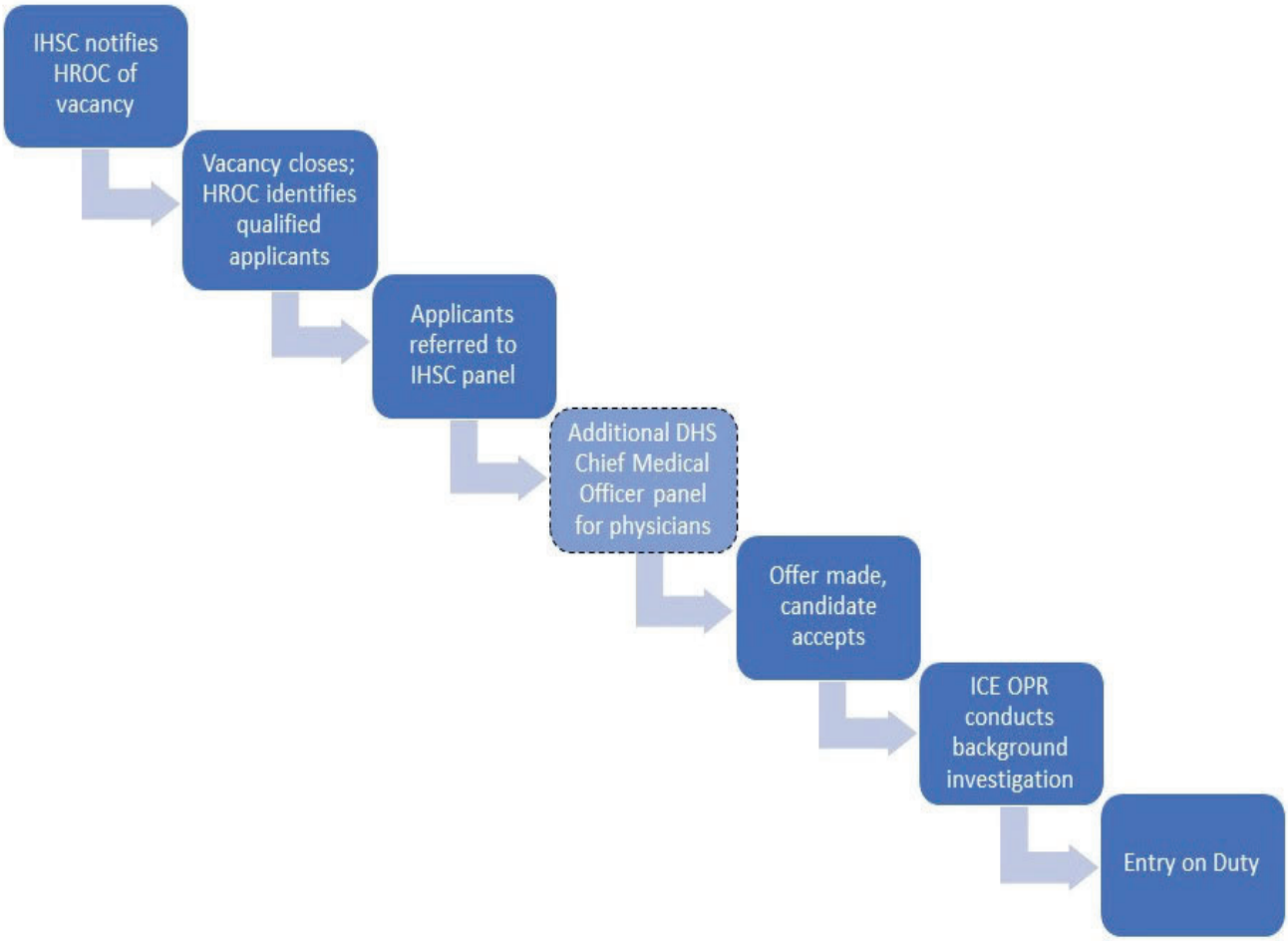
IHSC provides onsite medical care to detainees at approximately 20 ICE detention facilities.[5] In FY 2020, approximately 100,000 detainees were housed in facilities for which IHSC provided medical care.[6] In an additional 148 facilities, ICE contracted with private companies and government entities to provide care within the facilities. In FY 2020, approximately 169,000 detainees were housed in facilities for which private contractors provided medical care.[7] ICE also houses detainees in facilities in which the U.S. Marshals Service (USMS) manages the detention contract and ICE shares a contract rider.

IHSC-run facilities are staffed by Public Health Service (PHS) staff, General Schedule (GS) staff, and private contractors under IHSC supervision. IHSC facilities hire PHS officers and GS employees through ICE and DHS. IHSC's contractor manages hiring for contract staff. Most hiring processes for Federal medical staff at IHSC-run facilities are conducted through ICE's Office of Human Capital, Human Resources Operations Center (HROC) and Office of Professional Responsibility (OPR), which conducts background checks. See Figure 1 for the Federal hiring process; in addition to the steps listed, pre-employment checks are conducted for medical positions, which can lengthen the hiring process. See Figure 2 for a hiring timeline for Federal employees; the GS hiring process ranges

[5] IHSC routinely adds or removes facilities from its direct management. This number reflects IHSC's 2020 annual report.
[6] *U.S. Immigration and Customs Enforcement Health Service Corps Annual Report for Fiscal Year 2020*.
[7] *U.S. Immigration and Customs Enforcement Health Service Corps Annual Report for Fiscal Year 2020*.

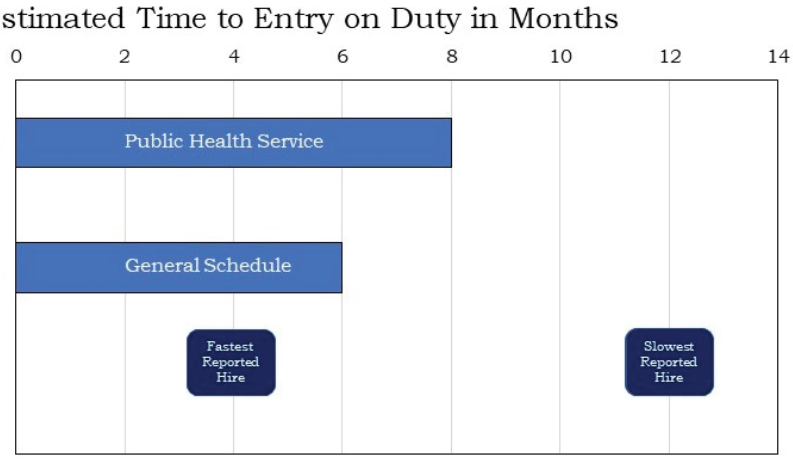
from several months to a year, and the PHS hiring process ranges from 7 to 9 months.

Figure 1. Hiring Process for IHSC Federal Employees



Source: DHS Office of Inspector General (OIG) analysis of information provided by ICE

Figure 2. Hiring Timeline for IHSC Federal Employees



Source: DHS OIG analysis of information provided by ICE

ICE-contracted facilities manage hiring for all medical and support staff for the facility. Contractors have wide flexibility to offer staff competitive pay, bonuses, and benefits. However, contract medical staff must still complete a background check, which ICE's OPR conducts for facilities at which ICE holds the contract. For facilities at which ICE shares a contract rider with USMS, USMS conducts background checks.

When the medical needs of a detainee are beyond the scope of what facility staff can provide, ICE is responsible for getting the detainee care within the community. Care can include appointments with specialists, such as podiatrists or orthopedists, or emergency care provided by a hospital's emergency department. In either case, ICE is ultimately responsible for financially compensating the providers. Reimbursements are processed through the Veterans Administration (VA) at VA authorized rates.

Oversight of Medical Care and Medical Vacancies

DHS has several entities monitoring medical care and medical vacancies; some only monitor compliance with ICE's detention standards related to medical care, such as access to care and timeliness of care, and some also monitor the quality of care (see Table 1).

Table 1. DHS Detention Oversight Entities

Entity	Responsible Office	ICE Oversight Mission	Criteria[8]
Office of Inspector General	DHS	• Oversight of ICE • Unannounced inspections	• ICE standards • Quality of care[9]
Office of Civil Rights and Civil Liberties (CRCL)	DHS	• Oversight of ICE civil rights compliance • Planned inspections	• ICE standards • Quality of care[10]
Office of the Immigration Detention Ombudsman	DHS	• Oversight of ICE detention[11] • Planned inspections	• ICE standards
Contracting Officer Representatives	ICE	• Contract compliance[12] • Informal site visits	• ICE standards
Medical Quality Management Unit	ICE IHSC	• Reviews of IHSC-run facilities[13] • Planned inspections	• ICE standards • Quality of care
Field Medical Coordinators	ICE IHSC	• Reviews of non-IHSC-run facilities • Planned inspections	• ICE standards • Quality of care
Office of Detention Oversight (ODO)	ICE OPR	• Independent assessment of detention facilities • Planned inspections	• ICE standards
Detention Service Managers	ICE ERO	• Compliance monitoring at select facilities[14] • Onsite presence	• ICE standards

Source: DHS OIG analysis

[8] Quality of care criteria vary by responsible office and are generally drawn from the American Correctional Association, National Commission on Correctional Health Care, and the Public Health Service.
[9] The DHS Office of Inspector General contracts with NCCHC Resources Inc. to review the quality of medical care provided to ICE detainees.
[10] CRCL evaluates medical allegations and opens an investigation into the standard of care provided to detained individuals. CRCL evaluates allegations regarding individuals currently in detention who may require immediate assistance. CRCL can refer complaints to ICE ERO. ICE ERO provides CRCL with a response to the specific allegations about the detainee's care, relevant medical information, and any corrective action taken. CRCL reviews and determines if there are additional case-specific actions needed or systemic medical concerns that require further action. CRCL also monitors detainees with chronic or acute medical or mental health conditions.
[11] *See* 6 United States Code (U.S.C.) § 205(b); Annual Report 2020, Office of the Immigration Detention Ombudsman, January 19, 2021, iii.
[12] *ICE Does Not Fully Use Contracting Tools to Hold Detention Facility Contractors Accountable for Failing to Meet Performance Standards*, OIG-19-18, January 2019, p. 5.
[13] *IHSC Annual Report for Fiscal Year 2020*.
[14] *ICE's Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements*, OIG-18-67, June 2018, p. 3.

Most ICE detention facilities have detailed staffing plans designed to ensure compliance with ICE standards and to meet IHSC quality of care measures. IHSC headquarters monitors medical vacancy rates at IHSC-run facilities. IHSC Field Medical Coordinators (FMC) and ICE's contracting officer representative (COR) monitor vacancy rates at contract facilities. Either may become aware if vacancy rates affect the timeliness or quality of medical care. FMCs conduct inspections of non-IHSC run facilities, reviewing timeliness of care, quality of care, medical staffing plans, and vacancy rates. FMCs also adjudicate detainee medical complaints.

CORs are responsible for ensuring contractors who operate ICE detention facilities comply with the terms of the contract, including compliance with detention standards. CORs generally conduct detention facility site visits to have first-hand knowledge to approve payments and address noncompliance. CORs have several means of monitoring staffing levels at ICE-contracted facilities, including their involvement in scheduling background investigations for new contract staff, regular meetings with facility staff, and listening to concerns raised by FMCs. CORs may seek financial penalties if the contractor does not meet the contract's standards for medical care.

To assess whether medical vacancies may affect detainee health care, we reviewed oversight reports on the timeliness and quality of medical care provided at ICE facilities, as well as on vacancy rates at those facilities. We conducted extensive interviews, including with IHSC headquarters and field staff, and ICE staff responsible for policy, personnel, background investigations, and contract administration. We also conducted in-depth reviews of six ICE detention facilities; IHSC provided medical care at two of these facilities, and contractors at the remaining facilities. We conducted our fieldwork between August 2020 and March 2021.

Results of Evaluation

Many factors hamper ICE's ability to recruit and retain medical staff. Specifically, remote locations, competing opportunities, difficulty recruiting medical staff, and cumbersome hiring processes adversely affect ICE's ability to attract qualified staff. However, it is difficult to measure medical vacancy rates; facility requirements are fluid, and strategies for ensuring adequate coverage vary widely. In addition, ICE has limited options to impose consequences if contractors do not meet staffing contract terms. ICE has sanctioned some contractors, but sanctions have limited value in resolving vacancy rates. To overcome the challenges ICE faces recruiting medical staff, resource-intensive mitigations are required.

Many of the challenges ICE faces hiring medical staff also affect ICE's access to offsite specialty care. Remote locations and reluctance among some medical specialists to treat detainees reduce access to specialty care. ICE's options are also constrained by its reimbursement system, because compensation rates are outside ICE's control.

Medical vacancies may increase the risk of inadequate care, but the full effects of medical vacancies are difficult to evaluate. The unusual circumstances presented by COVID-19 limited our ability to assess the costs and effects of medical vacancies during the period of our review. Specifically, the pandemic created challenges for detention centers to fill medical vacancies and increased demands on staff, while reducing the number of detainees held in ICE facilities. In addition, in-person observation by DHS oversight entities of compliance with ICE standards for medical care were also largely replaced by virtual observation, limiting the conclusions we can draw about the effects of medical vacancies on detainee care.

Many Factors Hamper ICE's Recruitment and Retention of Medical Staff and Vacancy Rates Can Be Difficult to Measure

Remote locations, cumbersome hiring processes, and competing opportunities hamper ICE's ability to maintain adequate staffing levels at detention facilities. Specifically, the remote location of facilities and the detention setting itself affect recruitment and retention. Although ICE is seeking ways to improve recruitment and retention of Federal employees, ICE struggles to provide competitive pay rates and to make hiring decisions expeditiously.

While contractors have more flexibility to offer higher pay and incentives to compete for medical staff in their local markets, recruitment and retention remains a challenge. ICE has limited options if contractors do not meet contract terms for staffing plans or for timeliness of medical care for detainees. Because facility requirements are fluid and strategies for ensuring adequate coverage vary widely, it is difficult to measure medical vacancy rates accurately.

Locations of ICE Detention Facilities Make Recruiting and Retaining Qualified Medical Staff Difficult

The location of a detention facility can affect recruitment for medical vacancies. During our review, we learned that facilities in remote locations tend to experience the greatest number of medical vacancies. For example, Eloy Detention Center in Arizona, Stewart Detention Center in Georgia, and Dilley Family Residential Facility in Texas experienced difficulties hiring and retaining medical staff due to

the limited number of qualified candidates living in these areas.[15] Medical staff at remote facilities told us that few qualified candidates live near the facilities. Potential candidates may be reluctant to drive an hour or longer each way to work at the facility. Urban locations may also present a challenge recruiting Federal staff because there are competing Federal entities, such as the Bureau of Prisons and the VA, offering higher salary and enhanced benefits (such as additional leave) for comparable work in those areas.

Medical staff we interviewed at detention facilities told us that the detention setting itself affects recruitment and retention. Some qualified medical staff are reluctant to work in a detention facility because it makes them uncomfortable. Given a choice, many would prefer to work in hospitals or doctors' offices. PHS staff at ICE family residential centers told us that even colleagues comfortable working in a detention setting expressed concerns about working with children in ICE custody. Although ICE detention facilities can attract medical staff seeking experience in a correctional setting or in treatment of patients from developing countries, the controversy surrounding ICE detention in general can also make recruitment difficult. For example, some medical staff cited protests outside ICE detention facilities, media attention, and lack of community support for detention as hindering recruitment.

Limited Compensation Packages and a Lengthy Hiring Process Can Impede Federal Recruitment

IHSC struggles to provide competitive pay rates to recruit and retain Federal employees. PHS officers working in remote ICE facilities are not eligible for cost of living differentials. They must choose between commuting from relatively expensive cities without cost of living adjustments or living in a rural area with fewer amenities. PHS officers working at a remote location told us they took a salary cut to work at the facility. Pay for GS medical staff in IHSC-run facilities is significantly lower than that for contract medical staff and other public sector medical staff with similar responsibilities. While somewhat balanced by the associated Federal benefits,[16] lower GS pay rates are further reduced by higher benefit costs. Medical staff at IHSC-run facilities told us the salary disparity between Federal and contract positions was about 30 percent. Some contract medical staff did not apply to transfer to vacant Federal positions because they could not afford the decrease in salary. In addition, IHSC does not offer recruitment and retention incentives other Federal agencies with medical staff

[15] Eloy Detention Center is located approximately 63 miles from Phoenix; Stewart Detention Center is located approximately 143 miles from Atlanta, and Dilley is located approximately 90 miles from San Antonio.
[16] https://www.opm.gov/policy-data-oversight/pay-leave/pay-administration/fact-sheets/federal-employee-compensation-package.

offer, such as student loan repayment. ICE human resources staff told us that applicants from other Federal agencies may decline employment offers for medical positions when they realize that ICE does not offer bonuses and incentives.

Although ICE is contemplating higher pay for some positions, salary matching is considered on an individual basis and is not well advertised. ICE is considering incentives for hard-to-fill medical specialties and is reviewing whether higher grade levels may be justified for other staff. Currently, new employees may submit a justification to obtain a match to other agency and public sector pay and benefits. However, such requests must be adjudicated individually by ICE's personnel office and the office of the DHS Chief Medical Officer, a process which can delay hiring for months and discourage qualified candidates. Moreover, GS candidates who are not aware that it is possible to negotiate the salary based on special needs or superior qualifications may be discouraged by the advertised pay rates.[17]

ICE's hiring process for Federal medical staff is lengthy and not adequately resourced, but ICE is seeking to streamline the process. ICE's HROC noted that there are currently only two staffing specialists dedicated to employment actions for approximately 1,600 IHSC staff, requiring HROC staff to work overtime to avoid delayed processing. In addition, although ICE's OPR prioritizes background checks for medical staff, prospective candidates may wait several months for a decision. A DHS Chief Medical Officer hiring panel must approve qualifications of senior Federal medical staff, as well as justifications for higher GS pay rates based on special needs or superior qualifications. The panel does not convene frequently and relies on IHSC expertise, limiting the added value of the panel. ICE HROC staff told us they are in the process of mapping the Federal hiring process to identify options for streamlining.

IHSC has taken steps to increase recruitment options to bring Federal employees to IHSC-run facilities but hiring for open positions has been slow. Specifically, IHSC has received permission from DHS to recruit medical staff to the PHS commissioned corps, which allows IHSC to assign new staff where there are vacancies. IHSC also offers transfers to PHS staff working for other Federal agencies. In FY 2020, IHSC received permission to increase PHS commissioned medical officers from 469 to 569. In FY 2020, IHSC also received permission to hire 172 new GS medical staff to replace some contract staff at IHSC-run facilities,

[17] An agency may determine that a candidate fills a special agency need if the type, level, or quality of skills and competencies or other qualities and experiences possessed by the candidate are relevant to the requirements of the position and are essential to accomplishing an important agency mission, goal, or program activity. https://www.opm.gov/policy-data-oversight/pay-leave/pay-administration/fact-sheets/superior-qualifications-and-special-needs-pay-setting-authority/.

increasing the number of GS medical staff from 39 to 211. However, of the 172 positions, only 52 (30 percent) were filled in FY 2020. ICE officials and recent hires estimated that it can take 7 to 9 months to fill PHS vacancies. Because GS hiring is a relatively new process, it is difficult to identify an average hiring timeline. Anecdotally, new GS hires took between several months to a year. Some GS staff may begin working with a preliminary background check that takes 10 days but can be terminated if the full background investigation identifies derogatory information. An ICE official described the GS hiring process as a cycle of applicants accepting and declining offers, and ICE re-listing positions. When these approximately 270 Federal positions are filled, IHSC expects the number of vacancies, the number of contract positions, and turnover rates to decrease.

Despite Greater Hiring Flexibility, Contractors Also Face Recruitment and Retention Challenges

Contractors have more flexibility to offer higher pay and incentives to compete in their local markets. For example, to fill chronic vacancies among contract medical staff at IHSC-run facilities, ICE approved the contractor's request to offer higher pay rates. Increased salaries for nursing staff and advanced practice providers improved retention. Some contractors at non-IHSC-run facilities offer incentives to their medical staff, including hiring bonuses and salaries that are competitive for their local markets. For example, some contract medical staff reported that their contractors responded to turnover by offering 10 to 20 percent increases in pay, training or continuing education allowances, or flexible work schedules.

Despite such incentives, recruitment and retention of contract medical staff remains difficult. ICE officials reported that during background investigations,[18] they are more likely to discover negative issues that preclude hiring among applicants for contract medical staff positions than those for Federal medical positions. ICE officials and contract staff at detention facilities told us applicants for contract medical positions who receive another offer before their background checks are completed are more likely than Federal applicants to withdraw their applications. Retention is also more difficult when contractors must compete in the local market for medical staff based on short-term pay and incentives. For example, medical staff at some facilities told us their contractors did not offer incentives, resulting in a more transient staff who sought experience before leaving for more competitive positions. Medical staff also noted that colleagues left

[18] Contract and Federal employees complete an online questionnaire developed by the Office of Personnel Management. ICE OPR then conducts criminal and credit checks, and other checks necessary for a background investigation. See https://www.opm.gov/forms/pdf_fill/sf85.pdf. According to ICE OPR, criminal records, bad debt, and past drug use are the primary reasons applicants for contract positions cannot be hired.

for hospital and nursing home positions during COVID-19 because these facilities temporarily increased pay and incentives.

Medical Vacancy Rates Can Be Difficult to Measure

Although most ICE detention facilities have detailed staffing plans, it is difficult to measure medical vacancy rates. Facility requirements are fluid, and strategies for ensuring adequate coverage vary widely. IHSC-run facilities develop staffing plans but can shift staffing when there is a need. For example, IHSC has increased its use of behavioral therapists and is expanding its use of telehealth to cover mental health counseling. IHSC can temporarily fill vacancies with headquarters medical staff who volunteer to work in the field for 30 days each year. Staff at one facility may assist another remotely; for example, facilities without a clinical director are covered by clinical directors at other facilities.

Facility requirements for contract facilities can also change. During COVID-19 the number of detainees requiring treatment fell, but there was a greater need for staff to manage increased screening and monitoring. In addition, although most of the recent ICE contracts include detailed staffing plans, the contracts are performance-based. This means contractors provide staffing plans they believe will allow them to meet ICE's detention standards, but contractors are also assessed on compliance with detention standards. As a result, for example, a contractor who does not retain the number of medical staff specified in a contract, but meets ICE's detention standards through overtime, pool nurses, and temporary reassignments, may not be considered to be out of compliance with the standards.

ICE Has Limited Options to Impose Consequences on Contractors with Chronically High Medical Vacancy Rates

ICE has limited options to impose consequences if contractors repeatedly do not meet contract terms for staffing plans or for timeliness of detainee medical care. For facilities where ICE holds the contract, ICE can sanction the contractor by withholding funds, or can limit reimbursements by moving some or all detainees out of the facility. For facilities where ICE has a rider on an existing USMS contract, ICE cannot impose sanctions but can elect to withdraw from use of the facility.

ICE has sanctioned some contractors, but sanctions have limited value in resolving vacancy staffing rates. CORs and FMCs told us that if contracts are not written with sufficient specificity, it may be difficult to impose penalties. For example, if a contract requires 80 percent medical staffing but does not require a minimum number of mental health staff, it is difficult to sanction the contractor

for mental health vacancies. Moreover, the prospect or threat of sanctions may have little effect in areas of the country where bed space is scarce. For example, the facility may have other entities wanting to use the bed space, allowing the facility to simply switch its bed space usage from ICE to another entity.

To address these issues, CORs and FMCs can cooperate to improve the language of contracts and compliance with their terms. CORs can consult FMCs before approving staffing plans in contract renewals or modifications. FMCs can also notify CORs if they have concerns about staffing levels at non-IHSC-run facilities. Among the CORs and FMCs we interviewed, there was generally good cooperation. However, CORs are not required to consult with FMCs about contract staffing plans, and CORs have limited resources for monitoring staffing levels and performance. FMC resources are also limited; approximately 40 FMCs are responsible for oversight of 148 non-IHSC staffed ICE detention facilities.

Hiring Challenges Require Resource-Intensive Mitigation

Challenges ICE faces recruiting medical staff leave ICE with resource-intensive mitigations. For example, adjudicating each GS staff's individual request for more competitive pay individually, rather than offering a higher pay rate to all, adds to ICE HROC's workload. Offering higher salaries for contract medical staff required ICE to amend its contract for IHSC-run facilities. Conducting multiple background investigations for the same position because the selected applicants ultimately accept other job offers or cannot pass security checks burdens ICE OPR's resources. Furthermore, re-posting vacancies when applicants decline medical positions creates additional burden on HROC staff. Evaluating the effect of medical vacancies on medical care at contract facilities increases the workload of CORs and FMCs. Finally, if contractors cannot provide enough staff, IHSC can divert staff resources and cover vacancies with PHS staff on temporary duty assignments.

Distance to Offsite Medical Facilities and Reluctance of Some Providers to Treat Detainees Limits ICE's Options for Specialty Care

Many of the challenges ICE faces hiring medical staff also affect ICE's access to offsite specialty care. Based on our review of IHSC-run and contract facilities, the remote location of some facilities may hinder access to specialty care. Some detention facilities are more than an hour's drive from the closest city offering medical specialists and full-service hospitals. These doctors may prioritize longer-term patients who live in the community ahead of detainees.

Further, medical staff at the detention facilities and specialty care providers told us that some specialists in the community are reluctant to treat detainees, although the reasons for such reluctance vary. Some medical specialists are reluctant to bring detainees, who are escorted and may be in restraints, into contact with other patients. Others have practices in communities that do not approve of immigration detention and might face criticism for accepting ICE patients.

In addition to geographic and cultural challenges, ICE's options are constrained by its reimbursement system. ICE cannot offer pay incentives to outside providers because ICE relies on the VA to both set reimbursement rates and provide the reimbursements. Although some outside providers reported problems with reimbursements, delays appeared to be outside ICE's control, related either to missing paperwork or slow VA processing. Because of these challenges, in some locations, ICE relies on specialty care from community hospitals, which cannot refuse to provide care, and from doctors and hospitals with experience in correctional care.

Full Effects of Medical Vacancies Are Difficult to Evaluate, Particularly during the COVID-19 Pandemic

The unusual circumstances presented by COVID-19 limited our assessment of the costs and effects of medical vacancies during the period reviewed. Although ICE established mandatory COVID-19 testing requirements and best practices,[19] the pandemic created challenges for detention centers to fill medical vacancies. Some medical staff working at the facility contracted COVID-19 or resigned for fear of contracting the virus at a detention facility. Others left to work at hospitals and nursing homes, which offered higher salaries and signing bonuses. In addition, ICE imposed testing and quarantine requirements, which increased the demands on staff. During the pandemic, the turnover rate at one facility we reviewed topped 50 percent.

Concerns about transmission of COVID-19 from detainees to the surrounding community and restricted access to non-emergency care also affected detainee access to offsite medical care. As the number of detainees held in ICE facilities dropped due to COVID-19 related changes in policy, the more favorable ratio of detainees to medical staff may have ameliorated the consequences of medical

[19] These include protecting employees, contractors, detainees, visitors to the facility, and stakeholders from exposure to the virus; maintaining essential functions and services at the facility during the pandemic; reducing movement and limiting interaction of detainees with others outside their assigned housing units, as well as staff and others, and promoting social distancing within housing units; and establishing means to monitor, cohort, quarantine, and isolate the sick from the well.

vacancies during the period of our review. However, due to COVID-19, in-person observation by DHS oversight entities of compliance with ICE standards for medical care, including our own evaluation, were also largely replaced by virtual observation, limiting the conclusions we can draw about the effects of medical vacancies on detainee care.

Overall, medical vacancies may increase the risk of inadequate medical care, but in our review of facility-specific oversight reports, staffing plans, and vacancy rates, we did not observe an evident relationship between high vacancy rates and negative medical outcomes. For example, IHSC oversight reports of non-IHSC-run facilities document vacancy rates, medical staffing plans, timeliness of care, and quality of care, but do not show a relationship between higher vacancy rates and lower quality care. Although recruitment and retention of medical staff were issues at most of the facilities we reviewed, IHSC oversight reports indicated that most IHSC-run and contract facilities met basic quality of care metrics. Most ICE and contract medical staff reported that the timeliness of detainee care was not negatively impacted by vacancies. The outside specialists we interviewed did not observe evidence of poor care among the detainees they treated. Our in-depth review of six ICE detention facilities showed that vacancy rates varied widely by facility (see Appendix D). However, among these six, there was only one USMS-contracted facility at which staff reported that medical vacancies currently affected the timeliness of detainee care. Still, two recent OIG spot inspections of contract ICE facilities concluded that staffing shortages were a factor in inadequate medical care.[20] We recognize there are inherent risks when facilities fall below their designated staffing levels.

Recommendations

We recommend the Acting Director, U.S. Immigration and Customs Enforcement:

Recommendation 1: Evaluate the feasibility of offering hiring and retention incentives for high-demand Public Health Service and General Schedule healthcare professionals. Provide evaluation results.

Recommendation 2: Evaluate staffing in Immigration and Customs Enforcement units supporting Immigration Health Service Corps personnel to ensure there are adequate staff to expedite processing applications for medical positions. Provide evaluation results.

[20] *ICE Needs to Address Prolonged Administrative Segregation and Other Violations at the Imperial Detention Facility*, OIG-21-12, December 2020, p. 5; *Violations of Detention Standards amid COVID-19 Outbreak at La Palma Correctional Center in Eloy, AZ*, OIG-21-30, March 2021, p. 9.

Recommendation 3: Evaluate the feasibility of including specific medical staffing requirements in future contract negotiations. Provide evaluation results.

Recommendation 4: Evaluate current staffing levels for Field Medical Coordinators to determine whether additional staff could enable more effective oversight of contract medical care. Provide evaluation results.

Recommendation 5: Integrate Immigration Health Service Corps personnel in contract re-negotiations with medical providers to create more oversight of medical staffing and its requirements.

Management Comments and OIG Analysis

ICE officials concurred with all five recommendations and described corrective actions to address the issues identified in this report. Appendix B contains ICE's management comments in their entirety. We also received technical comments to the draft report and revised the report as appropriate. We consider all five recommendations resolved and open. A summary of ICE's response and our analysis follows.

In the response, ICE officials concurred with the recommendations and highlighted some of the facts we presented in our report. Specifically, officials noted that IHSC either provides onsite medical care or oversees medical care at all ICE detention facilities. ICE noted our report documented that several DHS entities monitor compliance with standards for medical care and that ICE detention standards require all facilities to provide detainees with access to adequate medical care. ICE remains committed to continually enhancing its detention operations to promote a safe and secure environment for detainees and staff. In addition, ICE has a layered approach to oversight of conditions of detention.

ICE Response to Recommendation 1: ICE officials concurred with the recommendation, stating that ICE has taken action to offer hiring and retention incentives to healthcare professionals. For example, ICE now offers Assignment Pay to PHS officers who meet certain requirements and are in specific remote locations. ICE has also introduced some recruitment and retention incentives to GS staff and is in the process of developing a Special Salary Pay Rate proposal which would be used to hire staff for hard-to-fill healthcare professions at certain IHSC sites. ICE is also exploring other recruitment and retention incentives for new recruits and current employees. ICE estimates completion by December 31, 2022.

OIG Analysis: We consider this action responsive to the recommendation, which is resolved and open. We will close this recommendation when ICE submits documentation showing recruitment and retention incentives have been introduced for PHS and GS medical staff between January 2021 and December 2022.

ICE Response to Recommendation 2: ICE officials concurred with the recommendation, stating that ICE's Human Resources Operations Center and ICE ERO's Human Resources Division will evaluate current staffing to ensure it is adequate to support IHSC hiring and personnel actions, as well as to review and update operating procedures to clearly outline recruitment and retention incentive processes. ICE will evaluate existing hiring workflows to determine whether additional staff, training, or process improvements are needed. ICE estimates completion by March 31, 2022.

OIG Analysis: We consider this action responsive to the recommendation, which is resolved and open. We will close this recommendation when ICE submits the results of its evaluation of Human Resources staffing levels and processes.

ICE Response to Recommendation 3: ICE officials concurred with the recommendation, stating that ERO Custody Management will work with the Office of Acquisitions Management to explore the feasibility of including specific medical staffing requirements in non-IHSC staffed detention facilities to ensure compliance with ICE detention standards. In addition, the two offices will work together to improve contract language to include the option of sanctions for non-compliance with medical staffing standards. Custody Management personnel will also work with the Office of Acquisitions Management and IHSC staffing experts to review staffing plans annually and will provide IHSC copies of medial staffing plans for non-IHSC run facilities for better visibility. ICE estimates completion by March 31, 2022.

OIG Analysis: We consider this action responsive to the recommendation, which is resolved and open. We will close this recommendation when ICE submits the results of its feasibility study, documentation of efforts to improve contract language on medical staffing, and documentation showing that medical staffing plans for non-IHSC run facilities have been shared with IHSC.

ICE Response to Recommendation 4: ICE officials concurred with the recommendation, stating that, as a strategic goal for FY 2021, IHSC had analyzed FMC staffing level effectiveness. ICE used a variety of subjective and objective data to analyze staffing levels and concluded that it was necessary to add FMC positions. ICE officials stated that formal presentation of the evaluation and

staffing recommendations is pending, but that some new positions were created. ICE estimates completion by March 31, 2022.

OIG Analysis: We consider this action responsive to the recommendation, which is resolved and open. We will close this recommendation when we are informed of the result of the formal presentation of the staffing evaluation and recommendations to the IHSC Executive Governing Board.

ICE Response to Recommendation 5: ICE officials concurred with the recommendation, stating that ERO Custody Management will ensure that relevant subject matter experts from IHSC will be integrated into the contract re-negotiation process for non-IHSC staffed facilities. IHSC staff will also be integrated into contract compliance processes related to medical care. ICE officials stated that this collaboration will be an ongoing and regular process and will include written reports and assessment specific to the provision of medical care. ICE officials stated that IHSC staff will inform contracting officers of compliance or noncompliance with detention standards on medical care, to assist with decisions on sanctions. ICE estimates completion by March 31, 2022.

OIG Analysis: We consider this action responsive to the recommendation, which is resolved and open. We will close this recommendation when we are provided documentation, such as memorandums, emails, or reports, demonstrating that IHSC has been integrated into contract processes related to compliance with ICE detention standards on medical care.

Appendix A
Objective, Scope, and Methodology

The Department of Homeland Security Office of Inspector General was established by the *Homeland Security Act of 2002* (Pub. L. No. 107–296) by amendment to the *Inspector General Act of 1978*.

Our objective was to assess the causes and impact of medical vacancies at ICE detention facilities and determine whether existing medical staffing plans and vacancies at detention facilities hindered ICE detainees' access to adequate medical care.

We reviewed a variety of documents, including:

- CRCL reports, including reviews of detainee deaths and facility-specific reviews;
- ODO reports documenting deficiencies in detainee medical care, including the number of deficiencies, and conditions resulting from those deficiencies;
- annual IHSC assessments of the timeliness and quality of medical care provided at IHSC-run facilities,
- annual IHSC FMC assessments of the timeliness and quality of medical care provided at non-IHSC run facilities;
- staffing plans and medical vacancy rates for both IHSC-run and non-IHSC run detention facilities;
- a sampling of contracts for medical care, including examples of measures taken for insufficient staffing;
- policies, procedures, guidance, and training materials developed by ICE IHSC;
- samples of IHSC pre-occupancy assessments of space and staffing needs for ICE detention facilities; and
- ICE analysis of challenges recruiting, hiring, and compensating medical staff.

We evaluated five sources of information to identify vacancy rates:

- We analyzed IHSC's FY 2020 strategic plan, which revealed that IHSC tracks medical vacancies at IHSC-run facilities. Furthermore, IHSC has received permission to increase PHS commissioned medical officers from 469 to 569 and to hire 172 new GS medical staff to replace some contract staff at IHSC-run facilities, increasing the number of GS medical staff from 39 to 211. Until IHSC fills these vacancies, in many instances with contractors who already work at the facilities, IHSC vacancy rates will remain misleadingly high.
- We reviewed Federal vacancy announcements over a 10-month period to identify IHSC-run facilities with chronic Federal vacancies and high numbers of Federal vacancies. For example, several IHSC-run facilities did not fill Clinical Director positions for months.
- We aggregated information from FMC contract facility oversight reports, including data on filled and vacant medical positions. IHSC tracks medical vacancies at non-IHSC run facilities, but tracking methods are not consistent and are not aggregated. Specifically, FMCs submit facility specific reports which consistently document filled and vacant medical positions, but do not consistently compare these to the staffing plan.
- We analyzed medical staffing numbers at the six facilities for which we conducted an in-depth review, as shown in Appendix D.
- We requested information on staffing, vacancy rates, and timeliness of care through interviews with Federal and contract staff at IHSC-run and non-IHSC run facilities.

In our review of facility-specific oversight reports from IHSC, CRCL, and ODO, and our review of staffing plans and vacancy rates documented by IHSC and by facilities, we did not observe an evident relationship between high vacancy rates and negative medical outcomes. IHSC oversight reports indicated that most IHSC-run and contract facilities met basic quality of care metrics. We did not identify a relationship between facilities with higher medical vacancy rates and a lower IHSC score on quality of care. Nor did we identify a relationship between facilities with higher medical vacancy rates and a greater number of identified ODO deficiencies, or more serious ODO deficiencies. As noted in our report, measures taken by facilities to mitigate the effects of vacancies, such as overtime, pool nurses, and temporary reassignments, lessen the likelihood of identifying such a relationship. Nonetheless, because IHSC's FY 2020 vacancy rates were misleadingly high, and IHSC did not aggregate information on medical vacancies at contract facilities, ICE cannot currently review a complete and comprehensive picture of medical vacancy rates.

We conducted 73 interviews for this review. Among IHSC staff, we interviewed headquarters staff responsible for clinical care, policy, and staffing, as well as field medical staff at 10 of the 20 IHSC-run facilities, a sampling of FMCs, Regional FMCs, and Regional Clinical Directors. We interviewed ICE staff responsible for policy, human resources, background investigations, and contract administration.

We conducted in-depth reviews of six ICE detention facilities. These included two facilities for which IHSC provided medical care and four for which contractors provided medical care. The six facilities included one facility managed by ICE, one under a USMS intergovernmental service agreement, and four under ICE contracts. For these six facilities, we conducted interviews with health service administrators, long-term and recently hired Federal and contract medical staff, ICE ERO managers responsible for the facility, ICE contracting officers, representatives of the facility, specialists and hospitals providing offsite care, and detainees. We also reviewed relevant documentation about staffing, detainee medical care, and grievances.

We conducted our fieldwork between August 2020 and March 2021 under the authority of the *Inspector General Act of 1978*, as amended, and according to the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

Appendix B
Management Comments to the Draft Report

Office of the Chief Financial Officer

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

U.S. Immigration and Customs Enforcement

October 12, 2021

MEMORANDUM FOR: Joseph V. Cuffari, Ph.D.
Inspector General

FROM: Stephen A. Roncone
Chief Financial Officer and
Senior Component Accountable Official

SUBJECT: Management Response to Draft Report: "Many Factors Hinder ICE's Ability to Maintain Adequate Medical Staffing at Detention Facilities" (Project No. 20-058-SRE-ICE)

Thank you for the opportunity to comment on this draft report. U.S. Immigration and Customs Enforcement (ICE) appreciates the work of the Office of Inspector General (OIG) in planning and conducting its review and issuing this report.

ICE is pleased to note the OIG's acknowledgement that ICE detention standards require all facilities to provide detainees with access to adequate medical care. The OIG acknowledges that the ICE Health Service Corps (IHSC) either provides on-site medical services or oversees medical care at detention facilities. In fiscal year (FY) 2020, for instance, IHSC provided medical care to approximately 100,000 detainees, and contracted with private companies and government entities to provide care for approximately 169,000 additional detainees. The OIG also recognized that several DHS entities monitor compliance with standards for medical care.

More specifically, the OIG acknowledged that ICE detention standards establish consistent conditions of confinement, and set requirements for detainee healthcare, including initial health screenings, preventative care, diagnosis, health education, and treatment. In addition, the standards facilitate access to legal representation and safe and secure operations across the detention system, and establish consistent program operations and management expectations, accountability for compliance, and a culture of professionalism.

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ICE remains committed to continually enhancing its detention operations to promote a safe and secure environment for detainees and staff. ICE utilizes a layered approach to monitor conditions at facilities, with processes in place to implement corrective actions in instances of non-compliance with ICE detention standards. For example, ICE's detention operations are overseen by field office personnel, through inspections by ICE's Office of Professional Responsibility, and via other programmatic oversight and inspections by ICE Enforcement and Removal Operations (ERO).

The draft report contained five recommendations with which ICE concurs. Attached find our detailed response to each recommendation. ICE previously submitted technical comments addressing several accuracy, contextual, and other issues under a separate cover for OIG's consideration.

Again, thank you for the opportunity to review and comment on this draft report. Please feel free to contact me if you have any questions. We look forward to working with you again in the future.

Attachment

Attachment: Management Response for Recommendations Contained in 20-058-SRE-ICE

OIG recommended that the Acting Director of ICE:

Recommendation 1: Evaluate the feasibility of offering hiring and retention incentives for high-demand Public Health Service and General Schedule healthcare professionals. Provide evaluation results.

Response: Concur. The ICE ERO IHSC and ICE Office of Human Capital (OHC) have taken a number of actions to offer hiring and retention incentives to healthcare professionals. Within the Public Health Service, for example, IHSC collaborated with the Assistant Secretary for Health and the Public Health Service Commissioned Corps Headquarters (CCHQ) Immediate Office of the Director to implement an Assignment Pay (AP) incentive to officers who meet the eligibility requirements and are assigned to specific geographic remote locations. Effective January 13, 2021, AP is offered for specific categories, professions, and/or specialties and requires a contractual service obligation. AP is currently offered at the following IHSC facilities: (1) Alexandria Staging Facility, Alexandria, LA; (2) Berks County Residential Center, Leesport, PA; (3) Buffalo Federal Detention Center, Batavia, NY; (4) Caroline Detention Facility, Bowling Green, VA; (5) EL Paso Service Processing Center, El Paso, TX; (6) Elizabeth Contract Detention Facility, Elizabeth, NJ; (7) Eloy Detention Center, Eloy, AZ; (8) Varick Staging Facility, New York, NY; (9) Florence Service Processing Center, Florence, AZ; (10) Houston Contract Detention Facility, Houston, TX; (11) Krome Service Processing Center, Miami, FL; (12) LaSalle ICE Processing Center, Jena, LA; (13) Montgomery Processing Center, Conroe, TX; (14) Port Isabel Service Processing Center, Los Fresnos, TX; (15) South Texas Family Staging Center, Dilley, TX; (16) South Texas ICE Processing Center, Pearsall, TX; and (17) T. Don Hutto Detention Center, Taylor, TX; and a number of healthcare professions are eligible for AP if their site meets the vacancy rate criteria, and the officer agrees to fulfill the contractual service obligation. Covered positions include: Medical Officers, Dentists, Psych Nurse Practitioners, Nurse Practitioners, Physician Assistants, Psych Nurses, Psychologists, Social Workers, Pharmacists, Facility Healthcare Program Managers, Health Service Administrators, and Assistant Health Service Administrators.

IHSC, along with agencies such as the Federal Bureau of Prisons and Indian Health Service, are able to offer AP based on their "Isolated/Hardship Award" status designated by U.S. Public Health Service Commissioned Corps Instruction 633.06, Assignment Duty Pay, Section 6-3, dated January 13, 2021. To qualify for AP, IHSC locations must have a two-year average vacancy rate that is above 30 percent for a critical need category,

profession and or specialty. IHSC is tasked to send updated vacancy reports of categories, professions and specialties that are critical to meeting the agency's clinical and health care missions to CCHQ annually by the end of July each year, and is also tasked with budgetary responsibilities, as well as tracking AP applications.

For hiring under the General Schedule, IHSC collaborated with ICE OHC to identify recruitment and retention incentives for IHSC healthcare professionals. For example, in FY 2021, ICE implemented the Student Loan Repayment Program, which IHSC utilizes for recruitment and retention. IHSC also offers relocation incentives for Nurse Practitioners, Psych Nurse Practitioners, Physician Assistants and Medical Officers. IHSC and ICE OHC are in the process of developing a Special Salary Pay Rate (SSR) proposal for submission to the DHS Office of the Chief Human Capital Officer (OCHCO) and Office of Personnel Management (OPM) for review and decision. Once implemented, the SSR would be used to hire for hard-to-fill healthcare professions at 17 IHSC sites, such as Social Workers, Psychologists, Registered Nurses, Nurse Practitioners, Psych Nurse Practitioners, and Physician Assistants. The SSR will also align with the Public Health Service AP program. In support of this effort, IHSC and OHC meet each week to provide status updates of assigned roles and responsibilities. Based on OPM SSR criteria, IHSC is charged with developing a separate SSR package for each discipline and location. IHSC plans to submit the SSR proposal to OHC in June 2022, after which the proposal will undergo the review process by both DHS OCHCO and OPM. In the interim, IHSC is collaborating with the ERO Human Resources (HR) Division to determine the extent of recruitment and retention incentives available to offer to new recruits and current employees who are incumbering the hard-to-fill healthcare professions. To date, there would be approximately 98 new recruits and current employees eligible for this incentive program, if approved. Estimated Completion Date (ECD): December 31, 2022.

Recommendation 2: Evaluate staffing in Immigration and Customs Enforcement units supporting Immigration Health Service Corps personnel to ensure there are adequate staff to expedite processing applications for medical positions. Provide evaluation results.

Response: Concur. The ICE HR Operations Center and ERO HR Division will evaluate their current staffing to ensure it is adequate to expedite the processing of IHSC hiring and personnel actions, as well as review and update current HR policies and operating procedures to clearly outline recruitment and retention incentive processes. ICE HR Operations Center and ERO HR Division will conduct training so that program office representatives that support IHSC have the knowledge base to improve the efficiency in processing Senior Selection packages, Special Agency Need Salary requests, and recruitment incentive packages.

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The ICE HR Operations Center and ERO HR Division will also evaluate their workflow to determine whether more staff are needed, or if training and process improvements are more appropriate. This will also include a review of roles and responsibilities for each component to ensure staff is trained appropriately and the most efficient processes are in place to process IHSC's Civil Service recruitment and personnel actions. IHSC currently has a Personnel Unit comprised of eight employees that provide full-service HR services to Public Health Service officers. There are no additional staff needed to manage Public Health Service personnel at this time. ECD: March 31, 2022.

Recommendation 3: Evaluate the feasibility of including specific medical staffing requirements in future contract negotiations. Provide evaluation results.

Response: Concur. ICE ERO Custody Management (CM) will work with the Office of Acquisition Management (OAQ) to explore the feasibility of including specific medical staffing requirements in non-IHSC staffed detention facility contracts to ensure compliance with applicable ICE detention standards. Further, CM will also collaborate with OAQ to ensure future contract language includes Quality Assurance Surveillance Plans (QASP) and the option of sanctions for non-compliance as it pertains to medical staffing. In consultation with OAQ and IHSC staffing experts, CM will ensure staffing plans are reviewed annually to identify any changes to staff positions that may be required to ensure the delivery of health care services per the terms of the contract. In addition, CM will provide IHSC access to non-IHSC staffed facility medical staffing plans so that Field Medical Coordinators (FMCs) have the required visibility to assist with assessing quality of care and overall continuum for healthcare delivery. ECD: March 31, 2022.

Recommendation 4: Evaluate current staffing levels for Field Medical Coordinators to determine whether additional staff could enable more effective oversight of contract medical care. Provide evaluation results.

Response: Concur. IHSC evaluated FMC staffing level effectiveness, which was an IHSC Medical Case Management Unit (MCMU) strategic goal for FY 2021. Accordingly, IHSC established a working group at the end of FY 2020, which identified, collected, and analyzed sources of subjective and objective data using a workforce planning model with the overall goal of identification of data-driven programmatic needs. Data sources included the: (1) IHSC Medical Case Management Unit: Evaluation of Program Trends: Data Analysis Report, dated February 24, 2021; (2) FMC position description; (3) analysis of the FMC program strengths, weaknesses, opportunities, and threats; (4) a national FMC exit survey; (5) a national Field Office Director survey; (6) a IHSC Headquarters survey; (7) the IHSC organizational chart; and (8) FMC retention rates.

Based on its analysis, the working group recommended add eight FMC positions, including three regional program managers, three additional deputy regional FMCs, and two additional FMC positions (one in Phoenix and one in Dallas). Formal presentation of the FMC staffing evaluation and MCMU recommendations to the IHSC Executive Governing Board is pending, and the following actions have been completed or are in progress:

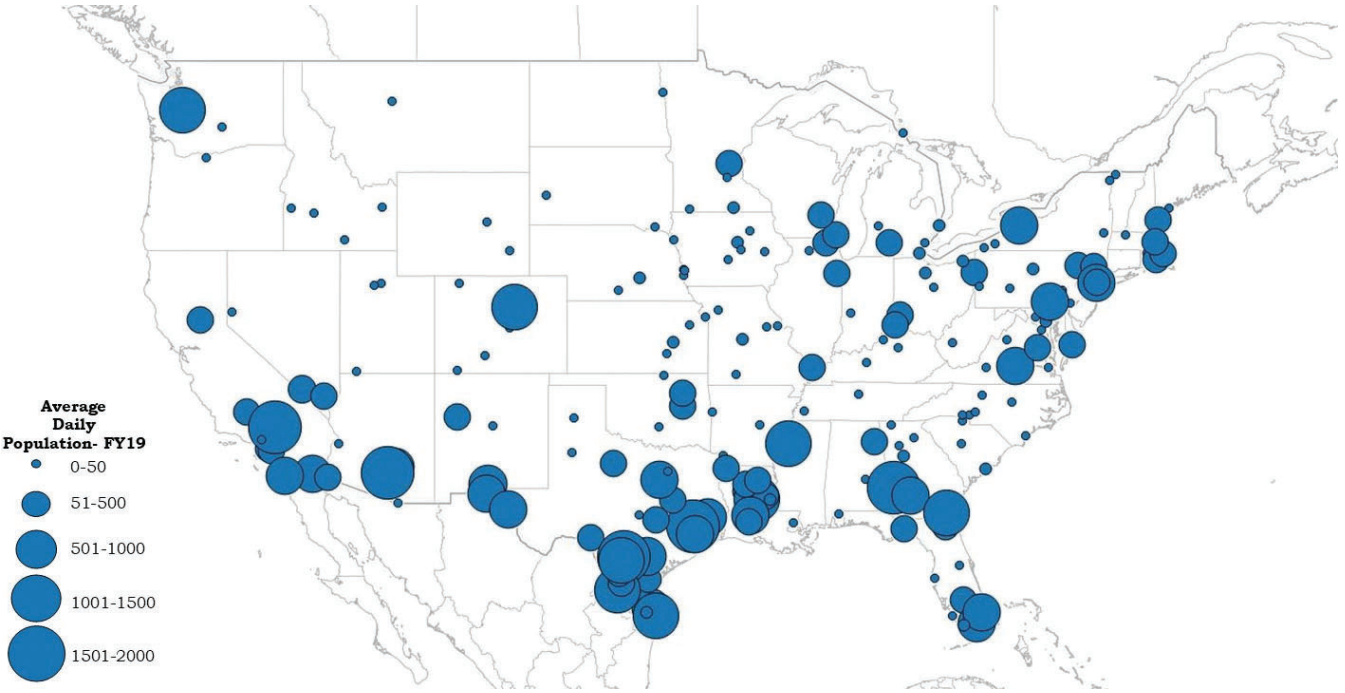
- Newly-created positions for three regional program managers were solicited and selected, and will be onboarding by November 30, 2021.
- The creation of three additional deputy regional FMC positions are pending IHSC headquarters approval.
- An FMC position moved from another office to Phoenix was solicited and selected, and will be onboarding by January 31, 2022.
- An additional Dallas FMC position is pending IHSC headquarters approval.

ECD: March 31, 2022.

Recommendation 5: Integrate Immigration Health Service Corps personnel in contract re-negotiations with medical providers to create more oversight of medical staffing and its requirements.

Response: Concur. ICE ERO CM will ensure that IHSC Acquisition Workforce personnel and FMCs are integrated into the contract re-negotiation process for non-IHSC staffed facilities. CM, IHSC, OAC, and the Contracting Officer's Representative (COR) will enhance communication regarding compliance with medically-related QASP elements during the contract's period of performance, as well as when the contract is recompeted. To initiate contract deficiency reports, the FMC will report any medical findings to the COR, who will then inform the Contracting Officer and OAQ about compliance or noncompliance with governing ICE standards and provide the information required for the Contracting Officer to implement sanctions permitted in the contract. Any IHSC findings and recommendations will be provided through the FMC to the COR. This collaboration will be an ongoing and regular process, and will include written reports and assessments specific to the provision of medical care. Further, the FMC will inform the COR and the Contracting Officer about compliance or noncompliance with governing detention standards. This information will assist the Contracting Officer in imposing sanctions permitted in the contract. ECD: March 31, 2022.

Appendix C
FY 2019 Detention Facilities Used by ICE ERO



Source: DHS OIG analysis of ICE detention data

Appendix D
Vacancy Rates at Six Reviewed Facilities

Facility	Vacancy Rate	Care Provider
Kay	0%	ICE Contract
Nevada Southern	4%	USMS Contract
Adelanto	15%	ICE Contract
Buffalo	17%	IHSC*
Jena	18%	IHSC*
Winn	35%	ICE Contract
Average Facility Vacancy Rate	**13%**	ICE/USMS Contracts**

* IHSC-staffed facilities – as noted in Appendix B, IHSC received permission for new positions in FY 2020. Until IHSC fills these vacancies, in many instances with contractors who already work at the facilities, IHSC vacancy rates are misleadingly high.
** Vacancy rates derived from FMC annual oversight reports.
Source: DHS OIG analysis of ICE Detention data

Appendix E
Office of Inspections and Evaluations Major Contributors to This Report

Tatyana Martell, Chief Inspector
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Appendix F
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