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

IHSC HEALTH SYSTEMS ASSESSMENT

IHSC Directive: 11-09
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By Order of the Assistant Director
Stewart D. Smith, DHSc, FACHE STEWART D SMITH Digitally signed by STEWART D SMITH Date: 2021.02.03 16:55:09 -05'00'

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1. **PURPOSE**: This directive establishes a comprehensive internal auditing program to annually assess U.S. Immigration and Customs Enforcement (ICE) Health Service Corps (IHSC) clinic compliance with applicable correctional health care standards. These standards include Performance-Based National Detention Standards (PBNDS), American Correctional Association (ACA), and National Commission on Correctional Health Care (NCCHC). The IHSC health system assessment (IHSA) assists clinics in preparing for external audits against these standards and contributes to the facility's ability to successfully provide high quality health care.

2. **APPLICABILITY:** This directive applies to all IHSC personnel, including but not limited to, U.S. Public Health Service (PHS) officers, civil service employees, and contract personnel. It is applicable to IHSC personnel supporting health care operations in ICE-owned and contracted detention facilities (CDFs) and to IHSC Headquarters (HQ) staff. This directive applies to contract personnel when supporting IHSC in detention facilities and at HQ. Federal contractors are responsible for the management and discipline of their employees supporting IHSC.

3. **AUTHORITIES AND REFERENCES:**

   3-1. DHS Medical Quality Management Directive 248-01 (October 2, 2009).

   3-2. DHS Medical Quality Management Instruction 248-01-001 (September 10, 2012).

   3-3. National Quality Assurance Committee Charter.

4. **POLICY:** IHSC internally assesses and audits the administrative and clinical services that the agency provides within IHSC-staffed facilities annually. The Medical Quality Management Unit (MQMU) oversees and manages the programs that perform these functions.

4-1. All IHSC-staffed facilities must complete an annual health system assessment in collaboration with MQMU. The IHSA involves a pre-arrival review meeting, pre-audit meeting, on-site review, leadership review, and data analysis.

4-1.1 The assessment is unannounced and conducted by designated IHSC personnel to determine whether the services provided at the facilities are within standards based on IHSC policies and accreditation bodies.

4-1.2 Local health staff coordinate their respective local facility team, with support from the Health Operations Unit regional health services administrators (RHSAs), to conduct self-assessments when specified.

4-2. Facility Exemption: IHSC facilities open for one year or less are exempt from the IHSA audit. However, MQMU conducts an initial pre-audit and on-site audit within 18 months from the initial opening date.

4-3. The MQMU Compliance Program manages the IHSA Program, which provides the framework for a collaborative, organization-wide, systematic approach to improving IHSC performance.

4-4. The MQMU senior compliance program manager (SCPM) and IHSA program analyst provide national guidance for the IHSA program. Support of programmatic functions may also include facility health care program managers (FHPMs), regional health services administrators (HSA), and Clinical Services Division (to include the Medical Services Unit (MSU), Nursing Services Unit (NSU), Behavioral Health Unit (BHP), and Public Health and Safety Preparedness (PHSP) Unit staff).

4-5. The IHSA program analyst assists in developing national IHSA policy and guides; serves as a subject matter expert regarding the processes and procedures of on-site assessment and local self-assessments; and provides support to the national process improvement workgroup as needed. The IHSA program analyst coordinates with IHSC divisions, with support from the Health Systems Support (HSS) Division, to implement on-site assessment processes and procedures.

5. RESPONSIBILITIES:

5-1. MQMU Senior Compliance Program Manager

5-1.1 Provides national guidance for the IHSA program in partnership with the IHSA program analyst.

5-1.2 Reviews all IHSA reports during the leadership review process.

5-1.3 Reviews and approves the IHSA annual assessment calendar.

5-1.4 Provides support of IHSA on-site reviews as needed.

5-1.5 Collaborates with the IHSA program analyst to ensure that all program data is analyzed and published for review.

5-1.6 Develops IHSA program goals and strategic plan.

5-1.7 Reviews and approves all executive summaries prior to submission to senior leadership.

5-1.8 Briefs MQMU chief and senior leadership on all IHSA program updates during quarterly and ad hoc meetings.

5-2. MQMU IHSA Program Analyst

5-2.1 Determines which sites may perform a self-assessment or require an on-site assessment, based on the site's previous performance. The IHSA program analyst, in coordination with the MQMU senior compliance program administrator, identify the self-assessment time frame annually.

5-2.2 Notifies sites of exemption from the annual IHSA self-requirement.

5-2.3 Assists with pre-audit chart reviews for on-site assessments as needed.

5-2.4 Designates the IHSA on-site assessment team lead and co-lead.

5-2.5 Assigns each pre-audit reviewer a section to review for on-site assessments.

5-2.6 Maintains and publishes annual schedule for all on-site observations and pre-audit reviews.

5-2.7 Collaborates with the data analysis team annually.

5-2.7.a Collaborates with the data analysis team to update the IHSA dashboard and obtains analysis report.

5-2.7.b Disseminates annual analysis reports at the completion of the assessment fiscal year to IHSC senior leadership and facility leadership.

5-2.8 Organizes and leads the IHSC Review Committee, which MQMU convenes as needed.

5-2.9 Approves and monitors completion status of recommendations from Improvement Plans (IP). Collaborates with IHSA Review Committee representatives and selected workgroup leads to obtain recommendations for process improvement.

5-2.10 Organizes and trains the pre-audit IHSA team.

5-2.11 Communicates IHSA findings to senior leaders (Assistant director (AD), all Deputy Assistant Directors (DAD), and Chief of Staff (CoS) via an executive summary at the completion of each on-site assessment.

5-2.12 Maintains and updates training materials for IHSA. Trains MQMU designated staff, as needed, to perform the roles and procedural functions of on-site assessments and/or pre-audit reviews.

5-2.13 Informs senior leadership of national trends and process improvement plans.

5-2.14 Participates in developing and implementing IHSA strategic planning and annual goals

5-3. Health Operations Unit (HOU) (Regional Health Systems Administrator (RHSA) and/or Health Systems Administrator (HSA))

5-3.1 Accompanies MQMU to conduct the IHSA on-site observations for sites receiving an on-site assessment.

5-3.2 Participates in the IHSA Review Committee meetings.

5-3.3 Assists with pre-audit chart reviews for on-site assessments as needed.

5-3.4 Participates in process improvement workgroup meetings.

5-4. Clinical Services Division (MSU, NSU, BHP, and PHSP)

5-4.1 Assist in the review of national QRP policy and providing applicable updates and feedback as needed.

5-4.2 Provide support to the national process improvement workgroup as an SME.

5-4.3 Identify facility personnel to assist with local QRP reviews and self-assessments as needed.

5-4.4 Provide subject matter expertise regarding medical, dental, and mental health processes evaluated during the IHSA review.

5-4.5 Review facility reports and findings upon completion of the review.

5-4.6 Assist in the development and review of questions as needed,

5-4.7 Assist with tracking local facility trends identified to ensure that quality improvement and patient safety are sustained.

5-4.8 Attend debriefing meetings and teleconferences scheduled by the review team as requested or when available.

5-4.9 Ensure transparency of report findings via leadership chain through communication methods outlined within the CSD.

5-4.10 Assist the local facility triad and FHPM with the development of IHSA corrective action plans related to medical, dental, infectious disease, environmental and/or administrative processes that impact the facility (i.e., annual competency/peer reviews, staff licensures, fit testing dosimetry badges).

5-4.11 Assist in the review of national QRP policy and provide applicable updates and feedback as needed.

5-5. IHSA Audit Team Lead and Co-lead

5-5.1 Schedule and conduct pre-audit meetings for on-site assessments.

5-5.2 Review pre-audit tracker results for improvement plans needed and on-site follow-up.

5-5.3 Complete the on-site review of the IHSC facility:

5-5.3.a Document observation information in the IHSA SharePoint Tool.

5-5.3.b Review chart review findings and document deliverables recommended.

5-5.3.c Recommend IPs based on defined levels.

5-5.3.d Conduct a post-audit meeting with the facility's regional health services administrator and MQMU staff to discuss deliverables for IPs and timelines for completion.

5-5.4 Submit a preliminary report to the IHSA program analyst, senior SCPM, MQMU chief, and deputy assistant director (DAD) of Health Care Compliance (HCC) via the IHSA SharePoint tool.

5-5.5 Review feedback and finalize the IHSA report.

5-5.6 Monitor and track all IPs developed by the facility.

5-5.7 Store completed IPs and supporting documentation in facility folder within the IHSA SharePoint tool.

5-5.8 Notify IHSA program analysts of completion and closure of IPs.

5-5.9 Send facility leadership a copy of the final report.

5-6. Health Services Administrators (HSA)

5-6.1 Develop actions and submit improvement plan draft.

5-6.1.a HSAs are responsible for the development of IPs recommended by IHSA team leads during on-site assessments.

5-6.1.b HSAs develop IPs based on the recommendation of the RHSA and MQMU for self-assessments.

5-6.2 Maintain local records of IPs and finalized reports.

5-6.3 Oversee the self-assessment process.

5-6.4 Establish local self-assessment team (i.e., selects team lead and co-lead, pre-audit chart reviewers, and observation team).

5-6.5 Establish the timeline for completion of tasks.

5-6.6 Submit a preliminary report to the RHSA via the IHSA SharePoint tool.

5-7. Regional HSA

5-7.1 Accompanies MQMU staff when performing an on-site assessment.

5-7.2 Trains MQMU and/or designated staff as needed to perform administrative reviews during on-site visits.

5-7.3 Reviews and approves IPs developed by HSAs for on-site assessment and self-assessment reviews in collaboration with MQMU. During self-assessments, the RHSA reviews the report, identifies areas in need of improvement, and determines IP level as outlined the 11-09 G-01, *IHSA Health Assessment Guide*, located in the IHSC Policy Library. Reviews IHSA measures and data

received from Deloitte data analytics team to identify national trends of national IPs.

5-7.4 Selects members of the process improvement workgroup.

5-7.5 Recommends updates to the database SharePoint Tool and pre-audit tracker as deemed necessary.

5-8. Process Improvement Groups

5-8.1 Meet as needed based on trends identified by the IHSA Review Committee.

5-8.2 Meet with IHSA review committee members to determine the reasons for continued low compliance reflective of trends that identified lop plans to address areas identified for national process improvements.

5-8.3 Collaborate with IHSA program manager, discipline chief(s), policy authors, and applicable subject matter experts to put into effect resolutions and improvement plans identified.

5-9. Chief and DAD of HCC

5-9.1 Review and provide feedback on final IHSA report submitted via the IHSA SharePoint Tool.

5-9.2 Approve national improvement plans and recommendations delineated by the IHSA process improvement group.

5-10. Senior Leadership (Assistant Director, Chief of Staff, and DADs)

5-10.1 Review and provide feedback on executive summaries submitted.

5-10.2 Review national improvement plans established and provide recommendations as needed.

6. PROCEDURES:

6-1. Initiation of Health Systems Assessment: MQMU will initiate the IHSA for all onsite assessments in the IHSA SharePoint Tool 2-4 prior to the assessment. The initiation process includes identifying the type of assessment, team leads, pre-audit reviewers, post-audit reviewers, and leadership reviewers. The SharePoint Tool automatically generates notification emails to inform pre-audit chart reviewers and IHSA team leads of the initiation of the assessment and follow up timeframe. The onsite IHSA review is unannounced. Reviewers and on-site participants are expected to

maintain confidentiality and not disclose on-site dates or locations. The IHSA includes five phases: (a) pre-audit review, (b) audit meeting, (c) onsite review (observations), (d) leadership review, and (e) data analysis.

6-2. Pre-audit Review: The pre-audit review includes chart review and documentation of 11 predetermined sections on the IHSA pre-audit review tracker: consents; transfer summary; intake, sick call; chronic care; physical exams; segregation; medical housing unit (MHU) full admission; suicide watch; hunger strike and language access.

Pre-audit chart reviewers consist of a multi-disciplinary team of IHSC HQ staff (i.e. MQMU, HOU, PHSP, FHPMs and other units as determined by senior leadership) for onsite assessments and field staff (i.e., facility HSA, AHSA, FHPM, nurse manager and other as designated) for self-assessments. Reviewers are responsible for performing chart reviews prior to the onsite review component.

Reviewers select charts randomly and include charts documented within 90 days of the onsite review. If ten charts are not available within the 3-month period, the reviewer will extend the 6-month timeframe. If ten charts are not available during the 6-month timeframe, the reviewer will then perform a review of available within the 6-month timeframe. If there are five or more that failed in compliance in 2 areas, the reviewer will document 25 charts for the section and document the sections reviewed in the pre-audit Excel tracker, and record results in the associated section on the IHSA SharePoint Tool.

6-2.1 **Onsite assessment:** The IHSA program analyst creates a roster of pre-audit reviewers annually and notifies the reviewers of their selection to assist in on-site assessment reviews via email 4-8 weeks prior to the initiation of the first onsite site review. The roster includes the facility name, onsite review date, preaudit reviewer names and section assignments. This roster is confidential and is not shared with the pre-audit review team. However, the IHSA program analyst does share the roster with the IHSA team lead and co-lead for awareness of pre-audit reviewer assignments. Pre-audit reviewers complete and document their reviews on the pre-audit review tracker within 2-3 weeks.

6-2.2 **Self-Assessment:** For self-assessments, the IHSA team lead and co-lead (selected by the facility HSA) notifies the pre-audit reviewers of sections they must complete. The team leads are responsible for notifying all pre-audit reviewers of the date they

must complete and document all reviews in the pre-audit review tracker.

6-3. Pre-audit Meeting: The meeting is scheduled 1-2 weeks prior to the observation period to discuss findings and results of the pre-audit review.

6-3.1 **Onsite assessment:** The IHSA program analyst provides the lead and co-lead of the site review with a roster of pre-audit reviewer and their assigned chart section(s). The team lead is responsible for notifying all pre-audit reviewers of the date and time of the pre-audit meeting.

6-3.2 **Self-Assessment:** For self-assessments, the IHSA team lead and co-lead (selected by the facility HSA) schedule the pre-audit meeting and notifies all pre-audit reviewers of the date and time of the meeting.

6-4. Onsite Review (observations): Onsite reviews include observations of clinic and administrative areas. During the observation component, the IHSA team leads identify areas of improvement based off established thresholds from the reviews and observation findings to recommend IPs as needed. The IHSA guide includes instructional guidance for the conduction of the onsite review. Onsite reviewers consist of MQMU and HOU staff and/or their designees identified by the IHSA Review Committee for onsite assessments. The local IHSA team (i.e. facility HSA, AHSA, FHPM, nurse manager and other staff as designated) conduct onsite reviews for self-assessments. Guidance for self-assessment observation review is in the 11-09 G-01, *IHSA Guide*, located in the IHSC Policy Library.

6-5. Leadership Review: All facility reports undergo a post-audit review. The IHSA program analyst routes the on-site and self-assessment reports via the IHSA SharePoint tool to the RHSA, MQMU, and DAD of HCC for self-assessments. When the HQ IHSA team conduct an on-site visit, the team lead routes the post audit report to the IHSA program analyst, SCPM, MQMU chief, DAD of HCC for review via the IHSA SharePoint Tool providing electronic notification of reports in need of review. All other senior leaders receive a synopsis of the IHSA findings and recommendations via an executive summary.

6-6. Data Analysis: Data analytics team conducts an annual data analysis on all on-site and self-assessment reports. Data analytics team analyzes the on-site, self-assessment, and pre-audit reports. A data analysis dashboard is available for review by field and HQ staff. The IHSA program analyst

disseminates analysis reports, annually, to senior leadership at the completion of the assessment fiscal year. Reports indicate an average score for all facilities and individual site scores by areas reviewed. Analysis reports assist in determining areas where process improvement is needed.

7. **Audit Results:** Facilities undergo a repeat on-site assessment when the calculated facility score is less than 75%, or as recommended by MQMU, HOU, and/or senior leadership. Facilities conduct a self-assessment when audit results reflect that the site performed satisfactory by obtaining a facility score of 75% or greater on the most recent on-site review, and when processes do not warrant a Level 3 improvement plan.

8. **HISTORICAL NOTES:** This is a new directive with no historical notes.

9. **DEFINITIONS:** Definitions are listed in the IHSC Glossary in the IHSC Policy Library.

9-1. Improvement Plan (IP): Actions initiated based on pre-audit and observation findings when recommended thresholds are not met. For the purpose of the IHSC Health Systems Assessment, improvement plans are tiered as Level 1, Level 2, or Level 3.

9-2. Levels

9-2.1 Level 1: Findings are issues that do not directly impact detainee safety or cause harm (i.e., missing language identification signs in the pre-screen area or poor documentation of the use of a translator within charts reviewed). These IPs are required by the IHSA Program Analyst, Senior Compliance Program Administrator, Regional HSA and any subject matter experts from consulting units (i.e., Medical Services Unit, nursing services unit, behavioral health unit, advanced practice provider unit) review and implementation by the facility (i.e., Facility Healthcare Program Manager and/or facility triad leadership) within 45 days of notification of identified concerns.

9-2.2 Level 2: Findings or issues that could potentially impact detainee safety or cause harm if not addressed (i.e., pill line medication verification process [5 rights of medication administration as referenced in the IHSC Medication Administration Guide] is not followed per policy, or threshold not met for the documentation of Physical Exam-Complex for chronic care patients). Level 2 IPs identify the need for a detailed review of facility processes immediately for safety concerns and within 30 days for less urgent

matters. As a result, MQMU notifies the facility immediately of the findings for rapid action. The facility must promptly address and implement Level 2 IPs upon notification of the issue(s).

9-2.3 Level 3: Entails a formal corrective action plan (CAP) for processes that warrant immediate improvement or when facilities are not continuing to progress and show improvements in the other levels. Level 3 IPs are high priority issues and can cause patient harm or impact safety if not abruptly addressed (i.e. missing/expired BLS or chart audits results indicating that the site is not meeting the threshold for daily mental health follow ups for patients on suicide watch). The facility should urgently review and quickly address Level 3 IP plans with an immediate plan for implementation.

10. APPLICABLE STANDARDS:

10-1. Performance Based National Detention Standards (PBNDS): Part 4: Care;

4.3 Medical Care; 2. Health Care Internal Review and Quality Assurance.

10-2. Family Residential Standards (FRS): Part 4: Care;

4.3 Medical Care; Health Care Internal Review and Quality Assurance.

10-3. American Correctional Association (ACA) Performance-Based Standards for Adult Local Detention Facilities, 4th Edition:

4-ALDF-7D-01 through 7D-02: Quality Improvement Practices.

11. RECORDKEEPING:

11-1. IHSC creates, receives, stores, retrieves, accesses, retains, and disposes of these records in accordance with DHS/ICE-013 Alien Medical Records Systems of Records and National Archives and Records Administration approved records retention schedules. Contact the IHSC Records Liaison for further information or guidance.

Protection of Detainee Health Records and Sensitive Personally Identifiable Information (PII)

11-1.1 ICE uses detainee health records and information maintained in the DHS/ICE-013 Alien Medical Records System of Records to provide for the care and safety of detainees. IHSC will limit access to detainee health records and information to those individuals who

need to know the information for the performance of their official duties, and who have appropriate clearances or permissions. IHSC will always secure paper records in a locked cabinet or room when not under the direct control of an officer or employee with a need for the paper record to perform their duties.

11-1.2 IHSC staff are trained at orientation and annually on the protection of patient health information and sensitive PII.

11-1.3 IHSC staff reference the Department of Homeland Security Handbook for Safeguarding Sensitive PII (Handbook) at DHS Handbook for Safeguarding Sensitive PII for additional information concerning safeguarding sensitive PII.

12. **NO PRIVATE RIGHT STATEMENT:** This directive is an internal directive statement of IHSC. It is not intended to, and does not create any rights, privileges, or benefits, substantive or procedural, enforceable against the United States; its departments, agencies, or other entities; its officers or employees; or any other person.

13. **POINT OF CONTACT:** Chief, Medical Quality Management Unit.