

**Health Care Monitor**  
**7<sup>th</sup> Report**  
**Lippert v. Jeffreys**  
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## Executive Summary

### *Addresses items II.A;*

**II.A.** *Defendants shall implement sufficient measures, consistent with the needs of Class Members, to provide adequate medical and dental care to those incarcerated in the Illinois Department of Corrections with serious medical or dental needs. Defendants shall ensure the availability of necessary services, supports and other resources to meet those needs.*

A major step in the Defendant's progress towards compliance with the Consent Decree occurred in August 2023 when the Implementation Plan was finalized and filed with the Court. The format for each section of this report now includes, in addition to the Consent Decree, the language of the Implementation Plan relevant to each of the subjects listed in the Table of Contents. The Monitor's evaluation of Defendant's progress is measured in relation to the Implementation Plan since these are the steps necessary to achieve compliance. As a result, fewer recommendations are made in this report since the Implementation Plan has incorporated the majority of those contained in prior reports.

The Implementation Plan contains the following statements which pertain to the relationship between Defendants and the Monitor:

**Implementation Plan narrative page 7-8:** *The Consent Decree requires the Monitor to provide input and assistance to IDOC and specifically states in Section IV.A:*

*The Defendants, **with assistance of the Monitor**, shall conduct a staffing analysis and create **and implement** an Implementation Plan to accomplish the obligations and objectives in this Decree.*

*To alleviate misunderstanding, input is defined as help, ideas, knowledge, advice or information given to IDOC by the Monitor **prior** to development or initiation of Implementation Plan tasks and **ongoing** help, ideas, knowledge, advice or information occurring during development and implementation of any IDOC effort to make changes called for by the Consent Decree.*

*Assistance is defined as contributing, supporting or helping in the effort to complete tasks. Assistance is provided on an ongoing basis, as deemed necessary by the Monitor or as requested by IDOC or its consultants, in the effort to attain compliance with the Consent Decree. Assistance **does not** imply or condone ultimate responsibility for implementation of tasks necessary to comply with the Consent Decree which rests with IDOC.*

*Input and assistance of the Monitor shall not unreasonably distract IDOC staff or consultants from their duties; will be evidenced by free and open communication between the Monitor and his consultants with clinical leadership of IDOC and their consultants; and will be arranged and scheduled by the Monitor and his consultants or at the request of the IDOC clinical leadership or their consultants. This communication shall not be controlled or directed by IDOC attorneys.*

The Monitor's assistance and input has been sought on a number of occasions. These have included substantive contributions in the review of policies and development of procedures, a proposed staffing study, and a capital construction report. There has also been an initial discussion about the nature and components of a comprehensive audit. The Monitor has provided ongoing advice and support for the expansion treatment for hepatitis C, the provision of adult immunizations, the performance of routine health maintenance screening tests, expanded access to physical therapy and dental hygiene services, nurse sick call, and the formation of an infection

control program. Communication between the Monitor team with IDOC and their consultants is notably improved.

**Implementation Plan narrative page 8** states: *The Illinois Department of Corrections, the Office of Health Services and Governor Pritzker take seriously the obligation to provide quality health care to the individuals in the custody of the IDOC. In keeping with our mission and vision, we commit ourselves to caring for some of the most disadvantaged and vulnerable members of society. While we recognize that there will be many challenges on the road to compliance, we understand the importance of looking critically at the care we deliver. We will work diligently and collaboratively with the Monitor to develop a system for the delivery of health care that is safe, effective and respectful of the individuals who are entrusted to our care.*

The two major barriers holding back IDOC's progress toward compliance with the Consent Decree and the resulting safe, effective, and respectful health care delivery system are staffing and the physical plant deficiencies. Half of the positions the medical vendor is responsible for providing are unfilled.<sup>1</sup> Approximately the same number of staff are working today as worked at the beginning of the Consent Decree. In this report, IDOC was unable to provide State employee staffing numbers with vacancies at their facilities. The findings reported by the Mortality Committee provide ample evidence of the lack of physician oversight in the clinical care provided to patients in IDOC facilities. Correctional officer vacancy rates have limited patient access to health care both within the facility as well as specialty care provided in the community. IDOC is unable to provide access to nursing, medical and dental care for non-urgent health problems. Throughout this report there is evidence of the state's inability to create and fill critical positions needed to implement the changes required by the Consent Decree. These include for example, physicians, dentists, project managers<sup>2</sup>, infection control nurses, facility quality improvement staff, registered nurses, licensed practical nurses, and nursing supervisors.<sup>3</sup> The state needs to radically change the recruitment and hiring process and expect the same from the contract vendor.<sup>4</sup>

IDOC completed a Master Plan for Facilities in May 2023 which documents the inadequacy of the space and physical plant at existing facilities. Among the recommendations were the construction of a geriatric unit, increased space for medical and mental health programs, and reduction of the deferred maintenance backlog. Another study initiated by IDOC was of the space needed at six facilities in the Southern Region to support medical and mental healthcare needs. This study concluded with two design options to address physical space needs for these programs. The Monitor commented that the resulting designs suffered from insufficient clinical input. Neither the Master Plan nor the space study for facilities in the Southern Region were informed by the Implementation Plan.<sup>5</sup> It is doubtful that the problems with the physical plant will be sufficiently resolved in the time period remaining for IDOC to attain compliance with the Consent Decree.

The Department has yet to select a vendor to provide an electronic medical record. The Consent Decree called for this to be done within the first 120 days, a deadline which passed four years ago. If a contract were signed today, it would likely take an additional two or more years to effectively implement the electronic record or the

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<sup>1</sup> The IDOC was unable to provide any information on how many state positions are allocated and vacant.

<sup>2</sup> Project managers for the Implementation Plan, policies and procedures, and implementation of the electronic health record.

<sup>3</sup> OHS has filled the two vacant Deputy Medical Director positions with qualified individuals. OHS also permanently appointed individuals to the Infectious Disease Coordinator and Quality Improvement positions. Both these individuals are pursuing additional education and certifications in the specialty and once completed will be considered appropriately qualified.

<sup>4</sup> Other correctional systems are recovering from the COVID pandemic and reducing vacancy rates; this has yet to be accomplished in the IDOC.

<sup>5</sup> The Implementation Plan includes an evaluation of the population of persons who are elderly, infirm, and/or disabled and incarcerated (items 64 – 70) as well as a focused review of clinical space and equipment necessary to provide adequate medical and dental care (items 95-99). Neither of these have been initiated yet.

seventh year of Consent Decree.<sup>6</sup> In the meantime, approximately 10% of deficiencies needing improvement in the minutes of Mortality Review Committee meetings were related to medical records documentation.

IDOC initiated a concerted effort to develop a comprehensive set of policies and procedures this last year. These drafts have been provided to the Monitor for review and input. However, the majority of these have not yet been finalized so implementation at the facilities has not begun. Based upon the erratic implementation of revised policies for immunization and colorectal cancer screening, OHS needs to attend to the implementation process and personnel outlined to do this in the Implementation Plan. There do not appear to be sufficient staff to implement policies.

Access to specialty care, including diagnostic testing is still poor. Timeliness of specialty referral and follow up remains problematic and constituted one of the most frequent deficiencies identified in mortality reviews. Even though collegial review was discontinued past referral practices continue to dampen provider's decisions to seek specialty consultation when it is the standard of practice to do so. The absence of physician oversight and insufficient support staff contribute to delays and poor communication about patient treatment. Reimbursement rates for specialty care providers appears to be a significant problem statewide and the state of Illinois needs to reexamine if the current method of reimbursement for offsite care is a barrier to access.<sup>7</sup>

Areas of health care delivery that are still noncompliant include the initial health assessment and creation of the problem list, infirmary services, pharmacy and medication administration, specialty care, hospital care, and dental access. There has been some forward progress in the Defendants ability to self-monitor and identify problems. The Defendants have the results of the 12 performance and outcome measures, completed four times at each facility over a 12 month period. Also, the Mortality Review Committee has completed more than 100 mortality reviews that resulted in nearly 900 opportunities identified for improvement. However only three quality improvement projects have been initiated.<sup>8</sup> No directions, expectations, training, or consultation has been provided at the facility level to correct problems identified. There has been no concrete progress toward development of the comprehensive audit, adverse event reporting has not been initiated, and the vendor's performance is not monitored. There is a long way yet to go in achieving the data and metrics to monitor and manage the quality of health care provided by the IDOC. Vendor Regional Medical Directors have not embraced the requirements for change required by the Consent Decree. One of the Regional Medical Directors was not familiar with the Implementation Plan, and openly challenged the results of performance and outcome results and findings from the SIU mortality reviews. Such recalcitrance only contributes to Defendants slow progress addressing the conditions which brought forth the Consent Decree.

After nearly five years, the lack of progress towards compliance with the Consent Decree can be summarized as a failure by the State to establish the foundations of an adequate medical program in the IDOC. The root cause of failures in hiring staff, obtaining qualified physicians, enacting capital improvements including for the elderly and disabled, getting a contract for, and implementing an electronic medical record, are due to practices not controlled by OHS that concern funding, personnel and contracting. Without the ability to hire, manage the workforce, make capital improvements, or obtain contract services much more expeditiously, it will be extremely difficult to achieve any semblance of compliance with the Consent Decree. The Monitor cautions Parties and the Court that IDOC will not attain compliance with this decree in the ten years that is specified for completion unless significant changes occur. The State should explain to the Court what changes they will make to bring IDOC into compliance within the remaining five years.

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<sup>6</sup> Implementation of the electronic record is to be completed within 36 months of the contract execution.

<sup>7</sup> This would include a consideration of whether the funding provided to UIC for specialty care and hospital care is sufficient for the volume of care IDOC is receiving and seeking and whether the inability to obtain services from other specialists is impeded by reimbursement rates.

<sup>8</sup> The improvement projects are colorectal cancer screening, immunizations, and standardizing how sick call requests are made.

Further details on these essential concerns are provided in the different sections of the report.



## Statewide Issues: Leadership and Organization

### Leadership Staffing

*Addresses item II.B.2; II.B.3; III.A.1; III.A.8; III.A.9*

**II.B.2.** *IDOC shall require, inter alia, adequate qualified staff, adequate facilities, and the monitoring of health care by collecting and analyzing data to determine how well the system is providing care. This monitoring must include meaningful performance measurement, action plans, effective peer review, and as to any vendor, effective contractual oversight and contractual structures that incentivize providing adequate medical and dental care.*

**II.B.3.** *IDOC must also provide enough trained clinical staff, adequate facilities, and oversight by qualified professionals, as well as sufficient administrative staff.*

**III.A.1** *The Chief of Health Services shall hereafter be board certified in one of the specialties described in paragraph III.A.2, below. The Deputy Chiefs of Health Services shall either be board certified or currently board-eligible in one of the specialties described in paragraph III.A.2, below.*

**III.A.8.** *Within eighteen (18) months of the Effective Date Defendants shall create and fill two state-employed Deputy Chiefs of Health Services positions reporting to the Chief of Health Services to provide additional monitoring and clinical oversight for IDOC health care.*

**III.A.9.** *Within nine (9) months of the Effective Date every facility shall have its own Health Care Unit Administrator ("HCUA"), who is a state employee. If a HCUA position is filled and subsequently becomes vacant Defendants shall not be found non-compliant because of this vacancy for nine (9) months thereafter.*

**OVERALL COMPLIANCE:** Partial Compliance

### FINDINGS:

**Implementation Plan narrative page 1:** *Defendants recognize the significant benefits associated with developing an enhanced leadership structure for OHS. Enhanced leadership includes additional OHS executive level staff, the development of audit teams, a quality improvement team, and increased data assistance. This affords OHS the ability to have more intensive oversight of health care staff, conduct more effective vendor monitoring and have the ability to dedicate staff to transforming the Department's quality improvement program. Accordingly, this task will serve as a primary focus for the Department.*

Implementation Plan narrative page 2: *Organize the OHS to effectively implement this plan.*

### **Implementation Plan item 2: Complete hiring of Executive OHS Leadership staff.**

*SIU will hire audit teams (1 coordinator, 2 physicians, 2 nurse practitioners, 4 RNs, 2 quality specialists, part-time dentist) 3 data team members, an executive director, a director of quality management, an administrative assistant, a quality improvement coordinator, 2 quality improvement specialists, 3 process analysts. IDOC will negotiate with SIU to hire project managers listed below. **Proposed End Date: May 2023***

### **Implementation Plan item 2a: IDOC will hire project managers for the following services:**

- 1. Full-time Implementation Plan project manager*
- 2. Full-time Electronic Medical Record project manager*
- 3. Full-time Policies and Procedures project manager*

**Proposed End Date: October 2023**

The Implementation Plan items listed above have only been partly accomplished. A list of allocated and vacant positions for OHS has not been provided but was requested. The table of organization lists 24 staff positions in OHS, six of which are executive secretaries or office associates. Of the 18 remaining OHS positions five (28%) positions are vacant.<sup>9</sup> The only position descriptions not received are the Food Service Manager, Dietician, and Risk Manager positions. All three Regional Coordinator positions are filled; position description for this position have been provided. Only two of 30 Health Care Unit Administrator positions are vacant<sup>10</sup>. IDOC does not currently maintain a table of allocated and filled OHS positions and did not provide allocated and filled positions for either OHS or for the facilities; only vendor staff allocated and vacant positions were provided. The Monitor was therefore unable to determine whether supervisory staffing has improved or deteriorated since the last report. The list of staffing is manually created at the facility level. OHS has asked for these lists but facilities did not provide them. It appears that OHS does not now have a process of tracking positions in OHS or in facilities.

Allocated and filled positions for SIU were also requested but have not been provided. In addition to OHS and facility leadership staffing, SIU is responsible for hiring multiple positions required in the Implementation Plan. SIU did provide a list of 24 different position types they have been budgeted to hire without informing how many positions have actually been hired. Hours-of-work accomplished by SIU from January to June of 2023 was provided and was equivalent to 10.21 full time equivalent positions but 3.86 were administrative.

With respect to the three project manager positions required in Implementation Plan item 2a none have been hired. Currently the Health Care Compliance Coordinator is acting in the role of a policy project manager. As of September<sup>11</sup>, IDOC was uncertain how to proceed with respect to hiring a policy project manager. In October, SIU listed a project manager position in their list of positions. SIU said that this is a policy project manager position, but this has not been verified with a position description, posting, or evidence of hiring. IDOC has stated that they are in the process of creating a posting for a personal service contract for project managers for the Implementation Plan and for the electronic health record. This is working its way through the state hiring process.

The full complement of staff required by the Implementation Plan has not yet been allocated or hired. Position descriptions and resumes for filled positions have not all been provided but have been requested. OHS will be impaired in implementing the Consent Decree with the lack of leadership staffing.

#### **Implementation Plan items related to organizational structure.**

**Implementation Plan item 4:** *Revise existing policy so that Agency Medical Director or designee will approve position descriptions (which include qualifications) for facility healthcare specific positions including facility infection control coordinators, chronic care nurses, and quality improvement coordinators. The Agency Medical Director will ultimately be responsible for recommending the hiring and firing for all health care employees through designees, **Proposed End Date: July 2023***

**Implementation Plan item 5:** *Create draft OHS organizational chart, including vendors, to demonstrate OHS reporting structure. The organizational chart will show that the Agency Medical Director is ultimately responsible directly or through designees for the recommendation of the hiring and firing of all health employees including the HCUA. The organizational chart will clarify the reporting and supervisory relationship between the Office of Health Services leadership to the facility Health Care Unit Administrator. **Proposed End Date: August 2023.***

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<sup>9</sup> Food Service Manager, Dietician, Risk Manager, Program Coordinator HIV, and Public Health Education Associate.

<sup>10</sup> August 2023 Facility Listing document provided for this report.

<sup>11</sup> Based on an email 9/5/23

**Implementation Plan item 6:** *The organizational chart will illustrate the relationship between the Office of Health Services leadership and vendor staff and the relationship between the HCUA and vendor staff at each facility. The table of organization shall represent supervisory relationships. **Proposed End Date: August 2023***

The Monitor has no evidence that the Chief OHS approves position descriptions for facility health staff. Facility infection control coordinators, quality improvement coordinators, and chronic care nurses do not exist as separate positions and there are no position descriptions.

The OHS table of organization does not yet demonstrate an effective line of clinical authority consistent with the Consent Decree and the Implementation Plan. Distinct silos of vendor and State staff remain without clear lines of authority. In the existing table of organization, the Regional Coordinators clinically supervise HCUAs by virtue of what is called the clinical matrix, but this is undefined. There is no unified table of organization of all elements of the health program that demonstrates that the Chief OHS is responsible directly or through designees for all health care staff which includes hiring, firing and assignments by way of their position descriptions. The table of organization does not provide this information. IDOC stated in the Implementation Plan that tables of organization were to be completed by August 2023 but effective tables of organization that show clear functional lines of authority from the Chief OHS to all medical staff are not yet in place.

We asked for facility tables of organization and received ten. In those ten, all HCUAs are shown to report to the Assistant Warden of Programs<sup>12</sup>. These ten tables of organization show no functional line of authority to anyone in OHS. Facility tables of organization varied considerably. In the Hill table of organization, the Assistant Warden of Programs supervised the HCUA who supervised no one. The Warden at Hill is shown to supervise the medical vendor Regional Manager who supervised the facility Medical Director and vendor DON. The vendor DON supervised all professional staff. There are still no clear lines of authority through the health program leading to the Chief OHS. Moreover, each facility table of organization appears to be different and does not show clear supervision of all medical staff (vendor and State employees).

With respect to item 6 of the Implementation Plan, there is no apparent line of authority of OHS over the vendor including the medical vendor and SIU. The medical vendor table of organization represents a separate entity. In an interview with a vendor Regional Medical Director, he stated that the Chief OHS was “administratively in charge”, but the vendor was responsible for clinical operations. This relationship cannot be found in position descriptions or tables of organization. In the same interview, the vendor Medical Director stated that HCUAs were responsible for the program onsite but also said that state and vendor nurses are supervised each by their respective supervisor (state or vendor)<sup>13</sup>. In other interviews with vendor medical directors, they said that vendor medical directors had no authority to supervise State nurses. Vendor LPN nurses at Dixon told the Monitor that State RN nurses would not supervise them. These are examples of a program without a functional line of authority. This is evidenced from vendor tables of organization and facility tables of organization which show no line of authority to the Chief OHS. Also, operational practice related to clinical processes is also not clearly under authority of the Chief of OHS.

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<sup>12</sup> The position descriptions of the Regional Coordinators do show that they provide “clinical supervision” to HCUAs but the latest position description of HCUAs does not show this supervision relationship. The HCUA position description for January of 2021 shows the HCUA reporting to the Assistant Warden of Programs.

<sup>13</sup> This was in response to documentation regarding immunization in which the vendor Medical Director said that nurses don’t use the Database to record immunization. When it was pointed out that the vendor was responsible for ensuring nurses documented data accurately on the Database, the vendor Medical Director said that the vendor did not supervise the state nurses who comprise a considerable number of nursing staff.

This ineffective organizational structure extends to supervisory staff. IDOC created a “clinic matrix” line of authority from the Chief OHS to HCUAs but despite the “clinical matrix” the Warden still hires and supervises the HCUA and exerts considerable control over clinical care which is why the Monitor still recommended that HCUA staff report in a line to the Chief OHS.

The Monitor continues to identify examples of this lack of OHS control over clinical operations. OHS has no policy on timing of administration of medication. As a result, the timing of administration of medication appears to be determined, by default, by Wardens. At the recent visit to Graham, the Warden told us that medications are administered when meals are served at 4 am, 1 pm and 7 pm. The 4 am to 7 pm times are too far apart and the 7 pm to 4am are too close for twice a day dosing. The 1 pm to 7 pm are too close for three times a day dosing. This decision at Graham is not an apparent medical decision but has clinical ramifications. The dose rate of administration of medication needs to be set by medical leadership relying on pharmacist consultation with respect to medication properties. Certain medications (e.g., anticoagulants, anti-seizure medications, antibiotics, and insulins) may need to be given within timeframes that ensure an effective blood level is reached with minimization of potential side effects. When a Warden makes this decision<sup>14</sup> for convenience or to be consistent with meal timing, medication may be given at times that modify blood levels of drugs adversely or increase the risk of potential side effects. If a drug needs to be administered every twelve hours (twice a day) or every eight hours (three times a day) but instead is administered at meal times the twelve or eight hour dosing rate cannot be accomplished which may adversely affect the effectiveness or safety of the medication administered.

A second example is timing of meals to insulin administration for which there are no medical policies which results in defaulting to custody procedures that can cause harm. There are multiple types of insulin. Rapid acting insulins have an onset of action of 5-15 minutes with a peak action in an hour. Regular insulin has an onset of action in half an hour with a peak action in 2-4 hours. Many patients in IDOC are on regular insulin. When regular insulin is administered, a patient needs to eat within half an hour or risks hypoglycemia. In a discussion with nine inmates with diabetes at Graham, they related that the timing of meals after insulin administration at Graham is such that they have experienced hypoglycemia as a result or have modified their insulin use because of fear of hypoglycemia. At Graham, people with diabetes are woken at 4 am for insulin. Whether a 4 am breakfast is reasonable is a separate issue. Inmates said that after insulin administration, they are returned to their housing units and are not immediately fed. One inmate described getting insulin at 4 am and breakfast at 5:40 am. As a result, many of them described serious hypoglycemia. One inmate described asking to lower his insulin dose to avoid hypoglycemia. Inmates in the discussion describe extensive use of commissary as a substitute for meals due to fear of hypoglycemia. This is inappropriate particularly because commissary food may not be nutritionally appropriate. On average, this group of nine inmates with diabetes described using commissary for approximately 40% of their nutritional content, in part as a result of meal timing issues. As recommended in the American Diabetes Association position statement on diabetes management in correctional settings<sup>15</sup>, “timing of meals and snacks must be coordinated with medication administration as needed to minimize the risk of hypoglycemia”.

Another example that came up relates to autopsies. It was noted that autopsies are often not obtained even though the Chief OHS wants them done and even though they are expected based on the Implementation Plan<sup>16</sup>. Wardens

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<sup>14</sup> We acknowledge that Wardens may not intentionally do this and that this decision may be inadvertent. But the history of HCUAs reporting to the Wardens biases their decisions. OHS needs to standardize clinical guidelines statewide so that they are clinically appropriate. That has not yet happened.

<sup>15</sup> American Diabetes Association Position Statement: Diabetes Management in Detention Facilities, October 2021 as found at <https://diabetes.org/sites/default/files/2021-11/ADA-position-statement-diabetes-management-detention-settings-2021.pdf>

<sup>16</sup> See item 80 in the Implementation Plan which states, “All deaths should include an autopsy”.

are the ones apparently authorized to approve autopsies which they do not always do<sup>17</sup>. Authorization of autopsies needs to be under the direction of the Chief OHS. That these issues default to control by the Warden defines the problem in IDOC. The IDOC medical leadership must have control over medical care practices which is not now the case.

Significant organizational barriers still exist that impair IDOC's ability effectively implement the Consent Decree.

There are still separate OHS, facility and vendor tables of organization. This represents actual practice in OHS facilities in which OHS, the facility, and the vendor work each in their own domain without a single leader that we recommend be the Chief of OHS.

In practice, this results in a lack of integration of the vendor into the implementation plans of OHS. In particular, vendor staff work separate from OHS and are not yet integrated into an effective management process to address the Consent Decree or Implementation Plan. This was evident in interviews with the three vendor Medical Directors during which the following was noted.:

- There is no effective clinical oversight over vendor providers. All three Regional Medical Directors acknowledged that performance reviews of physicians, nurse practitioners, and physician assistants are completed by a regional manager and not a physician. The Regional Managers are not all clinically trained staff. The performance reviews are mostly administrative but the regional managers contact the regional medical directors by phone to give comments on clinical performance. None of the regional medical directors had completed an actual performance evaluation of providers they supervise. It is not surprising that many vendor physicians do not understand the OHS mandate to perform colorectal cancer screening.<sup>18</sup>
- One Medical Director who supervised three physicians with prior licensing board disciplinary actions, two for clinical reasons, did not engage in any monitoring of those physicians and did not conduct performance evaluations of any of the physicians under his supervision.
- Another Medical Director, who supervises a physician without appropriate credentials (III.A.2, III.A.3), was asked if he performed any monitoring of this physician. He responded that because the physician had been hired prior to the Consent Decree, he was grandfathered in and the Consent Decree did not apply. This is inaccurate. Nevertheless, this Regional Medical Director performed no monitoring of this individual.
- One of the three Regional Medical Directors had not read the Implementation plan. Another who had read the Implementation Plan but said that his responsibility with respect to the Implementation Plan was in areas that specifically state the vendor is responsible or where the document refers to provision of medical care. The third Regional Medical Director said that he had no responsibility for the Implementation Plan but then added that he did have responsibility for assisting in cancer screening, ensuring the sites ordered FIT tests and encouraging vaccination. None of the Regional Medical Directors saw their responsibility to understand and to implement all aspects of the Consent Decree and Implementation Plan which involves multiple clinical processes.
- One of the three Regional Medical Directors agreed that SIU performance and outcome audit findings on colorectal cancer screening and immunizations were deficient but that the HCUAs were responsible for implementing OHS recommendations and policies and for audit findings and did not take responsibility for the results. Another Regional Medical Director said training on these audit measures was provided by the Chief OHS at quarterly meetings. He did not follow up with training until the Monitor identified that

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<sup>17</sup> See March 2023 System Leadership Quality Committee meeting minutes during which the Chief OHS attended a Warden's meeting to ask that they request autopsies. This should be an automatic request by Wardens as part of their responsibility. We agree with a concept of making this part of the Mortality administrative directive and audited by the Compliance Unit.

<sup>18</sup> OHS has mandated for over a year that colorectal cancer screening be managed using a fecal immunochemical test (FIT) but physicians at most facilities do not understand this requirement and continue to utilize outdated and unacceptable screening procedures.

providers he supervised didn't know what the current procedures were for colorectal cancer screening at which time, he initiated training. The third Regional Medical Director said he had not yet been provided instructions on colorectal cancer screening or immunization and that the Implementation Plan didn't assign responsibility to the vendor. This Regional Medical Director also said he had not received copies of the SIU clinical performance and outcome audits and only heard of them at quarterly meetings.

- Though all facilities performed poorly on the SIU audits for colorectal cancer screening and immunization, the vendor Regional Medical Directors were defensive and reluctant to accept the results. None of the Regional Medical Directors had personally engaged in training of their staff on recommendations of OHS with one exception at the one facility visited by the Monitor when the Monitor made an issue of providers failing to understand what the OHS guidance was. None had been monitoring whether the facility providers they supervised were acting in accordance with OHS recommendations.
- One Regional Medical Director questioned the methodology and accuracy of the SIU audits. Another Regional Medical Director said the criteria SIU used to judge the appropriateness of care on these audits was a higher standard than community standards. This Regional Medical Director did not agree with SIU findings. Another Regional Medical Director said he had not yet received the results for his facilities but said the criteria of the audit didn't agree with criteria used in the community.
- With respect to development of corrective actions based on mortality reviews performed by SIU, one Regional Medical Director said that until the vendor defines what the circumstances were with respect to a death, they won't develop a corrective action. This Regional Medical Director said that SIU reviewers frequently could not read the record and couldn't find information in the medical record which made the mortality reviews incomplete. However, the conditions of the medical record are a responsibility of the vendor because they supervise medical record personnel and supervise staff who make entries into the record. This Regional Medical Director said that the vendor has received mortality reviews since May of 2023 which has left as much as five months to review the records. Another Regional Medical Director did not recall how many SIU mortality reviews he read and had no specific recall of how many deficiencies SIU had identified in mortality reviews for facilities he supervised. The Monitor identified over 300 deficiencies in the region he supervised. Another Regional Medical Director said initially that he reviewed one mortality review he received from SIU in April and later said he had not reviewed any SIU mortality reviews. He said he did not agree with SIU's findings despite that he had not read the reviews. He said that if he could receive a copy of the mortality reviews, he could review them. He didn't know how many mortality reviews had been done for facilities he supervised (there have been 43 mortality reviews completed at facilities this Regional Medical Director supervises).
- One Regional Medical Director said he was unaware of any peer reviews initiated on any of his staff, despite two SIU peer reviews documenting recommendations for peer reviews for physicians at two of the facilities he supervised.
- One significant comment by a Regional Medical Director was an excuse that some of the nursing staff were state employees and that the vendor could not take responsibility when nurses did not follow procedure with respect to interpretation of colorectal cancer screening results<sup>19</sup>. This pointed out the problems with establishing a unified program in which all employees follow directions as established by the Chief OHS, which is reflected in tables of organization. A second Regional Medical Director said State nurses would not listen to vendor physicians. A third Regional Medical Director was asked about SIU findings on mortality reviews that deficiencies of nurses not acting on abnormal vitals were higher at facilities he supervised than at other facilities. He responded that some nurses are State nurses and he had no control over State nurses. That staff respond only to their own organization leadership is a key problem. Staff must be unified with all adhering to the same playbook and all staff interchangeable with respect to respecting and following directions of the Chief OHS and respecting supervisory staff whether they are State or vendor employees.

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<sup>19</sup> This was immaterial to whether patients were offered colorectal cancer screening.

These examples show the lack of effective lines of control between OHS and the vendor. These Regional Medical Directors are generally passive and indifferent to challenges posed to IDOC by the Consent Decree and Implementation Plan. Their lack of attempting to take initiative in supervising their staff and providing clinical medical direction for their facilities and taking corrective actions based on mortality reviews and performance and outcome audits by SIU is discouraging. This group does not contribute to implementing the Consent Decree. The lack of the vendor Regional Medical Directors in contributing to and collaborating with IDOC will thwart forward progress towards compliance with the Consent Decree and Implementation Plan. If this does not immediately improve, IDOC should consider whether reduction of funding for the Regional Medical Director positions could be applied toward hiring IDOC Regional Medical Directors who then would be ensured to follow directions of the Chief OHS.

In summary, the Monitor has received insufficient information from OHS to evaluate the adequacy of leadership staffing as staffing numbers have not been provided. Tables of organization remain the same and IDOC State employees do show evidence of reporting through OHS (Regional Coordinators clinically supervise HCUAs) but effective lines of authority are still unclear in the medical program as a whole. The Chief OHS does not yet supervise and does not have responsibility for hiring and firing of all health staff. Vendor and State staff maintain separate and autonomously functioning organizations which is a barrier to a unified health care staff. Vendor staff and IDOC staff must have unified constancy of purpose in attaining compliance with the Consent Decree. Vendor staff do not appear to participate fully and collaboratively in implementation of the Consent Decree and Implementation Plan. This must be corrected. A partial compliance is continued. Recommendations that repeat the Implementation Plan or Consent Decree requirements were removed.

#### **RECOMMENDATIONS:**

1. Identify a DON at each facility who is accountable to the Statewide DON for clinical practice and quality. Line authority would remain with the HCUA for daily operations.
2. IDOC is requested to provide quarterly up-to-date vacancy reports that include OHS and HCUA positions.
3. Physicians and other providers need to report through physician leadership ultimately reporting to the clinical direction of the Chief OHS.
4. Nursing staff need to report through a facility DON at each facility who, for clinical issues, reports to the statewide OHS DON.
5. HCUAs need to report for all matters (clinical and operational) to OHS administrative leadership (Regional Coordinators) who report to the senior OHS administrator (Medical Coordinator)
6. The IDOC staffing and particularly the leadership staffing (Medical Directors, DONs, HCUAs, Dentists, OHS) is critically low. The vendor and the State must expeditiously intensify their recruiting efforts.
7. IDOC needs to clarify its organizational structure to the Monitor.

## **Staffing Analysis and Implementation Plan**

### ***Addresses items IV.A.1-2; IV.B;***

**IV.A; IV.A.1; and IV.A.2.** *The Defendants, with assistance of the Monitor, shall conduct a staffing analysis and create and implement an Implementation Plan to accomplish the obligations and objectives in this Decree. The Implementation Plan must, at a minimum: (1) Establish, with the assistance of the Monitor, specific tasks, timetables, goals, programs, plans, projects, strategies, and protocols to ensure that Defendants fulfill the requirements of this Decree; and (2) Describe the implementation and timing of the hiring, training and supervision of the personnel necessary to implement the Decree.*

**IV.B.** *Within 120 days [July 1, 2019] from the date the Monitor has been selected, the Defendants shall provide the Monitor with the results of their staffing analysis. Within sixty (60) days after submission of the staffing*

*analysis, Defendants shall draft an Implementation Plan. In the event the Monitor disagrees with any provision of the Defendants’ proposed Implementation Plan, the matter shall be submitted to the Court for prompt resolution.*

**OVERALL COMPLIANCE:** Noncompliance

**FINDINGS:**

**Staffing Analysis**

**Staffing**

Implementation Plan narrative page 2: *Hire sufficient staff to implement the plan.*

**Implementation Plan narrative page 7:** *Presently, IDOC is proposing to add a considerable number of positions. IDOC expects to fill vacancies to attain no more than a 15% vacancy rate for non-critical positions.*

IDOC was unable to provide data on how many staff are allocated, hired, and vacant. This data was requested from facilities by IDOC counsel but facilities did not provide the data for this report. There apparently is no standardized methodology to track staffing statewide. If there is no standardized methodology to track staffing, there will be no way to verify compliance with staffing requirements of the Consent Decree.

IDOC did provided the medical vendor staffing numbers and hours worked by SIU staff. IDOC employees budgeted and vacant were not provided. Based on the medical vendor’s staffing data, the following table was constructed.

Vendor Positions 2022 to 2023				
Date	Total Positions	Total Vacancies	Vacancy Percent	Additional positions not budgeted
Sep-22	1080	542	50%	
Oct-23	1032	515	50%	13

The vacancy rate of medical vendor staffing is the same as the prior year. IDOC has indicated that they meet monthly with the vendor about staffing. No minutes are maintained. The Medical vendor has argued that the high vacancy rate is due to lingering effects of the COVID pandemic.

**Staffing Analysis**

**Implementation Plan narrative page 2-3:** *A staffing analysis was conducted through the combined efforts of the OHS leadership team and the Health Care Unit Administrators (“HCUA”) assigned to each facility. The positions presented in the staffing analysis represents IDOC’s best estimate of the additional health care staff currently necessary to meet IDOC’s identified mission and vision to provide “high quality medical care” to men and women in our custody. The analysis does not provide data as to what is minimally required by the Consent Decree or the U.S. Constitution. The staffing levels identified in the analysis are not meant to establish any minimum staffing level for*



*any particular position at any particular facility, or at IDOC in general. The analysis should be viewed with the understanding that the needs of IDOC's health care system are dynamic and that modifications of the staffing analysis will be required to accommodate those changes. The staffing analysis proposes to add over 280 positions. However, this analysis was conducted prior to implementing revised policies and practices, as well as an EMR. Without an assessment of the capacity of OHS to complete work as required by this Consent Decree, it also does not include many of the key recommendations of the Monitor. A full implementation of the updated policies and the EMR will likely impact the staffing needs. In order to address the evolving needs of the system, if IDOC determines it to be necessary, it may revise the staffing analysis as needed.*

Implementation Plan narrative page 7: *The Consent Decree requires that IDOC conduct a staffing analysis that will be integrated into an implementation plan. Both the staffing analysis and implementation plan are to be completed with the assistance of the Monitor. The IDOC finalized its staffing plan in August of 2021. For the staffing analysis, IDOC proposes the addition of more than 275 new staff. Positions have been added in multiple categories based on an IDOC internal analysis.*

**Implementation Plan item 1:** *Complete initial staffing analysis. **Proposed End Date: August 2021***

Implementation Plan narrative page 7: *IDOC will develop a precise staffing plan by hiring a consultant to complete a workload analysis to more precisely determine baseline staffing needs and to create a template for how to make future staffing changes using a workload template or algorithm. The workload analysis and template will guide future position additions or subtractions based on changing circumstances. IDOC will ensure sufficient key staff, including physicians, are hired as soon as possible.*

**Implementation Plan item 1a:** *IDOC will hire a qualified consultant to perform a workload analysis for all staffing needs. The workload analysis will form a baseline staffing need for all position types and the template or algorithm used in the analysis will be utilized to develop changes in staffing needs based on increases or decreases in inmate population or programmatic change. **Proposed End Date: December 2023***

**Implementation Plan item 1b:** *IDOC will ensure that the requirements of the workload analysis include analysis of all the Monitor's recommendations with respect to staffing. The workload analysis would provide a workload analysis methodology for staffing recommended by the Monitor. **Proposed End Date: March 2024***

IDOC stated it had identified a consultant to perform a workload analysis of staffing. Instead of a workload analysis, the consultant gave a proposal for a comparative staffing analysis<sup>20</sup>. IDOC asked the Monitor if he had any concerns and the Monitor sent IDOC its concerns with the methodology which are briefly summarized below.

The consultant proposed to use a comparative analysis consisting of the following.

- Obtain list of medical and dental positions at IDOC facilities.
- Interview a sample of 5-10 employees of each position type in IDOC facilities to develop a list of staffing by functional type and to characterize the functional types of staff.
- Select 10 facilities from multiple states.

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<sup>20</sup> A workload analysis evaluates the work required and analyzes how long it takes one person to perform the duties in a day and then extrapolates on how much work there is, how many staff are needed. A comparative analysis compares one facility with another facility and matches the amount of staff at a benchmark facility with the target facility.

- Match position list of IDOC to positions at the ten benchmark facilities by functional similarity.
- Review and combine information from the 10 benchmark facilities into a staffing algorithm that is used as the standard for how many staff should be hired in IDOC.
- From the algorithm, develop IDOC staffing levels.

The Monitor's comments on this plan are summarized as follows.

- The proposal was a comparative analysis and offered no methodology to analyze staffing needs within IDOC given conditions within IDOC.
- There was no assurance that the benchmark facilities were similar to IDOC facilities.
- The proposal ignored unique characteristics of IDOC facilities.
- The work settings of IDOC facilities were not included as part of the analysis which is important, particularly for old antiquated maximum security facilities within IDOC.
- The proposal did not consider any requirements of the Consent Decree or Implementation Plan.
- The proposal would have conducted interviews with IDOC during a time when they had not enacted processes that are necessary to obtain compliance with the Consent Decree so the staffing would not necessarily be comparable.

The Monitor was told that the consultant has withdrawn from consideration.

In record reviews, it is clear that physician staffing is inadequate and is causing harm<sup>21</sup>. It was also apparent that support staff for scheduling specialty care appointments and obtaining records from local hospitals and consultants is deficient. These positions need to be included in the workflow analysis of staffing.

In summary, because data regarding staffing levels could not be obtained, the Monitor could not evaluate progress on actual staffing except for the vendor. The vendor staffing vacancy rate is the same as in the prior year. IDOC did make an attempt to obtain a consultant for a workload analysis but is still seeking a consultant to perform a workload analysis.

## **Implementation Plan**

**Implementation Plan narrative page 2:** *Another initial focus of OHS is to institute the following structural components to its health care program: Organize the OHS to effectively implement this plan [the implementation plan];*

**Implementation Plan 2.a.:** *IDOC will hire project managers for the following services:*

1. *Full-time Implementation Plan project manager*

IDOC has not hire a project manager to oversee the Implementation Plan. The Monitor requested a table with the percent completed of each task of the Implementation Plan. A separate document with data supporting the percent completed was requested. Neither request was responded to, but IDOC stated they were working on this and was intending to provide a status document on completion of the Implementation Plan. This was being managed by the IDOC counsel but this person was recently named the acting legal counsel for IDOC and managing two positions. Not having an assigned person to handle this project appears to have delayed the response. Tracking

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<sup>21</sup> Vendor staffing has been provided and physician staffing is deficient. There are 33.47 budgeted positions with 12.59 vacancies. The vendor has an additional 1,425 physicians working additional hours which if credited equate to 11.17 vacancies or a 33% vacancy rate which is still inadequate. Data on the hours each physician works and where the physicians work has been requested but has not been provided. It is very difficult to determine physician staffing.

progress of the Implementation Plan is left entirely to the Monitor. Staffing remains a barrier to implementation of the Consent Decree, including the Implementation Plan.

## **Vendor Relationships**

### **Implementation Plan items 9-15:**

9. *Ensure RFP and contract is written to obtain sufficient staffing and be consistent with requirements of Consent Decree vis-a-vis its policies and procedures and include the possibility for using physicians from another source in the event the vendor cannot provide sufficient qualified physicians. Draft RFP to refer to appropriate agency consulting parties. **Estimated End Date: November 2022.***
10. *Send RFP to agency procurement department for review and approval. **Estimated End Date: January 2023.***
11. *Submit BEP Goal Setting form to BEP Compliance Officer. Submit Veteran's Business Program (VBP) Goal to Agency Compliance Officer. Send RFP to SPO for review and approval. **Estimated End Date: August 2022***
12. *Post RFP. **Estimated End Date January 2023***
13. *Public Pre-Bid Conference Review Technical Bid. Review and Score Diversity Commitment Submission. Send Technical Score to SPO for review and approval. Review and score Pricing. Send Technical and Pricing Submission for award approval Protest Period of 14 days. **Estimated End Date: August 2023.***
14. *Award RFP. Negotiate contract specifics. **Proposed End Date: October 2023***
15. *Draft contract consistent with Consent Decree/sign contract. **Estimated End Date: December 2023.***

The current medical vendor has a contract signed by IDOC on 6/30/23 that extends the contract to 9/29/23. IDOC has said that the existing contract will be extended again until a new contract is signed. Currently bids are still being evaluated and scored but the contract has not yet been awarded.

The medical vendor award has not been completed so a contract is not available and whether it will specify adherence to the Consent Decree will be determined.

**Implementation Plan item 42: *Develop Quality Improvement Partnership.*** *Develop a document that describes the detailed responsibilities of SIU with respect to the IDOC medical program including CQI. Update this document whenever those responsibilities change. **Proposed End Date: Ongoing***

There is no document that describes the responsibilities of SIU. The original contract with SIU was to provide physician services at four IDOC facilities. That contract was not implemented. Instead, IDOC changed the requirements but did not memorialize the changed responsibilities, which should be done. The responsibilities of SIU have changed over time and IDOC states appropriately that the end date for this item is "ongoing". A document memorializing responsibilities of SIU was requested. IDOC said that they don't have anything documenting this at this time but they are working on it.

The relationship with SIU has been very helpful to IDOC and SIU has performed well in obtaining data for the 12 performance and outcome measures and in mortality review. We encourage IDOC to continue that relationship and expand it as needed and possible.

**Implementation Plan narrative page 7:** *To comply with the Consent Decree and achieve our goal of providing high quality medical care, it will be critical to expose more providers to correctional health care as a career option during their training years. Academic relationships provide a*

*pipeline for potential employees through early exposure to correctional health care. IDOC is working diligently to develop and expand formal relationships with academic entities. Our current relationships have significantly improved the quality of care delivered within the Department and moved the Department closer toward compliance with the Consent Decree and the attainment of our goal to provide high quality medical care. For example, IDOC has an existing contract with the SIU School of Medicine to provide assistance with our quality improvement efforts, audit and data teams. We continue to explore opportunities for SIU physician services at our facilities. We are also exploring expanding UIC's involvement in both the provision of Hepatitis C and HIV services. Finally, we are building on these partnerships to explore opportunities for expanded telehealth care. It is IDOC's perspective that collaboration with university-based medical programs will significantly promote improved care in IDOC facilities and we are committed to that effort.*

IDOC continues the relationship with UIC with respect to provision of HIV and hepatitis C treatment via telemedicine. It has also initiated a telemedicine diabetic treatment program at facilities in the northern region. The HIV and hepatitis C programs are excellent. The Monitor has not yet been able to evaluate the diabetes telemedicine program but encourages IDOC to continue these. IDOC has also initiated the quality program with SIU that is process of being initiated. SIU was somewhat disadvantaged because the Implementation Plan had not yet been adjudicated by the Court. Performance and outcome measures have been performed for a year on a limited number of measures. Mortality reviews have been performed for about a year and yielded a significant number of opportunities for improvement. While corrective actions have not yet been developed, these efforts have had an excellent beginning. Now that the Implementation Plan is settled, we look forward to how the relationship with SIU develops.

Recommendations that reiterate the Implementation Plan were removed.

#### **RECOMMENDATIONS:**

1. IDOC needs to hire positions in their staffing analysis as soon as possible.
2. Facility positions should be officially titled by responsibility (quality improvement coordinator, infection control nurse, etc.) and label nursing positions by assignment so that workload can be properly assigned.
3. The Staffing Analysis needs to be augmented to include expected workload at the proposed Joliet Treatment Center.
4. All state, vendor and contract position descriptions for OHS and facility positions need to be provided
5. IDOC should respond to the Monitor's recommendations on staffing.
6. IDOC needs to consider all of the Monitor's recommendations for the Implementation Plan and respond why they do not believe they are necessary.
7. The IDOC audit, related to provision II.B.9., should include an evaluation of staffing.
8. Staffing vacancies by position type should be tracked on a monthly or quarterly dashboard and sent to key leaders of IDOC and the State (e.g., CMS, Attorney General, the Governor's counsel assigned to IDOC) until vacancy rates are 12%.
9. Budgeted and vacant State, vendor, and OHS positions, separated by type of position, need to be provided quarterly and in the document request. This needs to be provided by facility and with cumulative regional and systemwide aggregate numbers.

## **Statewide Internal Monitoring and Quality Improvement**

*Addresses item II.B.2; II.B.6.l; II.B.6.o; III.L.1;*

**II.B.2.** *IDOC shall require, inter alia, adequate qualified staff, adequate facilities, and the monitoring of health care by collecting and analyzing data to determine how well the system is providing care. This monitoring must include meaningful performance measurement, action plans, effective peer review, and as to any vendor, effective contractual oversight and contractual structures that incentivize providing adequate medical and dental care.*

**II.B.6.l.** *IDOC agrees to implement changes in the following areas: Effective quality assurance review;*

**II.B.6.o.** *IDOC agrees to implement changes in the following areas: Training on patient safety;*

**III.L.1.** *Pursuant to the existing contract between IDOC and the University of Illinois Chicago (UIC) College of Nursing, within fifteen (15) months of the Preliminary Approval Date [April 2020], UIC will advise IDOC on implementation of a comprehensive medical and dental Quality Improvement Program for all IDOC facilities, which program shall be implemented with input from the Monitor.*

**OVERALL COMPLIANCE RATING:** Partial Compliance

**FINDINGS:**

Implementation Plan narrative page 1: ***Develop a quality improvement program to satisfy requirements of the Consent Decree.***

**Implementation Plan narrative page 2:** *IDOC is also required to **implement the enhancement of its quality improvement program.** This program will drive health care improvement, including a focus on clinical and operational issues identified in the Consent Decree. The University of Illinois (“UIC”), College of Nursing completed an initial assessment of the IDOC’s existing quality improvement efforts. IDOC is now collaborating with Southern Illinois University School of Medicine (“SIU”) to build on that initial assessment in order to **implement a more productive and efficient quality improvement program.** This partnership will provide several key staff positions including an audit team, a data team, quality improvement consultants, and process improvement specialists. SIU is aggressively working to hire people for these key positions.*

IDOC’s quality program is early in its development. IDOC has established a relationship with SIU but that relationship is not yet memorialized in writing. Additionally, the Court recently adjudicated the Implementation Plan which was just filed in early August 2023. Despite this delay, IDOC has done the following over the past year and a half.

- Drafted a quality improvement policy.
- Released a statewide quality improvement plan.
- Established a statewide System Leadership Quality Council and have had several meetings.
- Created and obtained data over the past year for 12 performance and outcome measures.
- Are in the process of developing corrective actions with respect to three deficiencies identified in the performance and outcome measures.
- Have hired some of the staff for the quality program.
- Have completed 107<sup>22</sup> mortality reviews with discussion at the mortality review committee meetings.
- Have initiated quality improvement training for OHS leadership staff, regional state nurses, and health care unit administrators (HCUA).

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<sup>22</sup> This was the number of deaths reviewed and discussed in the mortality review committee meetings. We have mortality review meeting minutes through June of 2023.

The quality program is in the second year and is not yet completely implemented. Now that the Implementation Plan has been finalized the quality improvement plan needs to be modified to coincide and incorporate the tasks within it.

**Implementation Plan item 43b:** *Establish a systems leadership council that meets quarterly whose responsibilities include:*

1. *Direct CQI activities statewide;*
2. *Develop an annual quality improvement plan;*
3. *Meet quarterly and maintain minutes;*
4. *Review facility audits, performance and outcome measure dashboard, adverse event reports, mortality reviews, and other audits and evaluations and recommend corrective actions to individual facilities based on review of these audits;*
5. *Be responsible for attending an annual facility CQI meeting (this should be after the annual audit report) to summarize CQI findings with the facility and discuss corrective actions and approve facility annual CQI plan;*
6. *Standardize data for CQI reporting that facilities use;*
7. *Statewide CQI team will assign quality specialists to mentor facility CQI coordinators on corrective action assignments.*

**Proposed End Date:** *May 2023*

The system leadership council has been formed and meets quarterly but has not yet implemented all aspects of the quality program. Though this was to have been accomplished by May of 2023. Progress is being made but the submitted deadline was unrealistic. Progress is as follows:

1. The statewide quality program is not yet fully implemented.
2. The System Leadership Council developed an annual quality improvement plan but that plan was not consistent with requirements of the Implementation Plan or Consent Decree. IDOC is in process of modifying the plan.
3. The system leadership council meets quarterly and does maintain minutes that have been sent to the Monitor.
4. Audits and adverse event reporting have not been initiated so there is nothing to review yet. Twelve performance and outcome measures have been obtained quarterly over the past year. Deficiencies identified in performance and outcome measures are being developed into corrective actions but implementation of the corrective action is incomplete. Mortality reviews have been ongoing for the past year. Deficiencies identified in mortality review have not yet been developed into corrective actions.
5. System Leadership Council meeting minutes contain discussion of standardized data for facility CQI reporting but there is no evidence in facility meeting minutes of any standardization. IDOC has begun to work on standardized data for reporting but has not yet provided the Monitor with any detail about this effort.
6. IDOC has not yet assigned quality specialists to mentor facility CQI programs but SIU has begun to post and hire CQI “integrators” who ostensibly will fill this role. The position description of the integrators has not been provided so what they will do is unclear but progress to initiate training is evident.

**Implementation Plan item 49:** *Revise CMS 104 job description for Agency Quality Improvement Coordinator. This is also addressed in Task 4. Proposed End Date: August 2022*

A position description for a Quality Improvement Coordinator was revised by CMS effective 3/1/22. The position description is reasonable except that because details of the quality program are not yet developed and the quality plan and policy are still works in progress, specific responsibilities of the position are not in the

position description.

**Implementation Plan item 41:** *Fill IDOC Quality Improvement Coordinator position. Proposed End Date: June 2023*

IDOC has filled the agency Quality Improvement Coordinator position. The person filling this position lacks experience and will require significant mentoring as this is a complex assignment. To that end this individual has completed coursework at Institute for Healthcare Improvement (IHI) and has obtained a yellow belt in 6-sigma training.

**Implementation Plan item 43:** *OHS and SIU, with the assistance of the Monitor will make **changes to the existing quality improvement program** to one that includes a principal goal of improving care in order to attain compliance with the requirements of the Consent Decree. The changes to the CQI program will be present in the CQI policy:*

1. *IDOC will finalize Quality Improvement policy, and develop a training plan to be used for facility staff.*
2. *IDOC will develop a written plan for the statewide CQI program, as evidenced in policy and procedure, that will utilize the audit function as the principal driver of identifying systemic and other deficiencies whose correction will result in forward progress toward compliance with the Consent Decree. The audit reports, adverse medical event reports, performance and outcome measures, and opportunities for improvement identified in mortality review will also contribute to identification of deficiencies whose correction will contribute to forward progress towards compliance.*

**Proposed End Date: November 2023**

An original IDOC CQI Plan was first provided to the Monitor in June of 2022. The Monitor's 6<sup>th</sup> Report contained an appendix of the FY23 CQI Plan with comments. IDOC has said it will modify the annual CQI plan but no drafts have yet been provided. Many elements of the original plan were not consistent with the filed Implementation Plan.<sup>23</sup> On 3/15/23 IDOC sent the Monitor a draft Quality Improvement policy. The Monitor made significant changes to the 3/15/23 version and sent revisions back to IDOC on 5/12/23. The Monitor has not received a revised policy for review at the time this section of the report was written.

The FY23 CQI annual plan and prior policy did not address a comprehensive audit which is to be the main driver to the quality program. The Monitor had an in-person meeting with IDOC in July of 2023 to discuss differences of the Monitor and IDOC related to the audit. IDOC has not provided dates for a follow up meeting on this. OHS and the Monitor have not yet discussed changes that need to be made to attain compliance with the Consent Decree.

Training on CQI is discussed below.

The deadline date for this item is November 2023. IDOC has work remaining. Progress is being made but the deadline will not be reached.

**Implementation Plan item 93:** *See previous tasks on adverse event reporting, audits, quality improvement, and outcomes and performance. It is presumed that dental is to be included in all areas of quality improvement. Proposed End Date: November 2023*

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<sup>23</sup> The plan was filed 8/1/2023.

IDOC has initiated dental quality improvement. The IDOC Chief of Dental Services is a member of the System Leadership Council. The FY23 CQI Plan does not include a specific plan for dental but does include one dental performance and outcome measure; whether patients have had a dental hygiene visit in the past two years. No dental adverse event reporting has occurred. Comprehensive dental audits have not been initiated. SIU does collect data on dental services including staffing, examinations, cleaning, and equipment. The Monitor has not yet had a discussion with SIU regarding this data. The Monitor suggests further discussions between the Chief of Dental Services, SIU, and the Monitor's Dental Consultant regarding the dental CQI plan and the current data collected by SIU.

**Implementation Plan item 36:** *With the assistance of the Monitor IDOC will establish patient safety program that incorporates information gleaned from critical events, adverse events, mortality review and audit results. Safety initiatives will include, but are not limited to: infection prevention, injury prevention, and reduction of medication errors. Proposed End Date: November 2023*

A patient safety program has not been discussed in the Systems Leadership Council and there are no plans yet to initiate a patient safety program. The proposed end date does not appear attainable.

**Implementation Plan item 7:** *Develop written procedures for expectation of training to include:*

1. *Quality improvement and Safety training;*

*Training procedures shall include the format of training (in-person, video conference, onsite, quarterly meeting, etc.); copies of the new policy or procedure for all attendees; sign-off acknowledgement that training was received; in some cases, verification of competence with the training (taking blood pressure, using a point of care device, etc.). Proposed End Date: September 2023.*

There is no written procedure for expectations of training that include quality improvement or patient safety. Systems Leadership Council meeting minutes do describe a WebEx training on quality which was an introduction to CQI and a presentation of findings of the 12 performance and outcome measures collected over the past year. Attendance was not recorded. Plans for what training will be provided either do not exist or have not been provided. Training has not been based on the policy or CQI plan both of which are still being developed.

IDOC has initiated Institute for Healthcare Improvement (IHI) training for its leadership and HCUAs which is laudable and a significant step forward. The number of modules that will be taken is unclear. IDOC has not provided the evidence of completion for the staff involved. The vendor has not yet initiated training of any of its staff but stated they have an internal corporate training for CQI. Any training provided by the vendor needs to align with the training expectations determined by OHS.

The System Leadership Council meeting minutes contain a discussion to utilize resources of the Training Academy/OneNet Training for education and presumably for training. Using an existing IDOC training resource is a positive step. But there is not yet a formal plan for training of facility staff. This item is still in the beginning phase of development and was not accomplished by the proposed end date.

**Implementation Plan item 51:** *Initiate process improvement projects by focusing on key problems related to Consent Decree: medication administration, sick call, improving access to specialty care, improving chronic care delivery. Process analysts will systematically map all steps and procedures of specified processes; analyze input, process, and output using root cause analysis; determine the desired output; make the process more efficient,*



*with fewer errors, and in line with the movement towards compliance with the Consent Decree. **Proposed End Date: January 2024***

Except for medication administration, these process analyses have not yet occurred. For medication administration, in January of 2022, IDOC engaged a group from SIU to study the process of medication administration system wide. The process was initiated with a survey of the medication process at all facilities. IDOC stated in a 1/5/22 email that the process analysis group would visit some facilities. IDOC asked to meet with the Monitor team sometime in February to provide an update. The update never occurred and no further information was provided. Based on information that was provided to the Monitor, no process mapping has occurred.

IDOC stated that based on performance and outcome data, IDOC has initiated corrective actions for colorectal cancer screening, sick call, and immunizations. The corrective actions for immunization and sick call have not yet been defined. A colorectal cancer screening and assessment process<sup>24</sup> has been developed as a corrective action. This corrective action has not yet been completed. This corrective action would have benefited from a process analysis to determine why these processes fail. IDOC has initiated corrective actions and progress is incremental.

**Implementation Plan item 51a:** *Hire or contract for two process analysts to perform necessary process analysis as described below **Proposed End Date: October 2023***

SIU said that two of the quality specialists are process analysts. Position descriptions have not been provided which reference responsibility for process analysis among many other responsibilities. The Monitor has not been provided with any work product by SIU that would be considered a completed process analysis nor is it evident in other documents received concerning the quality improvement that SIU has performed process analysis. The October deadline has passed.

**Implementation Plan item 51b:** *Develop procedure for initiating a new process improvement analysis and effort when audits, mortality reviews, adverse event reporting, or performance and outcome data show a serious systemic problem that is a barrier to compliance with the Consent Decree or is a significant patient safety risk. **Proposed End Date: November 2023***

Though this item is proposed as being completed by November of 2023, no evidence has been provided by IDOC that systemic issues identified in mortality reviews, and performance and outcome measures have been analyzed by process mapping. Audits and adverse event reporting have not yet been initiated. There is no written procedure for initiating a new process improvement analysis.

**Implementation Plan item 51c:** *Revise policy and procedure for completed process analysis when a revised process differs from existing policy. **Proposed End Date: At completion of process analysis***

No process analyses have been completed so this item is not yet started.

**Implementation Plan item 51d:** *When a process analysis is completed, the process analyst and Medical Coordinator determine any staffing, equipment, or space needs are required beyond existing capacity. Additional needs are forwarded to Agency Medical Director who will discuss with Executive Director and Budget Director. **Proposed End Date: At completion of process analysis.***

Process analyses have not yet been initiated so this item is not yet been started.

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<sup>24</sup> Colorectal Cancer Screening & Assessment Process Outline

Recommendations that reiterate the Consent Decree or Implementation Plan have been removed.

## RECOMMENDATIONS:

1. The quality program implementation plan needs to include assistance and input from the Monitor to include a current focus on:
  - a. Development of an audit instrument;
  - b. Implementation of the audit function;
  - c. Integrating audit findings into the quality program;
  - d. Discussion of standardized data and how IDOC will obtain and utilize data;
  - e. Discussion of how to use process analysis; and
2. SIU should memorialize a statement of work with IDOC and update that statement as their responsibilities change.
3. The quality improvement policy needs to include definitions of the audit (II.B.9.), the performance and outcome measures (II.B.7.), and address all other provisions of the Consent Decree that relate to quality (II.B.6.i.; II.B.6.l.; II.B.6.m.; II.B.6.n.; II.B.6.o.; II.B.7.; II.B.9.; III.L.1.; III.M.2.).

## Audits

### *Addresses item II.B.9*

**II.B.9.** *The implementation of this Agreement shall also include the design, with the assistance of the Monitor, of an audit function for IDOC's quality assurance program which provides for independent review of all facilities' quality assurance programs, either by the Office of Health Services or by another disinterested auditor.*

**OVERALL COMPLIANCE RATING:** Noncompliance

## FINDINGS:

**Implementation Plan narrative page 1:** *Another initial focus of OHS is to institute the following structural components to its health care program: **Development of an audit function** to ensure compliance with the Consent Decree.*

An audit function has not yet been initiated. IDOC leadership met with the Monitor's team on 7/20/23 in Springfield to discuss the audit. This was a productive meeting. The Monitor has asked for a follow up meeting but this has not yet been scheduled. This should be a focus before the next report.

**Implementation Plan narrative page 3:** *The supplementation of OHS leadership provides increased oversight in various Consent Decree objectives. For example, with the addition of audit teams and quality improvement consultants, the IDOC plans to **create an auditing program to conduct annual facility audits and to generate reports identifying deficiencies**. The auditing program will also be responsible for conducting mortality reviews and sentinel event reviews. **Combining audits and reviews with incident reporting and performance and outcome measures will identify deficiencies that will serve as the source of quality improvement activity at individual facilities**. The quality improvement consultants will mentor facility staff and demonstrate how to **conduct improvement projects that correspond to identified deficiencies**. This information will be incorporated into an annual report that will measure and account for the system's performance. Once the results indicate that a facility is in compliance, IDOC will notify the Monitor who will perform a site visit and confirm whether there is an agreement as to compliance. This method allows the IDOC to self-monitor and maintain a superior provision of health care far beyond the timeframe of the Consent Decree.*

IDOC has not yet initiated an audit function and so has no audit reports. IDOC has initiated mortality reviews and performance and outcome measures. No corrective actions have been developed from findings in mortality reviews. IDOC has initiated three corrective actions related to the performance and outcome measures but has not completed these corrective actions. See the discussion in the section on mortality review. An annual facility report that combines data from the various evaluations (performance and outcome, mortality review, and audits) is not yet in place in part because the various component evaluations are not all completed. The Systems Leadership Council meeting minutes contain discussion of how to conduct improvement projects at facilities related to corrective actions but there is no evidence of these occurring yet. SIU plans to hire “integrators” presumably to fulfill this function, but the Monitor has yet to review position descriptions or the work product of these “integrators”.

**Implementation Plan narrative page 5:** *The Consent Decree requires IDOC to **design with assistance from the Monitor an audit function for the quality improvement program which provides for independent review of all facilities’ quality assurance programs, either by the Office of Health Services or by another disinterested auditor. IDOC is prepared to secure staff to manage the audit process. Two teams of auditors will be established, each consisting of a physician, a mid-level provider, 1-2 nurses, and a team of quality specialists, assisted by a part-time dental consultant. The team will be responsible for auditing each facility and producing a report of their findings. OHS with assistance from the Monitors will develop the audit instrument. The audit team will also be responsible for performing mortality reviews. Deficiencies and opportunities for improvement, identified by the audits, mortality reviews, performance and outcome measures, and adverse event reports will be collated in the audit reports and will be referred to the respective facility’s quality improvement program for corrective action. Deficiencies identified in audits, performance, outcome measures and incident reports will form the initial basis for quality improvement efforts. Facility quality improvement coordinators will be trained in methodologies and techniques commonly used in quality improvement work. The quality improvement program will provide leadership and front-line team training that will train facility leaders in quality improvement methodologies and give guidance on how to take corrective actions identified in audits.***

**Implementation Plan item 43a: Develop an audit process**

1. IDOC will use Consent Decree requirements, contemporary clinical nursing standards and physician clinical care standards (e.g., as in UpToDate) and dental clinical care guidelines as a basis and, with the input and assistance of the Monitor, develop a medical and dental audit instrument.
2. IDOC will conduct an onsite, annual, comprehensive independent audit of each facility. The evaluation will cover all areas of the Consent Decree and include all aspects of clinical care.
3. Procedures for these audits will be developed with assistance of the Monitor to include development of a document list, data that will be evaluated, chart selection, interviews, touring with inspection, and a written report.
4. The audit team will train on audit methodology with Monitor on multiple site visits.
5. IDOC will ensure facilities cooperate and make staff available during audit visits.
6. Audit team will incorporate mortality reviews, performance and outcome dashboard results, adverse event reports, and any other audits into their annual evaluation.
7. A report will be delivered to the facility and system-wide quality committee and that committee will decide on corrective actions that the facility quality improvement program is to address.
8. The system-wide quality committee will develop a methodology to track corrective actions.
9. IDOC will develop a methodology for referral to peer review for egregious practice issues.

10. *IDOC will aggregate audit findings into vendor oversight as represented in an annual report of findings. Proposed End Date: March 2024*

IDOC has not yet developed an audit instrument. On 7/20/23 the Monitor team and IDOC leadership had a discussion about the audit instrument but no follow up has been scheduled. The discussion was productive. It was agreed that further discussion and work needed to be done but a timeline or next meeting were not discussed. Because only the principles of the audit were discussed, detailed items 2-10 from Implementation Plan 43a were not discussed and have not been accomplished. The proposed end date is seven months away. Much work remains to be done.

The Monitor suggests that IDOC use the methodology for mortality review and expand it to include all relevant areas of service and operations. This would include dietary, nursing sick call, chronic care, urgent and emergent care, intrasystem transfers, nurse and physician intake assessments, infirmary care, specialty care, pre and post-hospital care, preventive care and dental care. A small group including a nurse, mid-level provider, and management person can do an abbreviated one-day site visit to examine clinical space, equipment, sanitation, and support services. Staffing, quality improvement, and policy adherence can be evaluated remotely. The dentist would have to review the dental units but these reviews can be a combination of in-person visits and tele visits. Interviews can be conducted remotely. A methodology for scoring and rating each service would need to be developed. This suggestion provides a pathway for IDOC to expand an existing practice into a requirement of the Consent Decree.

#### **Implementation Plan items 45-48**

45: *Develop position descriptions for audit team members. Proposed End Date: November 2021*

46: *Post position descriptions for audit team members. Proposed End Date: August 2022*

47: *Hire Audit Team Members. Proposed End Date: August 2022*

48: *Audit teams will train with the Monitor and consultants in auditing three to four facilities. Proposed End Date: March 2024*

SIU has hired staff who complete mortality reviews and collect data for performance and outcome measures. Three of these items (developing position descriptions of audit team; posting audit team positions, and hiring audit team members) are described as completed in 2021 or 2022 but because these staff were used to acquire performance and outcome data, it is not clear if the staff will continue to collect performance and outcome data or will change to participate in the audits. IDOC will need to re-visit these positions and discuss what changes need to occur to be acceptable for an audit staff based on discussions with the Monitor. Training with the Monitor has not been discussed.

#### **Implementation Plan item 86: *Develop with QI audit team audit questions necessary to demonstrate compliance with items III.K.1-13. Consider and determine who is to perform dental audits.***

1. *Audits of the dental provisions in the Consent Decree should be done by independent auditors with backgrounds and training in dental care (i.e., dentists and dental hygienists) and should include comprehensive dental treatment plans and comprehensive exam, x- rays, oral cancer screening, and appropriate charting.*

***Proposed End Date: November 2023***

There is no evidence that any work on a dental audit that evaluates *comprehensive dental treatment plans and comprehensive exam, x- rays, oral cancer screening, and appropriate charting* has been completed despite the end date of November 2023. The date proposed as an end date is unrealistic.

In summary, IDOC is making incremental progress. IDOC met with the Monitor in July 2023 to discuss audits but no follow up has occurred. An audit instrument is not yet conceptually designed nor is it written. The Monitor strongly suggests that the methodology for mortality review be modified and expanded to include all areas of review necessary for the Consent Decree as conceptualized above. Staffing for audits is incomplete and is currently diverted to gathering data for performance and outcome measures and mortality review which is considered part of auditing. Until the audit program design is accomplished this provision remains noncompliant.

Recommendations that are items in the Implementation Plan have been removed.

#### **RECOMMENDATIONS:**

1. Expedite a meeting between OHS, SIU and the Monitor on the audit.

#### **Performance and Outcome Measure Results**

##### *Addresses items II.B.7*

**II.B.7.** *The implementation of this Decree shall include the development and full implementation of a set of health care performance and outcome measures. Defendants and any vendor(s) employed by Defendants shall compile data to facilitate these measurements.*

**OVERALL COMPLIANCE RATING:** Partial Compliance

#### **FINDINGS:**

**Implementation Plan item 39:** *With the input of the Monitor, the OHS QI Coordinator, Deputy Chief, SIU, Chief Compliance Officer audit team members, and data staff will **develop performance and outcome measures that measure IDOC's compliance with the Consent Decree.** The **data manager** will query the EHR and/or develop other data collection instruments to collect. **Proposed End Date: September 2023***

IDOC proposed that this be accomplished by September 2023 but it is only partially accomplished.

IDOC collects data for 12 performance and outcome measures. Seven of the 12 performance and outcome measures failed, on average, to meet IDOC's goal and three additional measures, on average, were near to IDOC's goal. These would indicate systemic problems that would warrant corrective actions. With respect to individual facilities that were below goal, the following measures had significant numbers of facilities below goal:

- Timeliness of sick call- 90% of facilities failed;
- Colorectal cancer screening- 100% of facilities failed;
- A dental appointment every two years- 97% of facilities failed;
- Blood pressure at goal for people with hypertension- 76% of facilities failed;
- Hemoglobin A1c (a measure of diabetes control) less than 8%; 69% failed; and
- Blood pressure control in diabetes patients- 83% failed.

IDOC planned corrective actions focusing on three measures: colorectal cancer screening, pneumococcal vaccination, and sick call. Additional corrective actions should be considered.

No facility was 100% at goal for all measures. Twenty-seven of 29 facilities were at goal for COVID vaccination. But, for the remaining 11 measures, only 67 of 292 (23%) of facility scores were at goal. Statewide averages for colorectal cancer screening were only 11%; sick call responsiveness was 34%; preventive dental visits averaged only 41%; and pneumococcal vaccination measured 43%. Breast cancer screening measured at 85%; nephropathy

check for diabetes measured 84% and COVID vaccination measured 82%.

There needs to be significantly more measures and they need to be monitored continuously until all facilities are at goal for a period of time. In the 4<sup>th</sup> Report the Monitor suggested 51 measures. The Monitor and IDOC should discuss which measures should be used and make a decision on a larger number. An expansion of performance and outcome measures will likely not be possible until easier acquisition of data is accomplished.

Access to data is extremely difficult and is a significant barrier to obtaining performance and outcome measures. IDOC has no history of collecting standardized data and has no current support system to do so. Currently all data for performance and outcome measures is obtained by sending multiple staff to a facility to manually count performance measures in the medical record. For example, staff will go to a facility, obtain ten records of persons over 45 years of age and look through the record for evidence of colorectal cancer screening. Because there is no standardized place where this information is maintained, the staff performing the audit have to look in multiple areas of the record. This reveals that there is no standardization yet for documentation of data in the paper record and insufficient mechanisms to acquire reliable data.

To the best of our knowledge, SIU does not now use an electronic data resource to obtain data for performance or outcome measures. One source of data that should be used is the University of Illinois (UIC) laboratory data. UIC performs all laboratory results which are undoubtedly in a data table that SIU can acquire as a download. Measures, such as A1c values obtained for persons with diabetes and lipid studies for persons with diabetes, hypertension and cardiovascular disease, thyroid stimulating hormone values for persons with hypothyroidism, microalbumin for persons with diabetes, etc., can be used as performance measures. This anticipates data that would be available in an electronic record. This can be attempted to enlarge the scope of measures and could be done without manual record review.

Key positions regarding data management will be necessary for forward movement. For data collection, SIU uses positions intended for the audit function to manually obtain data from medical records for 12 performance measures. This is cumbersome and very labor intensive. Though a contract for the electronic record was expected to be signed by October, 2023, it is not yet accomplished. IDOC has not informed the Monitor of a plan for how IDOC will obtain data from the electronic record nor to ensure design of the record facilitates obtaining data. SIU has what is titled a Data Scientist but the Monitor not know if this position is the data manager as required by the Implementation Plan. SIU agreed to provide a crosswalk identifying which of their current positions match those called for in the Implementation Plan, but this has not been received as of yet.

With respect to the 12 measures used by SIU as performance and outcome measures, policy and procedure should be established to direct precisely where this information is to be recorded in the medical record. Staff should be trained on these procedures. This would clarify documentation expectations in the electronic medical record.

The Monitor was told that IDOC has brought on a Deputy Chief who will be responsible for data issues. Sufficient support will be necessary to develop data sources.

**Implementation Plan item 39a:** *The data manager will develop a dashboard to display monthly and annual performance and outcome measures by facility and in statewide aggregate. This dashboard will be available, online, to all IDOC medical employees. **Proposed End Date: November 2023***

The performance and outcome data is available but is not online. A new Deputy Medical Director has been assigned the task of developing a mechanism to present the performance and outcome data on a secure IDOC server so that it is available to all staff. This data is presented in tables but the tables are not electronic and are not

online.

Recommendations that are items in the Implementation Plan were removed.

## RECOMMENDATIONS:

1. The performance and outcome measures should be centralized and based on obtaining data automatically from the electronic record, laboratory, and other sources.
2. Develop a written plan for the dashboard to include:
  - a. Who will maintain this dashboard?
  - b. How will data be displayed to staff and how OHS intends staff to use the dashboard?
  - c. How will data be obtained?
  - d. Development of a glossary of definitions including
    - i. A narrative definition of the metric
    - ii. Numerator and denominator
    - iii. How the metric is calculated
    - iv. The data source
    - v. Reporting frequency
    - vi. A goal.
  - e. How will measures be integrated into the quality program.
3. IDOC, in preparation of implementation of an electronic medical record should anticipate how it will be able to capture data for its dashboard electronically from the medical record.
4. Additional performance and outcome measures should be provided as IDOC increases capacity to do so. Non-clinical measures pertinent to the Consent Decree should be added such as vacancy rates.

## Adverse Event and Incident Reporting Systems

*Addresses Items II.B.6.m; II.B.6.n*

**II.B.6.m.** IDOC agrees to implement changes in the following areas: Preventable adverse event reporting;

**II.B.6.n.** IDOC agrees to implement changes in the following areas: Action taken on reported errors (including near misses);

**OVERALL COMPLIANCE RATING:** Noncompliance

## FINDINGS:

**Implementation Plan narrative page 6:** *The quality improvement program will create and manage a centralized preventable adverse (clinical incident) reporting system. Such a system is required in the Consent Decree. This information, categorized and analyzed centrally, will be used by the facility to identify immediately risks and by the system-wide quality program to take corrective action to prevent systemic patient safety risk.*

**Implementation Plan item 33:** *With the assistance of the audit teams and the Monitor, OHS will implement a preventable adverse event reporting system. OHS with SIU will purchase third party adverse event reporting software currently in use in other health care settings or if IDOC decides not to purchase established off-the-shelf software, it will design its own electronic reporting system to capture any non-conformance to policy, procedure or perceived error or non-conformance. SIU will assist in the implementation of this system. Proposed End: Date November 2023*

The Monitor has not been asked to provide assistance on an adverse event reporting system. The Quality Improvement Coordinator stated that SIU has created electronic software to report adverse events but added that this program has not yet been implemented.

In the FY2023 Quality Improvement Plan, IDOC does not use the definition of adverse event that is defined in the Implementation Plan as “any non-conformance to policy, procedure or perceived error or non-conformance”. The definition of adverse event in the FY23 Quality Improvement Plan should be consistent with the Implementation Plan.

The FY23 Quality Improvement Plan does not give procedures for adverse events except to give instructions for reporting an event. Procedures for maintaining the adverse event reports, analysis of the events, and how the findings are used to promote patient safety are not evident. This item is proposed by IDOC to be completed by November 2023. Because this system is not yet defined, established in procedure, or implemented the November end date was not met.

**Implementation Plan item 34:** *IDOC will assign a full time quality improvement staff or hire (at OHS level not at facility level) to manage adverse event reporting reports and manage the patient safety program. This responsibility will include follow up on immediate remediation of adverse events, classification of all reports by type, organizing the reports systemically to show trends by facility, training staff at facilities on use of the system and on the procedure for making an adverse event report, and participating with the quality program in designing patient safety actions based on event reports. Proposed End Date: November 2023*

This item is proposed to be completed in November of 2023. A full time quality staff has not been hired nor has the Monitor been informed that a full time staff will be dedicated for the purpose of managing adverse event reporting and the patient safety program. SIU has been assigned apparently to “review sentinel events and any process identified as increasing the risk for a negative outcome” but, no procedure has been developed for this process. How and when immediate remediation will occur; how reports will be classified; how staff will be trained on use of the system; and how findings will be used to design patient safety actions are not demonstrated in policy or practice. This item was not accomplished by the proposed end date of November, 2023. This item is best initiated after an audit, performance and outcome measures, and mortality review processes are fully implemented.

**Implementation Plan item 35:** *With the assistance of the audit teams and the Monitor, develop and implement a procedure to analyze and use adverse event reporting to a) remediate the adverse event reported and b) subsequently analyze aggregate reports to prevent patient safety risks.*

1. *Immediate remediation is tracked to ensure effective remediation occurred (e.g., if a patient experiences a fall in a shower because there is no grab bar, is a grab bar installed to prevent future falls).*
1. *A responsible person in the quality program (see item above) is hired/assigned to classify the adverse event and categorize all events system-wide and collate the data.*
2. *Data generated from the adverse event reporting system shall be used to shape safety improvement initiatives.*
3. *Data will be provided to OHS Quality Improvement and audit teams for review and the team will design corrective intervention for systemic preventable adverse reports or for facility specific reports when that facility had excessive reports of a similar type.*
4. *Following staff education, the intervention will be implemented.*
5. *Audit and data teams will monitor results and re-evaluate the success of the intervention at the conclusion of the designated study period.*
6. *Policy and or processes will be modified to embed the resulting process.*

**Proposed End Date: January 2024**



IDOC has not provided the Monitor a procedure on how IDOC will remediate and analyze adverse events in order to prevent patient safety risks. Aside from IDOC stating that SIU has developed software to track adverse events, IDOC has not provide information to the Monitor to verify that any of the five subitems in this Implementation Plan item have been addressed. The proposed completion date for this item is January, 2024 and is unlikely to be implemented in that timeframe.

IDOC reports that adverse event reporting system has been established but has not yet been implemented. No procedures have been established for how this program will work and no training has been provided. There is no evidence of reports being received. This provision remains noncompliant.

Recommendations that reiterate Implementation Plan items were removed.

#### **RECOMMENDATIONS:**

1. Adverse event reporting needs to have capacity to allow anonymous reports. Staff need to be encouraged to reports errors and believe that report of errors will not result in discipline.

#### **Vendor Monitoring**

##### ***Addresses II.B.2.***

**II.B.2.** *IDOC shall require, inter alia, adequate qualified staff, adequate facilities, and the monitoring of health care by collecting and analyzing data to determine how well the system is providing care. This monitoring must include meaningful performance measurement, action plans, effective peer review, and as to any vendor, effective contractual oversight and contractual structures that incentivize providing adequate medical and dental care.*

**OVERALL COMPLIANCE RATING:** Noncompliance

#### **FINDINGS:**

**Implementation Plan item 2c:** *OHS will meet routinely with vendor to **review vacancies** for health care positions and progress on hiring of health care contractual staff. **Proposed End Date: Ongoing***

IDOC states that it meets with the vendor recruitment team no less than monthly to discuss vacancies, the impact of vacancies, and to ensure all possibilities are explored to increase staffing levels<sup>25</sup>. There are no meeting minutes documenting what was discussed or whether action steps have been taken to increase staffing levels. The Monitor was copied on a letter from the vendor to Plaintiffs on staffing vacancies. The vendor states it has done the following:

- Added monetary benefits in an effort to attract staff but did not provide starting salary offers for various positions.
- Contracted with an outside recruitment firm.
- Upgraded their application tracking system.
- Simplified the recruitment process.
- Hired a manager for hiring and has increased the number of recruitment staff.

Based on staffing levels provided by the vendor, these initiatives have not resulted in improved hiring. Staffing remains a preeminent barrier to progress toward compliance with the Consent Decree.

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<sup>25</sup> Email from Michael Arnold, State Attorney's office to Plaintiffs' counsel with copy to Monitor September 25, 2023.

**Implementation Plan item 16: *Monitor performance of medical vendor and take appropriate corrective action.***

1. *Develop a standardized procedure for contract monitoring of staffing and clinical performance.*
2. *Use performance measures of vacancy rate, positions filled compared to contract staffing numbers, and number of days without key personnel (Medical Director, DON, supervisory nurses) as a measurement of staffing performance.*
3. *Develop procedure to use annual facility audits in aggregate as measures of clinical performance of the vendor.*
4. *Develop a procedure for collating material from staffing and clinical performance to judge and score performance.*
5. *Develop standardized mechanism to notify vendor of results and to implement corrective action.*
6. *Develop a plan to track results of the corrective action.*

***Proposed End Date: May 2024***

This item has a proposed completion date in approximately six months. IDOC provided a spreadsheet titled “Contract Monitoring Database” as evidence for this item. This spreadsheet is difficult to interpret. IDOC has described this document as not consistently or accurately completed and did not suggest relying on it as indicative of anything. They said that review of these would be of little to no value.<sup>26</sup>

IDOC has not progressed with respect to Implementation Plan requirements for vendor monitoring. Rather than invent a new system for performing vendor monitoring, IDOC should make use of existing data for vendor monitoring.

IDOC tracks vendor staffing with respect to payment. Vendor vacancy rates and state vacancy rates by position type should be tracked as a performance measure. .

IDOC currently performs mortality reviews and identifies hundreds of deficiencies. If these were better organized, they could form an aspect of clinical performance measurement. Similarly, SIU now completes performance and outcome measures on 12 measures. These results can be used to monitor performance. Moreover, when a corrective action is initiated the performance of the vendor can be monitored based on measured performance improvement. This is the intent of this Implementation Plan item and IDOC should begin by using available information to construct tools for vendor monitoring.

**RECOMMENDATIONS:**

1. IDOC needs to develop a meaningful vendor monitoring system that monitors quality of care, physician quality, and ability to hire contracted staff against contract requirements. This can be joined with the audit process, mortality review, and the performance and outcome measurements. Monitoring should be standardized across facilities so comparisons can be made. The Monitor’s recommendation is to provide this service through the audit team.

**Mortality Review**

***Addresses items II.B.6.i; III.M.2;***

***II.B.6.i. IDOC agrees to implement changes in the following areas: Morbidity and mortality review with action plans and follow-through;***

***III.M.2. Mortality reviews shall identify and refer deficiencies to appropriate IDOC staff, including those involved in the Quality Assurance audit function. If deficiencies are identified, corrective action will be taken. Corrective action will be subject to regular Quality Assurance review.***

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<sup>26</sup> Email 6/20/23 from IDOC to Monitor

**OVERALL COMPLIANCE RATING:** Partial Compliance

**FINDINGS:**

**Implementation Plan item 80: *Develop and implement an effective mortality review process that is evidenced by an implemented policy.*** The policy will include the following Monitor's recommendations:

1. *Provide all death records to the Monitor as they occur.*
2. *All deaths should include an autopsy.*
3. *Provide a tracking log of all deaths at least quarterly. This log should include name, IDOC #, date of death, age, date of incarceration, facility at time of death, category of death, cause of death, whether the death was expected or unexpected, whether an autopsy was done and the date of the autopsy. The log should also include whether a mortality review has been completed.*
4. *A mortality review should be performed for each death by an audit team to include a physician and a nurse.*
5. *The mortality review needs to include at a minimum:*
  - a. *Date of review*
  - b. *Patient name*
  - c. *IDOC number*
  - d. *Date of death*
  - e. *Age and date of birth*
  - f. *Facility at the time of death*
  - g. *Place of death (e.g., hospital, infirmary, etc.)*
  - h. *Category of death (natural, homicide, suicide, etc.)*
  - i. *Expected or unexpected death*
  - j. *Cause of death*
  - k. *Mental health diagnoses*
  - l. *Medical diagnoses*
  - m. *IDOC problem list*
  - n. *Medications at facility at the time of death*
  - o. *Case summary that includes both nursing and physician input that includes a summary of the care of the patient for their illnesses and care related to the cause of death or care that needs to be highlighted to identify opportunities for improvement.*
  - p. *Autopsy diagnosis*
  - q. *List all deficiencies (opportunities for improvement) identified in the mortality review and recommendations for corrective action of these deficiencies.*
  - r. *Identified opportunities for improvement need to be evaluated by the OHS quality committee. That committee needs to assign responsibility for corrective action either to the facility quality committee or to an OHS responsible party. The OHS quality committee should monitor progress on resolution of the corrective action until it is completed. The facility quality improvement meeting minutes need to document their progress in resolving corrective action.*
6. *The quality improvement discussion regarding mortality review should be educational with a goal towards improving care.*
7. *Line staff employees should have an opportunity to provide anonymous information regarding events surrounding a death with an aim toward improving patient safety. A process for this should be established.*
8. *The quality improvement coordinator and audit teams should conduct follow up with facility quality programs to monitor actions taken to improve care based on information learned from mortality review.*
9. *IDOC will develop a procedure for referral of a nurse or provider to their respective peer review entity*

*when a mortality review identifies an egregious clinical act by a provider or nurse. This procedure will be written. The group of providers performing peer review for an alteration of privileges will be leadership physicians (Chief and Deputy Chiefs).*

**Proposed End Date: August 2023**

IDOC states that they have completed implementation of the mortality review process in August of 2023. But all steps of this process have not yet been implemented.

1. IDOC still does not send the Monitor medical records of all deaths. IDOC is unable to provide all death records to SIU or to the Monitor. SIU sends their own staff to facilities to scan the death records which is acceptable but the Monitor does not have staff or permission to do this. The Monitor has previously asked that the records SIU scans be sent to the Monitor. Though SIU only reviews one year of the record, it would reduce some work for IDOC. This has been requested but is not being done.
2. Autopsies are not yet available for all deaths.
3. A tracking log of deaths is sent upon request for Monitor reports but IDOC does not yet send a tracking log on a regular basis as requested. The log does not include the date of incarceration. The cause of death was known for 65 (52%) of the 125 deaths. Autopsies were obtained for 24 (19%) of the 125 deaths.
4. It appears that all deaths are reviewed but this cannot be verified. Updated mortality lists, mortality reviews and death records are not each provided in a manner that allows comparison.
5. The mortality reviews contain all items required in the Implementation Plan except corrective actions have not yet been developed for identified opportunities for improvement<sup>27</sup>. This is a significant deficiency.
6. Facility quality improvement meetings do not typically include discussions of mortality. When a death is occasionally mentioned, discussions are not meaningful nor are the discussion directed toward correcting mistakes to making improvements. No education has been developed based on identified opportunities for improvement.
7. Facility staff have not yet been involved in giving information to the mortality review committee.
8. Because a process for corrective actions has not yet been developed, the role of the Quality Improvement Coordinator has not yet been established with respect to mortality review.
9. IDOC has a draft policy on peer review but it is not yet finalized nor implemented. Though the Mortality Review Committee referred two cases to peer review, these have not yet undergone a peer review process.

**Implementation Plan item 80a: *A morbidity and mortality committee will meet monthly to evaluate deaths reviews and other sentinel events. Actions taken to complete this task will include:***

1. *The Agency Medical Director will chair this group and designate other senior OHS leadership; members (physician, nurse, mid-level provider) of the independent audit team who reviewed the facility; others designated as needed by the Agency Medical Director.*
2. *The deficiencies or opportunities for improvement identified by reviewers will be evaluated by the mortality review committee who will also review the completed death reviews and any available morality reviews of the Monitor. The Mortality Review Committee will assign corrective actions to the facility; if systemic risk is identified the Agency Medical Director will decide on a course of action and decide whether a process analysis is needed (this decision should be recorded in the minutes); unsafe patient safety risks that endanger patients are immediately remediated; and egregious care by a provider or nurse will be referred to the appropriate peer review entity.*
3. *Corrective actions are monitored through completion by the Quality Management Program. The policy on Quality Improvement will define how corrective actions are monitored.*

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<sup>27</sup> The Consent Decree requires identification of deficiencies. The Monitor has used opportunities for improvement which is consistent with contemporary quality improvement terminology.

**Proposed End Date: August 2023**

All deaths are subject to a review by a mortality review group led by SIU. Completed deaths are discussed in a mortality review committee which meets regularly. Minutes of these meetings have been provided to the Monitor. The span of time for the deaths reviewed was not made clear. SIU uses a form to document data and analysis from their mortality reviews. This information is placed into the Research Electronic Data Capture (REDCap) application which is a web-based application that creates databases and allows analysis of data captured. The SIU mortality reviews include demographic data, a synopsis and analysis of the death, and provide a list of nine categories of Opportunities for Improvement (OFI) (deficiencies) that are entered into REDCap.

SIU has reviewed 107 deaths in the mortality review meeting minutes sent to the Monitor. For these deaths, SIU identified 899 OFIs listed in the nine categories.

The nine categories with the number of OFI in each category are listed below.

<b>Categories of OFI with Number of OFI in Each Category</b>	
<b>Category</b>	<b># of OFI</b>
1. Evidence of failure to recognize, evaluate, and manage important symptoms and signs- so called "red flags". This category may include any discipline	187
2. Failure to follow Clinical Guidelines or Standards of Care including management of Chronic Diseases.	230
3. Delay in access to the appropriate level of care, including off-site consultation access.	119
4. Failure to identify and appropriately react to abnormal test result	62
5. Failure of appropriate communication between providers including points where transfer of care occurred	160
6. Medication delivery error, including a significant delay in a patient receiving medication or a medication delivered to the wrong patient	64
7. Practicing outside the scope of one's professional capability (may apply to LPNs, RNs, Mid-level Practitioners, or Physicians)	28
8. Physician failure to be readily available for consultation with a referring Mid-Level Practitioner	17
9. Delay or failure in emergency response, including delay in activation	32

The breakdown of deaths and OFIs by facility are shown in the table below.

<b>Deaths Reviewed by SIU to Date Sorted by Death Rate Highlighted Facilities With Below Average Death Rate</b>					
<b>Facility</b>	<b>Population</b>	<b>Deaths</b>	<b>Death Rate per 100,000</b>	<b>Number of OFI</b>	<b>OFI /1000 population</b>
Stateville	615	15	2439	129	209
JTC	163	2	1227	8	49
Pontiac	630	6	952	81	129
Menard	1917	15	782	149	78
Dixon	1449	11	759	61	42
Kewanee	179	1	558	2	11
Pinckneyville	1858	10	538	94	51
BMRCC	1148	6	523	29	25
Hill	1194	6	503	26	22
Lawrence	677	2	295	20	39
Western	1731	5	289	27	16
Danville	1591	4	251	36	23
NRC	1312	3	229	10	8
Robinson	933	2	214	13	14
Jacksonville	937	2	213	11	12
Shawnee	1508	3	199	37	25
Logan	1070	2	187	21	20
Vandalia	534	1	187	38	13
Taylorville	1091	2	183	4	4
Graham	1691	3	177	35	21
Centralia	1281	2	156	24	19
Lincoln	654	1	153	16	24
IRCC	1698	2	118	18	11
Sheridan	1036	1	97	10	10
Decatur	327	0	0	0	0
East Moline	491	0	0	0	0
Murphysboro	179	0	0	0	0
Southwestern	605	0	0	0	0
Vienna	698	0	0	0	0
JITC	15	0	0	0	0
<b>Total</b>	<b>29212</b>	<b>107</b>		<b>899</b>	
<b>Average</b>			<b>366</b>		<b>31</b>

IDOC has not developed any analysis of death rates. Four facilities had no deaths. These are small minimum

security facilities. Excluding JTC, the top death rates were at Pontiac, Dixon, Stateville, Menard, and BMRCC. Pontiac, Stateville, and Menard are the maximum security facilities and are the oldest facilities with the most challenging physical plants. This warrants investigation regarding whether the facility structure contribute to deaths. Pontiac, Dixon, Stateville, and Menard all have physician vacancies.

The northern region, as shown in the table below, with, by far, the lowest population has the highest death rate. It also has the highest rate of OFI.

<b>Deaths By Region SIU Reviews 2021-23</b>					
<b>Region</b>	<b>Population</b>	<b>Deaths</b>	<b>Death Rate</b>	<b>Number of OFI</b>	<b>Rate OFI/1000</b>
Northern	5260	33	627	220	42
Central	12614	33	261	275	22
Southern	11338	41	361	404	36
<b>Total</b>	<b>29212</b>	<b>107</b>		<b>899</b>	
<b>Average</b>			<b>366</b>		<b>31</b>

Though SIU has done significant work in completing mortality reviews, analyses of these deaths and initiation of corrective actions and improvements have been lacking. SIU has completed 107 mortality reviews and identified 899 OFIs but no corrective actions have been initiated.

Some OFIs include significant patient safety risks. Significant patient safety risks need immediate remediation and should be addressed promptly as adverse events. OFIs for the following conditions call for prompt corrective actions that may be facility specific but should be enacted systemically.

- Allowing potentially suicidal patients to have KOP medication that can cause overdose harm<sup>28</sup>;
- Not immediately cutting down a person who is hanging;
- Not having functional automated external defibrillators;
- Cardiopulmonary resuscitation (CPR) issues;
- Failing to contact poison control after a toxic exposure; and
- Discharging a suicidal patient from close monitoring.

The 899 OFIs could be organized in a manner that would lead to specific actionable steps as suggested in the following paragraphs. .

### **Medical Record OFIs**

There were 44 (5%) OFIs related to illegible entries in the paper medical record. A total of 77 (9%) of OFIs are related to the paper medical record. These are actionable items. The deficiencies for illegibility were assigned to five of the nine categories and the medical record related OFI were assigned to five of the nine categories. The categorization does not lead to a clear actionable corrective action or to compiling similar problems into the same category. For this group of OFI, reasonable corrective actions may be to obtain an electronic record and to counsel clinical staff whose writing is illegible to write clearer. SIU might consider re-organizing their categories and creating subcategories such as illegible writing that are more actionable.

### **Problem List OFIs**

<sup>28</sup> All of these descriptions of OFI here and in subsequent sections below are rephrasing of the OFI by the Monitor.

Twenty OFI (2%) identified issues with the problem list. These were assigned to three categories (#1, 2, and 5). The issue of the problem list is lost amongst the 577 other OFIs in categories 1, 2, and 5. The 20 OFI related to the problem list were identified at fifteen separate facilities indicating a systemic problem. The corrective action must start with policy and procedure on how to maintain the problem list, implementation of the problem and monitoring. How the problem list will be addressed in the new electronic record should be a corrective action.

### **Physician Orders for Life Sustaining Treatment OFIs**

Not having physician orders for life sustaining treatment (POLST) accounted for 15 (2%) of OFI. These OFI were found at 11 different facilities indicating a systemic problem. Corrective action should start with appropriate policy and procedure giving expectation and direction for initiating a POLST. Monitoring of this should be a corrective action which can be done through the annual facility comprehensive audits.

### **Emergency Response OFIs**

There were 24 (3%) OFIs related to lack of documentation of onsite emergencies or “codes”<sup>29</sup>. This was a systemic issue occurring at 14 different facilities. These OFIs were assigned to five different categories. A corrective action should include development of policy and procedure to create the expectation of appropriate documentation during emergency responses. This should be followed by implementation of the policy and subsequent monitoring.

### **Medication Administration OFIs**

There were 29 medication administration OFIs mostly found in category #6. A corrective action is already suggested in Implementation Plan #55, the implementation of which should be the initial corrective action for this OFI.

### **Nurse Practice OFIs**

Nurse practice issues are variously categorized but two stand out.

1. Failure to monitor vital signs including weight or point of care testing: 25 OFIs.
2. Abnormal vital sign(s) including weight not addressed: 6 OFIs.

These nursing issues are systemic; the Monitor has also found these deficiencies in record reviews. There currently is no policy, procedure, or practice for what constitutes an abnormal vital sign and what nurses should do about it. Nurses are left on their own to optionally determine when to call a provider and patients with extremely abnormal vital signs (including some that qualify as shock) are sometimes not referred. This speaks to a significant lack of physician oversight over clinical care. For a corrective action, IDOC should develop policy and procedure for this and implement the policy. SIU nurse specialists can work with IDOC regional nurses and Deputy Chiefs to determine a process for when a nurse should be required to contact a physician about an abnormal vital sign and how that is to be done. SIU nursing staff could be instrumental in developing a training curriculum and a nursing protocol for obtaining of all vital signs and point of care tests including pulse, respiratory rate, blood pressure, temperature, weight, oxygen saturation, peak expiratory flow rate, and capillary blood glucose and for procedures for actions when these tests are abnormal. This training should be delivered to all nursing staff in person or electronically with follow up testing. Provider training may need to be included.

### **Infirmiry Physician and Nurse OFIs**

There were 52 OFIs related to infirmiry nurse and physician practice that included the following:

- Lack of appropriate care or evaluation for dementia (9);
- Failure to manage or prevent decubiti (8);

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<sup>29</sup> This relates to the documentation in the medical record of chronologic events that occur during an emergency response. The Monitor has been critical of this deficiency as well.



- Failure to monitor patients (6);
- Failure of nurses to document care (5);
- Failure to adequately evaluate or manage a patient fall (5);
- Failure to attend to a patient need (5);
- Failure to provide physical therapy or rehabilitation (5);
- Failure to assist or appropriately attend to a patient on the infirmary (3);
- Lack of attention to a patient with serious needs (3);
- Failure to monitor an infirmary patient (2); and
- Inadequate management of an indwelling catheter or intravenous line (1).

There are two aspects to a corrective action for these infirmary issues. One corrective action should be to ensure adequate staffing which is not now occurring and contributes to these deficiencies. If staffing is not corrected it will be difficult to correct improper practices. A corrective action should also include development of expectation of nurses in the care of infirmary patients to include monitoring, decubiti prevention, fall management and prevention, assistance with activities of daily living, and management of patients who have dementia or are otherwise total care patients. Training on these issues should be a corrective action and can be over the Internet but will likely require establishment of policy and procedure for nursing infirmary care.

### **End-of-Life OFIs**

There were 44 OFIs related to end-of-life care. These included the following:

- Physician Order for Life Sustaining Treatment (POLST) not timely, inadequate or not found (14);
- Failure to provide recommended or needed palliative or hospice care (9);
- Significant lack of end-of-life or palliative treatment (8);
- Continued active treatment after comfort-care (hospice) is elected (5);
- Failure to identify health surrogate or make decisions about legal capacity to make medical decisions (4);
- Failure to establish a goal of care given end-of-life (2); and
- Failure to manage pain at end-of-life (2).

These deficiencies were widespread and therefore systemic. Corrective action for these issues should begin with development of appropriate policy and procedure. Specific procedures and training for obtaining POLST should be initiated. Policies should address procedures for obtaining release from prison under the Joe Coleman Act; where patients in hospice are housed; and general pain management and care management issues for both physicians and nurses. Training and implementation of policy and procedure should also be corrective actions.

### **Hospital and Specialty Care OFIs**

There were 166 (18%) of OFI related to specialty and hospital care found in multiple SIU OFI categories. This is a major issue identified by SIU. These included the following.

1. Failure to timely refer for specialty care (64);
2. Failure to timely refer to a hospital (35);
3. Recommendations of specialist not addressed (17);
4. Reports of hospital and specialist unavailable (17);
5. Failure to communicate patient problems with a hospital or specialist (16);
6. Failure to timely review records of the hospital or specialist or evaluate patient post consultation (9);
7. Recommended follow up with specialist failed or was delayed (4);
8. Lack of documentation of specialty or hospital care or failure to ensure effective communication with specialist (3); and
9. Specialty care delayed or cancelled due to lack of transportation vehicle (1).

These deficiencies are widespread, occurring at 20 (83%) of the 24 facilities that had deaths. In crafting corrective actions, a reasonable first corrective action is to develop a plan to complete Implementation Plan item 52 which partly addresses all of the items 1-9 listed above.

Whether the vendor will be helpful in addressing these widespread deficiencies is unclear. One of the vendor Regional Medical Directors said in a recent interview that access to specialty care was comparable to access in the community. This statement is not credible based on both SIU mortality reviews and Monitor mortality reviews. Another Regional Medical Director was asked about problems in getting patients referred for specialty care. He said that some hospitals and health systems would not see inmates due to Medicaid reimbursement rates. This answer applies only to hospitalization but the Regional Medical Director also added that orthopedic surgeons, as an example, would not see his patients. The log that tracks scheduling and completion of offsite appointments is required by the Consent Decree to be maintained by the HCUA is actually maintained by the vendor. The vendor controls all aspects of offsite scheduling and scheduling is not timely. The process analysis of this needs to be completed and should be initiated as a corrective action.

It has become clear based on observation and interviews of the Monitor that additional features should be analyzed. Hospital and specialty care delays at Stateville, Dixon, Sheridan, and Pontiac are related to rationing of specialty and hospital care based on the queues that develop due to waiting for free care at UIC. The arrangements for free care are an impediment to receipt of timely specialty and hospital care. The analysis also needs to include reimbursement rates for offsite care, scheduling and tracking processes, and provider referral practices. Corrective actions need to address these reimbursement rates as significant barriers to care.

A corrective action that should be considered consistent with requirements of the Consent Decree to review specialty consults with the patient (III.G.4., II.B.6.e., III.E.4., III.H.1., III.H.2., III.H.3., and III.H.4.) which address OFIs 1-9 above, is to create audit instrument items which measure compliance with these requirements annually at all facilities. In particular, a corrective action to track receipt of hospital and specialty reports; accuracy of the offsite log; timely review of hospital and specialty reports; and timely review of these with the patient can be outcome and performance measures that are presented quarterly to all facilities. This should be built into the audit function. If the log were reliable, it could be used for this purpose but currently it is unreliable.

### **Physician Practice OFIs**

The most prevalent OFIs were related to physician practice issues. The following were types of physician practice issues.

1. Significant symptom or sign unrecognized, not evaluated, or evaluated inappropriately (77);
2. Failure to timely refer to specialty care (62);
3. Failure to monitor or manage chronic illness or not managing consistent with standards of care (52);
4. Failure or delay to review or appropriately manage a test result (46);
5. Physician oversight or physician availability (38);
6. Failure to timely refer to a hospital (35);
7. Failure to order or timely obtain labs or tests when indicated (19);
8. Recommendation of specialist not addressed (17);
9. Medication management not monitored by provider (9);
10. Failure to evaluate patient post hospitalization (4);
11. No clear indication for Foley catheter (4); and
12. Physical assessment not performed every two years (2).

Physician practice issues constituted 284 (32%) of the 899 OFIs identified. Oversight of physicians is needed but does not occur. While the vendor Regional Medical Directors supervise physicians, they do not meaningfully participate in oversight. One of the Regional Medical Directors had only read one of the mortality reviews.

Another said that until the vendor could define what the circumstances of death were, they would not establish any corrective action. Another said he couldn't recall any specific opportunities for improvement. Once physician staffing levels are corrected, physician practice will require active physician oversight but this is not now being provided with respect to findings on mortality review.

The volume of OFIs related to physician practice requires that provider support and staffing must be considered. While a workload analysis has not yet been completed, physician staffing issues remain, in the Monitor's opinion, a serious problem that results in the volume of deficiencies identified in mortality reviews. Approximately 33% of existing physician positions remain vacant and additional physician positions are needed. One of the results of lack of physicians is the lack of attention to physician practice. One of the vendor Regional Medical Directors said he wasn't sure if more staff were needed. Yet at a recent site visit the coverage physician said he had no time to participate in quality improvement activity because he was overwhelmed with work. The current staffing analysis does not increase physician positions. Nothing is done to monitor or track physician workload. A corrective action for this needs to include a specific workload analysis for physicians. A second corrective action should be to track the precise number of patients seen per day by every physician.

Expectations for physicians are made by HCUs (who are not physicians) who focus on adherence to administrative directive requirements for seeing patients. This is done irrespective of the quality or clinical appropriateness of the work accomplished. No performance monitoring of physicians based on physician-directed expectation is accomplished. All three vendor Regional Medical Directors confirmed that they perform no formal or written performance evaluation of their physicians. Clinical performance evaluations are not done. Performance evaluations of physicians has been requested but was not provided. Based on record reviews accomplished to date by the Monitor, clinical performance is not good. The root cause of this based on site visits and record reviews must include lack of support for physician practice (lack of an electronic record, no reference material, an ineffective specialty scheduling system, lack of management in obtaining hospital and specialty care reports, poor clinic space, lack of nursing support for chronic care and infirmary care, staffing deficiencies, and lack of medical leadership to set expectations for performance). There is no evidence that any clinical expectations for physicians have been established.

**Implementation Plan item 68:** *Review selection of aged/infirm/disabled deaths over past year in order to make recommendations for improved medical care. Proposed End Date: June 2023*

The Implementation Plan requires review of deaths of the aged and infirm in order to make improvements. In the Implementation Plan, IDOC listed the responsible parties as the consultant hired to analyze the aged and infirm and SIU. Multiple end-of-life issues were identified in mortality reviews performed by SIU and these should be shared with the aged and infirm consultant for the consultant to analyze and make recommendations. This has not yet been accomplished as a consultant has not yet been hired.

In their reviews, SIU did include a category designated "red flag" ( OFI #1). This nomenclature was added to any event that was serious and contributed to the death in a significant manner. This nomenclature is reasonable but should be additive to the baseline OFI. For example, if failure to refer to a hospital contributed significantly to death, then failure to refer to a hospital should be the base categorization with an added nomenclature of "red flag".

In summary, IDOC has begun implementation of a mortality review policy. SIU mortality reviews are a positive development. Meaningful opportunities for improvement are being identified. The Monitor suggests the scope of review be widened to include all aspects of care. If this were done, the manner of conducting mortality review gives insight into how audits may be performed. Corrective actions have not been initiated based on identified opportunities for improvement even though clear corrective actions are called for. Peer reviews have not been

completed. SIU should consider revising their categorization of OFI to make it easier to identify actionable corrective actions. SIU mortality reviews have included some findings for the aged, infirm, and findings should be provided to the consultant hired to make recommendations on the aged and infirm. The Monitor is still not provided all charts of deaths. A partial compliance is warranted.

Recommendations that reiterate Implementation Plan items were removed.

## **RECOMMENDATIONS:**

1. IDOC needs to make REDCap accessible to the Monitor and his team.
2. The mortality review committee meetings should be open to the Monitor and his team.

## **Medical Records**

### ***Addresses item II.B.4; III.E.3; III.E.4; III.G.3***

**II.B. 4.** *No later than 120 days after the Effective Date of this Decree, IDOC shall have selected an EMR vendor and executed a contract with this vendor for implementation of EMR at all IDOC facilities. Implementation of EMR shall be completed no later than 36 months after execution of the EMR contract.*

**III.E.3.** *IDOC shall abandon “drop-filing”.*

**III.E.4.** *The medical records staff shall track receipt of offsite medical providers’ reports and ensure they are filed in the correct prisoner’s medical records.*

**III.G.3.** *IDOC shall use best efforts to obtain emergency reports from offsite services when a prisoner returns to the parent facility or create a record as to why these reports were not obtained.*

**OVERALL COMPLIANCE RATING:** Noncompliance

## **FINDINGS:**

**Implementation Plan item 17:** *Complete facility wiring for EHR. Proposed End Date: August 21*

**Implementation Plan item 18:** *Arrange for assigned person in DoIT or hire consultant to annually meet with OHS and to review facilities to determine need for additional wiring, devices or equipment as new staff is onboarded, as equipment requires replacement, or when new programs require additional equipment or wiring. This will result in a brief summary of the review to OHS and director of DoIT. Proposed End Date: Annually*

**Implementation Plan item 22:** *Determine necessary device count for future healthcare staff use of EHR. IDOC OHS will identify point of care devices to integrate into EHR system such as glucometers, thermometers, automated blood pressure, pulse oximetry, ultrasound etc. as well as laptops, desktop computers, printers, scanners, and other devices necessary to effectively implement the EMR. Proposed End Date: February 2024*

**Implementation Plan item 23:** *Ensure acquisition of devices for future healthcare staff to operate the EHR.*

- a. *OHS and DoIT will develop a written procedure for requesting new devices in the event of new staff exceeding the existing device capacity;*
- b. *reporting of defective or malfunctioning equipment so it can be replaced;*
- c. *or requesting a meeting of DoIT with OHS designee(s) to request equipment needs for new initiatives which cost will be proposed through an expedited (for critical projects) or normal budget process (for routine projects)*

**Proposed End Date: June 2024**

IDOC stated in its Implementation Plan that all wiring for the EMR has been in place since 2021. IDOC meant by this that wiring in the health care units is complete. However, not all health care is provided in health care units. Medication administration in some facilities (e.g., Logan) is completed on living units. At Graham, intake is completed in the gymnasium. Nurse sick call occasionally occurs off the health unit. IDOC needs to be clear that wiring needs need to ensure that wherever the electronic record will be needed that there will be a capacity to do so.

Both wiring and device needs were initially determined for existing staff in existing space arrangements. The Monitor has concerns that there will be insufficient devices and wiring as new staff are brought on. Also, IDOC has provided no information with respect to plans for anticipating new device needs or interfaces with the electronic record to blood pressure equipment, glucometers, other point of care devices, thermometers, scales, etc.

IDOC has not provided procedures for requesting new equipment, replacing defective equipment, or requesting DoIT for new equipment, devices, or wiring.

**Implementation Plan narrative page 1:** *Another primary focus of OHS is to institute the following structural components to its health program: System-wide implementation of an Electronic Medical Record (“EMR”);*

**Implementation Plan item 19:** *Post RFP for EHR. Proposed End Date: September 2023*

*Public Pre-Bid Conference.*

*Evaluate Bids received.*

*Select vendor for EHR.*

**Implementation Plan item 20:** *Finalize implementation of Electronic Health Record. Proposed End Date: November 2025*

A contract for an electronic medical record and implementation of an electronic record are both delayed with respect to timelines stipulated in the Consent Decree. IDOC proposed in its Implementation Plan that the electronic record bid posting would be completed by September of 2023, The RFP has been released but an award date is still uncertain.

IDOC informed the Monitor that the electronic medical record is in the final stages of the evaluation process prior to an award announcement. This has been ongoing for several months. It is uncertain precisely when an award will be made. IDOC has also stated that the electronic medical record will be fully implemented by November of 2025. This is an aggressive target, given the current status.

The Monitor has asked for any documents or summary of plans for the new electronic record but has not received any. This includes a requirements document or an implementation plan for the electronic record.

**Implementation Plan narrative page 4:** *Implementation of the Electronic Medical Record (“EMR”) at all sites is a critical component of the IDOC’s compliance with the Consent Decree. With the implementation of a system-wide EMR, the OHS leadership team recognizes the benefit of creating a branch of OHS dedicated to health care information technology (“IT”). The addition of an IT Department to collect health care data will allow OHS to adhere to the Consent Decree. These individuals will have the expertise to modify EMR user interfaces, generate specific queries, and translate health care information into reports or to populate health system dashboards. This expertise will also allow IDOC to provide data for use in quality improvement programs and to*

*verify compliance with the Consent Decree. The addition of an IT department dedicated solely to OHS is essential for monitoring the processes, encounters, and trends in IDOC's delivery of health care. This type of data management is crucial to appropriately tracking clinical progress and outcomes. The IT team will also assist the IDOC and the audit teams in developing and implementing a set of health care performance and outcome measurements. Additionally, the data team will assist IDOC in evaluating the electronic medication administration process to ensure that it functions in all facility settings and delivers sufficient data to verify aggregate and individual receipt of medication. The IT program will ensure that a call center is available to all staff on all shifts for problems with access to or use of the electronic record. The IT program will also ensure that new staff are appropriately trained in use of the EMR related to their work responsibilities before they begin their assignments.*

**Implementation Plan narrative pages 5-6:** *IDOC will hire additional staff to improve data acquisition. Accurate data is a critical component of quality improvement work. IDOC will ensure that data requirements as specified in V.G. of the Consent Decree; data needs for auditing; and data to provide the Monitor for his reports as required by the Consent Decree will be obtained from the electronic record or other electronic sources. IDOC will hire a data team to perform this function. The data team will do the following:*

- Develop screens in the electronic record to fully conform to IDOC clinical and data needs; and to fulfill requirements of the V.G. provision, needs of the audit team, and needs of the Monitor for his reports;*
- Work to ensure that all necessary data elements are present in the medical record;*
- Extract and compile data from the electronic record—in useable and acceptable format—for the audit team, Monitor (for verification of compliance and his reports), and for supporting quality improvement projects;*
- Develop performance and outcome measures as required by the Consent Decree; and develop a dashboard of those measures utilizing data obtained from the electronic record to monthly show facility progress on these performance and outcome measures;*
- Provide data to verify the degree of compliance with requirements of the Consent Decree;*
- Assist OHS and quality teams on other data and project needs as needed.*

**Implementation Plan item 2:** *Complete hiring of Executive OHS Leadership staff.*

*SIU will hire ... 3 data team members... IDOC will negotiate with SIU to hire project managers listed below.*

**Proposed End Date: March 2020**

- 2. Full-time Electronic Medical Record project manager. Proposed End Date: May 2023*

**Implementation Plan item 21:** *Hire or reassign a qualified dedicated full-time IT professional as project manager for the EHR implementation. Proposed End Date: October 2023*

IDOC has provided no plans for acquisition of data either from the electronic record or otherwise. Currently, to acquire data for the 12 performance and outcome measures, SIU sends staff to facilities and manually obtains the data from the paper record which is a tedious process. In 2019, IDOC planned to create and hire three positions: a health information technology coordinator, an electronic health record administrator, and a health information analyst. These positions have since been eliminated. The Implementation Plan states SIU will hire a data team, but there is no evidence that this has been done. IDOC is in the process of creating a posting for a personal services contract for an electronic medical records project manager but IDOC added that creation of this position is working its way through the state personnel process. Proposed dates of completion for hiring a data team and electronic record project manager have passed without completion. Both the data team and an electronic record

project manager should have been in place prior to letting the RFP.

**Implementation Plan item 7: *Develop written procedures for expectation of training to include:***

1. *Electronic medical record training both initial and ongoing;*
2. *New employee training;*

*Training procedures shall include the format of training (in-person, video conference, onsite, quarterly meeting, etc.); copies of the new policy or procedure for all attendees; sign-off acknowledgement that training was received; in some cases, verification of competence with the training (taking blood pressure, using a point of care device, etc.). **Proposed End Date: September 2023***

**Implementation Plan item 24: *Provide staff training on the use of the EHR. At least three months prior to “go live” develop a standardized plan that is then applied to each facility. Each facility may have barriers (no space to conduct the training, work schedules that conflict with training schedules, etc.). For that reason, each facility will modify the standardized plan based on facility specifics. Employee-specific task training will be the standard (medication nurses receive training on the eMAR, providers receive training on chronic illness documentation, etc.) \*training specifics will be outlined with the assistance of the selected EHR vendor in coordination with OHS leadership and the Department of Innovation and Technology (DoIT). Provide initial, end-user specific staff training to include: Medical, dental, and mental health providers, nurses, ancillary staff, facility administrative staff, OHS executive staff and Quality teams. The training plan shall include 1) where the training will occur, 2) ensuring that sufficient space and devices are obtained so that every trainee has a device to use and the space is conducive to a training session, 3) ensuring that prior to beginning training all staff have sufficient computer skills to utilize the operating system, 4) that sufficient time is allocated for training and that those who need more time to learn have an opportunity to do so, 5) that training groups are established (providers, medication nurses, schedulers, etc.) so that training is provided specific for the responsibilities of staff trained, 6) that there is a test requirement that ensures that the staff trained have acquired the skills necessary to effectively use the electronic record. **Proposed End Date: November 2024*****

Though the vendor proposals for an electronic record are being evaluated, a procedure for training has not yet been developed. IDOC had proposed a completion date of training proposals to include for the electronic record by September of 2023, but no information has been provided yet.

Specific training on use of the electronic record was planned to occur just prior to each facility “go live” event. That was anticipated as being completed by November of 2024. This is a very aggressive date. However, the plans for what is to occur for the training was proposed to be completed by September of 2023 and there is no plan yet.

**Implementation plan item 25: *Hire 3 IT professionals to manage a help desk and to provide continuity training for new hires, new EHR features, upgrades, and revisions. IDOC may elect to contract out this service. **Proposed End Date: November 2024*****

IDOC has provided no plan for a help desk and has no plans to hire staff to manage a help desk.

With respect to “drop-filing”, there is no evidence that IDOC tracks this Consent Decree requirement. With respect to medical record staff tracking offsite medical provider reports, facilities optionally track this item and the term consultation report is undefined and staff appear to count any communication, including brief handwritten comments on a transfer form as a consultant report. In SIU mortality reviews, similar to prior Monitor mortality reviews, there were numerous episodes of failure to have consultant or hospital reports. IDOC should

develop policy and procedure on consultation report and define a consultation report as a typed full consultant report.

In summary, the signing of the contract for the electronic record is still not completed approximately four years into the Consent Decree. IDOC provides limited insufficient data or information to verify its compliance with any of the provisions regarding the medical record. These provisions remain noncompliant.

#### **RECOMMENDATIONS:**

1. Base the roll out and device needs on expected numbers of employees and expected workflows and not on current employee numbers or existing workflows.
2. Modify the Staffing Analysis and Implementation Plan to include staff to manage and support the electronic medical records including initial and ongoing training for users and a help desk function.
3. Ensure that point-of-care<sup>30</sup> devices are integrated into the electronic medical record.
4. Ensure that label printing of laboratory requisition and other similar devices are integrated into the electronic medical record as part of the implementation of the record.
5. Ensure that the new electronic medical record has the capability to track and report clinical and operations data that is needed to assess IDOC's compliance with the Consent Decree and data that is vital to IDOC's ongoing efforts to track and improve the delivery of quality care.

## **Policies and Procedures**

### **Medical & Dental**

#### *Addresses item II.B.8; III.K.4; III.K.5*

**II.B.8.** *The implementation of this Decree shall also include the development and implementation, with the assistance of the Monitor, of a comprehensive set of health care policies by July 1, 2020. These policies shall be consistent throughout IDOC, and cover all aspects of a health care program.*

**III.K.4.** *IDOC shall implement policies that require routine disinfection of all dental examination areas.*

**III.K.5.** *IDOC shall implement policies regarding proper radiology hygiene including using a lead apron with thyroid collar, and posting radiological hazard signs in the areas where x-rays are taken.*

**OVERALL COMPLIANCE RATING:** Partial Compliance

#### **FINDINGS:**

The Monitor requested the following documents specifically to review for compliance with the items from the Consent Decree listed above.<sup>31</sup>

1. Any more recent versions of the Administrative Directives listed in Appendix A. Also provide any other administrative directives that pertain to medical and dental care not listed in appendix A.
2. Updated list of all implemented policies since beginning of Consent Decree with date of implementation.

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<sup>30</sup> Point-of-care devices are small devices that provide a diagnostic test locally and which can be used by nursing or provider staff where care is delivered. These devices include glucometers to test blood glucose, or devices to test blood to determine whether anticoagulation (INR) is sufficient. Electronic vital sign machines are similar to point-of-care devices in so far that they can be connected to the electronic medical record and the testing results can be automatically directed to the appropriate place in the electronic medical record.

<sup>31</sup> Monitor's documentation request dated 8/4/2023, items 38 and 39. The only document provided was Administrative Directive 04.03.108 Response to Medical Emergencies dated 3/1/2023. It is discussed in the section of this report on Urgent/Emergent Care.



The Monitor's 6<sup>th</sup> report described IDOC's effort to develop a comprehensive set of policies as sporadic and disorganized and that progress towards completion had regressed from earlier efforts.<sup>32</sup> Since then IDOC has established a process to develop policy and procedures, identified someone to coordinate the process, and has drafted 89 policies, with procedures, which have been provided to the Monitor for review.

The Implementation Plan, which was filed with the Court on August 1, 2023, references in eight places the development and implementation of a comprehensive set of health care policies as well as a process for their review and revision. Each is listed and followed by a description of IDOC's progress toward attainment.

- **Implementation Plan narrative page 1:** *OHS is to institute the following structural components to its health program: Development of a **comprehensive set of health care policies and procedures** that address all the provisions of the Consent Decree;*
- **Implementation Plan narrative page 4:** *OHS will hire a **project manager to expedite and facilitate** a process to develop an enhanced set of policies and procedures if necessary. Several drafts are in progress. As drafts of these policies are completed, they will be circulated to the OHS leadership, IDOC officials, and the Monitor's staff for comments. Once a policy is completed, IDOC and any project manager it hires will **ensure that training on the policy is provided to all sites**. Going forward, these crucial documents will form the guidelines for practice and become the standard for measurement and accountability for performance.*
- **Implementation Plan item 40:** *OHS will develop **comprehensive medical policies with the assistance of the Monitor to cover all aspects of a health care program**. Policies will reference existing, widely accepted, correctional health care accreditation standards such as those promulgated by the National Committee on Correctional Health (NCCHC) and the American Correctional Association (ACA).*
  1. *Hire project manager or other person solely assigned to manage policy development, ongoing review, and maintenance. (Agency Medical Director) **Initiate 2/23; ongoing***
  2. *Establish an initial list of policies to be developed to address every provision in the Consent Decree as well as every NCCHC accreditation standard. (Project Manager) **Completion 3/23***
  3. *Establish, with the assistance of the Monitor, the essential elements and criteria that must be addressed in each policy on the list. (Project Manager and Agency Medical Director) **Completion 4/23***
  4. *Assign subject matter experts for each policy to be developed from amongst OHS leadership, regional staff, SIU, and vendor staff to draft the initial policy and to make revisions during the review process. (Initially Agency Medical Director or designee) **Initiate 4/23 Completion 8/23***
  5. *Establish a process, calendar, and timeframes for the IDOC and Monitor to review and comment on drafts through to finalization. Manage the development of draft policies through to finalization and provide monthly reporting to the Agency Medical Director, Chief Compliance Officer, and the Monitor on progress toward completion.(Project Manager) ) **Initiate 4/23 Completion 8/23***
  6. *Establish the document format for every policy. The document format requirements need to include development of a standardized procedure for implementation at the facility level, as well as the elements to be included in tools to evaluate compliance with policy and procedure. (Project Manager) **3/23***
  7. *Identify policy subjects that would benefit from process mapping and arrange facilitation of these with SIU. (Project Manager) **4/23***

<sup>32</sup> Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys, March 13, 2023, pages 38 & 40.

8. *Evaluate whether additional resources are needed to implement each policy and procedure and secure the necessary equipment, supplies or personnel to do so. (Subject Matter Expert, Regional Coordinators). **Initiate 6/23, Completion 9/23.***
  9. *Establish a plan to provide standardized training and centralized reporting of training completion and subject knowledge in the set of comprehensive medical policies and procedures. Plan is to include the initial training of existing staff, orientation of new staff, annual evaluation of staff knowledge and compliance with P & P, and the method to inform staff of revisions to P & Ps. (Project Manager, Training Manager) **Initiate 4/23, Implement 9/23, Completion 11/23***
  10. *Establish a methodology for the Agency Medical Director to consider requests for exceptions to specific requirements in policy and procedure and to document any approved deviations. The Agency Medical Director will solicit input from the Monitor in making these determinations. (Agency Medical Director and Project Manager) **Initiate 6/23; Completion 11/23***
  11. *Establish the timeframes and expectations for implementation of policies at the facility level. (Project Manager, Agency Medical Director) **Initiate 6/23, Completion 11/23.***
  12. *Develop tools and methodology to measure conformance with each policy and procedure. (Audit Manager) **Initiate 8/23, Completion 12/23***
- **Implementation Plan narrative page 3:** *In summary, this implementation plan focuses on establishing improved system-wide health care policies and operational requirements. Staff will need to be trained on new policy initiatives, and the new policies will need to be implemented.*
  - **Implementation Plan item 7:** *Develop written procedures for expectation of training to include:*
    1. *Procedural training (new policies, new procedural initiatives and new or modified processes);*
    2. *New employee training;*  
*Training procedures shall include the format of training (in-person, video conference, onsite, quarterly meeting, etc.); copies of the new policy or procedure for all attendees; sign-off acknowledgement that training was received; in some cases, verification of competence with the training (taking blood pressure, using a point of care device, etc.). **Proposed End Date: September 2023***
  - **Implementation Plan item 51c:** *Revise policy and procedure for completed process analysis when a revised process differs from existing policy. **Proposed End Date: At completion of analysis process.***

On March 16, 2023 the Agency Medical Director informed the Monitor of progress that OHS made in establishing a policy and procedure manual that provided detail about medical operations not covered by the Administrative Directives and that OHS had a process in place to make changes to policy and procedure.<sup>33</sup> The minutes of the System Leadership Council document establishment of a policy and procedure committee in September 2022 consisting of OHS leadership.<sup>34</sup> This committee is reported to meet every two months. The Medical Compliance Administrator was described as actively coordinating the process for policy and procedure development.<sup>35</sup>

The next day IDOC Special Litigation Counsel sent a document comprised of 49 draft policies and procedures to the Monitor for review. The document also included a table of contents which lists all of the policies and procedures OHS intends to develop. On the basis of the list alone it is not clear if every provision in the Consent

<sup>33</sup> Monitor's monthly meeting with OHS on 3/16/2023.

<sup>34</sup> Minutes of System Leadership Council 9/8/2023

<sup>35</sup> Monitor's monthly meeting with OHS on 3/16/2023. This position reports to the Chief Compliance Officer and is responsible for monitoring procedures for health services to verify corrective system change. CMS-104 Position Description

Decree as well as every NCCHC accreditation standard will be addressed.<sup>36</sup> It is suggested that this be reviewed once the policies and procedures listed in the table of contents have been circulated and any additional subjects that need policy and procedure be identified. The Agency Medical Director was identified as the contact for basic questions encountered during the Monitor's review and has been available as needed for clarification.

The Monitor reviewed these initial drafts and returned them with changes as requested. OHS reviewed the Monitor's suggested revisions and returned a second draft or response to 38 of the first 49 draft policies and procedures. The Monitor reviewed these second drafts and has since returned comments to OHS for further consideration. In addition, OHS and the Monitor met on July 20, 2023, to discuss possible resolution for areas of disagreement that continue in the second draft of several policy/procedures. This was a productive exchange and is suggested as the format to resolve differences necessary to finalize other policies and procedures.

Since May 2023 OHS has sent 39 drafts of additional policies/procedures for the Monitor to review.<sup>37</sup> At the time this section of the 7<sup>th</sup> report was written the Monitor had reviewed and made suggested revisions to 21 of these additional policies and procedures. The deadline for finalization of the policies and procedures set out in the Implementation Plan Monitor is August 2023. At this time the Monitor is not aware of any policies/procedures from the group first received in March that have been finalized, in addition there are 28 drafts that the Monitor has provided comments on that IDOC has not been responded to yet and 22 drafts that the Monitor has not yet reviewed.

According to the minutes of the System Leadership Council copies of the draft policies and procedures have been distributed to the facilities and regional Health Services Coordinators are to address questions and facilitate implementation.<sup>38</sup> There has been some preliminary discussion with the IDOC training department about a platform and resources to deliver education and training for health care personnel.<sup>39</sup> No other information or documentation has been provided as yet for training or a plan to provide training in the new procedures as part of the implementation process.<sup>40</sup> The completion date for development of expectations for procedural training in the Implementation Plan is September 2023, and the completion date of a plan to provide standardized training in the comprehensive set of medical policies and procedures is November 2023 to include centralized reporting of training completion and subject knowledge.

IDOC indicates that the Medical Compliance Administrator is the acting project manager to ensure completion of the policies and procedures and that it intends to have a position or contract with someone whose primary responsibility is the ongoing management of the health care policies and procedures.<sup>41</sup> However it is not yet clear how the position will be established.<sup>42</sup> The Medical Compliance Administrator will retain some responsibility for auditing compliance with the health services policies and procedures once they are finalized.<sup>43</sup> The completion

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<sup>36</sup> The Monitor listed applicable references to the Consent Decree in the list of reference section at the end of each policy and procedure, but this revision was rejected by IDOC. There will have to be a separate reconciliation of the Consent Decree and the policies and procedures before finalization to accomplish item 40, subpart 2 of the Implementation Plan.

<sup>37</sup> On 5/19/2023 16 draft policy/procedures were received by the Monitor for review; on 6/23/2023 18 additional were received and on 8/23/2023 five more were received for review.

<sup>38</sup> System Leadership Council Minutes 9/8/2022 and 3/29/2023.

<sup>39</sup> Correspondence between the IDOC Training Academy and the Agency Quality Improvement Coordinator dated 6/22/2023 and the System Leadership Council minutes for 6/28/2023.

<sup>40</sup> Training has been provided on quality – see the section on Statewide Internal Monitoring and Quality Improvement in this report.

<sup>41</sup> Correspondence between the Monitor and the IDOC Special Litigation Counsel dated 9/5/2023. IDOC recently reported to the Monitor that the Medical Compliance Administrator has taken the position of the OHS Medical Coordinator and will continue to be involved in policy development.

<sup>42</sup> Correspondence between the Monitor and the IDOC Special Litigation Counsel dated 10/12/2023.

<sup>43</sup> Meeting with Chief Compliance Officer on 3/30/2023. The method and process to audit compliance with the comprehensive set of health services policies has not been established.

date for this step in the Implementation Plan is December 2023.

The policy and procedure drafted by OHS concerning policies and procedures (A.05.01) establishes the authority of IDOC Health Services to develop those necessary for the administration and operation of the health care program and that all entities involved in delivering health care are to follow these. The Monitor has agreed to the second draft with the understanding that a plan for standardized training and reporting of completed training in the policies and procedures will be developed, a method for the Agency Medical Director to consider requests for exceptions to policy and procedure is established, and timeframes and expectations for policy implementation at the facility will be delineated in the next revision. Each of these steps are included in the Implementation Plan, item 40 subparts 8-12.<sup>44</sup>

The Monitor has yet to observe or be provided documentation as proof of practice that policies/procedures previously considered final have resulted in changes in performance at the facilities. These include a directive regarding immunizations and preventive cancer screening in effect since January 2021.<sup>45</sup> Another is the quality improvement program, which was effective October 1, 2022, and required monthly meetings at the facility to review the functions outlined in the quality manual.<sup>46</sup> These examples are offered to emphasize the importance of planning for and documenting implementation of required changes as described in item 40 of the Implementation Plan.

- **Implementation Plan item 83: *With input from Monitor develop set of comprehensive standardized dental policies and procedures.***
  1. *Provide the drafts of these and other dental policies to the Monitor for input.*  
**Proposed End Date: December 2023**

The Monitor has received two dental policies addressing Comprehensive Treatment Planning and Infection Control. The Infection Control policy is comprehensive, comprising eleven sections. The Monitor has initiated the process of reviewing and examining these policies in September 2023. The Comprehensive Treatment Planning policy was returned with comments and will be scheduled for further discussion with IDOC's Chief of Oral Health Services.

- **Implementation Plan item 82: *Review and identify any language in the vendor's dental policies that impose a potential barrier or a restriction to any aspect of dental care. Proposed End Date: September 2023***

The Monitor raised concern about the fees IDOC was charging for replacement prosthetics.<sup>47</sup> In an email exchange with the Special Litigation Counsel, the Monitor was informed that a Statewide Request for Variance was issued and finalized on May 30, 2023. This request eliminates the fee for replacing oral prosthetics, with one exception: "unless restitution is recommended by the Adjustment Committee in accordance with Departmental Rule 504.140." The Monitor finds this change acceptable and will continue to assess compliance through dental record reviews and site visit inspections.

In summary, IDOC made progress in the initial development of a comprehensive set of health care policies.

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<sup>44</sup> Monitor's comments on second draft of A.05.01 dated 6/13/2023.

<sup>45</sup> There is limited evidence in record reviews that staff are consistently acting in accordance with this policy and medical staff interviewed during the site visit to Graham Correctional Center 7/17-19/2023 had no knowledge of expected practices for cancer screening.

<sup>46</sup> Based upon review of monthly QI minutes, these meetings do not take place at each facility monthly and have yet to include review of all of the functions described in the quality manual.

<sup>47</sup> Illinois Department of Corrections Administrative Directive 04.03.102. Page 3

However, there is still significant work yet to be done to finalize the drafts, implement them, and ensure practices are consistent with policy throughout IDOC. The Implementation Plan provides the direction to accomplish the work remaining.

## RECOMMENDATIONS:

1. Eliminate the fee for replacement of dental prostheses as noted in Administrative Directive 04.03.102.II.F.6.b.
2. Ensure that policies describe changes necessary for compliance with the Consent Decree.
3. Discuss with the Monitor areas of disagreement to seek resolution in order to finalize the draft policies/procedures.

## Facility Implementation of Policies and Procedures

### Medical and Dental

#### *Addresses item II.B.8.*

**II.B.8.** *The implementation of this Decree shall also include the development and implementation, with the assistance of the Monitor, of a comprehensive set of health care policies by July 1, 2020. These policies shall be consistent throughout IDOC, and cover all aspects of a health care program.*

**OVERALL COMPLIANCE RATING:** Noncompliance

## FINDINGS:

The Monitor requested an updated list of all implemented policies since beginning of Consent Decree with date of implementation as well as any Administrative Directives which have been updated since the last report.<sup>48</sup> The Implementation Plan that was filed with the court on 8/1/2023 includes several items pertaining to the implementation of a comprehensive set of health care policies. The primary focus of these items is to ensure that staff are appropriately trained and demonstrate competency in the delivery of services consistent with the policy and procedure.

Implementation Plan narrative page 4: *Once a policy is completed, IDOC and any project manager it hires will ensure that training on the policy is provided to all sites.*

#### **Implementation Plan item 7: *Develop written procedures for expectation of training to include:***

- 1. Procedural training (new policies, new procedural initiatives and new or modified processes).*
- 5. New employee training.*
- 6. Training procedures shall include the format of training (in-person, video conference, onsite, quarterly meeting, etc.), copies of the new policy or procedure for all attendees, sign-off acknowledgement that training was received, in some cases verification of competence with the training (taking blood pressure, using a point of care device, etc.)*

***Proposed End Date: September 2023***

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<sup>48</sup> Monitor's documentation request dated 8/4/2023, items 38 & 39. The Monitor received a revised Administrative Directive on emergency services which is discussed in the section of this report on Urgent/Emergent Services. No other documents were received in response to these two requests.

**Implementation Plan item 8.a:** *Hire a training coordinator to track training, coordinate support for the training, and ensure staff training occurs for all relevant staff. Proposed End Date: September 2023*

**Implementation Plan item 40, step #9:** *Establish a plan to provide standardized training and centralized reporting of training completion and subject knowledge in the set of comprehensive medical policies and procedures. Plan is to include the initial training of existing staff, orientation of new staff, annual evaluation of staff knowledge and compliance with P & P, and the method to inform staff of revisions to P & Ps. To be done by project manager and training manager. To be initiated April 2023, Implemented September 2023 and Completed November 2023.*

In an earlier section of this report on Statewide Policies and Procedures the progress being made by IDOC to develop policies and procedures is discussed. Since none of these documents has been finalized, no implementation has taken place at the facility level yet. The Department is still exploring how training in the policies and procedures will be accomplished. The end dates for hiring a training coordinator, developing a procedure for delivery of training, and the training plan have all passed without any of the items being completed.

Earlier attempts to implement two specific policies have never been effectively accomplished at the facility level. These are the policy and procedures for immunizations and colorectal cancer screening and are discussed in the preventive health care section of this report. This is the reason the Implementation Plan emphasizes having the personnel, plan, methods, and support system in place to train staff in what the Agency Medical Director described as the first time there are policies that detail the services provided by the health care program in the IDOC.<sup>49</sup>

#### **RECOMMENDATIONS:**

1. IDOC needs to follow the Court-ordered Implementation Plan with respect to training at the facility level for all newly developed policies. This should result in a standardized methodology for implementing policies and procedures that ensures all employees are properly trained for those procedures that they will need to fulfill their job responsibilities.

## Facility Specific Issues

### Facility Staffing

**Addresses items II.B.2; II.B.3; III.A.10;**

**II.B.2.** *IDOC shall require, inter alia, adequate qualified staff, adequate facilities, and the monitoring of health care by collecting and analyzing data to determine how well the system is providing care. This monitoring must include meaningful performance measurement, action plans, effective peer review, and as to any vendor, effective contractual oversight and contractual structures that incentivize providing adequate medical and dental care.*

**II.B.3.** *IDOC must also provide enough trained clinical staff, adequate facilities, and oversight by qualified professionals, as well as sufficient administrative staff.*

**III.A.10.** *Each IDOC facility shall have registered nurses conducting all sick calls. Until IDOC has achieved substantial compliance with nursing provision of the staffing plan, facilities may use licensed practical nurses in sick call, but only with appropriate supervision.*

**OVERALL COMPLIANCE RATING:** Noncompliance

#### **FINDINGS:**

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<sup>49</sup> OHS-Monitor monthly meeting 3/16/2023

IDOC still lacks adequate qualified staff. IDOC was able to provide for this report data only for vendor staffing. IDOC does not routinely collect or analyze State staffing and for this report the Monitor received no information. A third of positions are State positions, and without tracking their vacancies, IDOC will be unable to provide the trend of compliance with attaining adequate staffing. Vendor vacancies, as discussed below, are unchanged from the prior report.

Implementation Plan narrative page 3: *While the OHS staff has already expanded considerably; an outside vendor will be considered to augment OHS leadership staff in key areas that may be difficult for IDOC to recruit.*

Based only on discussion, SIU stated they will provide the policy project manager position<sup>50</sup>. This has not been able to be verified. IDOC is working through the process to create project manager personal service contracts for project managers for the Implementation Plan and for the electronic health record. IDOC medical leadership has had considerable difficulty in implementing various initiatives or clinical guidance including for immunization and cancer screening including colorectal cancer screening. IDOC has a leadership presence at the facilities in the HCUs but the HCUs are nurses and they do not have the clinical training or capacity to supervise physicians. For this IDOC must rely on vendor Regional Medical Directors who have not been as collaborative as is necessary to implement the Consent Decree. In some areas, the vendor Regional Medical Directors are actually an impediment to progress forward. To some extent, the vendor Regional Medical Directors disagree with findings of SIU in both the performance and outcome measures and in mortality reviews. Their participation in implementation efforts of OHS with respect to immunization, cancer screening as well as correcting problems identified on mortality review are not apparent. These are deficiencies identified early in implementing the Consent Decree. Their response has been defensive, unaccepting of findings, and lacking in corrective actions. If vendor Regional Medical Directors continue in this fashion, IDOC should consider creating its own Regional Medical Director positions or look for another solution.

**Implementation Plan item 2d:** *OHS will meet with IDOC human resources, the vendor, and CMS to identify and conduct corrective actions to facilitate the hiring of health care staff based on established goals. This group will establish and work to improve time-to-hire goals and establish workplans for corrective action for vacancy rates greater than 10% or any vacancies in critical positions (Medical Directors, HCUs, Directors of Nursing, Dentists, project management staff, and OHS non-support staff). This group will track and report its progress over time as a performance and outcome measure as measured on a dashboard. **Proposed End Date: Ongoing until 15% vacancy attained.***

Counsel for Defendants stated in an email<sup>51</sup> that “IDOC meets with Wexford recruitment and executive staff frequently, no less than every month, to discuss vacancies and their impact and engages Wexford to ensure all possibilities are explored to increase staffing levels”. However, the Monitor has not been provided any other information related to participation of IDOC human resources or Central Management Services (CMS). The vendor, in a letter copied to the Monitor, stated that from the time of posting (notification of position) to an employee being prepared to work ranges from 73 to 248 days. The vendor describes this as “excluding time necessary to initially identify candidates to begin the Recruitment Process”. In an email communication about project managers, a high level, senior position, IDOC stated, “we have discussed creating a state position [for Implementation Plan and electronic records project managers] but that takes considerable time. We are in the process of creating a posting for a personal service contract for the implementation plan and EHR project managers which would allow faster posting and fulfillment. However, there are still multiple steps in the process and we are working through that”. Thus, both the vendor and the State struggle with the state hiring process. The

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<sup>50</sup> The specific roles of the Medical Coordinator and policy project manager with respect to policies needs to be clarified.

<sup>51</sup> Email from Michael Arnold, attorney general counsel, on 9/25/23

rationale for involvement of IDOC personnel and CMS is to speed up the existing process to expedite hiring, especially for key personnel. This has not occurred. While IDOC's deadline for this was "ongoing", they have not presented evidence that IDOC personnel or CMS are actively involved in resolving hiring issues and assisting in speeding up the hiring process.

With respect to existing staff and vacancies, IDOC provided the vendor's budgeted and vacant staff, but did not provide IDOC's allocated staff with vacancies. The vendor had 1032 positions with 515 vacancies. This excluded 13,334 positions that were hired in addition to allocated positions. Nevertheless, this is still a 50% vacancy rate. With respect to IDOC positions and combined vendor and State positions, IDOC does not have a routine tracking system for this information. Staffing information given for prior reports was information especially prepared for the Monitor, and requires polling of each facility to generate, and was not something IDOC regularly tracked.

**Implementation Plan items 3 and 3a-c:** *Hire staff outlined in the Staffing Analysis as soon as possible with expedited hiring for key positions (Medical Directors, HCUAs, Directors of Nursing, Dentists, project management staff, and OHS non-support staff)*

- *SIU will post SIU positions.*
- *Vendor will post contracted positions.*
- *IDOC HR and facility HR will post IDOC positions.*

**Proposed End Date:** *Ongoing except SIU will post positions August 2022.*

All allocated or budgeted positions were to have been posted by the IDOC deadline of August of 2022, but the Monitor cannot verify that it has been completed. IDOC has not provided information related to posting of positions. The Wexford website for jobs,<sup>52</sup> searched for Illinois Department of Corrections yielded 212 jobs. Based on a table of budgeted and vacant positions of the vendor provided recently by IDOC, the vendor had 515 vacancies. The postings on the vendor website do not match existing vacancies. IDOC did not provide its budgeted or vacant positions for this report. The website for health job postings for IDOC is not a separate site but is comingled with all state employment opportunities. Searching specifically for IDOC health care positions yielded correctional officers, chaplains, and other custody positions. The website does not provide how many IDOC healthcare positions are posted. The SIU correctional medicine website for position postings also includes other SIU departments and does not separate SIU correctional medicine from SIU in general. Identifying all posted positions was something the Monitor was unable to do using the respective websites of IDOC and the vendor. For this information, the Monitor is dependent on IDOC to provide. The Monitor did not include job postings as requested information for this report. Staffing and vacancy numbers were requested but not provided.

**Implementation Plan item 4a:** *IDOC will develop an alternative source of obtaining physicians. IDOC will initiate negotiations with SIU, UIC or other parties (FQHCs, etc.) for arrangements to provide physician staff for any facility with vacant vendor Medical Director or physician for six months or more (without use of a "traveling medical director" or coverage doctor arrangement). IDOC will make contract modifications to the vendor contract so that these positions can be filled with alternate physicians and to allow the new physician to be the clinical authority at that facility. Proposed End Date November 2023.*

IDOC proposed that this Implementation Plan item would be completed by November, 2023 but there is no evidence that this has been completed. While IDOC has not developed a process of providing physician staffing, they have instituted a program of UIC physicians providing care for some diabetic patients at the Stateville facility. The Monitor was told subsequently that this was expanded to the Northern region of facilities. The Monitor supports this initiative which is still in early phases of development. Staffing information from the vendor dated as of 6/30/23 and provided in August shows that 11.17 physician positions ( 33%) are vacant from

<sup>52</sup> Found at [https://jobs.wexfordhealth.com/?\\_search\\_banner=Illinois%20department%20of%20corrections](https://jobs.wexfordhealth.com/?_search_banner=Illinois%20department%20of%20corrections)



33.47 budgeted positions. This is an improvement from the 18 (53%) vacant physician positions from the last report. However, this is still a significant vacancy rate. Fifteen facilities have a vacant or partially vacant physician or Medical Director positions. As discussed in the mortality review section of this report, this lack of physicians is likely related to deficiency findings in mortality reviews.

**Implementation Plan item 8a:** *Hire a training coordinator to track training, coordinate support for the training, and ensure staff training occurs for all relevant staff. Proposed End Date: September 2023*

The Monitor has not been informed that a training coordinator has been hired nor has the Monitor been informed that hiring a training coordinator is planned. .

## **RECOMMENDATIONS:**

1. Develop a recruitment plan with the explicit mission to reduce the rate of vacancies. Responsible parties include OHS, Wexford, Human Resources, and the Office of Budget and Management. The recruitment plan needs to include clearly defined benchmarks to monitor progress toward specific objectives set out in the plan. In addition to vacancy, turnover and retention rates suggested metrics to evaluate progress include: the number and outcome of recruitment activities, time from inquiry to first contact, and time from job offer to start date.
2. A recruitment priority should be to recruit and hire into vacant DON and Nurse Supervisor positions to increase accountability for performance improvement.
3. Prioritize recruitment of nursing positions at the facilities with the lowest ratio of RNs and the lowest actual nurse staffing.
4. The number of mandatory overtime assignments should be reported to OHS by each facility monthly.
5. Monitor patient care quality and health outcomes more closely at facilities with the most turnover, highest vacancy rates and largest number of mandatory overtime assignments.
6. Develop job descriptions that define the training and experience necessary for each position and provide them to the Monitor for input before finalization. Establish positions at each facility responsible for Infection Control and Quality Improvement.
7. Establish a database that includes the number of nursing positions by type, the number vacant currently, the number who left employment each calendar year, the number leaving voluntarily each calendar year and the number of positions filled currently.
8. Identify performance and health outcome measures to compare with staff mix and staffing levels to identify desirable staffing ratios and patterns. Measures to evaluate staffing adequacy include quality patient care parameters (numbers of emergencies, patient falls, acquired infection etc.), risk management information (deaths, grievances, errors etc.), time taken to fill vacant positions and retention in registered nurse positions as well as compliance with items III.A.10, III.I.1, III.I.2 and III.I.3 of the Consent Decree.
9. Add at least one additional physician to the budgeted physicians each at Dixon, Stateville, NRC, Graham, Menard, BMRCC, and Pinckneyville. The workload analysis of physician needs to be accomplished.

## **Credentialing of Physicians**

*Addresses items II.B.6.r; III.A.2-7*

**II.B.6.r.** *IDOC agrees to implement changes in the following areas: That Defendants and the vendor shall timely seek to discipline and, if necessary, seek to terminate their respective health care staff that put patients at risk;*

**III.A.2.** *All physicians providing direct care in the IDOC (whether they are facility medical directors or staff physicians) shall possess either an MD or DO degree and be either board certified in internal medicine, family practice, or emergency medicine, or have successfully completed a residency in internal medicine which is*

*approved by the American Board of Internal Medicine or the American Osteopathic Association, or have successfully completed a residency in family medicine which is approved by the American Board of Family Medicine or the American Osteopathic Association, or have successfully completed a residency in emergency medicine which is approved by the American Board of Emergency Medicine.*

**III.A.3.** *Physicians currently working in IDOC who do not meet these criteria shall be reviewed by the Monitor and the IDOC Medical Director to determine whether the quality of care they actually provide is consistent with a physician who has the above described credentials and who is practicing in a safe and clinically appropriate manner. If the Monitor and the IDOC Medical Director cannot agree as to the clinical appropriateness of a current IDOC physician, IDOC shall not be found non-compliant because of that vacancy for nine (9) months thereafter*

**III.A.4.** *If a current physician's performance is questionable or potentially problematic, and the Monitor and the IDOC Medical Director believe that education could cure these deficiencies, the IDOC will notify the vendor that said physician may not return to service at any IDOC facility until the physician has taken appropriate CME courses and has the consent of the Monitor and the IDOC Medical Director to return.*

**III.A.5.** *Defendants may hire new physicians who do not meet the credentialing criteria, only after demonstrating to the Monitor that they were unable to find qualified physicians despite a professionally reasonable recruitment effort and only after complying with the provisions of paragraph 6, below.*

**III.A.6-7** *Physician candidates who do not meet the credentialing requirements shall be presented to the Monitor by the Department. The Monitor will screen candidates who do not meet the credentialing criteria after a professionally reasonable recruitment effort fails and determine whether they are qualified. The Monitor will not unreasonably withhold approval of the candidates. The Monitor will present qualified candidates to the IDOC for hiring approval. If the IDOC Medical Director has concerns regarding the rejected candidates, he or she will meet and confer with the Monitor in an attempt to reach a resolution. In instances in which the Monitor rejects all viable candidates for a particular vacancy, the Department will not be found noncompliant because of that vacancy at any time during the next twelve (12) months. The credentialing requirements contained in paragraph 2 above do not apply to physicians employed by universities*

#### **OVERALL COMPLIANCE RATING: Partial Compliance**

The continued rating of partial compliance was based on IDOC's adherence to hiring only physicians who meet the credential criteria detailed in III.A.2 and communicating with the Monitor as noted in III.A.6-7 when they are considering physician candidates who do not meet the credentialing requirements.

#### **FINDINGS:**

The Monitor requested and received two documents for the Credentialing of Physicians section.

The first document request was a spreadsheet listing all physicians with name, facility, highest level of post-graduate education, residency type completed, date residency completed, internship/residency training sites, license expiration date, DEA expiration date, board certification type, board certification date, re-certification date, and expiration date of board certification. **The Monitor asked that this listing should be updated and provided to the Monitor every quarter or sooner if new physicians are hired and when physicians leave the IDOC. IDOC should automatically provide timely notification when physicians leave employment in IDOC and when new physicians are hired. This is not done.** There is a specific tracking sheet used for this purpose which is the vendor Training and Credentials spread sheet which contains physician name, assigned IDOC facility, Illinois license expiration date, DEA expiration date, board certification, board certification expiration date, certification description, board eligible residency Y or N, ECFMG (if indicated), correctional medicine experience, other experience (years), and name of training (type of residency, fellowship). The Monitor received the 7/31/23 Training and Credential spreadsheet on August 23, 2023.

The second document request was primary source verification of all facility physician credentials. Primary source verification is to include: copies of official documents from the original source (medical school diploma, residency training program or specialty fellowship certificates, etc.) verifying completion of training or board certification status, National Practitioner Data Bank, any prior disciplinary reports, or actions including sanctions by state licensing agencies, AMA Profiles, and a recent CV. Primary source verification of license and DEA license can be a photocopy of the licenses with home address and license number blacked out. If AMA report is used it must be a recent AMA profile or the license and DEA license must be separately verified. Osteopathic physicians must have the osteopathic boards verified with primary source verification. This data should be included in the current vendor's training and credential spread sheet. Primary source data was not initially provided for five new physicians on the credential spreadsheet until a repeat request was sent to the IDOC. On August 23, 2023 primary source documentation was received by the Monitor. However, the documentation received was not adequate for one of the five new physicians.<sup>53</sup> Though Implementation Plan item 75 states: *IDOC to establish an account with National Practitioner Data Bank. Proposed End Date: December 2023.* This has not been accomplished.

**Since the signing of Consent Decree, IDOC has only hired physicians who have met the credentials criteria as noted in Consent Decree III.A.2.** As noted in the table below, since the initiation of the Consent Decree the percentage of IDOC physicians who meet the primary care credentials criteria has increased from 69 percent to 86 percent and the number (percentage) of physicians who do not have the qualifying credentials has decreased from eleven (31 %) to four (14%) of the total IDOC physicians.<sup>54</sup> The Monitor notes that the vendor staffing data, show that as of 8/9/23, there were 33.47 budgeted physicians with 11.17 vacancies. Working physicians were therefore 22.3 physicians. Yet, the table showing current credentials lists 36 physicians. Because the vendor fails to produce data on the hours worked by each physician, it is impossible to know who is working and how many hours each physician is working.

Physicians with Primary Care Credentials* in IDOC		
	2/1/20	7/31/23
Board Certified	15 (42%)	16 (57%)
Not Board Certified; Completed 3 Year Primary Care Residency	10 (27%)	8 (29%)
Total Qualified (III.A.2)	25 (69%)	24 (86%)
Not Board Certified; Did Not Complete 3 Year Primary Care Residency	11 (31%)	4 (14%)
Total Physicians **	36	28
*Primary Care includes Board Certified or completed a residency in Family Medicine, Internal Medicine, or Emergency Medicine		
** The 9/12/22 staffing data provided by IDOC documents 18 FTE physicians but there are 27 physicians on the vendor's credential spreadsheet. The Monitor was not informed how much each of the 27 physicians were working. This may change the percent of credentialed physicians. No explanation was provided by IDOC.		

<sup>53</sup> A sixth new physician was noted on the 7/31/23 Training and Credentials spread sheet and the credentials packet was received 9/29/2023

<sup>54</sup> One of the four physicians who is listed as not meeting the credentials criteria is a newly hired physician whose credentials packet did not include any primary sources documents. OHS has been contacted by the Monitor and is working with the vendor to obtain the documents required to verify that the physician has completed a 3 year primary care residency.

Since the enactment of the Consent Decree and in accord with **III.A.6-7**, IDOC leadership has only contacted the Monitor about two physician applicants who had not completed residency in Internal Medicine, Family Medicine, or Emergency Medicine and did not meet the credentialing criteria in **III.A.2**.<sup>55</sup> The Monitor reviewed their credentials and interviewed both applicants by phone. The Monitor advised the IDOC that the applicants did not meet the criteria of the Consent Decree and their candidacies were not supported by the Monitor. Neither of these two providers were hired.

In addressing Consent Decree **III.A.3**, the Monitor has previously referred three physicians to the IDOC Medical Director who did not meet the credentialing criteria and, based on medical record review, whose performance was questionable, potentially problematic and/or their quality of care was not consistent with the delivery of safe and clinically appropriate health care. All three are no longer working in the IDOC. The Monitor has verbally advised IDOC on several occasions about a physician without credentials who is not performing in a safe or clinically appropriate manner. IDOC provided no evidence that they review the quality of care of this provider. This physician continues to work without any oversight. The Monitor will continue to communicate to OHS any data gathered by the monitor team that indicates a physician's quality of work may be putting patients at risk. The Monitor is hopeful that IDOC's development of its quality program, an adverse event reporting process, and the mortality reviews by SIU Office of Correctional Medicine will identify opportunities to improve the quality of clinical care provided in the IDOC.

In May 2023, the Monitor was provided with the vendor's April 20, 2023 Training and Credentials spread sheet which listed five new physicians who had been hired. At this time, it was also noted by the Monitor that since the previous November 11, 2022 Training and Credentials spreadsheet five other physicians were no longer working in the IDOC. The Monitor had not been informed that five physicians had left employment in the IDOC and only identified both the newly hired and the departed physicians by comparing the two spread sheets. It has been repeatedly requested that IDOC provide the Monitor with timely updates when new physicians are hired and or when physicians leave employment in the IDOC.

The Monitor had not been initially provided with credentials packets and AMA Profiles on any of the five new physicians identified on the April 20, 2023 Training and Credentials spread sheet to verify their residency training and board certification status and to determine if these physicians met the credentialing requirements of the Consent Decree.<sup>56</sup> On June 14, 2023 the Monitor requested the credentials packets for these five new physicians but did not receive the packets until August 23, 2023 when a batch of forty-one documents were forwarded to the Monitor for the 7th Court Report. Upon review of the packets, it was identified that the curriculum vitae (CV) of one of the physicians listed completion of a one year transitional residency followed by a three year residency in Family Medicine. However, the packet did not include any primary source documentation verifying the completion of a primary care residency program (residency certificates and listing of a completed ACGME accredited training program in the AMA Profile). The AMA profile only indicated Board Certification in non-primary care field<sup>57</sup> which does not meet the credentialing criteria of the Consent Decree. There was no mention in the individual's CV or in the AMA Profile of the physician's participating in this non-primary care training program. The Monitor has notified OHS leadership about this physician's absence of primary source documentation and the need to expeditiously have the medical vendor provide the Monitor and OHS with the missing primary source documents and clarify the AMA Profile's declaration that the physician was board certified in a non-primary care field. If the completion of a 3 year primary care residency cannot be verified, this

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<sup>55</sup> A third physician candidate who does not meet the credentialing criteria was referred for Monitor review on 12/13/23 and has not been evaluated at the time of the completion of this report.

<sup>56</sup> Consent Decree III.A.2

<sup>57</sup> American Board of Pathology

physician should be terminated. It is responsibility of the medical vendor to ensure that physician candidates' credentials packets are complete. The vendor must not forward physician applicants to the OHS until their credentials packet is complete.

It has not been possible to identify how many physicians are working in IDOC based solely on review of the credential spreadsheet. To verify credentials, the Monitor has asked for no less than quarterly updates of the physician list and whenever there is a change in staffing. This is not done timely and as a result both the assignment and vendor's credentials spreadsheet are frequently not in sync. This makes timely verification of new physician credentialing impossible. Frequently, the Monitor becomes aware that a new physician has been hired only when their name appears on the facility assignment or on the Training and Credentials spreadsheet.

#### **RECOMMENDATIONS:**

1. IDOC needs to provide for the initial credentials review by the Monitor the same credentials packet that the vendor has provided to the IDOC/OHS. This initial credentials packet must include copies of the physician's medical school diploma, internship, residency and fellowship certificates, State license, DEA license, privilege sheet, curriculum vitae, and a current AMA profile.
  - a. When the AMA profile does not support the physician's credentials because the physician is an Osteopathic physician, the primary source information must be provided.
  - b. The medical vendor should not refer physician candidates to OHS unless a candidate's complete credentials packet accompanies the referral. This needs to include diplomas, certificates, State license, DEA license, curriculum vitae, National Practitioner Databank report, and AMA profile.
2. IDOC needs to routinely provide the following information quarterly and three months prior to the due date of each upcoming Monitor report.
  - a. A table of current physicians in a spreadsheet format with physician name, facility assignment, internship and residency completed, date internship or residency completed, board certification, date of board certification, current status of board certification, State license expiration date, and DEA expiration date.
  - b. All peer reviews including any disciplinary peer review or actions taken with respect to privileges.
  - c. Annual professional performance evaluations for all physicians, nurse practitioners, and physician assistants
  - d. Current assignment(s) list of all physicians with hours/day worked at each site of assignment.
  - e. Timely notification when a physician is hired and when a physician leaves employment with the State or the contracted medical vendor.
  - f. Any monitoring being provided for any physician, nurse practitioner, physician assistant.
3. When AMA profiles are being used to verify credentials, the AMA profile should be current.
4. Any sanctions on a license and a report detailing the plan for monitoring should be reported to both OHS and the Monitor
5. IDOC's health care vendor should continue to hire only physicians who are Board Certified and/or have completed a residency in a primary care field.
6. All physicians need to be required to use a stamp that contains their name which needs to be used for all of their paper medical record notes and orders so that their medical record entry can be verified as theirs. This practice should continue until the EMR is fully installed.<sup>58</sup>
7. IDOC should vigorously explore opportunities to expand affiliations with academic medical centers in Illinois to include the recruitment and hiring of physicians.

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<sup>58</sup> This is recommended due to extensive illegibility in the paper record. Neither the Monitor nor SIU, in mortality reviews, can identify providers or nurses due to illegibility.

## Oversight over Medical, Dental, and Nursing Staff

*Addresses II.B.6.q; II.B.6.r;*

**II.B.2.** *IDOC shall require, inter alia, adequate qualified staff, adequate facilities, and the monitoring of health care by collecting and analyzing data to determine how well the system is providing care. This monitoring must include meaningful performance measurement, action plans, effective peer review, and, as to any vendor effective contractual oversight and contractual structures that incentivize providing adequate medical and dental care.*

**II.B.6.q.** *IDOC agrees to implement changes in the following areas: Annual assessment of medical, dental, and nursing staff competency and performance;*

**II.B.6.r.** *IDOC agrees to implement changes in the following areas: That Defendants and the vendor shall timely seek to discipline and, if necessary, seek to terminate their respective health care staff that put patients at risk;*

**OVERALL COMPLIANCE RATING:** Non Compliance

### **FINDINGS:**

#### **Oversight over Medical Staff**

**Implementation Plan item 77: *Develop plan for no less than annual review of the clinical services provided by both credentialed and non-credentialed existing physicians and dentists.***

- 1. The plan for physician review as codified in policy and/or standard operating procedure should include the elements of care that would be annually reviewed, the process for identification and referral of staff to peer review, the establishment of a fair process and the standards used to evaluate professional care and clinical decision making, the qualifications physicians individuals must have to perform peer review, as well as the documentation of the evaluation, assessment, deliberation and decisions made in the review process.*
- 2. The elements of care reviewed should include clinical services provided in sick call, onsite urgent/emergent care, chronic care clinics, infirmary admissions and progress notes, discharge and transfer care, timely and appropriate referrals to specialty care, continuity of care after offsite emergent, hospitalization, and specialty consultation care, intake healthcare services at reception centers including intake health assessments, review of diagnostic tests, mortality and morbidity reviews, annual performance reviews, health care patient grievances, corrective action plans, peer reviews for cause, etc.*
- 3. Review of the physicians should be performed by independent contracted or consulting physicians such as SIU physicians with training in similar fields as the physicians being reviewed (i.e., primary care, specialty physician, dentist, etc.).*

***Proposed End Date: December 2023***

**Implementation Plan item 78: *Develop peer review process for providers.***

- 1. Develop policy and forms outlining provider review process. The annual peer review forms may contain administrative and process elements but should primarily focus on aspects of clinical care.*
- 2. Train independent contracted or consultant staff on provider peer review process.*

***Proposed End Date: December 2023***

IDOC drafted a peer review policy for addressing egregious medical events. This policy has undergone two reviews by the Monitor who sent comments back to IDOC. A final policy is pending. With respect to annual

performance evaluations of physicians, IDOC has not yet drafted policy or procedure for this. Meaningful performance evaluations of physicians is not yet occurring despite IDOC stating a deadline for completion of a policy and implementing that policy by December of 2023. The vendor history of performance evaluations has been negligible and unacceptable. Vendor Regional Managers, who are not physicians, currently perform performance evaluations of physicians which were described as mostly related to managerial operations<sup>59</sup>. A review of clinical performance is not being done. An independent party has not yet been identified to conduct these evaluations. If mortality reviews included specific physician review, they could be used for this function but this has not yet been attempted.

**Implementation Plan item 76: *Develop a mechanism to remove unqualified physicians. Recommendations for removal will be based on the following:***

1. *Utilize mortality reviews of care or other methodologies (Task 77 part 2) of IDOC to identify egregious clinical errors that either cause harm or are likely to result in harm to the patient and are inconsistent with adequate medical care.*
2. *Confer with the Monitor to discuss problematic physicians.*
3. *Meet at regular intervals to discuss monitoring that has occurred.*
4. *Remove or take corrective actions on problematic physicians.*

***Proposed End Date: September 2023***

**Implementation Plan item 79: *OHS to review physician/dentist annual assessments, peer reviews, adverse events, corrective action plans, and other evaluations and make appropriate recommendations for performance improvement, corrective action, and even termination. Proposed End Date: August 2023***

IDOC has not yet developed a mechanism to identify unsafe and clinically inappropriate practice for physicians not meeting credentialing requirements of the Consent Decree (III.A.3) or those whose performance is questionable or potentially problematic (III.A.4). The Monitor has suggested and now the Implementation Plan requires that mortality review or other methodologies be used for this purpose. The SIU mortality reviews have included referral to peer review for two providers but formal peer reviews have not yet occurred. There is sufficient information in the mortality reviews to conduct a performance evaluation but this would require additional evaluation. Provider signatures are frequently illegible and, when illegible, it is not possible to identify the provider who wrote a note. The Monitor used SIU mortality reviews to confirm prior advisement to IDOC of the unacceptability of a non-credentialed physician whose work was found in Monitor mortality reviews to be unsafe and clinically inappropriate. The Monitor continues to recommend dismissal of this individual in accordance with provision III.A.3.

Regarding the request for peer reviews of physicians over the past year IDOC responded Wexford reports having none.

**Oversight over Dental Staff**

***Addresses item II.B.6.q; III.K.9***

***II.B.6.q. IDOC agrees to implement changes in the following areas: Annual assessment of medical, dental, and nursing staff competency and performance;***

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<sup>59</sup> In interviews with the vendor Regional Medical Directors, none documented performing written performance evaluations of physicians they supervised. All stated that the Regional Manager completes the review. They all stated that they provide some input into clinical care of the individual being studied. One of the Regional Medical Directors said that the evaluations were mostly about managerial operations. These evaluations are not provided to the Monitor though requested.

**III.K.9.** *Within twenty-one (21) months of the Preliminary Approval Date of this Decree [October 2020], IDOC shall establish a peer review system for all dentists and annual performance evaluations of dental assistants.*

**Implementation Plan item 78:** Develop peer review process for providers:

1. *Develop policy and forms outlining provider review process. The annual peer review forms may contain administrative and process elements but should primarily focus on aspects of clinical care.*
2. *Train independent contracted or consultant staff on provider peer review process.*

**Proposed End Date: December 2023**

**Implementation Plan item 90:** Develop a dental review instrument and methodology including who is to perform the dental peer review

1. Contract with independent consulting dentists to perform annual dentist reviews.

**Proposed End Date: November 2023**

The Monitor received 21 dentist peer reviews conducted from 10/17/22 to 6/5/23. Upon examining the list of dentists who underwent peer reviews, the Monitor has uncovered the omission of several dentists, indicating that the list does not fully represent the entire group of providers. Two dentists, dentist #1 (Joliet Treatment Center) and dentist #2 (Western), who did reviews, did not have reviews performed of their clinical care and respective programs. Five additional dentists were assigned for PRN (as-needed coverage) at sites and did not have peer reviews. Dentist #3 provided care at BMR, Hill, Jacksonville, Logan, Menard, and Western. Dentist #4 provided care at Centralia, Menard, Shawnee. Dentists #5, #6, and #7 provided care at Danville, BMR, and Shawnee, respectively.

The primary purpose of a dental (dentist) peer review is to ensure the quality of dental care and address concerns or disputes regarding a dentist's practice. Therefore, all dentists employed by IDOC or their vendor are subject to a peer review, regardless of whether they work part-time or PRN (as needed). When dentists work a cumulative total of forty hours per week in multiple locations, it is more practical to conduct a single peer review rather than requiring multiple reviews at each facility.

**The Implementation Plan, item 78,** calls for an "independent contracted or consultant staff to be trained to perform peer reviews." Currently, peer reviews are performed by dentists within the IDOC network. This practice does not lead to objectivity or critical review. For example, dentist #8 received a "GOOD" rating despite notable deficiencies in health history documentation, the absence of health history reviews, non-compliance with SOAP format, issues with dental record maintenance, and inadequate patient education. This review is barely acceptable, yet this same dentist performed a peer review on a colleague. In another instance, dentists #9 and #10 only had one chart review for their respective peer reviews. Reviewing one record review is not a representative sample to make a valid inference or generalization about the dentist's practice.

**Implementation Plan item 90** of the Implementation Plan calls for establishing a "methodology" for conducting peer reviews. However, there is no established methodology for conducting peer reviews, and a lack of standardization within the process. For example, the rating protocol used by the reviewers lacks uniformity. In the case of dentist #8, it raises questions about how a peer review with so many discrepancies could result in a "GOOD" rating. Additionally, it's unclear how a peer review that only assesses one patient record could lead to a dentist receiving an "EXCELLENT" rating. This lack of consistency and clarity in the peer review process raises concerns about the accuracy and reliability of the ratings.



The absence of a standardized methodology is evident in how peer reviews are conducted and submitted. Peer review reports vary significantly in the number of patient records they assess; one reviewed 33 patient records, another reviewed 15 patient records, and eight reports reviewed five or fewer records. Moreover, several instances revealed incomplete required forms (PR-001C), with some records missing crucial patient identifiers, including inmate numbers. This lack of consistency and completeness in the peer review process underscores the need for a more structured and uniform approach to conducting and documenting peer reviews.

The Wexford peer review (Form PR 001C) emphasizes administrative and process-related aspects. While it does touch upon the appropriateness of care, it falls short in assessing the quality and performance of care. This deficiency results in an incomplete evaluation of staff competency. Therefore, it is crucial to consider enhancing the existing instrument (PR 001C) to include evaluating clinical care standards, ensuring a more comprehensive assessment of healthcare providers' performance and competence.

While the Monitor acknowledges that administrative and process elements are important in healthcare, they are generally considered secondary to clinical care. Process elements are designed to support and facilitate the delivery of clinical care efficiently and safely. Peer reviews can certainly encompass administrative and process aspects, but these should complement, rather than overshadow, the central focus on clinical care to ensure the highest quality of patient care.

There is no documented evidence to suggest that the Chief of Oral Health Services has reviewed any of the peer review reports. In situations where sample sizes are inadequate, forms are incomplete, or ratings are inconsistent, the Chief of Oral Health Services should step in and address these issues. Moreover, in cases where peer reviews receive a "fair" or below-average rating, the Chief of Oral Health Services should conduct additional follow-up to ensure future compliance. This lack of review can impede assessing dental providers' performance accurately.

Evaluations of vendor or State-employed dental hygienists and dental assistants were not provided to the Monitor for review. Since the Decree specifically states that IDOC will conduct annual "performance evaluations," compliance with this aspect of the Decree is not in compliance.

### **Oversight over Nursing Staff**

The Monitor requested the following documents to review:

- Vendor job descriptions for DON, Nurse Supervisor, RN, LPN, and certified nursing assistant.<sup>60</sup>
- Nursing performance reviews over the past year.<sup>61</sup>
- Nursing disciplinary actions over the past year.<sup>62</sup>
- Nurse training and credentials' verification in the last 12 months for six individuals from Centralia, JTC, Lawrence, Pinckneyville, Sheridan, and Stateville.<sup>63</sup>

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<sup>60</sup> Monitor's documentation request dated 8/4/2023, item 13. This information was not provided.

<sup>61</sup> Monitor's documentation request dated 8/4/2023, item 47. WHS provided a list of nurses reviewed in 2022 however no detail or description was provided about what the review consists of.

<sup>62</sup> Monitor's documentation request dated 8/4/2023, item 49. The list provided by WHS indicated whether the employee had received discipline the previous 12 months but did not indicate the reason disciplinary action was taken.

<sup>63</sup> Monitor's documentation request dated 8/4/2023, item 51. Lawrence provided sign off on knowledge of ADs, CPR training, privilege requests, authority to order labs for chronic clinics. Sheridan provided a copy of the license, BLS training, training on protocols dated 7/22, a list of procedures privileged to perform and notice about PPE. JTC provided copies of license and documentation of BLS training. Pinckneyville provided only license verification. A list of nurses and their license number was provided by WHS for Centralia, Logan, Menard, Stateville and NRC but no documentation of training or competency verification was provided.

At the time of the site visit to Graham 7/17/2023 – 7/19/2023 the DON position and both Nursing Supervisor positions were vacant so there was no effective oversight of nursing service. We have no reason to believe that the number of filled nursing leadership positions has changed substantially since the 6<sup>th</sup> Report “when almost half of the Directors of Nursing, and 75% of the nurse supervisor positions are vacant.”<sup>64</sup> Effective supervision or oversight of nursing is nearly nonexistent with these vacancy rates.

The health care vendor provided a list of 143 nurses who had a review in 2022. No information was provided about what was considered in the review, how the review was completed or the qualifications of the person completing the review. No information was provided about performance review of nurses employed by IDOC. Neither the vendor or IDOC have provided evidence of meaningful performance measurement or contractual oversight of nursing practice as required by II.B.2 of the Consent Decree.

The vendor did not provide any of the job descriptions that were requested. IDOC previously provided job descriptions for the state nursing positions which have been reviewed by the Monitor. These position descriptions have no explicit expectations of annual assessment of competency as required by II.B.6.q.

Verification of nursing licensure was received from all six facilities. Three of the six facilities provided documentation that nurses had completed training in basic life support or CPR and one facility provided documentation of training in the use of the treatment protocols. Two facilities provided documentation that nurses were privileged to perform certain tasks such as initiating lab requests in advance of chronic clinic appointments or establishing intravenous lines. There was no documentation provided that nurses’ practice competency is evaluated.

The Implementation Plan includes several items that address the training and competency of nursing staff.<sup>65</sup>

- **Implementation Plan item 40(9):** *Training Plan for policies and procedures to include the initial training of existing staff, orientation of new staff, annual evaluation of staff knowledge and compliance with P & P, and the method to inform staff of revisions to P & Ps. Proposed End Date: December 2023*

One facility provided documentation that nursing staff are knowledgeable of the Administrative and Institutional Directives but there was no evidence that compliance with these is considered in the review of employee performance.<sup>66</sup>

- **Implementation Plan item 53(6 & 8):** *Training and supervision of nurses to ensure appropriate clinical assessment and decision making using the nursing protocols and methods to determine the continuing competency of nurses assigned to sick call. Proposed End Date: March 2024*

Administrative Directive 121 on Treatment Protocols requires the facility Medical Director to provide training annually for nurses in use of the protocols and audit their use monthly. The results of these audits and corrective action are to be included in the monthly Quality Improvement minutes. Only one of the six facilities requested by the Monitor provided evidence of annual training. Fourteen of the facilities fail to report the results of the Medical Directors’ audit in the monthly Quality Improvement minutes.<sup>67</sup>

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<sup>64</sup> Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys, March 13, 2023, page 42. WHS provided a list of allocated positions as of 6/30/2023 at which time 15 of 29 DON or Nurse Supervisor positions were vacant (52%). The Monitor requested a list of each allocated position for each facility and OHS by position type with vacancies (item 12), Lippert IDOC 7<sup>th</sup> Report Documentation Request dated 8/4/2023. This information had not been received as of 10/10/2023.

<sup>65</sup> See Implementation Plan items 7 (3), 28 (4), 40 (9), 53 (6 & 8), and 94 (1 & 2).

<sup>66</sup> See Implementation Plan item 40.

<sup>67</sup> Monthly Quality Improvement Minutes Quarters 1 and 2 2023.

- **Implementation Plan item 94(1 & 2):** *Standardize provision of urgent/emergent services to include expectations for training, demonstrated competency and clinical proficiency in determining the urgent or emergent nature of the response needed, and documentation thereof. Train staff to provide urgent/emergent services consistent with policy and procedure, validate staff competency in urgent/emergent care initially and annually thereafter. Track and report training completion and competency evaluation through the quality improvement process. Proposed End Date: November 2023*

There is documentation that nursing staff have Basic Life Support training. There is no documentation of the assessment of staff competency in the clinical evaluation of an emergency, judgements about the nature of the response needed or documentation thereof. The two facilities that sent documentation of clinical privilege do not assess clinical assessment and decision making competency but instead have staff certify that they are qualified to use specific pieces of emergency equipment.

- **Implementation Plan item 76a:** *Develop a mechanism to remove other health care staff. Utilize mortality reviews of care or other methodologies of IDOC to identify egregious clinical errors that either cause harm or are likely to result in harm to the patient and are inconsistent with adequate medical care. Proposed End Date: September 2023*

Five nurses employed by the vendor were listed as having received discipline in the past 12 months. However, no information or description of the nature of the disciplinary action was provided so it is not possible to determine if it was a result of meaningful clinical supervision or due to poor attendance or another non-clinical expectation. No information was provided by IDOC about disciplinary actions or removal of nursing staff whose practice pattern puts patients at risk. The Monitor is not aware of any nurse referred for peer review as a result of mortality review.<sup>68</sup>

The documentation received in response to the Monitor's request for information to evaluate the oversight of nursing staff demonstrates no change in existing practices as described in II. B. 6.q and r. with regard to assessment of nursing competency and performance review or timely disciplinary action and removal of nursing personnel whose practice pattern puts patients at risk of harm. No evidence was provided that demonstrates meaningful performance measurement, action plans, and effective peer review in providing adequate medical and dental care per II. B. 2.

These recommendations have been modified slightly since the last report and the last recommendation has been added.

## **RECOMMENDATIONS:**

1. Standardize evaluation formats so that all clinical staff of the same type are evaluated in the same manner.
2. An independent professional knowledgeable of the scope of practice and capable of evaluating the clinical care of the professional should perform the evaluation. This requires a physician, dentist and nurse independent reviewer.
3. Clinical professional performance evaluations should be shared with the employee who should sign the review after discussion with the reviewer.

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<sup>68</sup> Monitor's documentation request dated 8/4/2023, item 32, for a list of all peer reviews performed as a result of mortality reviews. No information was provided by IDOC.

4. Involve the Chief of Dental Services and the SIU audit teams in the re-assessment of the existing dentist, dental hygienist, and dental assistant annual evaluations so as to include metrics that evaluate the quality of dental care and clinical skills of the dental team.
5. The Chief of Dental Services should establish clear guidelines concerning antibiotic prophylaxis for dental procedures, obtaining x-rays prior to dental extractions to ensure the utilization of x-rays meets existing dental standards of care, and for signed consent forms prior to dental care. These guidelines would also allow for more objectivity in the dentists' peer review evaluations.
6. **Expand Peer Review Criteria:** Recommend expanding the dental peer review instrument to include an evaluation of clinical care quality and performance. This extension will provide a more comprehensive assessment of staff competency and the quality of dental care delivered.
7. **Annual Evaluations Of Vendor Or State Employed Dental Hygienists And Dental Assistants:** Develop and initiate professional performance evaluations that assess the clinical competency and clinical performance of all dental staff.
8. Annual peer reviews, not Salary Compensation Calibration, of the onsite Medical Director, staff physicians, nurse practitioners, physician assistants, Directors of Nursing and Nurse Supervisors should be provided to the Monitor.
9. Finalize policy C.02.01 Licensure and Credential Verification (draft commented on by Monitor).
10. The facility DON must demonstrate clinical supervision of all nursing personnel assigned to work at the facility (state and vendor employed staff). Clinical supervision is demonstrated by completion of an annual competency evaluation which is considered in the annual performance evaluation, written documentation of performance improvement expectations, and evidence of timely disciplinary action for clinical performance deficiencies.
11. The position descriptions for registered nurse and licensed practical nurse should be revised to include the explicit expectation that competency to practice nursing is evaluated by a nursing supervisor annually. Competencies shall include, but not be limited to the items in the Implementation Plan which are discussed in this section.

## Operations

### Clinical Space

*Addresses item II.B.2 in part; III.B.1; III.C.2; III.F.1;*

**II.B.2.** *IDOC shall require, inter alia, adequate qualified staff, adequate facilities, and the monitoring of health care by collecting and analyzing data to determine how well the system is providing care. This monitoring must include meaningful performance measurement, action plans, effective peer review, and as to any vendor, effective contractual oversight and contractual structures that incentivize providing adequate medical and dental care.*

**III.B.1.** *IDOC shall provide sufficient private and confidential sick-call areas in all of its facilities to accommodate medical evaluations and examinations of all Class members, including during intake, subject to extraordinary operational concerns and security needs of IDOC including, but not limited to, a lockdown.*

**III.C.2.** *IDOC shall provide sufficient private and confidential areas in each of its intake facilities for completion of intake medical evaluations in privacy, subject to extraordinary operational concerns and security needs of IDOC including, but not limited to, a lockdown.*

**III.F.1.** *Sick call shall be conducted in only those designated clinical areas that provide for privacy and confidentiality, consistent with the extraordinary operational concerns and security needs of IDOC including, but not limited to a lockdown.*

### OVERALL COMPLIANCE RATING Partial Compliance

**FINDINGS:**

Implementation Plan narrative page 1: *IDOC, through the Capital Development Board (CDB), will hire a consultant to determine whether adequate physical clinical space and equipment is available at all facilities; and develop an analysis of deficiencies and write a report with findings and recommendations to correct deficiencies and needs. This will include recommendations made by the consultant hired to determine needs of the aged, infirm and disabled. IDOC will use this report to take corrective actions to remedy the deficiencies and needs. IDOC (and CDB) is partially compliant with the Implementation Plan requirement to hire a consultant to determine the adequacy of physical clinical space and equipment. IDOC did hire a consultant but the specifications of the contract did not include to review all facilities to determine adequacy of clinical space and equipment. Nor did IDOC include the recommendation of a consultant hired to determine the needs of the aged, infirm, and disabled.*

**Implementation Plan narrative page 2:** *In addition, IDOC will evaluate the health care needs of the aging, infirm, and disabled populations housed in IDOC facilities. IDOC will seek assistance from the Illinois Department of Aging or a qualified consultant to develop a survey to quantify the numbers of these population groups within IDOC, and assess the health care and health-care-related housing needs of these populations. IDOC will develop options and recommendations to address the clinical care need gaps and clinical-care-related housing need gaps identified in the survey. IDOC will take appropriate actions to correct gaps in housing and clinical care needs of these populations. IDOC is not compliant with Narrative page 2*

**Implementation Plan narrative page 5:** *As required by the Consent Decree, IDOC will survey all facilities to ensure there is adequate physical space and equipment for clinical care. This includes fixed and mobile equipment, dental equipment, and clinic space, including special medical housing for the infirm, disabled, and aged with dementia and memory deficits. This survey will be performed by the Illinois Department on Aging or qualified consultant done at every facility and will be memorialized in reports and provided to the Monitor. IDOC is partially compliant with the Implementation Plan narrative (page 5) on the basis of hiring a consultant to evaluate clinical space but the specifications required by IDOC were not consistent with all requirements of the Implementation Plan. A consultant to evaluate the infirm, disabled, and aged was not accomplished.*

**Implementation Plan item 95:** *A qualified consultant will be retained to survey all clinical spaces. A qualified (in health facility design and operation) consultant will be retained to evaluate structural space and equipment relative to a useful life determination. Proposed End Date: December 2023. IDOC is partially compliant with Implementation Plan item 95 because it hired consultants but the specifications of work were not consistent with all requirements of the Implementation Plan item 95.*

**Implementation Plan item 96:** *Develop structural space and fixed equipment requirements for all clinical activities necessary to provide adequate medical and dental care. Clinical spaces include all health care units, dental units, intake areas, clinical examination rooms, support spaces necessary to carry out medical functions, infirmaries or other specialized housing for those with severe disabilities, are severely infirm, or have dementia or memory issues and are unable to care for themselves for each major facility. Benchmark requirements consist of space and equipment typically available in a contemporary health program. Proposed End Date: October 2023. IDOC is partially compliant with Implementation Plan item 96 because it hired consultants but*

**the specifications of work were not consistent with all requirements of the Implementation Plan item 96.**

**Implementation Plan item 97:** *Using the requirements in Task #96 as a benchmark, develop useful life analysis of physical status of existing medical and dental space and other medical, dental, support and housing (infirmaries and other housing spaces for infirm, disabled, or persons with dementia (including dental and medical support space) and living space for persons who need medically supervised housing (aged, infirm, and disabled). This analysis would include any physical space or structure that impairs the delivery of care, access to care, or the safety of staff and/or the incarcerated population. The consultant will use the staffing analysis, to estimate current and future needs of staff who may work for IDOC. Use the recommendations of the survey of the aged, infirm and disabled to estimate housing and other needs of this population, The analysis will result in a report with recommendations on how to establish adequate medical and dental clinical and support space as well as adequate specialized infirmary or medical housing for the aged, infirm and disabled who need to live in a medically monitored unit. The recommendation will provide an opinion regarding deficient space and whether to rehabilitate existing space or build new space to provide adequate facilities. The analysis and recommendations will be given by facility. Proposed End Date: January 2025. Implementation Plan item 97 is not yet rated due to the January 2025 end date.*

**Implementation Plan item 98:** *Based on recommendations in the consultant's report, develop a plan to address physical plant and equipment deficiencies identified. Proposed End Date: January 2025. Implementation Plan item 98 is not yet rated due to the January 2025 end date.*

**Implementation Plan item 99:** *Work with appropriate State partners to implement recommendations for sufficient medical and dental space and equipment for current and future healthcare operations and care for all inmates in need of medical care or medical supervision. Proposed End Dates: July 2024. Implementation Plan item is not yet rated due to the July 2024 end date. Neither CGL nor Introba addressed space or equipment based on the expected staff in the Staffing Analysis. It is also the Monitor's opinion that it will be difficult for IDOC to have developed detailed recommendations and implement those recommendations for sufficient space and equipment for current and future health operations and care for all inmates by the proposed end date.*

**Implementation Plan item 99a:** *Develop a timeline for completion of any rehabilitation or construction. Proposed End Date: Will be completed when scope of work is completed.*

**Implementation Plan item 99a is not yet rated but reasonable timelines and end date should be proposed by IDOC.**

The following information<sup>69</sup> was requested and was, for the most part, received from the IDOC to evaluate progress toward compliance with the items in the clinical space section of the Consent Decree:

- Provide an inventory for each facility of the rooms used by health care personnel for patient examination from fourteen facilities
- Progress of consultation on status of physical plant issues statewide and by facility
- Report of physical space consultant's analysis of existing space with respect health care.
- Copy of renovation plan as described in the Implementation Plan.
- List of construction, remodeling, or physical plant improvements for any of the health care units

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<sup>69</sup> Monitor document requests #52, 53, 54, 55, and 60

The Monitor selected fourteen facilities to provide an inventory of rooms used for patient examination with a list of types of uses for each room and received applicable information from nine sites.<sup>70</sup> There was no discernable change in the assessment of the room inventories compared to the data provided for the 6<sup>th</sup> Court Report. The format used to report the inventories was still not standardized and varied in the level of detail from site to site. There continues to be insufficient numbers of examination rooms to ensure private and confidential examinations and evaluations and to allow adequate access to clinical care. In almost all of the nine facilities reporting room inventories it is apparent that there are more budgeted clinical staff including physicians, nurse practitioners, physician assistants, sick call nurses, and chronic care nurses who need to use examination rooms than there are examination rooms. If all clinicians had to see patients simultaneously, virtually all the facilities would not have an adequate number of properly equipped rooms to accommodate the needed clinicians. This results in clinicians occasionally having to see patients in poorly equipped spaces without examination tables and lacking privacy.

The surveys also noted that of the twenty-eight rooms labeled as examination rooms, fourteen were shared by other staff or used for other activities including physician office space, phlebotomy, treatments, telehealth, storage, vital signs, and injury assessments. The lack of sufficient number of examination rooms continues to be a barrier to access to care in IDOC's correctional centers.

During multiple site visits, the Monitor team has identified existing space needs that hampered the delivery of health care services to the incarcerated population. The deficiencies observed have included insufficient number of examination rooms to accommodate the number of clinical staff at the facility, the lack of adequate workspace for nursing staff, the lack of sufficient dental chairs to accommodate dentists and dental hygienists, the inadequate space to provide needed services and programs for infirmity patients, undersized waiting rooms, inadequate space to house physical therapy services, cramped and undersized onsite dialysis centers, inappropriately designed, located and jerry-rigged intake screening spaces, insufficient and inadequate telemedicine space, insufficient space to store and manage medications, and insufficient conference room space for the purpose of meetings and training. When full staffing is attained based on the IDOC staffing analysis, staff will increase by 84% from current levels and this needs to be accounted for in any analysis of the need for clinical space but there is no evidence this has occurred.

Some clinical care is conducted in locations not designed or intended for clinical care. During the most recent site inspection,<sup>71</sup> it was noted that intake screening at Graham is performed in the middle of a gymnasium which has to be vacated on days that new admissions arrive. This space lacks adequate audio and visual privacy. It also results in a disjointed and inefficient intake process. Dental screening, vision assessment, and physical examination require new admissions to be transported to the health care unit over a number of days to complete the reception screening. The multiple movements place a burden on the correctional staff and potentially delay the provision of needed care. The same gymnasium is also used by the physical therapy assistant for the daily physical therapy session and intermittently by the physical therapist who performs the initial assessments. This space also lacks audio and visual privacy. The therapy provided is very restricted due to inadequate space to secure larger exercise apparatuses. IDOC needs to identify a more professional and private space so that an increased array of recommended physical therapy treatment modalities can be offered.

The Capital Development Board (CDB) of the State of Illinois hired CGL, a consultant group, who was "tasked with developing a correctional system master plan that would prioritize physical plant needs for the next five years and beyond". The Monitor welcomes IDOC's efforts to begin the process to develop a master custody facility plan for housing and services. The monitor team supports a number of the consultants' general and specific recommendations. However, this is not a detailed survey of the present and future space and equipment needs of

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<sup>70</sup> 3 facilities only provided lists of equipment and 2 facilities only provided information on mental health rooms

<sup>71</sup> Graham Correctional Center and Reception and Classification Center 7/17-19/23

the medical and dental services in *all* IDOC facilities needed to provide adequate medical and dental care as required in the Consent Decree and the Court approved Implementation Plan. Neither the 14 strategic goals<sup>72</sup> of the IDOC nor the Master Plan Recommendations<sup>73</sup> present in this report addressed Lippert Consent Decree or Implementation Plan requirements.

A benefit of the CGL report was a thorough evaluation of existing IDOC facility buildings and infrastructure. The following were identified.

- Twenty percent of IDOC’s capacity are in facilities opened prior to 1926 and include infrastructure (plumbing, heating, air conditioning, and electrical) that “have passed end of life”.
- Most facilities were built prior to passage of the American with Disabilities Act (ADA) in 2004 which creates “serious implications” for accommodating needs of the disabled.
- The report notes that maintenance has been deferred over the years to a point where it is at a “critical level” and deferred maintenance costs exceed deferred maintenance cost of any other state agency.
- The top four facilities with deferred maintenance costs and that have ADA inadequacies and infrastructure that are passed end of life are Stateville, Pontiac, Dixon, and Menard. These facilities have four of the highest five morality rates in the IDOC which suggests that facility structure may play a role in health outcomes.
- Facility building inspection analyses showing structural concerns by facility included the following:
  - Eleven of Stateville’s buildings need replacement and the facility was unable to comply with ADA requirements.
  - 29% of Logan’s buildings were severely degraded and were deemed “inoperable”. The facility, built in the 1930s as a mental health institution, does not meet the needs of modern correctional practices.
  - 35% of Pontiac’s buildings were inoperable. The facility is 130 years old. Its design and infrastructure was never intended to be a rehabilitative or supportive environment and it has the highest vacancy rate for correctional officers in the state.
  - Most of the structures at Dixon date back to the 19<sup>th</sup> century and were designed to manage mental health patients consistent with practices in the 19<sup>th</sup> century.
  - Five facilities did not meet custody operational assessment needs and 19 additional facilities only partly met custody operational needs.

CGL and its subcontractors should apply the same thoroughness used to investigate buildings and infrastructure in the IDOC to evaluate the medical and dental spaces and equipment as required by the Consent Decree and Implementation Plan. CGL reported that the “aging units used for the geriatric population are not designed to support their needs and that health care units (HCU) did not have sufficient geriatric, ADA, and infirmary beds to meet the needs of the facilities”. As a result, CGL recommended that IDOC consider dedicated housing and services for the elderly population. Their recommendation for a 200 bed dedicated geriatric unit was made without first quantifying the number of elderly or to assess the needs of this population as required in the

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<sup>72</sup> The strategic goals included in the CGL report were: 1) Improve Re-entry Outcomes; 2) Reduce Recidivism; 3) Update Parole Supervision Practices; 4) Improve Reception Practices/Establish Incentives-Based System; 5) Improve Safety for Staff and Incarcerated Individuals; 6) Improve Operational Efficiency; 7) Improve Mental Health Quality /Availability; 8) Improve Services for Women in IDOC Custody; 9) Enhance Training; 10) Improve Intel/IA Units; 11) Created Diverse/Equitable Environment for staff and incarcerated; 12) Improve Inmate Affairs; 13) Overhaul Policies/Compliance Processes; and 14) Improve Usefulness of IT Platform.

<sup>73</sup> 1) Address Deferred Maintenance Backlog; 2) Replace the Dixon Psychiatric Unit; 3) Add Mental Health Treatment/Staff Spaces across IDOC; 4) Replace Stateville Housing; 5) Address Women’s Facility Needs; 6) Develop Vocational Space at Stateville; 7) Add Program Space at Medium Security Facilities; and 8) Consider Reducing Pontiac’s Capacity. These recommendations were from the CGL report: IDOC Facility Master Plan May 2023



Implementation Plan.<sup>74</sup> IDOC has not hired a subject-matter expert consultant to evaluate and determine the space, housing, health care, and programmatic needs of the aged, infirm, demented, and disabled housed in the IDOC. Instead, the IDOC consultant recommended a specific number of geriatric beds without first performing an analysis of this population which is premature.

In summary, the CGL report was not intended to and did not specifically address medical and dental space and equipment at all IDOC facilities and IDOC did not perform the analysis of the infirm, aged, and disabled population to determine their needs.

In April, 2023, the CDB contracted with Introba, a building engineering firm, to provide permanent medical office space at six facilities in IDOC's southern region.<sup>75</sup> The contract was reported to have been issued by the State in response to the mental health and medical litigation. An impetus for the Introba report was lack of space, specifically for mental health which was absorbing medical clinical space and medical office space.<sup>76</sup> The Introba report developed "program health care standards"<sup>77</sup> and algorithms based on an institution's population to calculate the number and square footage of various types of medical, dental, and mental health clinical rooms and support spaces.<sup>78</sup> The program health care design standards are often inappropriate and appear to have been created without sufficient clinical input or knowledge of the medical missions of each facility.<sup>79</sup> The six facilities surveyed were all X-type housing facilities with large bed capacities<sup>80</sup> and centralized health care units. Among the six facilities studied only Graham CC is also a Reception and Classification Center. There were no design criteria presented for the development of a comprehensive intake screening center at Graham.<sup>81</sup> A decision has been made by IDOC and CDB to initially study Big Muddy River CC as a pilot prior to proceeding with the other five facilities.

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<sup>74</sup> See Implementation Plan narrative pages 2 and 6; items 64, 65, 66, 69 and 70

<sup>75</sup> Six Southern region IDOC facilities studied were BMR, Danville, Graham, Pinckneyville, Shawnee and Taylorville.

<sup>76</sup> The stated purpose of the consultation as listed on the Introba CDB contract was to "provide permanent medical office space at various Southern locations". A major recommendation in the CGL evaluation was to add mental health treatment and staff spaces across IDOC. This was due to mental health staff needing to absorb medical office and clinical space for purposes of treatment (see page 118 of the CGL report for this discussion). This purpose does not address the requirements of the Lippert Consent Decree or Implementation Plan. The CGL and Introba reports were related more to the needs of the Rasha Settlement Agreement and did not consider the requirements of the Lippert Settlement.

<sup>77</sup> The program health care standards were developed by Introba in conjunction with IDOC but some are inconsistent with realistic or comprehensive care needs of the patients. These standards are space design standards to be used in their report. Examples included the following. 1) Chronic care and dialysis would not be provided onsite. 2) Long-term care for the elderly would not be provided onsite (this was determined without a definition of who would qualify for long-term care or identification of where long-term care will be provided). 3) Patient examination rooms are based on a formula of one examination room for every 300 inmates, irrespective of the tasks necessary to accomplish at any given facility. 4) A single telemedicine room per facility without knowing the telemedicine program needs or individuals obtaining telemedicine. 5) One infirmary bed for every 100 inmates regardless of the acuity of patients at the facility.

<sup>78</sup> Number of rooms and spaces and square footage standards were provided for clinical examination and treatment rooms, emergency/urgent rooms, dental suites, telehealth rooms, physical therapy areas, optometry and audiology spaces, various types of storage rooms, patient waiting areas, infirmary patient rooms and infirmary support services, pharmacy and medication distribution spaces, staff and administrative support areas (offices, workstations, supply rooms). There are separate standards for the adjacent mental health unit.

<sup>79</sup> For example, it is unreasonable and impractical to conduct all chronic care visits and dialysis visits offsite as the transportation cost would be prohibitive and virtually impossible to coordinate.

<sup>80</sup> The November 2023 censuses for these six facilities ranged from 1,059 to 1,921 men.

<sup>81</sup> Graham's Reception Center is currently performed in the center court of the gymnasium. It lacks audio and visual privacy and does not allow the timely and efficient completion of the intake health screenings.

The Introba contract and report are also not responsive to requirements of the Consent Decree and Implementation Plan<sup>82</sup> because *they did not accomplish the following*.

1. Evaluation of clinical space and support spaces **at all facilities** (Implementation Plan narrative pages 1 and 5, and item 96).
2. Evaluation of fixed and mobile equipment, dental equipment for all clinical areas (Implementation Plan narrative page 5)
3. Include the report of the consultant on the aged, infirm and disabled to quantify the population of this group in developing housing needs, support services, and specialized equipment for this population (Implementation plan narrative pages 1, 2, 5, and item 96).
4. Develop a useful life analysis of existing medical and dental space (Implementation Plan items 95, and 97)
5. Introba set a limit that physical therapy rooms will only be provided to facilities greater than 900 individuals but there is no accompanying plan on how patients in facilities less than 900 individuals will receive physical therapy when needed.
6. The consultant will use the staffing analysis, to estimate current and future staffing in consideration of space and equipment needs (Implementation Plan item 97)
7. Develop *recommendations* based on items 1-4 above (Implementation Plan item 98).
8. Develop a timeline for completion of any rehabilitation or construction (Implementation Plan item 99a).
9. The report does not include operations that are not yet in place because they have not yet been implemented.

The Introba report created template designs to be used in the six newly constructed replacement medical and dental health care and mental health units. The Monitor is not opposed to use of preliminary template designs, provided that unique needs of every facility are modified accordingly. The Monitor team's initial review<sup>83</sup> of the health care design standards, drawings and space calculations identified concerns that suggested a lack of adequate input from the Monitor, OHS and IDOC clinical leadership. These included the following.

- The drawings lacked radiology units;
- Medical telehealth rooms were undersized and would not accommodate the mandated presence of a nurse;
- The lack of sub-waiting for medical units would result in waiting chairs being placed in the corridors;
- The dental hygienist area appears to be a work/lab/storage/sterilization area not a dental hygienist cleaning and exam room;
- Chronic care<sup>84</sup> and dialysis are considered specialty care and will be provided offsite;
- Setting a limit that a physical therapy room is not provided until the census of a facility reaches 899 inmates without first determining a plan for physical therapy<sup>85</sup>;
- Long-term care will be provided offsite without analysis of how many persons will need long-term care or where it will be provided offsite.

<sup>82</sup> Based on all Implementation Plan items listed above including narrative statements on page 1,2, and 5; item 95, 96, 97, 98, 99, and 99a.

<sup>83</sup> The preliminary written review and critique of the Introba INC report by the Monitor team was discussed with the OHS leadership and reportedly forwarded to the CDB.

<sup>84</sup> The CGL and Introba consultants' need to define what they mean by "chronic care management". It is likely that the consultants are using this term to mean nursing home care or long term residential care. The monitor team uses the term "chronic care management" to mean the delivery of outpatient care to patients with chronic illnesses including diabetes, hypertension, seizure disorders, thyroid disorders, anemia, etc., This question needs to be clarified.

<sup>85</sup> The Monitor agrees that a physical therapy unit may not be needed at every site with less than 900 beds, but a plan for how patients at every site will obtain physical therapy, if needed, should be in place. There is no such plan.

The engineering consultant's design of the infirmary is also problematic. The infirmary patient rooms are single bed rooms which will likely have solid doors, pass through slots, and small viewing windows in the door. There appears to be limited lines of sight into the infirmary patient rooms. The location and design of the nurse stations need to be reviewed to ensure that the nurses have adequate work space and optimal lines of sight into the patient rooms. There is not a designated security observation station in the infirmaries. It is unclear where the correctional staff will be posted in the infirmary. If the officers are assigned to the "open" nurse stations, these stations will be dominated by correctional staff. The infirmary, which will continue to house aged, infirm, disabled, and dementia patients, has no communal activity rooms with card/reading/game tables, dining tables, TVs, or limited exercise equipment. This infirmary design will result in chronically ill, long term infirmary residents being housed in what is the equivalent of "solitary confinement".

Although the engineering report includes adjustments for the number, type, and size of certain rooms and spaces based on the population housed in the facility; there is a risk of promulgating cookie-cutter correctional facility designs in the IDOC that do not meet the needs of varied populations served in a facility. IDOC needs to ensure that newly designed and constructed facilities have built-in space flexibility to meet both the current and future service needs of the incarcerated patient population.

The engineering and consulting report stated that "long term, chronic care, (and) dialysis" services would be most feasibly provided at off-site facilities. The Monitor strongly disagrees. If the IDOC decides to provide dialysis treatments that require transportation to an offsite dialysis center, not only will this place an extraordinary burden of the correctional staff, but will result in missed dialysis appointments due to failed transportation or late arrival. Conducting chronic care visits offsite as if chronic care were a specialty service is inconsistent with any correctional care program nationwide and would not be feasible due to the extraordinary number of trips that would be required. There are strong logistical, medical, fiscal, and legal reasons that almost all prisons in the USA provide onsite dialysis. The Monitor is aware of no prison, nationwide, that conducts chronic care visits offsite.

The CGL and Introba firms are acceptable consultants but the work specifications do not meet the requirements of the Consent Decree and the Implementation Plan. The project to replace and expand the health care units of six facilities does not completely address the structural and space needs of the six intended facilities nor are evaluations of the other twenty-two other IDOC facilities completed.<sup>86</sup>

These consultations need to include a strategic plan for the health and dental programs, similar to the CGL plan for custody, including:

- How the larger IDOC plan to eliminate, rearrange, and reorder prison facilities as evident in the CGL report will strategically affect medical and dental care. IDOC must develop a strategic medical plan to include:
  - A medical classification system, completed in conjunction with custody, that will ensure inmates are appropriately housed based on their medical acuity and custody classification;
  - A reorganization of classification to ensure high medical acuity patients are housed at facilities close to needed specialty and hospital care;
  - Separation of patients by medical classification to ensure the facility they are housed in will meet their medical needs;
  - Whether telemedicine will be expanded and to determine specifications for telemedicine rooms and how the need for telemedicine will affect classification assignments by housing;

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<sup>86</sup> It is likely that some of the other 22 existing facilities may be closed.

- The hiring of an expert consultant to evaluate the clinical care and related housing of the aged, infirm, disabled, demented and memory deficit men and women and quantify the numbers of these categories of patients in the IDOC before the design or building of new medical structures;
- Consideration of ADA accommodation needs with respect to classification and housing; and
- Developing a list of equipment required in all health care rooms, for each facility, and ensure that the availability of equipment is standardized across IDOC's thirty facilities. This needs to include radiology equipment, upgrades to digital radiology equipment at all facilities, dental equipment, and a digital dental x-ray system.

Because these reports were commissioned prior to completion and filing of the Implementation Plan, it is the monitor team's recommendation that the CDB should expand the existing contract with CGL and Introba to be consistent with the Implementation Plan and Consent Decree requirements<sup>87</sup>. These consultants should receive input from the Monitor. The analysis of the aged, infirm, and disabled needs to be completed prior to a final physical plant analysis is completed. Introba should coordinate their work with the consultant for the aged, infirm and disabled as well as with CGL. The Monitor also recommends that the engineering and consulting report would be enhanced if significantly more input from the OHS and IDOC leadership was solicited. IDOC has a once in a generation opportunity to address the existing physical plant deficiencies in clinical space and clinical care related housing of the aged, infirm, disabled, demented and memory deficient patients. The two reports provided should be thoroughly vetted by health care and correctional leadership before extensive remodeling, renovation, and construction is initiated. **For these reasons, the physical plant items of the Operations section are partially compliant.**

#### **RECOMMENDATIONS:**

1. IDOC should implement the recommendations in the narrative pages 1, 2, and 5 and Implementation Plan items 95, 96, 97, 98, 99, and 99a.
2. The IDOC must hire a subject-expert consultant or agency to evaluate the health care, special housing, and programmatic needs of the aged, infirm, disabled, dementia and memory deficit incarcerated persons, quantify the numbers of this patient population, and provide recommendations on the clinical care needs and clinical care related housing required for this population. This analysis should precede completion of the physical plant analysis.
3. The OHS and IDOC clinical leadership should thoroughly review and provide additional input on the engineering and clinical report space design and preliminary drawings of Introba and CGL, or other consultants as chosen by the CDB. The consultants should meet with the Monitor to obtain input.
4. Dialysis services should be performed in the IDOC facilities where the renal failure patients are housed.<sup>88</sup>
5. Chronic care management should be performed onsite but can be facilitated by telemedicine and e-consults.
6. The CDB should revise the contracts with CGL and Introba to ensure that the medical and dental physical plant analysis is consistent with Consent Decree and Implementation Plan requirements and occurs after completion of the analysis of the aged. If CGL can obtain a gerontologist to complete the analysis of the aged, it may expedite the process.
7. OHS needs development of a strategic plan to address classification by medical acuity including disabilities, consideration of classification housing locations based on hospitals and specialty care proximity to the housing locations, and facility medical and dental design considerations based on clinical

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<sup>87</sup> Finding appropriate consultants is the prerogative of IDOC. The Monitor finds the two consultants appropriate but decisions on selecting a consultant is the responsibility of IDOC.

<sup>88</sup> Given the limited number of females with chronic renal failure, it would be reasonable to perform hemodialysis at an offsite dialysis center.

needs based on medical classification acuity needs.

### **Equipment and Supplies**

*Addresses item II.B.6.p; III.B.2; III.I.4;*

**II.B.6. p.** *IDOC agrees to implement changes in the following areas: Adequately equipped infirmaries;*

**III.B.2.** *These areas shall be equipped to fully address prisoner medical needs. The equipment shall be inspected regularly and repaired and replaced as necessary. Each area shall include an examination table, and a barrier on the examination table that can be replaced between prisoners. The areas shall provide hand washing or hand sanitizer.*

**III.I.4.** *All infirmaries shall have necessary access to security staff at all times. (See Infirmary Section)*

**OVERALL COMPLIANCE RATING:** Partial Compliance

### **FINDINGS:**

**Implementation Plan narrative page 5:** *As required by the Consent Decree, IDOC will survey all facilities to ensure there is adequate physical space and equipment for clinical care. This includes fixed and mobile equipment, dental equipment...*

**Implementation Plan item 95:** *A qualified consultant will be retained to survey all clinical spaces. A qualified (in health facility design and operation) consultant will be retained to evaluate structural space and equipment relative to a useful life determination. **Proposed End Date: December 2023***

**IDOC has not engaged a qualified consultant to evaluate equipment relative to useful life determination. IDOC is not compliant with Implementation Plan item 95**

**Implementation Plan item 96:** *Develop structural space and fixed equipment requirements for all clinical activities necessary to provide adequate medical and dental care. Clinical spaces include all health care units, dental units, intake areas, clinical examination rooms, support spaces necessary to carry out medical functions, infirmaries or other specialized housing for those with severe disabilities, are severely infirm, or have dementia or memory issues and are unable to care for themselves for each major facility. Benchmark requirements consist of space and equipment typically available in a contemporary health program. **Proposed End Date: October 2023***  
**IDOC has not developed fixed equipment requirements and benchmark requirements for equipment typically available in a health program. IDOC is not compliant with Implementation Plan item 96.**

**Implementation Plan item 97a:** *Develop an analysis of all existing fixed and mobile medical and dental equipment typically necessary to equip facilities for the types of services provided at each facility. The analysis will describe whether necessary fixed and mobile equipment is currently available and functional. The meaning of functional will include a useful-life perspective. The analysis will result in a report with recommendations on how to remedy any deficiencies identified. Equipment beyond useful life will be identified in the report. **Proposed End Date: January 2025.*** **Implementation Plan item 97a is not yet rated due to the January 2025 end date.**

**Implementation Plan item 98:** *Based on recommendations in the consultant's report, develop a plan to address physical plant and equipment deficiencies identified. **Proposed End Date: January 2025.*** **Implementation Plan item 98 is not yet rated due to the January 2025 end date.**

**Implementation Plan item 99:** *Work with appropriate State partners to implement recommendations for sufficient medical and dental space and equipment for current and future healthcare operations and care for all inmates in need of medical care or medical supervision. **Proposed End Dates: July 2024.*** **Implementation Plan item 99 is not yet rated due to the July 2024 proposed end date.**

The Monitor requested three data and information reports from IDOC for this section of the report. IDOC has provided documents for two of the three requests.<sup>89</sup> The request for lists of durable equipment (#56) could not be opened and stated “file empty”. The request for a list of equipment that requires calibration (#57) did not provide any dates of most recent calibration and appears to be the list of durable equipment. The third request was to provide information on most recent IEMA radiation safety inspections from all facilities with x-ray units but provided this information from only seven facilities.

Based on Illinois Emergency Management Agency (IEMA) codes the IDOC radiology units are considered Class B Illinois radiation installations<sup>90</sup> and should expect to be inspected approximately every two years. IDOC provided IEMA radiation safety inspection data for seven facilities. Five facilities had passed inspections within the last two years.<sup>91</sup> One facility provided data that indicated that their radiology unit had not been inspected in the last 3 ½ years.<sup>92</sup> The other radiology unit was not functional since 12/1/22 and the inspection had been postponed as of July 23, 2023.<sup>93</sup> The Monitor has not received information about the status of the non-functional Toshiba unit at this facility.

Information for durable equipment<sup>94</sup> was not standardized and varied in the number and type of equipment reported. Most sites provided a long inventory list of equipment. The equipment was listed in differing orders from site to site making it difficult if not impossible to compare equipment in IDOC facilities. No information was provided on the inventory list of the dates of calibration performed by contracted biomedical companies. Accordingly, it was impossible for the Monitor to access IDOC’s compliance with the required annual calibration of clinical equipment for this report.

Review of the inventory list from twenty-one facilities identified seven sites<sup>95</sup> that appear to have only a single automated external defibrillator (AED). The Monitor has strongly recommended in previous reports that each IDOC facility should have at least two AEDs to ensure that a functional AED is always available for emergencies. Three other facilities<sup>96</sup> did not have any AEDs reported on their equipment list. Logan CC was one of facilities that did not list any AEDs on the equipment inventory. However, during the Monitor’s February, 2020 site visit it was verified that two AEDs were at the facility. This raises concerns about the validity of the equipment inventory list or whether certain equipment is tracked on another list, possibly the equipment calibration list.

OHS has informed the monitor team that beds in all IDOC infirmaries had been upgraded with semi-electric beds donated by IEMA.<sup>97</sup> During the site visits to the infirmaries at Dixon<sup>98</sup> and Graham<sup>99</sup> it was verified that the outdated manual beds had been replaced with the electric beds. The equipment lists from seven facilities were audited to confirm that infirmary bed upgrade was a systemwide action. Only one<sup>100</sup> of the seven equipment lists

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<sup>89</sup> Document requests #57 list of equipment that requires calibration and #61 IEMA inspections were provided; #56 durable equipment list could not be opened/“file empty”.

<sup>90</sup> IEMA, Illinois Code 320.10 subchapter b: Class B radiation installations include units that are used solely for diagnosis should be inspected by IEMA approximately every two years.

<sup>91</sup> Danville, JTC, Lawrence, Pinckneyville, Pontiac CCs.

<sup>92</sup> Jacksonville CC

<sup>93</sup> Centralia CC

<sup>94</sup> Document request #57

<sup>95</sup> Decatur, Jacksonville, Murphysboro, Pinckneyville, Robinson, Vandalia, and Western CC listed only one AED on their inventory of equipment.

<sup>96</sup> Danville, Hill, and Logan CC did not have any AEDs on their equipment list.

<sup>97</sup> The semi-electric beds that been purchased during the peak of the pandemic to quarantine COVID-19 patients in McCormick Place and other large settings.

<sup>98</sup> Dixon CC infirmary bed inspection 12/5-7/2022

<sup>99</sup> Graham CC Infirmary bed inspection 7/17-19/2023

<sup>100</sup> Vandalia equipment list noted 1 fully electric and 7 semi-electric infirmary beds.

specifically reported that “semi-electric beds” were in their infirmary. The other six sites reported the number of “hospital”, “medical”, or “steel railing” beds, or did not list beds on their equipment list. The nomenclature was unclear and is a barrier to verifying the standardization of adequate equipment in the IDOC.

As noted in the 6<sup>th</sup> Court Report, the equipment lists provided have limited value without having a systemwide standardized list of equipment that is expected to be available in each of the different clinical rooms and areas in all IDOC facilities. The number of pieces of equipment would, of course, vary based on the number of examination rooms, urgent care rooms, dental suites, infirmary beds, specialized treatment services (dialysis, physical therapy), special equipment needed to support disabled and infirm patients, and whether the facility is an intake center. IDOC has previously committed to ensuring that there is adequate fixed, mobile, medical, and dental equipment. Developing a standardized list of expected equipment is the first step necessary to accomplish this goal. The hiring of a qualified consultant as recommended in Implementation Plan item 95 to evaluate equipment relative to useful life determination<sup>101</sup> and to develop a plan to address equipment deficiencies<sup>102</sup> has not yet been accomplished.

There has been essentially no change in the status of this item since the Monitor’s 4<sup>th</sup> report. IDOC does not yet have a standardized equipment list required for each facility including for the infirmary. The Monitor has previously provided input on drafts of a list of emergency supplies, an equipment survey checklist, and a list medical equipment by facility. No further information about these drafts or any efforts to standardize other equipment has been provided by IDOC. The Monitor’s recommendation from previous reports remains the same.

#### **RECOMMENDATIONS:**

1. IDOC should identify a consultant to accomplish the recommendations in Implementation Plan narrative page 5, and items 95, 96, 97a, 98, and 99 to survey and upgrade equipment in IDOC medical and dental units.
2. IDOC must establish a systemwide standardized list with uniform nomenclature of equipment that must be available and maintained in each of the different clinical service rooms (examination rooms, telemedicine rooms, urgent care, infirmary, dental suites, specialty rooms, etc.) at all correctional centers.
3. IDOC must implement a systemwide annual calibration and evaluation of the clinical equipment and incorporate a replacement or repair plan to ensure that all sites have functional equipment at all times. This annual calibration evaluation should be provided to the Monitor and auditors (II.B.9).
4. IDOC should utilize the consultant who IDOC hired to survey clinical space to provide consultation on required equipment that is needed in all health care service rooms and areas in the IDOC.
5. All IDOC facilities should have at least two AEDs.

#### **Sanitation**

##### ***Addresses item III.J.3***

**III.J.3.** *Facility medical staff shall conduct and document safety and sanitation inspections of the medical areas of the facility on a monthly basis.*

**OVERALL COMPLIANCE RATING:** Noncompliance

#### **FINDINGS:**

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<sup>101</sup> Implementation Plan item 95

<sup>102</sup> Implementation Plan item 98

**Implementation Plan item 60:** *Hire Environmental Services Coordinator responsible for ensuring the adequacy and functionality of clinical space and sanitation to deliver adequate health care and ensure patient safety. These responsibilities also include establishing policies, practices, and procedures to identify inmate illness or injury potentially related to environmental factors. The Environmental Services Coordinator develops oversight and reporting systems to identify deficiencies in clinical space and equipment as well as environmental conditions that need correction at the facility as well as identification of systemic issues that are directed to the patient safety and quality improvement committees for review and action. **Proposed End Date: February 2024***

The Environmental Services Coordinator position was filled then transferred from OHS to the IDOC Compliance Team. The actual field duties assigned to this position have not been communicated to the Monitor. **At this time, the Monitor is unable to rate Implementation Plan item 60.**

**Implementation Plan item 61:** *Develop a standardized safety and sanitation policy detailing procedures for cleaning and sanitizing medical areas and identifying a responsible party at each facility. The policy will also outline necessary training, supplies and equipment to be used. Policy details will address security issues such as lockdowns and safeguarding areas containing medical supplies. See Task 40 for additional steps to be taken in developing and implementing the safety and sanitation policy. **Proposed End Date: June 2024***

IDOC has drafted a safety and sanitation policy that has not yet been finalized or approved. **IDOC is partially complaint with Implementation Plan item 16.**

**Implementation Plan item 62:** *Develop safety and sanitation inspection tool that surveys all clinical spaces, equipment, supplies, etc.*

1. *Test safety and sanitation inspection tool with Monitors at multiple sites to ensure adequacy of the tool.*
2. *Establish the frequency and calendar for a facility safety and sanitation inspections of all clinical spaces, equipment supplies, etc.*
3. *Identify who is responsible for performing safety and sanitation inspections and train them to produce reliable results.*
4. *Audit the reliability of safety and sanitation inspections.*

**Proposed End Date: August 2024**

The Monitor has not been provided with a standardized inspection tool. **IDOC is not compliant with Implementation Plan item 62**

**Implementation Plan item 63:** *Implement periodic safety and sanitation inspections, using the validated inspection tool, to evaluate the presence, condition, and functionality of clinical space and equipment with a standardized process for reporting results.*

1. *Establish a method to prioritize the repair or replacement of identified deficiencies that prevent disease or injury.*
2. *Report the results of safety and sanitation inspections to the responsible party at the facility for corrective action and follow up.*
3. *Track the progress of corrective action to the OHS Audit Committee.*
4. *Analyze results of safety and sanitation inspections to identify systemic issues concerning patient safety or that impede the delivery of timely, adequate health care. Report these results to the SLC via the patient safety or audit functions with necessary further action identified.*

**Proposed End Date: November 2024**

**IDOC is not compliant with Implementation Plan item 63.**



Two documents were requested for this report.<sup>103</sup>

- Safety and Sanitation Reports.
- Each Facility's cleaning and sanitation schedule for health care areas. This was not provided.

Results and/or reports of monthly safety and sanitation inspection reports continue to be provided to the Monitor on a quarterly basis for most facilities. Safety and sanitation reports for the 2<sup>nd</sup> quarter of 2023 were provided for 22 (75%) of the 29 IDOC facilities.<sup>104</sup> Seven (25%) sites did not provide inspection reports for any of the three months in this quarter. The monthly reports submitted include some type of safety and sanitation inspection at IDOC facilities. Previous safety and sanitation inspection reports appeared to be the only process in place to evaluate the physical plant, plumbing, lighting, ventilation, and cleanliness of the housing units, kitchen, cafeteria, and laundry. However, in this quarter only six (27%) of the 22 reporting facilities reported inspections in housing units and/or kitchens.

The deficiencies identified in non-medical areas included broken toilets, mold in showers, non-functional lights, peeling paint, cracked floors, holes in walls, rusty vents, missing ceiling tiles, and broken washing machines and dryers. Almost all of these deficiencies had been reported in **each** of the three months of the 2<sup>nd</sup> quarter of 2023. At one facility<sup>105</sup> flying pests and rodents were noted in the kitchen and cockroaches and birds in one housing unit. Many of the physical plant deficiencies noted in the non-medical areas especially the congregated housing units have the potential to put the incarcerated population at risk for injuries and exposure to infectious material. This is especially true for individuals who have chronic medical conditions and who are aged infirmed, frail, disabled, or with mental deficits. It is a concern that there was no mention in any of the 2<sup>nd</sup> quarter 2023 safety and sanitation reports of the crumbling and cracked sidewalks that put both incarcerated persons and staff at risk for injury.<sup>106</sup> The recent CGL Facility Master Plan noted that "walk ways ...are in very poor condition creating trip hazards..." and are barriers to accessibility in a number of facilities.<sup>107</sup> This same report also discusses many physical plant issues which have resulted in a recommendation to replace many buildings within the IDOC system. Deterioration of structures is magnified due to deferred maintenance.

At one facility<sup>108</sup> the security staff recently issued a memo informing the nurse assigned to doing safety and sanitation rounds only to inspect the health care unit. If clinical staff will no longer be doing safety and sanitation rounds in the non-medical units, then security must develop an inspection tool with the input of the IDOC clinical leadership and the Monitor to identify conditions and deficiencies that have a potential impact on the health of the incarcerated population. The security inspection reports of non-medical spaces should be presented to the monthly CQI meetings for review and discussion about potential impacts on the health of incarcerated individuals and staff.

Sixteen (73%) of the twenty-two reporting sites only reported on conditions in the HCU, infirmaries, and mental health units. Four facilities reported that were no issues in the HCU.

Deficiencies documented in the inspections of the other health care areas included dirty sinks, rusty and dirty vents, missing curtains around infirmary beds, inoperable sinks, absence of non-slip surfaces in the infirmary showers, missing and/or cracked tiles in showers and hallways, examination tables with torn vinyl, non-functional ceiling lights in hallways and bathrooms, broken toilets, water leakage in ceilings, and missing and broken

<sup>103</sup> Document request #s 62-63 requested August 2, 2023

<sup>104</sup> Western's Safety and Sanitation report (CQI minutes) for the 2<sup>nd</sup> quarter could not be opened.

<sup>105</sup> Stateville CC had flying pests and rodents in the kitchen and cockroaches and birds in the C gallery.

<sup>106</sup> The monitor team has previously reported on the dangerous and hazardous conditions of sidewalks at Logan CC and Dixon CC and deteriorated stairs and loose railings at the ramp to the HCU entrance at Pontiac CC

<sup>107</sup> CGL IDOC Facility Master Plan, May 2023

<sup>108</sup> Murphysboro CC June 2023 CQI minutes, Safety and Sanitation report

windows and peeling paint. It was also worrisome that only one facility reported on the lack of non-slip surfaces<sup>109</sup> in their showers and not a single center reported the presence or absence of safety grab bars in bathrooms and showers.<sup>110</sup>

As noted in a previous paragraph on deficiencies in the non-medical areas, almost all of the deficiencies in the health care areas also had been repeatedly reported but had not been corrected for at least the last three months. The health care area inspections almost exclusively focused on physical plant issues and not on clinical space, equipment function and calibration, handling of medical waste, functioning of infirmary beds, and safety features in the patient showers and bathrooms, emergency bags, dental and radiology equipment, etc.<sup>111</sup>

The safety and sanitation inspections identified vermin in the HCU at Sheridan CC and cockroaches, rodents, and insects in the infirmary at Stateville CC.<sup>112</sup> In one death record reviewed by the Monitor a morbidly obese, confused, incapacitated, and bed-ridden patient with decubiti and open sores between his abdominal folds was noted by a nurse to have a cockroach exit his abdominal folds when initiating wound care. This was in February of 2021 and safety and sanitation reports from 2021 through 2023 continue, for all safety and sanitation reports reviewed, to document roaches in the infirmary including in patient rooms. Flying pests and rodents were also intermittently noted. Safety and sanitation reports note frequent extermination efforts which apparently were futile. The CGL report, discussed in the Operations section of this report, noted that all inmate housing in the original Stateville facility needs replacement. This infirmary is unsafe housing and, in particular, it should not be used to house disabled or incapacitated or bed-ridden patients.<sup>113</sup> IDOC should consider alternatives to use of the Stateville infirmary until appropriate infirmary housing can be obtained.

There continues to be notable variation in what is reported. Most safety and sanitation reports do not contain the detail necessary to adequately evaluate the space, equipment, safety, and sanitation of the medical areas. Negative pressure unit inspections were only reported by three (17%) of the reporting twenty facilities with infirmaries.<sup>114</sup> Documentation of spore testing of autoclaves was reported in only six (33%) of the reporting eighteen facilities with dental suites.<sup>115</sup> The reports commonly do not identify the presence of safety concerns that impact on the health and safety of both the patient population and the health care and correctional staff throughout the IDOC.

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<sup>109</sup> Centralia CC reported that from May-June 2023 that non-slip surfaces were needed in showers of housing units.

<sup>110</sup> During virtually every site visit to IDOC correctional centers the Monitor has observed and reported the need for non-slip surfaces and safety grab bars in showers and toilets of housing units.

<sup>111</sup> Aside from the limited reporting of negative pressure units and spore testing of autoclaves, only two facilities reported on clinical issues. Centralia CC noted every for three months that multi-dose insulin vials were not being dated when initially opened and the facility needed additional oxygen tanks from the vendor. Dixon CC noted that a dental ultrasound was broken and that a dental hygiene chair was needed to be purchased.

<sup>112</sup> Vermin at Sheridan was only noted in the June 2023 safety and sanitation report. Cockroaches were documented in the infirmary at Stateville in January through May of 2021 and from July of 2022 through June of 2023. But the Monitor did not review all safety and sanitation reports in between those dates. It appeared that roaches, rodents and pests have been *continuously* present at least since 2021. It was noted in a preceding paragraph that Stateville CC also had cockroaches and birds in a housing unit and rodents and flying pests in the kitchen.

<sup>113</sup> An infirmary bed is similar to a hospital bed insofar as it may house, and, in this patient example, did house, an incapacitated patient unable to fend for himself. Illinois State regulation (Illinois Administrative Code Title 77, §250.1730 Insect and Rodent Control) is an Illinois Department of Public Health hospital licensing requirement that prohibits conditions conducive to harboring or breeding of insects, rodents or other vermin. Stateville has had cockroaches and rodents in the infirmary for years without the ability of extermination. The Department of Health should be consulted regarding next steps.

<sup>114</sup> Dixon CC, Graham CC, and Southwestern CC reported on the inspection of negative pressure units during safety and sanitation rounds.

<sup>115</sup> Dixon CC, Graham CC, JTC, Menard CC, Stateville NRC, and Sheridan CC reported on the performance on spore testing of the autoclaves that sterilization instruments during safety and sanitation rounds.

Physical plant deficiencies in the housing units and medical service areas were identified with similar prevalence as cited in previous Monitor reports.<sup>116</sup> IDOC has made no progress on improvements to sanitation or inspections. It is a significant concern that the vast majority of physical plant deficiencies noted in the 2<sup>nd</sup> Quarter 2023 had been repeatedly reported without correction for three months and likely much longer. This is unacceptable and creates potential health and safety risks for the incarcerated population and staff. It also creates an unprofessional work environment that hinders the recruitment and retention of the health care and correctional staff.

The safety and sanitation presentations documented in the monthly CQI minutes are not standardized and have significant variation regarding what is audited, documented, and reported. Based on the variation of data reported, it is evident that IDOC has either not developed a systemwide inspection tool or has not trained staff on the use of a systemwide inspection tool.

IDOC is now committed to the development of a tool to inspect the safety of the physical plant and sanitation of clinical spaces. The tool will need to be reviewed by the Monitor and tested at multiple facilities to ensure its accuracy. The current safety and sanitation rounds do not adequately and consistently review and document the condition or operability of clinical equipment, furniture, emergency response bags, equipment, negative pressure units, and infirmary beds in the health care unit (HCU) and in satellite clinical spaces in the housing units. Work orders placed to repair deficiencies are slowly if at all addressed.<sup>117</sup> IDOC has not provided logs that track work orders or the correction of deficiencies identified on the safety and sanitation rounds. This section is accordingly rated as noncompliant.

## **RECOMMENDATIONS:**

1. IDOC is to implement the recommendations in Implementation Plan items 61-63.
2. The safety and sanitation inspections do not, but should, include a more detailed evaluation of the HCU and all other clinical treatment areas including satellite clinics that would include the functioning and calibration of medical, dental, and radiology equipment, the condition of gurneys, examination tables, chairs, and infirmary beds, the emergency response bags, functionality of the negative pressure rooms, and the sanitation of all clinical spaces.
3. OHS should finalize with the input of the Monitor their draft of a standardized systemwide Health Care Unit/clinical space audit instrument that would focus on all the key safety and sanitation issues in all clinical areas.
4. If separate non-medical-area safety and sanitation rounds will be performed by security staff then a separate non-medical area inspection tool should be developed with input of the IDOC clinical leadership and the Monitor to ensure that potential health and safety related deficiencies are inspected and reported to the monthly facility CQI committee for review and analysis.
5. The IDOC must expeditiously address and track the deficiencies noted in safety and sanitation reports prioritizing those work orders that have an impact on preventing disease and injury to inmates and staff.
6. IDOC needs to consult with the Illinois Department of Public Health, to determine whether the Stateville infirmary is sufficiently safe to house incapacitated and infirm individuals given the persistent problem with rodents, cockroaches and vermin.

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<sup>116</sup> Health Care Monitor 2<sup>nd</sup> to 6<sup>th</sup> Reports Lippert v. Jeffreys.

<sup>117</sup> This is consistent with the CGL report which gives extensive detail on the excessive deferred maintenance that exists within IDOC.

## Onsite Laboratory and Diagnostics

*Addresses item II.B.6.g;*

**II.B.6. g.** IDOC agrees to implement changes in the following areas: Timely access to diagnostic services and to appropriate specialty care;

**OVERALL COMPLIANCE RATING:** Partial compliance

### FINDINGS:

This service area was not reviewed for this report. Prior recommendations are continued.

### RECOMMENDATIONS:

1. IDOC must begin the process to convert all of its non-digital medical and dental radiology units to digital equipment.
2. Expand tuberculosis skin testing (TST) with interferon-gamma release assays (IGRA) blood testing to all facilities.
3. IDOC should evaluate the need for radiation exposure monitoring badges in all its facilities providing radiology services and, in addition, investigate and implement any needed safety measures for the panorex units at Logan CC and Menard CC.
4. Create a log to track the results of point-of-care colorectal cancer screening and report this data on a regular basis to the facility's CQI committee meeting.

## Dietary

*Addresses item II.B.6.j.*

**II.B.6.j.** IDOC agrees to implement changes in the following areas: Analysis of nutrition and timing of meals for diabetics and other Class members whose serious medical needs warrant doing so;

**OVERALL COMPLIANCE RATING:** Partial Compliance

### FINDINGS:

**Implementation Plan item 37:** *Hire dietician(s) based on a workload analysis (based on requirements of the Consent Decree) or engage consultant services that will complete an analysis biennially of nutrition and timing of meals at all facilities for the population of inmates with chronic illness whose condition is affected by dietary conditions. The dietician will also provide individual consultation and counseling for individuals who have serious medical needs affected by diet and require such analysis. OHS to consult SIU or other entity to develop process for dietary counseling. Proposed End Date: November 2023*

**Implementation Plan item 38:** *Dietician will review prescribed medical diets and the overall nutritional content of the meals for non-medical diets. OHS to consult SIU, or other entity, to develop process for dietary counseling. Proposed End Date: May 2024*

IDOC has not yet performed a workload analysis of dietician needs. Therefore, there has been no analysis of the hours of dietician consultation needed to biennially complete an analysis of nutrition and timing of meals for inmates and for consultation with persons needing individual consultation due to serious medical need affected by diet. IDOC has arranged for SIU to provide dietary consultation but apparently this only relates to consultation regarding meal planning. Since October of 2022, this consultant dietician provided 160 hours of service.

The Monitor did request the number of individual and group dietary consultations and patient information sessions listing names and number of inmates and the facility where consultations took place at but IDOC stated it does not track this information. Currently the Monitor has no evidence that any individual dietary counseling sessions occur.

IDOC provided a draft five-week therapeutic diet manual for IDOC. This manual updates general dietary menu types with examples of sample menus. The manual uses the MyPlate principles which is a United States Department of Agriculture initiative to use the Dietary Guidelines for Americans 2020-2025 in helping individuals to **choose** appropriate foods for improved nutrition. In the IDOC, individuals lack choice for many meals and their choices are significantly reduced. The manual gives general sample menus for the general diet, and a variety of menu types including vegetarian, a variety of dysphagia diets, jaw fracture, clear liquid, medical diets including for chronic kidney disease, consistent carbohydrate meals plans for diabetes, low fat, fiber restricted, gluten free, heart-healthy, high-fiber, lactose controlled, pregnancy, breast feeding, gestational diabetes, sodium restricted, halal, and kosher diets. The five week plan for the general diet was provided on a spreadsheet. Plans for other diets types were not provided. How the diet manual translates to actual meals and the hours of meals will determine the participation in meals and the degree to which less nutritious commissary foods become the source of nutrition for inmates. Diet plans for individual facilities was not assessed.

Based on discussions with persons with diabetes at Graham, nutrition was a major problem for persons with diabetes at this facility. Insulin administration is not given consistently with consideration about meal timing and altered eating patterns were present for almost all of the persons with diabetes interviewed. They expressed fear of taking insulin due to hypoglycemia from taking insulin and not being fed timely. Six of nine inmates with diabetes described significant hypoglycemia episodes. None of these individuals had been offered any counseling or dietary consultation with respect to accommodating their diabetes to the IDOC diet. All nine thought dietary consultation would be helpful. There is currently no procedure for how a dietary consultation is obtained and it does not appear to be a service that is provided to inmates. Based on an estimate of nine inmates with diabetes at Graham, 40% of their diet is commissary due to scheduling of meals, fear of hypoglycemia due to scheduling disparities between meals and insulin administration, and palatability of the meals,

Meal participation should be evaluated on an ongoing basis by performance and outcome measures. Commissary should be addressed by the nutritionist, including nutritional content of commissary items, estimates of volumes of commissary consumed and meals consumed to estimate nutritional content of food consumed. Information learned should be shared with inmates.

The SIU mortality reviews identified three persons with protein calorie malnutrition. One was end-of-life who did not appear to have a reasoned indication for placement of a feeding tube. Two other persons had unrecognized severe protein calorie malnutrition. The Monitor has found similar incidents in persons with dementia or other conditions. Due to the lack of attention by current staff to malnutrition in the disabled elderly, there should be some attention in the manual for feedings for those persons with dementia, memory issues, severe disabilities, or cognitive issues specifically, how and when they need assistance with meals. It would be useful for the nutritional manual to address how and when a nutritional consult is indicated. Alternatively, this can be in policy and procedure.

The dietician also developed a 14 page manual on maintaining dietary needs during a disaster.

In summary, IDOC developed a general diet manual but has not yet translated the diet manual to meal plans at individual facilities. Dietary consultation for individual inmates with nutritional issues related to their chronic illness has not yet been established in policy, procedure or practice. There is currently no evaluation of

nutritional adequacy for individual patients including for those with illnesses that typically require modification of diet. Significant malnutrition is noted as unrecognized on record reviews by both SIU and the Monitor. This is especially true for the elderly with dementia and with severe disabilities. This provision is partially compliant based on efforts to create a dietary manual and hiring a dietician consultant. Much work remains to be done.

Recommendations that reiterate the Implementation Plan were removed.

#### **RECOMMENDATIONS:**

1. The percentage of fat, protein, carbohydrates and sodium in diets should be calculated and documented for all master menus.
2. Inmates should have access to information on food components in their meals so that those inmates who must choose components based on their medical conditions can do so. This is especially true for diabetics but is also true for those with hypertension and high blood lipids.
3. Diet managers at facilities need supervision by and consultation access to a registered nutritionist/dietician.
4. Access to dietician/nutritionists can be by telemedicine or in person (individual and group) via hiring registered nutritionists/dieticians.
5. The therapeutic diet manual should be rewritten to include all therapeutic diets.
6. Mealtimes should be adjusted reasonably so as not to be a barrier to participation in meals.
7. The commissary food and snack panels must be evaluated and adjusted to include healthy choices appropriate for all inmates including those with diabetes.
8. The extremely low participation in eating meals and high use of commissary should be studied to evaluate how to improve consumption of healthy food. IDOC should analyze timing of meals, behavior, recipes, and preparation factors that may be resulting in the extremely low participation in meals.<sup>118</sup> Reasonable adjustments should be made to encourage healthy dietary patterns. This must be done in a manner that permits both a secure environment and nutritious meals that are eaten.
9. Policy, procedure, and practice should be established to ensure persons with diabetes have access to a registered nutritionist/dietician consistent with American Diabetes Association guidelines.
10. Policy, procedure and practice for all chronic care conditions should include evaluation of diet and access to appropriate referral to a registered dietician/nutritionist when indicated.

## **Intrasystem Transfers**

#### ***Addresses item III.D.1; III.D.2***

**III.D.1.** *With the exception of prisoners housed at Reception and Classification Centers, IDOC shall place prisoners with scheduled offsite medical services on a transfer hold until the service is provided, contingent on security concerns or emergent circumstances including, but not limited to, a lockdown. Transfer from Reception and Classification Centers shall not interfere with offsite services previously scheduled by IDOC.*

**III.D.2.** *When a prisoner is transferred from one facility's infirmary to another facility, the receiving facility shall take the prisoner to the HCU where a medical provider will facilitate continuity of care.*

**OVERALL COMPLIANCE:** Partial Compliance

#### **FINDINGS:**

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<sup>118</sup> An example of how this was done, albeit for schoolchildren, is the Centers for Disease Control School Health Guidelines to Promote Healthy Eating and Physical Activity found in Morbidity and Mortality Weekly Report Sept 16, 2011 as found at <https://www.cdc.gov/healthyschools/npao/pdf/mmwr-school-health-guidelines.pdf>. This document shows how behavior, food preparation and presentation promoted healthy eating.

The Monitor requested the following information from IDOC to aid in evaluation of compliance with III. D. 1 and 2 for this report:

- List of persons referred per facility for specialty care and placed on transfer hold from January through March 2023 listing the date the medical hold was placed. The Monitor suggests adding a column to the log of off-site specialty referrals to document the date a transfer hold is placed.
- For all incoming transfers who arrived at Stateville, Decatur, East Moline, Hill, Jacksonville, Murphysboro, and Taylorville, during the 3<sup>rd</sup> and 4<sup>th</sup> week of March 2023 provide copies of the intersystem transfer form, nurse reception note, documentation of documents received at receiving facility including medical record, problem list, MAR, health summary, active medications, and any referrals to chronic care clinic. If the patient was referred directly to a physician by the receiving nurse, the physician's note should be provided.
- Copies of the intrasystem transfer audits completed by receiving facilities and reported as part of the monthly CQI meeting.<sup>119</sup>

Records of incoming transfers were received from all the facilities listed above but in some cases the documents were incomplete.<sup>120</sup> The Monitor reviewed these records as well as the monthly reports that contain information about medical holds and intrasystem transfer audits. Records of persons who died in IDOC custody during the period covered by the 7<sup>th</sup> Report and other documents pertinent to continuity of care on transfer to another IDOC facility were reviewed.

The Monitor has received drafts of policy and procedure for intrasystem transfers and medical holds.<sup>121</sup> The Monitor's comments on both documents were to incorporate the items that had been included in Task 39 of the December 2021 draft version of Defendant's implementation plan into policy and procedure for intrasystem transfers.<sup>122</sup> The comments also addressed the issues related to medical holds that were discussed in the Monitor's last report.<sup>123</sup>

Six of the IDOC facilities have revised the offsite specialty care log to include the date a medical hold was placed.<sup>124</sup> Three of these facilities are in the Central Region, two are in the South, and one is in the Northern Region. It is not clear what the impetus was for these sites to act on the recommendation that this be included in the specialty care log, but the other sites are urged to adopt this practice as a means to document compliance with III.D.1. The offsite specialty logs from these facilities were reviewed and of 13 patients who were transferred in spite of having a medical hold, only one was listed on the offsite log at the receiving facility.<sup>125</sup> In addition, two of the charts reviewed had pending offsite referrals at the time of transfer in March 2023; one was for an

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<sup>119</sup> Monitor's documentation request dated 8/4/2023, items 69-71.

<sup>120</sup> Records sent from Hill only included the transfer summary (DOC 0090) and those from Murphysboro only included the nurses intake interview progress note (DOC 0084). Stateville only sent one record of a direct admit to the infirmary but there was no transfer summary. Without the other documentation requested it was not possible to evaluate continuity of patient care when transferred to these facilities.

<sup>121</sup> E.03.01 Intrasystem Transfer and Continuity of Care and E.10.01 Medical Holds. The Monitor had commented on an earlier draft of policy on transfers in August of 2020.

<sup>122</sup> Monitor's redline and comments on the 12/31/21 version of the Defendant's draft implementation plan submitted 9/27/2022. Task 39 is to develop guidelines and forms and procedures for transferring facilities to reconcile medications, problem lists, in-house referrals, coordinate continuity of care, documentation of handoff communication, coordination by OHS of patients with complex care needs, standardized procedures for transfer to ensure care continuity, and development of an audit instrument and education of staff.

<sup>123</sup> Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys, March 13, 2023, pages 68-69.

<sup>124</sup> Big Muddy, Illinois River, Jacksonville, Kewanee, Lawrence, and Lincoln.

<sup>125</sup> Transfer patient #37.

orthopedic evaluation and the other was a neurology consultation. Neither appear on the offsite specialty log at the receiving facility.<sup>126</sup>

Lincoln CC also records on the offsite log the date the medical hold expires. We applaud this improvement however the holds are routinely set at six to 12 months duration which seems to be an inordinately long time to hold a person at a single correctional facility.<sup>127</sup>

While there is a mechanism to place medical holds as required by III.D.1, few facilities have initiated documentation that the hold is placed when a specialty services are ordered. However, no guidance has been issued by OHS about medical holds, as of yet, and it does not appear that patients receive ordered specialty care when transferred to another IDOC facility.

Facility CQI minutes that are provided quarterly were reviewed, in particular the transfer study and CQI meeting minutes. During this report period only East Moline, and Murphysboro audited the condition of records received when patients were transferred to the facility. East Moline reported receiving files from Dixon and Graham which had drop filing. In CQI minutes Jacksonville discussed having difficulty having patient records arrive at the receiving facility and Sheridan, Danville, Big Muddy, and Centralia reported filing backlogs. Three of the charts reviewed did not have a transfer summary.<sup>128</sup>

The Monitor has recommended that the transfer audit tool be expanded to evaluate *continuity of care* as called out in III.D.2.<sup>129</sup> The tool should be revised to include the accuracy of the clinical information (diagnoses and medications) entered on the Health Status Transfer Summary (HSTS) DOC form 0090, whether the MAR was transferred concurrently, and that care was continued without interruption (medications, pending appointments and completion of referrals).

Documentation of transfer screening and continuity of care in the medical records of transfers received the 3<sup>rd</sup> and 4<sup>th</sup> week of March 2023 was reviewed.<sup>130</sup> There is considerable variation among facilities in the documentation of transfers. Murphysboro does not complete the receiving portion of HSTS. Instead, an intake interview is documented on DOC form 0084, effective in 2002. East Moline uses DOC form 0090 and documents an intake interview on DOC form 0194. Hill and Jacksonville use DOC form 0090 but document an interview and chart review on DOC form 0084. We commented in the 5<sup>th</sup> report that documentation on the receiving portion of the HSTS, form 0090, appears to be voluntary and there is no standardized practice for documentation of receiving screening and cited Dixon as an example of this variation.<sup>131</sup>

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<sup>126</sup> Transfer patients # 6 at Decatur and #22 at Taylorville.

<sup>127</sup> See the discussion in the Monitor's 6<sup>th</sup> report about complaints from patients who are prevented from transfers that would otherwise benefit them or their family on page 68.

<sup>128</sup> Transfer patients # 17, 21, 44.

<sup>129</sup> Health Care Monitor 2<sup>nd</sup> Report, Lippert v. Jeffreys, August 6, 2020, pages 78-79, Health Care Monitor 3<sup>rd</sup> Report, Lippert v. Jeffreys, February 15, 2021, page 57, Health Care Monitor 4<sup>th</sup> Report, Lippert v. Jeffreys, September 16, 2021, page 92, Health Care Monitor 5<sup>th</sup> Report, Lippert v. Jeffreys, June 22, 2022, page 73, Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys, March 13, 2023, page 69.

<sup>130</sup> Thirty records of transfers to Decatur, East Moline, Hill, Jacksonville, Murphysboro, Stateville, and Taylorville

<sup>131</sup> Health Care Monitor 5<sup>th</sup> Report, Lippert v. Jeffreys, June 22, 2022, pages 73-74.



HSTS forms were completed by RNs and LPNs at sending facilities on average four days before the transfer.<sup>132</sup> Receiving screening was completed by RNs at all facilities reviewed except at Hill where it is done by LPNs. Receiving screening requires independent assessment and clinical decision and is therefore outside the scope of practice for LPNs. A provider documented review of the charts of transferred in patients at East Moline and Taylorville. Two records of transfers to Stateville were direct admissions to the infirmary and in both cases, there is physician documentation the day of transfer but there was no evidence of direct communication from the provider at the sending facility.<sup>133</sup>

Critical information was missing on the HSTS in nine of the charts reviewed.<sup>134</sup> For example, one individual was transferred to Taylorville for recent onset of tremor and had a pending neurological appointment.<sup>135</sup> The tremor is not documented on the HSTS and neither is the fact that he uses a quad cane to ambulate. Another patient was transferred to East Moline.<sup>136</sup> The HSTS documents that he received routine mental health follow up, yet the purpose of transfer was to place him in a crisis cell. No information was provided about precipitating factors that led to the need for crisis placement.

Information about patients' medical problems or diagnoses was missing as evidenced by patients who were on medication without a supporting diagnosis on the problem list or HSTS.<sup>137</sup> Sometimes the HSTS had problems listed that were not on the problem list<sup>138</sup> or diagnoses that were on the problem list were not included on the transfer summary.<sup>139</sup> Sometimes the information about the patients' condition was so vague as to be meaningless. For example, one patient is described on the HSTS as having been "stabbed 2012" but nothing is documented about where he was stabbed, the nature of the injury, or present day complications.<sup>140</sup>

Discontinuity of patient care was evident in several of the transfers. Most frequently this was because bridge medications expired, or the receiving facility did not initiate medication timely.<sup>141</sup> One patient was to receive his monthly injection of antipsychotic medication three days after his transfer, but it was 50 days before he received it.<sup>142</sup> Other instances of discontinuity in patient care included the failure to note additional evaluation or follow up that needed to take place.<sup>143</sup> For example one patient was to have a follow up lab test to monitor response to treatment of syphilis that did not get noted or scheduled when the patient was transferred.<sup>144</sup>

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<sup>132</sup> The range was 0 to 23 days.

<sup>133</sup> Transfer patients # 25, 43.

<sup>134</sup> Transfer patients # 5, 7, 9, 10, 19, 22, 23, 25, 27.

<sup>135</sup> Transfer patient # 22.

<sup>136</sup> Transfer patient # 10.

<sup>137</sup> Transfer patients # 3, 11, 17.

<sup>138</sup> Transfer patients # 5, 6.

<sup>139</sup> Transfer patients # 7, 19, 22.

<sup>140</sup> Transfer patient # 27.

<sup>141</sup> Transfer patients # 1, 3, 18, 22, 24.

<sup>142</sup> Transfer patient # 24.

<sup>143</sup> Transfer patients # 1, 2, 9, 14, 16, 28.

<sup>144</sup> Transfer patient # 1.

Of 30 records sent that included information about the patient's subsequent plan of care, eight were referred to a provider appropriately<sup>145</sup> and 10 should have been referred.<sup>146</sup> One of these, for example, was a patient who had orders for serial blood pressure checks and a follow up visit with a physician at the time of transfer. His blood pressure the day of transfer was recorded by the receiving nurse as 132/96. Neither the patient's elevated blood pressure nor the orders for blood pressure monitoring resulted in scheduling an appointment with a provider at the receiving facility.<sup>147</sup> Elevated blood pressure readings taken by nurses at receiving facilities are routinely ignored.<sup>148</sup> No follow up blood pressure checks were scheduled or done, and no referrals made. For example, another patient's only problem was documented as "cardiac", and he was taking atenolol and hydrochlorothiazide. His blood pressure is documented as 146/90 at the receiving facility. The nurse did not ask him if he was taking ordered medication, when he was last seen by a provider, or retake his blood pressure. All of these would help to determine how urgent it was to be seen by a provider.

Patients who have complicated medical conditions are most at risk of discontinuity of care when transferred to another prison facility. One of the records reviewed was a patient who had hypertension, congestive heart failure, diabetes, hyperlipidemia, and end stage renal disease.<sup>149</sup> He was prescribed 12 different medications. Except for insulin, all his medications were "Keep on Person". He wore glasses and used a quad cane. He had a tremor and had been referred to a neurologist for evaluation. The HSTS doesn't list his diagnosis of congestive heart failure and neither the HSTS or the problem list document the presence of the tremor or that he used a cane. He was not allowed to bring the cane with him when transferred. At the receiving facility the nurse did not acknowledge the pending neurology appointment nor verify what medications he had or whether he was taking them correctly. Within two days after arrival at the receiving facility he should have received refills of ten of his medications, yet none are documented as being distributed to him the rest of that month. He asked for a cane but was told he would have to go without until it was ordered. An advanced practice nurse reviewed the chart eleven days later and did not acknowledge the pending neurology referral, the tremor or the patient's need for a cane. The APN also did not review the patient's medication compliance or inquire if he had received medications.

Another record reviewed was of a patient who was transferred from NRC to Graham on 5/15/2023.<sup>150</sup> This patient had been scheduled for dialysis on 5/11/2023 but this was cancelled because there was no transport vehicle. The physician was contacted upon the patient's arrival at Graham and ordered the patient sent to the ED for dialysis that same day. There was no documentation in the record of advance planning and handoff between medical providers at NRC and Graham to facilitate the continuity of this patient's care.

Another record reviewed was of a patient who died during the period covered by this report.<sup>151</sup> His problem list noted that he was seen in chronic clinic for HCV and hypertension. However, at the time of transfer the HSTS documents that he also has bilateral obstructive uropathy, benign prostatic hypertrophy with urinary retention- neither of which are on the problem list. He was admitted directly to the facility infirmary for a pending biopsy of the prostate. The physician writing the infirmary admission note painstakingly documents that the patient's chart had no records from the recent hospitalization for the obstruction and only every second page of the records of the urology office visits were included. His recent medical history and plan of care are not well summarized on the HSTS. Current treatment is noted as a foley catheter, follow up care is "as recommended", specialty referral is "urology". The physician reviewing the chart wrote a four page note attempting to reconstruct the

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<sup>145</sup> Transfer patients 4, 8, 9, 10, 11, 12, 13, 21.

<sup>146</sup> Transfer patients # 3, 5, 6, 7, 14 -17, 20, 29.

<sup>147</sup> Transfer patient # 16.

<sup>148</sup> Transfer patients # 14, 16, 20, 26, 29, 30, 31.

<sup>149</sup> Transfer patient # 22.

<sup>150</sup> Transfer patient #45.

<sup>151</sup> Transfer patient # 25.

chronology of the patient's medical history. This patient had recently been hospitalized for acute kidney failure which is not mentioned on the transfer summary. There was no evidence of communication between providers at the sending and receiving facility to ensure this patient's continued care.

In conclusion IDOC there does appear to be an institutional practice that allows medical holds to be placed, however there are no written instructions to guide this practice. We found evidence that patients transferred with pending appointments or treatments are often lost to follow up after transfer. The IDOC does not monitor the use or appropriateness of medical holds. We also found failures to seamlessly transfer complete and relevant information about the patient along with the medical record and medication administration record (MAR) with notable risk in the interruption of needed care. Neither does IDOC monitor continuity of care when patients are transferred from one facility to another. Recommendations are unchanged from the Monitor's 6<sup>th</sup> Report.<sup>152</sup>

## **RECOMMENDATIONS:**

1. Finish the policy and procedure and ensure that the means and methods to carry out III.D. 1 & 2 are detailed, develop performance measures, and monitor performance to document compliance with the Consent Decree. The procedure should define what steps the sending facility is to take in documenting pending referrals, identifying tasks not yet completed, reconciliation of medication lists, and detailing current medical and mental health problems. The procedure needs to do the same with regard to specifying the receiving facility's obligation to verify the transfer information, examine the patient and document actions taken to continue ongoing care and address new problems.
2. Augment the scope of the Medical Record Transfer study to include the concurrent transfer of the MAR, evaluate the accuracy of the clinical information (diagnoses and medications) entered on the Health Status Transfer Summary and whether there is any discontinuity in the plan of care in the immediate days after arrival at the receiving facility.
3. The receiving screening form should be revised to coincide with the revised policy and procedure on intrasystem transfers. We have suggested the form include the time the person arrived at the receiving facility in addition to the time the nurse reviewed the record. The time elapsed from arrival to transfer screening at the receiving facility should be less than six hours.
4. If someone refuses receiving screening the nurse should document observation of the person's condition, review of the records sent from the sending facility, and the disposition of the person when this review is completed. Documentation that receiving screening was refused is insufficient.

## **Medical Reception**

### **Nurse Intake Screening and Health Assessment<sup>153</sup>**

#### ***Addresses Items II.A; II.B.1; II.B.6.a; III.C.1***

**II.A.** *Defendants shall implement sufficient measures, consistent with the needs of Class Members, to provide adequate medical and dental care to those incarcerated in the Illinois Department of Corrections with serious medical or dental needs. Defendants shall ensure the availability of necessary services, supports and other resources to meet those needs.*

**II.B.1.** *IDOC shall provide access to an appropriate level of primary, secondary, and tertiary care*

**II.B.6.a** *IDOC agrees to implement changes in the following areas: Initial intake screening, and initial health care assessment*

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<sup>152</sup> Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys, March 13, 2023, page 72.

<sup>153</sup> Dental intake screening is addressed in the dental section of the report.

**III.C.1.** *IDOC shall provide sufficient nursing staff and clinicians to complete medical evaluations during the intake process within seven (7) business days after a prisoner is admitted to one of IDOC's Reception and Classification Centers.*

**III.C.3.** *IDOC shall ensure that a clinician or a Registered Nurse reviews all intake data and compiles a list of medical issues for each prisoner.*

**III.C.4.** *If medically indicated, IDOC shall ensure follow up on all pertinent findings from the initial intake screening referenced in C.3. for appropriate care and treatment.*

**OVERALL COMPLIANCE RATING:** Partial Compliance

**FINDINGS:**

The Monitor requested the following information to evaluate the items in the Consent Decree related to Medical Reception.

1. For providers, the documentation of assignments for intake health assessments for the month of May 2023.
2. Provide copies of health records for 20 new admissions to NRC and 10 admissions for each of Menard, Logan, and Graham for the month of March 2023. Records to be sent include the problem list, data base, intake screening forms, medical history, physical examination, dental exam and instruction in oral hygiene, health assessments, and corresponding progress notes, orders, and results of diagnostic testing for the first 45 days following the reception date.<sup>154</sup>

The Monitor also visited Graham Correctional Center, which is one of four Reception and Classification Centers, on July 17-19, 2023, to tour the physical facility and review health records of persons newly admitted to the IDOC. IDOC currently conducts no clinical quality reviews of the initial health assessment and has provided no plans for this in the near future. Therefore, the evaluation of compliance is based upon conclusions drawn from the site visit to Graham CC, review of 30 intake records from intakes received in March 2023, review of mortality records, monthly reports, memos to the Monitor, and other documents provided since the last report.

A finding of partial compliance with II.B.6.a was made in the Monitor's 5<sup>th</sup> report based upon the fact that IDOC had drafted a policy and procedure for medical reception, increased positions allocated to the intake centers, and initiated IGRA testing in screening for tuberculosis infection as part of medical reception.<sup>155</sup> The Monitor's 6<sup>th</sup> report found no additional progress had been made by IDOC in changing the processes for initial intake screening and health care assessment.<sup>156</sup>

IDOC has yet to address the staffing disparity among intake centers and does not use a workload driven metric to allocate positions. Incomplete staffing information was provided by IDOC for this report.<sup>157</sup> The Monitor's 5<sup>th</sup> Report in 2022 documented the addition of some positions at the four reception centers.<sup>158</sup> However 33% of the primary care positions and 43% of the dentist positions were vacant at the reception centers at the end of June 2023.

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<sup>154</sup> Monitor's documentation request dated 8/4/2023, items #40 and #73. Twenty-eight facilities sent provider assignments in response to item #40. Menard, Logan, and Graham sent a total of 30 useable medical records of new admissions. NRC sent none with the explanation that no one was still at the facility 45 days after admission.

<sup>155</sup> Health Care Monitor 5<sup>th</sup> Report, June 22, 2022, page 75.

<sup>156</sup> Health Care Monitor 6<sup>th</sup> Report, March 13, 2023, page 74.

<sup>157</sup> No information was provided by IDOC to account for the status of allocated state positions for this report. The vendor, Wexford, did provide information on positions allocated, filled and vacant as of 6/30/2023.

<sup>158</sup> Health Care Monitor 5<sup>th</sup> Report, June 22, 2022, page 75. Logan added a physician position, NRC added 1.5 NP/PA and Menard added 1 NP/PA.

All four of the Reception and Classification Centers sent the physician assignment sheets for the month of May 2023 but they were uninformative with regard to the adequacy of staffing or evaluation of workflow. At Graham, all the physician's assistants and nurse practitioners are responsible for intake, with no one specifically assigned. At Logan a specific nurse practitioner is assigned responsibility for intake. At Menard a specific nurse practitioner is responsible for intake but does chronic clinic as well. At NRC, the site medical director is listed as responsible for intake three or four days a week, however the intake records reviewed were all completed by nurse practitioners. The assignment sheets verify record review findings that physician involvement in the initial health assessment and plan of care is minimal to non-existent.

The Consent Decree includes one measure of the adequacy of staffing for medical reception; whether the intake process is completed within seven (7) business days after a prisoner is admitted to one of IDOC's Reception and Classification Centers (III.C.1.). This metric is not reported by the reception and classification centers, is not monitored as part of quality improvement, and is not a performance and outcome measure. Only 27% of the intake records reviewed for this report had the medical evaluation completed within this timeframe.<sup>159</sup> Further, labs were not available at the time of the initial health care assessment in 15 – 20% of the charts reviewed. The lack of timeliness completing medical reception and the lack of data with which to make informed decisions about patient care impedes access to an appropriate level of care (II.B.1). Reception screening needs to be completed timely, but the provider must have labs and other pertinent diagnostic results available for review during the health assessment in order to thoroughly assess the patient's health status and determine the plan of care. This is why the Monitor has suggested the reception process be re-designed.<sup>160</sup> The redesign of medical reception needs to result in a thorough evaluation of every patient and the initiation of a comprehensive plan of care.

A re-design of the intake process must incorporate the Consent Decree and Implementation Plan requirements. The Consent Decree items are listed above. The Implementation Plan includes three additional items that concern the process and outcomes of medical reception. One of these is item 54 that describes improvements to the program of *chronic care*, subtask 16. *Intake assessment* to conclude with an *initial assessment and therapeutic plan for all chronic illnesses*. Other sections of item 54 relevant to the initial assessment and therapeutic plan include:

1. Ensuring that *chronic problems* are accurately **entered** into the medical record *problem list* by providers.
3. Ensuring that *adequate history is taken*, and analysis of why adequate histories are not currently obtained.
4. Ensuring that there is an *assessment and therapeutic plan for each problem*.
8. That *immunizations* are routinely *tracked* updated with use of a reliable immunization tracking mechanism (e.g., I-CARE).
11. That *laboratory tests are* documented as *reviewed and are ordered* when indicated by the patient's condition or as directed by Disease Management Guidelines.

The second is **Implementation Plan item 28** to *assess immunization and RHM/cancer screening status at intake and update immunizations/RHM/cancer screenings prior to conclusion of the intake process*.

The third is **Implementation Plan item 88** which is to *Develop a standardized protocol for patient treatment at the reception center to ensure*: (the four subitems (3, 4, 5, and 6) pertinent to medical include):

3. *Chronic and acute illnesses and dental conditions are listed on a problem list*.

<sup>159</sup> Only eight of 30 records received in response to document request #73 were completed timely (27%). In none of five records reviewed at Graham was intake completed within seven days. Death records that were reviewed from NRC all documented completion of the medical reception in less than seven days.

<sup>160</sup> Health Care Monitor 6<sup>th</sup> Report, March 13, 2023, pages 79-80

4. *Problem lists are completed by providers.*
5. *Medical and dental history and physical examinations are completed.*
6. *Patients receive initial medical and dental treatment plans and timely referrals for evaluation and development of comprehensive medical and dental treatment plans based on acuity.*

The existing intake process and practice is outlined in Administrative Directive 04.03.101 as the first periodic examination of inmates entering IDOC. This Administrative Directive does not adequately address requirements of the Consent Decree and Implementation Plan. It separates taking a history, (which is assigned to “trained staff” documenting on an Offender Medical History form DOC 0092), from the intake physical examination, (which is completed by a provider on the Offender Physical Examination form DOC 0099). This legacy design and associated forms (DOC 0092 and DOC 0099) and practices have resulted in several problems related to Consent Decree and Implementation Plan requirements including:

- Nurses and providers are not given direction to ensure coordination in addressing all the needs of the patient;
- Nursing histories fail to gather all necessary information about the patient and providers take virtually no history of the patient’s conditions;
- Failure to address immunization and periodic screenings recommended by the United States Preventive Services Task Force (USPSTF) and the Centers for Disease Control Advisory Committee on Immunization (ACIP);
- Failure of providers to maintain the problem list;
- Failure of providers to address immediate medical needs of the patient the day of reception; and
- Failure to develop an initial comprehensive plan of care for medical patients after review of all laboratory and radiologic testing and after review of all nursing assessments and treatments;

IDOC has developed an initial draft policy and procedure that included receiving screening<sup>161</sup> as part of its efforts initiated earlier this year to complete a comprehensive set of policies and procedures. The Monitor provided initial feedback on the draft in April 2023. A second draft policy, E.05.01 Intersystem Receiving Screening, was provided in August 2023 and has yet to be commented on by the Monitor.

The re-design of medical reception needs to include a new intake form and the following elements which the Monitor will include in comments to the draft policy.

- More comprehensive information gathering and nursing management **by registered nurses** to include:
  - Immunization histories to include updating vaccinations from the ICARE database;
  - Giving necessary immunizations;
  - Status of patient’s need for gender/age specific screening consistent with United States Preventive Health Services Task Force (USPSTF) A & B recommendations;
  - Cardiac risk factor history (including comprehensive smoking history);
  - Obtaining information from civilian medical providers, when indicated;
  - Inventory of medical conditions;
  - Inventory of current medications;
  - Obtaining vital signs and necessary point of care screening (capillary blood glucose, peak expiratory flow rate, oxygen saturation, etc. as indicated);
  - Gross vision and auditory screening and referrals for abnormalities;
  - Ensuring patients have laboratory tests completed per intake protocol;
  - Identification, by way of nursing assessment, of those patients who need an immediate provider evaluation;
  - Coordination with providers on the day of intake regarding laboratory, and other medical orders

<sup>161</sup> Draft IDOC policy and procedure E.03.01 Intrasystem Receiving, Transfer, and Continuity of Care Screening received 3/15/23.

- (medications, disability accommodation, special housing, etc.) specific for the patient's needs and in preparation of the comprehensive medical evaluation appointment; and
- A nursing assessment to determine the urgency of referral to providers for timely comprehensive examination.
  - A brief history and physical examination **by a provider on the day of intake** for all persons with serious or unstable illness or who need immediate medical attention for the following:
    - Review of abnormal vital signs and point of care testing;
    - Ensuring necessary laboratory and radiologic tests are ordered based on the patient's condition and that exceed protocol routine laboratory testing; and
    - Orders for necessary treatment, medication, disability accommodation or housing that cannot wait until the comprehensive examination.
  - A comprehensive history and physical examination by a provider **based on acuity before seven days** to include:
    - Evaluation of patients in sequence based on the urgency of nurse referral;
    - Review of all nursing-gathered data based on protocol and results of ordered treatments;
    - Performance of a **provider history** and physical examination consistent with the needs and conditions of the patient;
    - Review of all laboratory and radiologic testing ordered on the day of intake;
    - A complete history, examination, and assessment with a medical plan of action for each problem resulting in development of a comprehensive medical treatment plan; and
    - Evaluation of the need for physician orders for life-sustaining treatment (POLST) when indicated.

The Monitor recommends a separate dental reception screening policy. See the section on dental screening.

Findings from record review indicate that medical reception has not changed during the course of the Consent Decree and that evidence of progress toward completion of the tasks in the Implementation Plan delineated above is minimal. A total of 42 records from three sources were reviewed to evaluate the adequacy of Medical Reception. Thirty records were received from three of the four Reception and Classification Centers in response to the Monitor's documentation request #73. These were intakes received in March 2023. The average age of this group of patients was 34; only four were 45 years and or older and only eight had a chronic or urgent medical condition; therefore, the sample was a relatively healthy population. The initial intake screening and health care assessment in seven mortality records were reviewed because the date of death was within a year or less of intake. These were intakes received from 3/2022 through 3/2023. Six of these were persons who had been received at NRC. The average age of these patients was 38 and three were 45 years or older. Five of the seven mortality review charts were patients who had a chronic or urgent medical condition at the time of admission. Finally, five records of patients over age 50, received on intake in June 2023 at Graham were reviewed during the site visit.

The only facility which consistently documented a full set of vital signs, including vision screening, during reception screening was Menard.<sup>162</sup> Graham consistently documents all vital signs except vision screening.<sup>163</sup> Five of ten charts reviewed from Logan had no documentation of vital signs on the initial intake screening,<sup>164</sup> four charts lacked documentation of vision screening,<sup>165</sup> and one had no temperature or vision screening.<sup>166</sup> Only one of the seven mortality charts reviewed was without documentation of a full set of vital signs.<sup>167</sup>

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<sup>162</sup> There was one chart from Menard that only documented height and weight. Reception patient #23.

<sup>163</sup> Reception patients #1-10, 38- 39, 41-42.

<sup>164</sup> Reception patients # 13-16, 20

<sup>165</sup> Reception patients # 11-12, 17, 19

<sup>166</sup> Reception patient # 18

<sup>167</sup> Reception patient # 31

While Graham and Menard records had consistent documentation of an immunization history, documentation at Logan and NRC continues to be inconsistent. There was no evidence in any of the intake records reviewed that I-CARE, the Illinois vaccine registry, was checked at any time before completion of medical reception. Admission labs and diagnostic procedures were routinely initiated at the initial intake screening. These include blood tests for tuberculosis, HIV, hepatitis C, and syphilis infection, a comprehensive metabolic panel, and for women, a urine pregnancy test.

There still is no guidance as to which conditions reported during intake screening should prompt a request to obtain previous records. No requests for previous records were initiated as a result of initial intake screening among the charts reviewed. Of 30 intake records received in response to the Monitor's document request, item #73, 16 should have had a request for previous records initiated. These included individuals who had a recent suicide attempt or other traumatic injury, current treatment for multiple chronic conditions, or current treatment for psychiatric disorders.<sup>168</sup> Six of the seven mortality records reviewed should have documented initiation of requests for previous records.<sup>169</sup> All five of the intakes reviewed while at Graham should have had additional health information sought. One of these was because of a recent colostomy reversal with an open area at the site of the colostomy; he also gave a history of traumatic brain injury.<sup>170</sup> Two individuals gave a history that included treatment for cardiac disease.<sup>171</sup> One was an insulin dependent diabetic with elevated blood pressure.<sup>172</sup> The fifth came with multiple medications for treatment of hypertension (Tadalafil, HCTZ, Nebivolol, Lisinopril, and Norvasc) but gave an unclear history.<sup>173</sup>

There is little to no documentation of follow up questions to elicit more information when patients report a significant physical or mental health condition. For example, one patient sustained a head injury two years earlier and there was no further inquiry about the nature of the injury, treatment received, or any ongoing symptoms.<sup>174</sup> This patient also reported being a diabetic and having asthma. No information was solicited about symptoms of these conditions and no point of care testing was done.<sup>175</sup> Another patient reported having hypertension and there was no further inquiry about current or past treatment of hypertension. Twenty-two days later at the initial health assessment the patient's blood pressure was 160/88.<sup>176</sup> When patients report taking medications for certain medical or mental health conditions there also was no attempt to elicit the corresponding medical history.<sup>177</sup> There were numerous examples of persons with abnormal findings, for whom there was no follow up or the problem was not identified. These include persons with hearing or vision deficits, elevated blood pressure readings coupled with a history of hypertension, an asthmatic with irregular respirations, and recent reports of disease exacerbation or acute injury.<sup>178</sup> As an example, one patient gave a history of asthma, diagnosed in 2015 and reported the last asthma exacerbation was a month earlier. The nurse did not document a medical referral and did not obtain bridge orders for either of the two medications she reported taking at the time of admission.<sup>179</sup>

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<sup>168</sup> Reception Patients #1, 3-5, 7,9, 11, 14-19, 21, 23, 26, 31-34, 36-37.

<sup>169</sup> Reception patients #31-34, 36-37.

<sup>170</sup> Reception patient #38.

<sup>171</sup> Reception patients #39, 40.

<sup>172</sup> Reception patient #41.

<sup>173</sup> Reception patient #42.

<sup>174</sup> Reception patient #19.

<sup>175</sup> Peak flow and capillary blood glucose would have been appropriate point of care tests to complete.

<sup>176</sup> Reception patient #12.

<sup>177</sup> For example, one patient gave a history of mental health treatment and was currently taking Zyprexa, an antipsychotic medication and Remeron, an antidepressant medication. The nurse did not attempt to expand upon the patient's mental health history; if so, three or four previous suicide attempts would have been identified (Reception patient #35). Another patient was taking ferrous sulfate, an iron supplement and prazosin, an antihypertensive medication but the only medical history documented by the nurse was mental health treatment and dry skin (Reception patient #15). See also Reception patient #17,

<sup>178</sup> Reception patients # 2, 6, 10, 14, 16, 19, 32 and 34.

<sup>179</sup> Reception patient # 16.



Five of the 30 records received in response to item #73 had an urgent condition but were referred routinely.<sup>180</sup> Five of ten intake records from Logan had no referral urgency documented and two of these should have been considered urgent mental health referrals.<sup>181</sup> Four of the seven mortality records reviewed should have been referred urgently and were not.<sup>182</sup> Of the five records reviewed at Graham, three should have been referred urgently.<sup>183</sup> When these omissions<sup>184</sup> are considered individually they may not be significant, however the collective frequency indicates that intake screening does not accurately and thoroughly identify persons with conditions that require initiation of essential health care and treatment.

III.C.3 of the Consent Decree requires that a clinician or Registered Nurse reviews all intake data and *compiles a list of medical issues* for each prisoner. Of the records received in response to the Monitor's documentation request only those from Menard consistently demonstrate the providers' development or use of the problem list. There also has been no improvement in the accuracy or completeness of patient problem lists. The word "psych" or "MH" continues to be listed on the problem list rather than a recognizable psychiatric diagnosis.<sup>185</sup> Diagnosed medical conditions are often not listed on the problem list either.<sup>186</sup> For example, a 50 year old man was listed as having hypertension, depression, and a hernia on the problem list, yet he was treated for hyperlipidemia and GERD, which are not on the problem list. Further the provider who completed the initial health care assessment diagnosed obesity but did not add it to the problem list.<sup>187</sup> Another patient gave a past medical history of anemia, pancreatitis, and hypertension but none of these diagnoses are on the problem list.<sup>188</sup> Generic diagnoses such as diabetes, asthma, and thyroid disorder are often used on the problem list when they would be more informative if a more detailed diagnostic statement were made. Problem lists also did not routinely identify patients with hearing or vision deficits.<sup>189</sup>

The initial health care assessment by a provider took place, on average, 28 days after intake health screening in the 30 records received in response to the Monitor's documentation request. Of the seven mortality records reviewed, two patients expired before the initial health assessment took place. The remaining patients were all received at NRC and the initial health assessment was the same day as intake for three, one patient was seen the next day, and the fifth patient was seen three days later. The initial intake screening took place on average within 15 days in the five charts reviewed during the Graham site visit.

Only 20% of the records received in response to the Monitor's documentation request included a thorough history and examination. Furthermore, the plan of care did not address all of the findings from initial screening and the health care assessment as required by III.C.4. The history and physical exam was incomplete in all five intake records reviewed while at Graham, clinical conditions were not all identified and assessed appropriately; therefore, the plan of care was inadequate.<sup>190</sup> None of the mortality records reviewed had an adequate initial

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<sup>180</sup> Reception patients # 5, 7, 9, 11, 23.

<sup>181</sup> Reception patients #11, 15-19.

<sup>182</sup> Reception patients # 32, 34-35, 37.

<sup>183</sup> Reception patients # 38, 41- 42.

<sup>184</sup> Incomplete vital signs, lack of immunization history, failure to elaborate or follow up on abnormal findings, and failure to identify the need for urgent referral.

<sup>185</sup> Reception patients # 3, 5, 9, 13, 19, 23, 24,

<sup>186</sup> Reception patients #1,10-13, 15-16, 22, 29, 32, 34, 36.

<sup>187</sup> Reception patient #1.

<sup>188</sup> Reception patient #16.

<sup>189</sup> Reception patients # 2, 14, 29, 34

<sup>190</sup> Reception patients # 38 -42. Each of the patients whose chart was reviewed gave a history of injury or disease that should have been further described or elaborated on and was not. For example, # 41 reported having diabetes and high blood pressure. The history and physical provides no additional information about these diseases except current symptoms (blood pressure reading and blood glucose

health care assessment.<sup>191</sup> As an example, one patient told the provider he had been diagnosed with hypertension three months earlier. The provider listed hypertension on the problem list and ordered propranolol, a medication used to treat hypertension. Despite the diagnosis, the only blood pressure reading taken was at intake screening (119/77). No further history or assessment of his condition was performed at that time. The provider did not order serial blood pressure readings or labs, did not note that the patient was obese (BMI 40), and did not schedule the patient for even a baseline evaluation in chronic clinic.<sup>192</sup>

The current practice, based on policy, that nurses complete the medical history must be changed. The nurse *should* gather information about the patient's medical conditions and complete a nursing assessment, but this is to determine if the patient is contagious or needs care initiated immediately, to determine if outside records need to be requested, and the urgency with which the provider needs to see the patient for the health assessment. In order to *develop a comprehensive plan of care* the provider must be responsible for elucidating a comprehensive history of the patient's medical problems and cannot rely solely on the nurse's intake screening.

Only Menard and Graham provided lab results from intake screening in the charts that were sent in response to the Monitor's documentation request (N=20). Of those only three patients were seen for the initial health care assessment before the results of testing had been received.<sup>193</sup> None of the five mortality review charts from NRC documented review of IGRA screening by a provider when the initial health care assessment was completed.<sup>194</sup>

Preventive health screening during medical reception is inconsistent. As noted earlier in this section completion of the immunization history is sporadic. Of records sent in response to the Monitor's request results varied by facility. At Graham seven of 10 admissions in March 2023 were offered COVID vaccine. While one consented, all others refused.<sup>195</sup> Documentation of the administration of the one accepted vaccine was not included in the records sent. No other vaccines were offered. At Logan, four of ten patients reported having received all eligible vaccines. No vaccine was offered to the remaining six patients.<sup>196</sup> At Menard vaccine for hepatitis A and B was offered to eight of ten patients; one patient accepted and received these vaccines.<sup>197</sup> No other vaccines were offered. COVID and influenza vaccine was documented as offered to five of six patients whose death chart was reviewed, and one patient was offered hepatitis B vaccine. Only one person accepted a COVID vaccine.<sup>198</sup>

Two patients were eligible by age and history to be screened for lung cancer which was not offered.<sup>199</sup> Four patients were eligible by age for colorectal cancer screening which was not offered at the initial health care assessment.<sup>200</sup> Another patient, who was 40 years of age, gave a history of having a colonoscopy two years earlier. There was no further elaboration in the medical history as to the reason or results of this procedure and no plans for future testing were included in the patient's plan of care.<sup>201</sup> None of the patients whose chart was reviewed for this section of the report was old enough to be referred for screening for abdominal aneurysm. For women,

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readings). Another example is #38 who gave a history of a recent reversal of a colostomy. The abdomen was documented as normal on exam and the reason for the colostomy not stated.

<sup>191</sup> Reception patients # 8, 12, 20, 24-25, 28, 31-36.

<sup>192</sup> Reception patient # 32 was a 24 year old male who expired three and a half months later from hypertensive cardiovascular disease. A psychiatric provider ordered labs to monitor for metabolic syndrome about six weeks later. These labs were returned with abnormal results (increased lipid levels and elevated TSH) but even when reviewed by a provider did not prompt any further assessment.

<sup>193</sup> Reception patients # 27, 29, and 30.

<sup>194</sup> Reception patients #31-34, 36.

<sup>195</sup> Reception patient #2 accepted. Reception patients #4-5, 7-10.

<sup>196</sup> Reception patients #13-15, 17, 19-20.

<sup>197</sup> Reception patient #21 accepted. Reception patients # 23, 25-30 refused.

<sup>198</sup> Reception patients #31-32, 34, 35, 36.

<sup>199</sup> Reception patients #1 and 29.

<sup>200</sup> Reception patients #1,6, 28, 29.

<sup>201</sup> Reception patient #2.

symptoms of pregnancy are screened at the initial intake screening and a urine pregnancy test ordered. All but one of the charts reviewed documented offering a pap smear.<sup>202</sup> None of the women in the charts provided in response to the Monitor's documentation request were eligible by age alone for mammography. Three patients gave a family history of breast cancer, which in one of the charts reviewed was not elaborated on. However, this patient also had a breast lump on palpation and an ultrasound was ordered.<sup>203</sup> As noted in the prevention section of this report, a smoking history is seldom identified in medical records.

IDOC currently conducts no clinical quality reviews of medical reception and has provided no plans for this in the near future. No changes have been made to initial intake screening or the initial health care assessment. Staffing of reception centers is insufficient as measured by the lack of timeliness and inadequacy of the initial intake screening and health care assessment and the initiation of plans for subsequent health care. There have been no improvements accomplished during this report period in medical reception.

## **RECOMMENDATIONS:**

1. Redesign the medical reception process that ensures:
  - a. All findings and treatments from nurse intake health screening are evaluated by providers,
  - b. Ensure that prior records are requested and available to providers as needed during the initial health care assessment.
  - c. Immunization history should be designed into the reception screening process and be part of nurse information gathering. By protocol or physician review, immunizations should be updated and vaccines given by nursing staff based on the Advisory Committee on Immunization Practice (ACIP) and Center for Disease Control (CDC).
  - d. Nurses, as part of their information gathering, identify what cancer screenings are necessary based on USPSTF A & B recommendations. This information is used by providers to order cancer screening as part of the comprehensive treatment plan.
  - e. All patients have their status of preventive measures updated based on the A & B recommendations of the USPSTF.
  - f. All medical problems are identified and entered onto a problems list by providers,
  - g. For every medical problem ensure that providers document an adequate history, focused physical examination, assessment, and therapeutic plan. The assessment of chronic conditions shall include complications, including hospitalizations, with chronic disease markers, documentation of the most recent civilian therapeutic plan, and medication history.
  - h. All intake laboratory and other diagnostic tests are evaluated at the comprehensive medical evaluation by providers as part of the intake process, and
    - i. Patients are enrolled in chronic clinic for all of their chronic medical conditions.
2. Finalize the policy and procedure on medical reception consistent with the process map and metrics; then implement it.
3. Develop a staffing standard for receiving screening that is workload driven.
4. The Monitor acknowledges that IGRA testing is now established at all Reception Centers. The Monitor recommends that IDOC adopts IGRA testing for all inmate tuberculosis screening.
5. The intake screening should document the patient's history of smoking, the number of pack-years smoked, and if the patient has quit smoking, the year that smoking was stopped. Without this information on tobacco use, it will be impossible to determine which individuals require screening for lung cancer. This information is also useful as a cardiac risk assessment.
6. IDOC should add universal hepatitis B screening (HBsAg, antibody to HBsAg, and total antibody to hepatitis

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<sup>202</sup> Reception patient #17.

<sup>203</sup> Reception patient #14.

B core antigen) to the routine laboratory testing performed at intake screening in conjunction with a hepatitis B vaccination program.

7. Develop a clinical audit tool that evaluates the appropriateness, quality, and continuity of health care during medical reception as well as compliance with the policy and procedure. Audit medical reception with this tool (s) at least quarterly until performance is better than 90% on each criteria for three successive quarters.
8. Develop metrics to provide information on the timeliness and thoroughness of medical reception (III. C. 1, 3 & 4) and report performance results to CQI on a regular basis.
9. Providers will develop a comprehensive treatment plan when the nurse has concluded information gathering. This plan is completed when screening laboratory tests are completed.
10. Nurses are to contact providers for phone orders for all medications, treatments, accommodations, or protected housing on the day of arrival for all patients to ensure continuity of treatment. Provider will perform a preliminary evaluation of all patients assessed by nurses as needing earlier evaluation because of the seriousness of their condition.

## Nursing Sick Call

**Addresses Items II.A; II.B.1; III.A.10; III.E.2; III.F.1; III.F.2;**

**II.A.** Defendants shall implement sufficient measures, consistent with the needs of Class Members, to provide adequate medical and dental care to those incarcerated in the Illinois Department of Corrections with serious medical or dental needs. Defendants shall ensure the availability of necessary services, supports and other resources to meet those needs.

**II.B.1.** IDOC shall provide access to an appropriate level of primary, secondary, and tertiary care

**III.A.10.** Each IDOC facility shall have registered nurses conducting all sick calls. Until IDOC has achieved substantial compliance with nursing provision of the staffing plan, facilities may use licensed practical nurses in sick call, but only with appropriate supervision.

**III.E.2.** Lists and treatment plans will be amended pursuant to the order of a clinician only.

**III.F.1.** Sick call shall be conducted in only those designated clinical areas that provide for privacy and confidentiality, consistent with the extraordinary operational concerns and security needs of IDOC including, but not limited to a lockdown.

**III.F.2.** There shall be no set restrictions on the number of complaints addressed during a specific sick call appointment. Medical providers must use their medical judgment to triage and determine which issues should be evaluated and treated first to maximize effective treatment and relieve pain and suffering.

**OVERALL COMPLIANCE RATING:** Partial compliance

### FINDINGS:

The following information was requested from IDOC to evaluate progress towards compliance with the items of the Consent Decree listed immediately above:

1. Nurse assignment sheets. Provide daily assignment sheets used at the facility to assign nurse staff to their daily work. Daily assignment sheets for any 7 day period in May or June 2023 from NRC, Graham, Menard, Logan, Stateville, Centralia, and Pontiac.<sup>204</sup>
2. Provide nurse training and credentials' verification in the last 12 months for six individuals from Centralia, JTC, Lawrence, Pinckneyville, Sheridan, Stateville.<sup>205</sup>

In addition to the material received from the list above, CQI minutes were reviewed as well as the results of the performance audit conducted by SIU that included responsiveness to health care requests. During the site visit to

<sup>204</sup> Item 43 Monitor's documentation request dated 8/4/2023.

<sup>205</sup> Item 51 Monitor's documentation request dated 8/4/2023.

Graham on July 17 – 19, 2023 sick call was observed, and records of sick call encounters were reviewed. Death records received during this report period were also reviewed.

The Defendants' Implementation Plan has IDOC initiating four process improvement projects, one of which is the improvement of the sick call process. Implementation Plan item 51: ***Initiate process improvement projects by focusing on key problems related to Consent Decree: medication administration, sick call, improving access to specialty care, improving chronic care delivery. Process analysts will systematically map all steps and procedures of specified processes; analyze input, process, and output using root cause analysis; determine the desired output; make the process more efficient, with fewer errors, and in line with the movement towards compliance with the Consent Decree.***

***Proposed end date: January 2024***

The Monitor has yet to be informed of a process analyst responsible for the sick call process improvement project. The Monitor understands that SIU has staff qualified to facilitate process analyses, but none are specifically assigned to this project yet.<sup>206</sup>

The specific steps in the ***process improvement project for sick call*** are listed in Implementation Plan item 53 and are the following:

1. ***Timely monitoring of access and identification of barriers to access sick call. Establish standardized process to review and account for addressing access issues.***
2. ***Identify inefficiencies in the sick call process and reassign work, revise procedures, or obtain staffing necessary for timely responses to sick call requests.***
3. ***Define and establish the resources necessary to promptly achieve a face-to-face encounter with a registered nurse.***
4. ***Identify the methods and practices needed to fully address patient requests including how to document the patient's presenting complaint in their own words, and those with multiple requests.***
5. ***Revise the use of nursing protocols to include limitations on their use with patients who require close clinician monitoring, elimination of the protocol for Non-Specific Discomfort and design a process for the periodic review and revision of treatment protocols based upon CQI, performance and audit data.***
6. ***Establish a methodology to train registered nurses in the use of treatment protocols and practice clinical judgment with supervision until initial competency is established and the methods to determine the continuing competency of nurses assigned to sick call.***
7. ***Establishing tools to monitor performance and quality of sick call.***
8. ***The results of the process improvement project will be revised policy and procedure for sick call, clear definitions of the staffing and resource requirements needed to conduct sick call, training and supervision of nurses to ensure appropriate clinical assessment and decision making using the nursing protocols, limiting the use of protocols in patient populations requiring monitoring by clinicians, and audit methods to monitor and account for compliance with the Consent Decree, procedures and protocol.***

***Proposed End Date: March 2024***

The following is the Monitor's evaluation of IDOC's progress toward completion of each step involved in item 53 of the Implementation Plan.

1. ***Timely monitoring of access and identification of barriers to access sick call. Establish standardized process to review and account for addressing access issues.***

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<sup>206</sup> Interview with the Executive Director, Office of Correctional Medicine, SIU, 10/18/2023.

The IDOC, with its partner SIU, monitors documentation of timeliness in following up on sick call requests.<sup>207</sup> This tool measures whether sick call is completed according to the timelines set out in AD 04.03.103 Health Care Services.<sup>208</sup> For the second quarter 2023 (April 1, 2023, through June 30, 2023) statewide performance for these expectations was 34%. This is compared to 38% for the same measure in the third quarter of 2022 (July 1, 2022, through September 30, 2022). See the table for performance of each facility. Facilities whose performance improved from the third quarter of 2022 are capitalized and in bold font; at 12 facilities performance improved.

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<sup>207</sup> SIU, Office of Correctional Medicine, IDOC Clinical Quality measure Tool #1 dated 7/6/2022. The methodology for the performance tool only looks at 10 sick call encounters, which is a small sample for sick call for such a high volume activity.

<sup>208</sup> The expectations in the AD are that requests for health services result in an evaluation by health care staff within 24 hours of receipt of the request or within 72 hours on weekends. If the evaluation results in a referral the patient will be seen by a provider within 72 hours or upon next scheduled visit. These expectations are more lenient than those set forth in the 2018 NCCHC Prison Health Standards (P-E-07 Nonemergency Health Care Requests and Services, pages 98-99). The AD and/or the IDOC policy and procedure as well as the performance and outcome tool should be revised to reflect at least the standards of the NCCHC.

FACILITY	Sick Call Timeliness 2nd quarter 2023	Vendor's RN Vacancy Rate	Vendor's provider vacancy rate
Centralia	0%	88%	100%
Illinois River	0%	83%	0%
Lawrence	0%	62%	33%
Menard	0%		40%
Robinson	0%	86%	25%
Shawnee	0%	75%	0%
Sheridan	0%		50%
Vienna	0%		50%
Graham	10%		75%
<b>PONTIAC</b>	<b>10%</b>		65%
<b>BIG MUDDY</b>	<b>20%</b>	82%	0%
Jacksonville	20%		0%
Western	20%	100%	0%
<b>VANDALIA</b>	<b>30%</b>		23%
<b>DANVILLE</b>	<b>40%</b>	80%	50%
Kewanee	40%	0%	0%
Logan	40%	91%	33%
<b>EAST MOLIN</b>	<b>50%</b>		40%
Lincoln	50%	75%	0%
<b>TAYLORVILLE</b>	<b>50%</b>	60%	44%
<b>HILL</b>	<b>60%</b>	79%	0%
<b>JTC</b>	<b>60%</b>	33%	0%
Pinkneyville	60%	71%	0%
<b>SOUTHWEST</b>	<b>60%</b>	56%	0%
<b>DIXON</b>	<b>70%</b>		33%
<b>STATEVILLE</b>	<b>80%</b>	61%	25%
Decatur	100%		0%
<b>MURPHYSBORO</b>	<b>100%</b>	0%	100%
<b>STATEWIDE</b>	<b>34%</b>	72%	34%

Only Decatur and Murphysboro met or exceeded the performance goal set by IDOC of 90%.

A major barrier to access to primary care as required by II.B.1 is staffing. The registered nurse vacancy rate is also listed in the table. The dark shaded boxes are facilities which sent no information on allocated, filled, and vacant positions. However, of 18 facilities which did provide nurse staffing information, the percentage of vacant positions is alarmingly high at all except Kewanee and Murphysboro. Vacancy rates for providers are also listed and show great variation among facilities. The reality is that providers allocated to one facility cover other facilities where there are no providers. So, a facility which has no vacant positions is highly likely to have providers who are covering elsewhere and thus their availability at either facility is less than the allocated time. The statewide average shows 24% of the provider positions are vacant<sup>209</sup> and this undoubtedly impacts the timeliness with which providers can see patients referred from sick call.

IDOC elected to use the California prison health care system as a community based comparison on this performance measure.<sup>210</sup> California's performance metric differs somewhat from IDOC's metric. IDOC allows 72 hours for a nurse evaluation if the request falls on a weekend and in California the timeframe is 24 hours. California stipulates that only registered nurses perform these evaluations while the IDOC does not. California stipulates that urgent referrals to a provider are seen within one day and routine referrals 14 days. IDOC requires a provider to see patients referred from sick call within three days or the next scheduled visit, which can be much longer than three days.<sup>211</sup> California exceeded its goal of 85% in all three areas (time to nurse evaluation, time to provider for urgent and routine referrals) for the same time period (April 2023 through June 2023) as IDOC. California prisons also report the percentage of positions vacant and for the same time

period nurse vacancies were 24% and provider vacancies were 27% compared to 72% for nurses and 24% for providers in the IDOC.

<sup>209</sup> Provider vacancies include physicians (33% vacancy rate) and physician assistant/nurse practitioners (18% vacancy rate) which when combined yield a 24% vacancy rate.

<sup>210</sup> Per the footnote on the quarter 4 FY 2023 performance report this comparator was adopted in 2022.

<sup>211</sup> Murphysboro, for example documented a provider was onsite twice in each of April, May, and June 2023 in the CQI minutes.

The CQI minutes and record reviews corroborate the results of the performance audit.<sup>212</sup> Of those facilities providing minutes of CQI meetings three reported internal audits that found non-compliance with the sick call requirements in the AD for timeliness.<sup>213</sup> Danville was one of these and also conducted a follow up CQI audit that found only 57% of those persons submitting sick call requests were seen by nursing staff within 24 hours of receipt. Lawrence and Sheridan reported backlogs for nursing sick call and referrals from sick call seen by a provider.<sup>214</sup> Robinson reported that sick call was cancelled because they had no nurses.<sup>215</sup>

At Graham, sick call does not take place when the HCU is not staffed adequately, correctional officer staffing is not sufficient or there is a unit lockdown. The Monitor was informed during the site visit that sick call is cancelled for security reasons about five times a month. Four records were selected for review from lists provided of requests for health care attention. Two of the records document delays of three and six days before being seen in nurse sick call.<sup>216</sup> In both instances there is documentation in the record that the delay was because of staffing or lockdown. Another chart that was reviewed during the site visit documented that the patient<sup>217</sup> requested health care attention on 5/5/2023 and was not seen until 5/8/2023 due to a shortage of nurses. A record of a patient at a facility other than Graham whose chart was reviewed during this report period was 62 year old and followed in chronic clinic for hypertension.<sup>218</sup> He had been receiving Tylenol 500 mg since 2019 for low back pain. On 12/19/2022 he submitted a request dated Monday, 12/19/2022 complaining of pain in his chest that radiated to his shoulder and nausea. He was not seen until Saturday, 12/24/2022 or five days later.

Five records of patients at Graham referred from nursing sick call to a provider were reviewed. Two patients were not seen timely. One was an individual who after the initial injury to his ankle was seen twice at nurse sick call for pain and swelling. At the second sick call he is documented to have 2+ pitting edema of the ankle and was referred, appropriately to a provider. He was, however, not scheduled to see a provider for a month (4/12/2023) which is too long a time to wait. He was seen on nurse sick call for a third time on 4/12/2023; the note documents that he was not seen as scheduled by the provider and was rescheduled again for 5/1/2023. He was not seen until 5/18/2023 or two months after referral for swelling of the ankle.

Another patient was recently admitted to IDOC and gave a history of gastric problems and a recent colostomy reversal. He submitted a sick call request on 7/6/2023 because of an open area on his abdomen at the site of the previous colostomy. The nurse referred him appropriately to a provider, but as of 7/18/2023 when the chart was reviewed, he had not been seen by a provider.

A record from another facility that was reviewed during this report period also evidenced delay in access to the primary care provider.<sup>219</sup> This was a 65 year old man whose medical history included diabetes, hypertension, high lipids, and hypothyroid disorder. He was seen at nurse sick call for complaints of pain over the sternum, that was dull but increased with activity and walking long distances and his abdomen was distended. He had been seen for the same pain two and a half weeks earlier. The nurse appropriately referred the patient to be seen by a nurse

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<sup>212</sup> CQI minutes for Graham (July), Hill (July and September), Taylorville (July), and Western (July). Reporting information on sick call timeliness has not been required so no assumption can be made that the problem was limited to these facilities.

<sup>213</sup> Centralia, Danville, and Jacksonville.

<sup>214</sup> April, May, and June 2023 CQI minutes.

<sup>215</sup> Ibid

<sup>216</sup> Sick call patient # 1 submitted a request because of vomiting. When seen three days later the nurse documented he had not been seen as scheduled due to lockdown. Sick call patient # 2 complained of pain and was not seen for six days. The record documents he was not seen as scheduled first due to security and then a second time because of a nursing shortage.

<sup>217</sup> Sick call patient # 3.

<sup>218</sup> Sick call patient # 4. This patient was at Menard at the time.

<sup>219</sup> Sick call patient # 5.



practitioner, but this did not take place for five days and was the first available appointment.

There are insufficient staff to provide access to an appropriate level of primary care as required by II.B.1.

2. *Identify inefficiencies in the sick call process and **reassign work, revise procedures, or obtain staffing necessary for timely responses to sick call requests.***

An example of an inefficiency in sick call was identified during the site visit to Graham.<sup>220</sup> The first three hours of nurse sick call encounters (8am – 11 am) were for nursing follow up and scheduled treatments such as blood pressure checks, dressing changes, and ear flushes. It was only after 11 am that patients with symptom based complaints were scheduled to be seen.<sup>221</sup> Patients not seen that day are rescheduled for the next day. Changing the scheduling so that patients with more urgent, symptom based complaints are seen first would be more consistent with the triage judgement required by III.F.2.<sup>222</sup> Patients seen for nursing follow up (treatments, monitoring etc.) should not be included in sick call performance metrics. Another example of an inefficiency identified is having the nurse assigned to sick call also respond to medical emergencies which requires inmates on sick call to wait until the nurse has time to see them. This practice was found to contribute directly to delays accessing non-emergent health care attention.<sup>223</sup>

Sick call is one of three areas selected by OHS for project based improvement with the goal being to standardize the sick call process. OHS is currently attempting to establish a uniform method for individuals to request health care attention that is simple and reliable.<sup>224</sup> OHS is also working on establishing the metrics to report and monitor sick call. Using the skills of a process analyst was included in the process improvement project for sick call to aid in identifying inefficiencies and to streamline sick call to achieve the goal of standardizing the process.

3. *Define and **establish the resources necessary to promptly achieve a face-to-face encounter with a registered nurse.***

The Monitor has suggested that a workload driven metric be developed based upon how much time on average it takes to address a sick call request and use this to determine the number of positions that are necessary at each facility and then to allocate the positions. IDOC has not conducted a staffing analysis that would achieve a workload driven formula to calculate the resources needed to respond in a timely and clinically appropriate manner to requests for health care attention.

There is no uniform measure used by IDOC to document that only registered nurses conduct sick call. The average vacancy rate for registered nurses among those facilities that reported this information was 72%. Nursing sick call is considered the signature practice area of correctional nurses and cannot be easily assumed by nurses employed by agencies unless they have prior experience working in correctional health care. At Graham, agency-employed nurses are not assigned to sick call because the skill set is not transferable.<sup>225</sup> The National Commission on Correctional Health Care states that better decisions about patient care result when the most experienced staff

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<sup>220</sup> Sick call was evaluated at Graham on Tuesday July 18, 2023.

<sup>221</sup> NCCHC P-E-07 states that health care requests are prioritized to be seen based upon the urgency of symptoms (2018 Standards for Health Care in Prisons, page 98-99).

<sup>222</sup> Patients with symptom based complaints should be scheduled before patients with treatments and scheduled follow up.

<sup>223</sup> Health Care Monitor 2nd Report Lippert v Jeffreys (August 6, 2020) page 85, 87.

<sup>224</sup> OHS – Monitor Monthly Call 11/16/2023, 10/18/2023, 4/19/2023, 3/16/2023.

<sup>225</sup> Agency nurses at Graham are assigned to care for infirmary patients.

are assigned to sick call.<sup>226</sup>

Illinois River reports the number of occasions that an LPN was assigned to sick call in the monthly CQI minutes.<sup>227</sup> This is laudable. No other facilities report this metric. Record review indicates that LPNs continue to be assigned responsibility to conduct sick call.<sup>228</sup> There also was no evidence that the LPNs with this responsibility have appropriate supervision.

The vacancy rate for registered nurses precludes IDOC from compliance with III.A.10. IDOC has not completed a sufficient evaluation on which to base decisions about the number of registered nurses needed to complete sick call.

4. ***Identify the methods and practices needed to fully address patient requests including how to document the patient's presenting complaint in their own words, and those with multiple requests.***

OHS has been in discussion with facilities about how to ensure that what the patient is requesting is documented accurately, particularly multiple requests.<sup>229</sup> Methods that have been suggested to provide evidence of compliance with III.F.2. are to document the patient's statement of why they want to be seen as the first entry on the treatment protocol. The alternative is to include the written request in the health record.<sup>230</sup> This should be accomplished as part of the current effort to standardize sick call.

Conducting sick call where privacy and confidentiality are compromised is an impediment to fully addressing patient requests. The use of exam rooms at Graham was not sufficient to meet the privacy and confidentiality required by III.F.1. because the exam room door was left open and other individuals in custody were seated on benches in the hallway and could overhear conversation in the exam room. At Pontiac patients were seen cell side so the patient's request could not be fully addressed because a complete examination could be done, and they were not private or confidential encounters.<sup>231</sup> At facilities previously visited by the Monitor the privacy and confidentiality of sick call encounters was insufficient to comply with III.F.1.<sup>232</sup>

5. ***Revise the use of nursing protocols to include limitations on their use with patients who require close clinician monitoring, elimination of the protocol for Non-Specific Discomfort and design a process for the periodic review and revision of treatment protocols based upon CQI, performance and audit data.***
6. ***Establish a methodology to train registered nurses in the use of treatment protocols and practice clinical judgment with supervision until initial competency is established and the methods to determine the continuing competency of nurses assigned to sick call.***

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<sup>226</sup> Standards for Health Services in Prisons (2018) page 99.

<sup>227</sup> In March 2023 LPNs were assigned to sick call 15 times, in February it was 32 times, and in January LPNs were assigned 4 times. IRCC has not produced CQI minutes since March 2023.

<sup>228</sup> Sick call patients # 4, 5.

<sup>229</sup> Discussion with the Agency DON 10/20/2023.

<sup>230</sup> Health Care Monitor 3<sup>rd</sup> Report Lippert v. Jeffreys, February 15, 2021, page 76; Health Care Monitor 4<sup>th</sup> Report Lippert v. Jeffreys, September 16, 2021, pages 108-109; Health Care Monitor 5<sup>th</sup> Report Lippert v. Jeffreys (July 27, 2022) page 90; Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys, March 13, 2023, page 92.

<sup>231</sup> January 2023 CQI minutes.

<sup>232</sup> Health Care Monitor 2<sup>nd</sup> Report Lippert v. Jeffreys (August 6, 2020) pages 87-88; Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys, March 13, 2023, page 87.

Revision of the nursing treatment protocols and training of registered nurses has yet to be accomplished. The Monitor has expressed concern about the use of the nursing treatment protocols since the 3<sup>rd</sup> Report.<sup>233</sup> For example, when the 65 year old man with chest pain described three pages ago was first seen for grinding chest pain the nurse did not use a protocol.<sup>234</sup> The progress note fails to document a complete assessment and an EKG was not done. This patient was seen by nurses previously for chest pain described as “ feels like someone is trying to break my chest”. The protocol for Indigestion/Heartburn was used. At this encounter the patient had abnormal vital signs with a pulse of 102 and blood pressure of 161/94. This patient had hypertension, abnormal vital signs, and chest pain with shortness of breath, any of which the protocol directs the nurse to refer to a provider urgently. The nurse simply gave the patient Pepcid. Another patient was seen emergently for a possible stroke.<sup>235</sup> The nurse used the protocol for non-specific discomfort, an unfortunate choice, since it is primarily directed at the symptom of pain and provides very little clinical guidance in the evaluation of neurological symptoms the patient was having. While the nurse did a rudimentary neurological assessment (speech, tongue alignment, and gait) grip, pupil size and reaction, orientation and mental status, were not evaluated. Charts reviewed for this report evidenced patient encounters where the nurse should have used a protocol and did not, or used an inappropriate protocol, or failed to follow the guidance provided by the protocol.<sup>236</sup>

7. *Establishing tools to monitor performance and quality of sick call.*

Currently there are two tools to monitor sick call performance. One is completed by the Office of Correctional Medicine, SIU at each facility once each quarter and was described earlier in this section. The results are reported to Systems Leadership Council. The other tool is the audit of compliance with the Administrative Directive 04.03.103 Offender Health Care Services.<sup>237</sup> Facilities are expected to audit compliance annually.

Neither tool monitors the quality of sick call encounters or the appropriateness of clinical judgements, nor do they include items in the Consent Decree.<sup>238</sup> The Monitor has been in discussion with OHS about a comprehensive audit as required by II.B.9 and provided an example of an audit tool for sick call in May 2023. There was further discussion of the audit in July, but the Monitor has not yet seen any further proposals for an audit of sick call.<sup>239</sup>

The facility Medical Director is expected to review the documentation of nurses evaluating patients using the nursing treatment protocols. This review is to reinforce complete documentation. The only clinical questions are whether the correct protocol was used and if the patient was referred, was it appropriate. Only 15 facilities report these reviews as taking place.

8. *The results of the process improvement project will be revised policy and procedure for sick call, clear definitions of the staffing and resource requirements needed to conduct sick call, training and supervision of nurses to ensure appropriate clinical assessment and decision making using the nursing protocols, limiting the use of protocols in patient populations requiring monitoring by clinicians, and audit methods to monitor and account for compliance with the Consent Decree, procedures and protocol.*

<sup>233</sup> Health Care Monitor 3<sup>rd</sup> Report Lippert v. Jeffreys, February 15, 2021, pages 10, 72-75, 77; Health Care Monitor 4<sup>th</sup> Report Lippert v. Jeffreys, September 16, 2021, pages 15, 106-109; Health Care Monitor 5<sup>th</sup> Report Lippert v. Jeffreys (July 27, 2022) pages 12, 87-89, 91; Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys, March 13, 2023, page 91-93.

<sup>234</sup> Sick call patient # 5.

<sup>235</sup> Sick call patient #3; this patient’s symptoms were decreased movement of the left arm and tenderness in the left shoulder with decreased grip strength in the left hand.

<sup>236</sup> Sick call patients # 4, 6, 7, 8, 9, 10.

<sup>237</sup> Effective 1/1/2020.

<sup>238</sup> Auditable items from the Consent Decree are whether the patient was seen by a registered nurse, if the encounter was private, if the nurse had the proper equipment, and whether the encounter addressed all complaints when the patient had more than one complaint.

<sup>239</sup> Email from the Monitor to OHS dated May 19, 2023. Meeting with OHS on 7/20/2023.

This last step in item 53 of the Implementation Plan lists the work products resulting from the process improvement project. The proposed end date is March 2024, two months after the process improvement project is initiated with inclusion of the process analyst. OHS has developed a draft policy and procedure for sick call and forwarded it to the Monitor for review.<sup>240</sup> The status of the other outcomes listed here have been described in preceding sections.

The Monitor's recommendations have been revised so as not to duplicate those that are now part of the Defendants' Implementation Plan.

## RECOMMENDATIONS:

1. **Implement items 51 and 53 of the Implementation Plan.**

## Chronic Care

*Addresses Items II.A; II.B.1; II.B.6.f; III.E.1*

**II.A.** *Defendants shall implement sufficient measures, consistent with the needs of Class Members, to provide adequate medical and dental care to those incarcerated in the Illinois Department of Corrections with serious medical or dental needs. Defendants shall ensure the availability of necessary services, supports and other resources to meet those needs.*

**II.B.1.** *IDOC shall provide access to an appropriate level of primary, secondary, and tertiary care*

**II.B.6.f.** *IDOC agrees to implement changes in the following areas: Chronic disease care: diabetes, Chronic Obstructive Pulmonary Disease (COPD), asthma, HCV, HIV/AIDs, hypertension, hyperlipidemia*

**III.E.1.** *IDOC shall maintain a list of prisoners' current medical issues in their medical charts.*

**OVERALL COMPLIANCE RATING:** Partial Compliance

## FINDINGS:

IDOC has not initiated programmatic changes with respect to the chronic disease program except for a telemedicine collaboration with UIC for diabetes care in the Northern Region. A CQI study completed at Dixon reported that 16 of 22 patients enrolled in the UIC diabetes clinic had a significant reduction in hemoglobin A1c. At the end of the first six months<sup>241</sup> 50 patients were enrolled in this clinic. The Monitor supports this effort and IDOC's intent to take this program statewide.

Existing physician staffing deficiencies is a significant problem that does not permit patients to be timely or adequately evaluated for their chronic conditions. This appears to the Monitor to be due to both vacant positions and a deficiency of allocated physicians. This should be addressed with the workload analysis. The chronic care nurse at Graham said that Graham had 691 backlogged chronic care visits and patients were about five months behind in being seen for their chronic care appointments. Of 20 facilities that provided minutes of their CQI meetings 11 report backlogs in chronic care. Four facilities failed to meet the requirements of the Administrative Directive regarding chronic care during an internal audit and one failed to meet these requirements on an external audit. Deficiencies include not completing the baseline chronic care visit within 30 days or not seeing patients when scheduled for an interval chronic care visit.

**Implementation Plan item 7: *Develop written procedures for expectation of training to include:***

<sup>240</sup> E.06.01 Non-Emergency Health Care Requests and Services forwarded to the Monitor on 6/23/2023.

<sup>241</sup> Dixon CQI minutes May 2023.

*1. Clinical practice training and updates (e.g., provider training on asthma management, nurse training on vital sign assessment, medication administration, nurse training on use of a point of care device, etc.);*  
*6. Training procedures shall include the format of training (in-person, video conference, onsite, quarterly meeting, etc.); copies of the new policy or procedure for all attendees; sign-off acknowledgement that training was received; in some cases, verification of competence with the training (taking blood pressure, using a point of care device, etc.).* **Proposed End Date: September 2023**

There is no evidence that IDOC engages in any clinical practice training of providers or nurses related to chronic care. The deadline for this item has passed.

**Implementation Plan item 8:** *Have dedicated staff for chronic care nurse, at each facility.* **Proposed End Date: January 2024**

IDOC does not have dedicated nurses allocated or assigned to chronic care. Nurses have been assigned to chronic care duties as part of their overall responsibilities. During the Graham visit, this was confirmed as the nurse assigned to chronic care also had other assignments. The nursing shortage throughout IDOC contributes to backlogs and untimely chronic care.

**Implementation Plan item 54:** *This process improvement for chronic care should address:*

- 1. Ensuring that chronic problems are accurately entered into the medical record problem list by providers.*
- 2. Developing of a chronic care roster to track persons with chronic illness.*
- 3. Seeing patients for all of their chronic illnesses in a single clinic and addressing all chronic conditions at every clinic.*
- 4. Ensuring that adequate history is taken, and analysis of why adequate histories are not currently obtained.*
- 5. Ensuring that there is an assessment and therapeutic plan for each problem.*
- 6. Clinic scheduling will be based on the patient's degree of control.*
- 7. Ensuring appropriate and timely referral to specialists when management exceeds the experience or knowledge of the provider and that follow up appointments with specialists are scheduled.*
- 8. That immunizations are routinely tracked updated with use of a reliable immunization tracking mechanism (e.g., I-CARE).*
- 9. That a therapeutic dental plan is made at the conclusion of the intake dental examination.*
- 10. That dental x-rays are digitalized and organized in a picture archiving and communication system (PACS).*
- 11. That laboratory tests are documented as reviewed and are ordered when indicated by the patient's condition or as directed by Disease Management Guidelines.*
- 12. Ensure that clinical care follows national standards.*
- 13. Make access to UpToDate available in all clinic examination rooms.*
- 14. Ensure ability of providers to evaluate medication compliance and current medications at chronic care visits.*
- 15. Make chronic clinic documentation more efficient and supportive of preventive measures (vaccinations, cancer screening, etc.) with implementation of the EHR.*
- 16. Intake assessment to conclude with an initial assessment and therapeutic plan for all chronic illnesses.*

**Proposed End Date: March 2024**

IDOC has drafted a chronic disease policy. The Monitor has returned this draft with multiple comments. This policy has not yet been approved or implemented. Implementation Plan items 9 and 10 above should be covered in dental policy for which a draft has been received but not yet reviewed. Implementation Plan item 54 subitems

1-6 and subitem 11 with respect to ordering laboratory tests are covered in draft policy F.02.01 Chronic Care; subitem 15 is covered in policy B.01.01, Preventive Service and Periodic Health Assessment. Other subitems of Implementation Plan item 54 are not covered in policy.

IDOC has not yet initiated an audit process to verify compliance with items 1-16 above. The vendor Regional Medical Directors do not review chronic care performance of physicians they supervise. SIU has identified multiple problems related to chronic care in their mortality reviews. The OFI “Failure to follow Clinical Guidelines or Standards of Care including management of Chronic Diseases” had 230 findings, the most of any of the nine categories. The Monitor reviewed multiple chronic clinic visits for three patients<sup>242</sup> which showed poor compliance with items 1, 3-8, 12, 14, and 15 above.

A partial compliance rating is given because of the initiation of the UIC diabetes program which provides university level care for diabetes to patients in the Northern Region and because of a draft chronic disease policy. Dedicated chronic disease nurses are not hired and provision of nursing service to assist with chronic care is optionally provided at each facility based on staffing. The lack of allocated and filled physician positions results in delays in chronic disease management. Clinical practice training on chronic care has not been provided to nurses or physicians. Oversight of chronic care by vendor medical directors is still not evident. Chronic care practice based on requirements of the Implementation Plan item 54 are not evident based on SIU mortality reviews and Monitor record reviews. A comprehensive audit that includes evaluation of chronic care is not yet in place.

## RECOMMENDATIONS:

1. Use national standards as guidelines for care instead of writing guidelines for all common health conditions.
2. Support for chronic disease management needs to improve as soon as possible.
3. For physicians without appropriate credentials based on Consent Decree requirements, monitoring should be done to ensure that they are capable of managing patients according to contemporary standards.
4. When any provider does not know specifically how to manage a patient’s condition, the provider should refer the patient to an appropriate specialist for management consultation, including for gerontology.
5. Discontinue prescribing sliding scale Regular Insulin with 70/30 insulin for insulin requiring diabetics<sup>243</sup>.
6. A team approach to chronic care needs to be instituted. Daily and weekly huddles need to be instituted to improve communication amongst staff. Huddles should include nursing, schedulers, and a pharmacist.
7. The Monitor encourages the expansion of the UIC diabetes program.

## Urgent and Emergent Care

**Addresses Items II.A; II.B.1; II.B.6.b; III.E.4; III.G.1; III.G.2; III.G.3; III.G.4**

**II.A.** *Defendants shall implement sufficient measures, consistent with the needs of Class Members, to provide adequate medical and dental care to those incarcerated in the Illinois Department of Corrections with serious medical or dental needs. Defendants shall ensure the availability of necessary services, supports and other resources to meet those needs.*

**II.B.1.** *IDOC shall provide access to an appropriate level of primary, secondary, and tertiary care*

**II.B.6.b.** *IDOC agrees to implement changes in the following areas: Urgent care;*

**III.E.4.** *The medical records staff shall track receipt of offsite medical providers' reports and*

**III.G.1.** *Each facility HCUA shall track all emergent/urgent services in a logbook, preferably electronic.*

**III.G.2.** *Appropriate medical staff shall have the obligation to determine whether a situation is urgent or*

<sup>242</sup> Chronic disease patients 1 and 2 and Specialty care patient 1.

<sup>243</sup> This is not discussed in this report but has been discussed in prior reports. If IDOC has any questions about this recommendation, they should contact the Monitor for explanation.

*emergent.*

**III.G.3.** *IDOC shall use best efforts to obtain emergency reports from offsite services when a prisoner returns to the parent facility or create a record as to why these reports were not obtained.*

**III.G.4.** *Facility medical staff shall ensure that a prisoner is seen by a medical provider or clinician within 48 hours after returning from an offsite emergency service. If the medical provider is not a clinician, the medical provider shall promptly review the offsite documentation, if obtained, with a clinician and the clinician shall implement necessary treatment.*

**OVERALL COMPLIANCE RATING:** Partial compliance

**FINDINGS:**

The following documents were requested by the Monitor for this report:

- List of all emergency medical response bags from Centralia, Logan, Menard, Murphysboro, NRC and Stateville. The list should identify the facility, the location of the bag, the contents of the bag including medication, and whether the bag is sealed and if so, how.
- Documentation from each facility of inspections of emergency response equipment and supplies.
- Log of persons seen for an emergency onsite but were not sent to a hospital for Q4 2022 and Q1 2023.
- The date, time, location, and subject of any *medical emergency response drills* conducted at each facility during Q4 2022 and Q1 2023, including the debriefing and review documents.<sup>244</sup>

All facilities, except NRC, responded to the request for the location and contents of emergency bags. No information was received about the inspection of emergency equipment, the log of emergencies which were resolved without going offsite, and the medical emergency response drills.

**Implementation Plan item 94** defines the *changes in urgent emergent care* which include:

1. *Standardize policies and procedure for provision of urgent/emergent services to include expectations for training, demonstrated competency and clinical proficiency in determining the urgent or emergent nature of the response needed, and documentation thereof.*
2. *Train staff to provide urgent/emergent services consistent with policy and procedure, validate staff competency in urgent/emergent care initially and annually thereafter. Track and report training completion and competency evaluation through the quality improvement process.*
3. *Standardize the clinical and operational review of onsite emergency response episodes as evidenced in policy and procedure.*
4. *Define criteria for acceptable documentation received from offsite services, as well as documentation of effort to obtain such documentation.*
5. *Tracking of all onsite and offsite urgent/ emergent services in separate log books.*
6. *Develop workload metrics necessary to ensure that patients are seen and their plan of care reviewed within 48 hours of return from off-site emergency services.*

**Proposed End Date: November 2023**

**Implementation Plan item 72: Develop a standardized emergency response bag with a list of contents.**

1. *Work with fiscal to procure emergency response bag and contents for each facility.*
2. *Develop policy that ensures each facility has identical contents in their emergency response bag.*
3. *Educate staff on new emergency response bag policy.*

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<sup>244</sup> Monitor's documentation request dated 8/4/2023, items 58, 59, 75, 76.

4. *With the assistance of the Monitor and the audit team, develop a process to ensure emergency response bags contain appropriate items and are securely stored.*

**Proposed End Date: May 2024**

#### **II.B.6.b. Changes in urgent care.**

The IDOC has made forward progress in improving the response to medical emergencies as called out in the Consent Decree. Administrative Directive 04.03.108 Response to Medical Emergencies was updated effective 3/1/2023. The update appears to establish that non-medical personnel are permitted to administer nasal naloxone. Another revision is that the Chief Administrative Officer and HCUA are *to consult with each other* in establishing local policy and procedure for response to medical emergencies as well as the quantity and location of emergency equipment and supplies.

The Department also has drafted three policies and procedures and sought the Monitor's input on each.<sup>245</sup> These are D.01.01 Emergency Plans and Drills, E.08.01 Emergency Services and E.09.01 Emergency Response on the Facility. If the Monitor's comments and redline revisions are incorporated into the final policies, IDOC will have established the framework to proceed in making other changes required by the Consent Decree and listed in the implementation plan.

OHS is also standardizing the equipment used to respond to emergencies as called for in the Implementation Plan item 72. Work to date completed by IDOC includes development of a list of supplies and equipment. Facilities have been asked to verify the presence of each. This is consistent with the first task listed to *work with fiscal to procure emergency response bag and contents for each facility*. Bags to hold the supplies are being manufactured by correctional industries. Once these are completed the list will be updated to indicate which compartment each item is to be placed into.[1]

As mentioned above OHS has a drafted E.08.01 Emergency Services which, if redline revisions are accepted, will accomplish the second task to *develop policy that ensure each facility has identical contents in their emergency response bag*. The remaining two items have yet to be implemented; these are *the education of staff* to the policy and procedure and *monitoring* to ensure emergency response bags contain appropriate items and are securely stored.

Other than development of policy and standardizing emergency equipment and supplies the status of urgent/emergent services as discussed in the 6<sup>th</sup> report remains unchanged. The following are the Monitor's findings from review of records, other documents, and interviews.

Several of the facilities reported the results of internal or external audits of compliance with the Administrative Directive (AD) for emergency services during this report period. Reasons for noncompliance include not inspecting the equipment, not identifying members of the emergency team, not conducting required drills, and not evaluating drills timely. Only 13 facilities report in the CQI minutes whether emergency or mass disaster drills have taken place and fewer yet include any critique. Many of these drills only consider whether the response was timely, and the proper equipment was brought. Seldom do the drills include any demonstration of knowledge or skills competency in delivering medical care in an emergency.

A mass casualty disaster took place at Graham in January 2023, but the review and critique of the emergency response had not been completed by July when the Monitor visited Graham. The HCUA commented that writing up the review was difficult because other than times for the initial response there is no clear timeline<sup>246</sup>. We

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<sup>245</sup> The monitor provided comments and redline revisions on 9/13/2023.

<sup>246</sup> SIU mortality reviews documented 24 instances where documentation of event surrounding an onsite emergency was inappropriate.



suggested using a scribe to document the timeline during response to medical emergencies. We were told that the opportunities for improvement identified were the availability of Narcan, communication between the site and OHS when multiple casualties are involved, as well as internal communication. Emergency drills are not included in the CQI minutes at Graham and should be.<sup>247</sup> During the site visit we were given copies of the critique of two medical emergencies by the facility medical director.<sup>248</sup> One of the drills included a clinical response; the other only stated that the response time was good<sup>249</sup> and the correct equipment was brought.<sup>250</sup>

Previous reports have discussed the variation from facility to facility in emergency supplies and equipment.<sup>251</sup> Information provided for this report evidences continued variation. For example, some form of instant glucose should be available in the emergency supplies maintained in the HCU. Of five facilities which provided lists of the contents of emergency bags only two list this item as included.<sup>252</sup> During the site visit to Graham the emergency equipment that is maintained in the first aid room was examined. This equipment consists of a stretcher with backboard and cervical collar, wheelchair, portable oxygen, a cutdown knife, suction, and EKG. Two emergency jump bags and one AED are kept in a cabinet locked with plastic tags. Each of the bags was different in configuration.<sup>253</sup> There is no list of contents or expiration dates.<sup>254</sup>

The contents of the jump bags at Graham differ from the standardized list provided by OHS. Several of the standardized medications and the pen light are kept in the medication room rather than in the jump bags for inventory control and security purposes.<sup>255</sup> Access to these supplies in an emergency would require a trip to the medication room. The AED was charged but was without replacement pads. The HCUA did not know how long the replacement pads had been gone.

Narcan has been available at Graham since August 2021. However, the jump bag includes only one box of Narcan or two doses. Following a mass casualty event in January 2023 Narcan has been placed in six additional locations at the facility and plans are to have Narcan available in the housing units eventually. It does not appear that injectable Narcan is used – all preparations examined at the facility were nasal inhalants.

The Morbidity and Mortality Committee has identified other opportunities to consider including the equipment needed to respond to patients who have hung themselves and the need for cervical stabilization.

No facilities provided documentation of the inspections of emergency response equipment and supplies. At Graham a count sheet is maintained in the first aid room to verify the presence of most of the equipment stored

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<sup>247</sup> All CQI minutes from Graham reviewed since January 2021 have “NA” listed under the heading emergency drills.

<sup>248</sup> One was an actual emergency which took place 3/22/23 at 9:05 am in a housing unit and involved an individual with low blood sugar. The other was a drill that involved a person who was unresponsive and took place in dietary at 2:30 pm on 4/12/23.

<sup>249</sup> Response time was five minutes which is a minute longer than the time recommended by ACA, however the critique was that the response time was good.

<sup>250</sup> The drill which took place in April 2023 involved an unresponsive individual, the critique was that the proper equipment was brought, however there is no indication that it included portable oxygen which would be expected. Also, it does not indicate how soon Narcan was available. This is after the February 2023 Warden’s Bulletin about the availability of Narcan and its use.

<sup>251</sup> Health Care Monitor 4th Report, Lippert v Jeffreys, September 16, 2021, page 118, Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys, March 13, 2023, page 93.

<sup>252</sup> Facilities that did not list instant glucose as among the items maintained for emergency response were Logan, Murphysboro, and Menard. Only the list provided by Stateville matches the list of items that was sent by OHS to the facilities. The list from Menard is part of an institutional directive last updated in 2018 and does not include Narcan in any form.

<sup>253</sup> One was a back bag and the other a duffle. It was easier to find specific items in the duffle because of the wide opening.

<sup>254</sup> Listing expiration dates for supplies and medications is recommended to ensure their viability and to rotate out those items with near expiration dates so the product isn’t wasted.

<sup>255</sup> Injectable epinephrine, glucagon, glucometer and strips, and the pen light.

in the first aid room. The count sheet is completed each shift. We did not verify the count during the inspection of the emergency equipment. The HCUA indicated they could accommodate changes put in place to standardize and improve emergency equipment and response.

We noted in our review of records that the documentation concerning the emergency and any subsequent decision to send a patient to the emergency room was nonexistent or extremely brief and nonspecific. The Morbidity and Mortality Committee confirmed this finding with multiple opportunities for improvement related to poor documentation of onsite emergencies including “codes”. Once a provider determines that a patient is to be taken to the hospital emergency room or EMS arrives, there is seldom any further documentation. Notes are written retrospectively and there is no detailed timeline of events that took place. The findings were the same in the review of death records.<sup>256</sup> The documentation in one chart by a nurse timed the response to the Code 3 at 11:20 am however the physician note is timed at 11:00 am and is a summary of the response to the emergency and decision to send the patient to the hospital.<sup>257</sup> An example of the brevity of documentation was this progress note written by a registered nurse “Code 3 was called to HU15 wing A, room 14. CPR was started until EMT arrived.”<sup>258</sup> Four nurses responded to this emergency and not a single one documented vital signs or an assessment of the patient’s condition. It is customary to document periodic assessment of the patient’s condition and any support measures (oxygen use, IV fluids, splinting etc.) used when caring for a patient in an emergency until the patient leaves the facility.

### III.G.1 Emergent/urgent services logbook.

IDOC facilities were provided with an electronic log to list patients sent to the emergency room. However, the log is not used by a third of the facilities.<sup>259</sup> Of the sites that do keep the log there is considerable variation in how complete the log is. For example, some sites only document the trip out to the emergency room but may not document the reason why or the discharge diagnosis or whether discharge paperwork was received. The Monitor has commented in previous reports that information recorded in the log is not accurate.<sup>260</sup> Continuing that trend, nine emergent offsites at four facilities which keep a log, were reviewed for this report and only five appeared on the corresponding ED log.<sup>261</sup> The Monitor has previously recommended some additional data columns be added, but this has not been done.<sup>262</sup>

No facilities provided logs of persons seen for an emergency onsite but did not require care in the emergency room. We confirmed this during the site visit to Graham. The Consent Decree clearly states that each facility HCUA shall track *all* emergent/urgent services in a log, preferably electronic and the fifth task of Item 94 in the Implementation Plan is *tracking of all onsite and offsite urgent/ emergent services in separate log books*. See the Recommendations section for the data that should be tracked on a log of emergencies that were resolved on site.<sup>263</sup>

The information in the logbooks should be reviewed daily by the DON or Charge Nurse and discussed in a daily huddle to facilitate decisions about the priority of services, need for follow up communication, and follow through

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<sup>256</sup> Urgent emergent patients #6-11.

<sup>257</sup> Urgent Emergent Patient #1.

<sup>258</sup> Urgent emergent patient # 9

<sup>259</sup> Big Muddy, Centralia, Danville, Dixon, JITC, Lincoln, Pinckneyville, Shawnee, Sheridan, and Southwestern. This is up from four sites that did not keep the log in 2019 at the time of the Monitor’s 2<sup>nd</sup> Report.

<sup>260</sup> Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys, March 13, 2023, page 95.

<sup>261</sup> Urgent emergent patients #1-3, 5, 12. Medical records from seven facilities were reviewed. Two facilities kept no log of urgent/emergent off site visits; these were Pinckneyville and Shawnee.

<sup>262</sup> Health Care Monitor 2<sup>nd</sup> Report, Lippert v. Jeffreys, August 6, 2020, page 100, Health Care Monitor 3<sup>rd</sup> Report, Lippert v. Jeffreys, February 15, 2021, page 90; Health Care Monitor 4<sup>th</sup> Report, Lippert v. Jeffreys, September 16, 2021, page 119, Health Care Monitor 5<sup>th</sup> Report, Lippert v. Jeffreys, July 22, 2022, page 98.

<sup>263</sup> This recommendation has been made since the Health Care Monitor 2<sup>nd</sup> Report, Lippert v. Jeffreys, August 6, 2020, page 100.

care for acute or at-risk patients in the population.<sup>264</sup>

### **III.G.2. Appropriate medical staff shall have the obligation to determine whether a situation is urgent or emergent.**

The revised Administrative Directive was changed so that the facility Medical Director or HCUA consults with the Chief Administrative Officer in the designation of appropriately trained staff to an emergency response team. This eliminated the concern expressed in previous reports about the lack of the qualifications of the Chief Administrative Officer to appoint health care staff to the emergency response team.<sup>265</sup> The revised AD however does not add any more clarity about what these teams do or how they are to perform. The revised AD also added language that once lifesaving measures are initiated, they are to be continued until otherwise *directed by medical personnel or emergency medical services*. This is the first acknowledgement that once a medically trained person arrives on scene, they are responsible for directing the medical response to the patient. The Monitor's redline suggestions on the three draft OHS policies and procedures are intended to delineate the leadership responsibilities of medical personnel to determine the urgency of the situation and direct the clinical response to the patient as required by III.G.2.

The documentation of emergency response should be reviewed to identify repeated instances or trends in care that can be addressed by training, practice, or change in equipment or procedure to improve the timeliness and appropriateness of emergent/urgent care. For example, among charts reviewed for this report were two instances when CPR had not been initiated by the correctional staff who called the code and was not initiated by responding health care staff.<sup>266</sup> There also were instances where the emergency equipment either wasn't working or was not brought to the scene timely.<sup>267</sup>

Failure to recognize the urgency of medical situations<sup>268</sup> continues to be a problem identified in records reviewed for this report.<sup>269</sup> One of these was a patient with multiple chronic medical problems<sup>270</sup> who had been hospitalized twice in the previous two weeks for paroxysmal atrial fibrillation. A nurse contacted the treating physician to report the patient had been complaining of chest pain since the evening before. The provider gave no orders. Eight hours later the physician was contacted again because the patient was short of breath, using accessory muscles and complained of having a "heavy, heavy chest". His blood pressure was 89/60 compared to 142/80 eight hours earlier, respirations 22, pulse 87. The physician ordered medical observation and to monitor vital signs every two hours. It was not until the following day that he was transferred emergently to the hospital where he was treated for acute coronary syndrome.

OHS has established an independent process to review the care of patients who die while in custody. These reviews have resulted in the identification of opportunities to improve health care, several of which concern response to medical emergencies. Other than the standardization of equipment and development of policy guidelines we are unaware of any other actions taken at this time by OHS to act on these improvement opportunities. OHS is encouraged to use these identified opportunities to build staff training in emergency response and competency evaluation as per step 2 of item 94 in the Implementation Plan.

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<sup>264</sup> Health Care Monitor 2<sup>nd</sup> Report, Lippert v. Jeffreys, August 6, 2020, page 100, Health Care Monitor 3<sup>rd</sup> Report, Lippert v. Jeffreys, February 15, 2021, page 90; Health Care Monitor 4<sup>th</sup> Report, Lippert v. Jeffreys, September 16, 2021, page 120, Health Care Monitor 5<sup>th</sup> Report, Lippert v. Jeffreys, July 22, 2022, page 99, Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys, March 13, 2023, pages 95-96.

<sup>265</sup> Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys, March 13, 2023, page 96.

<sup>266</sup> Urgent emergent patients #6, 7, 9.

<sup>267</sup> Urgent emergent patient #9, 10, 11.

<sup>268</sup> SIU mortality reviews are replete with instances of failing to recognize the urgency of medical situations.

<sup>269</sup> We reported this finding in the Monitor's 5<sup>th</sup> report, see page 100 and 6<sup>th</sup> report, see page 96. Urgent emergent patients #8, 11.

<sup>270</sup> Urgent emergent patient #8.

**III.G.3 Best effort to obtain emergency report or document reason report not obtained.**

**III.E.4 Track receipt of offsite reports and ensure filing in the patient's medical record.**

Practices with regard to obtaining appropriate documentation from the emergency room remain unchanged from previous reports and are insufficient to transfer responsibility for care of the patient back to the facility provider. The Monitor has suggested language in the draft OHS policies and procedures that defines acceptable documents.<sup>271</sup>

**III.G.4 Provider follow up after emergent/urgent services within 48 hours of return to the facility.**

The Implementation Plan calls for IDOC to develop workload metrics necessary to ensure that patients are seen and their plan of care reviewed within 48 hours of return from off-site emergency services. IDOC proposed a staffing study and requested the Monitor's review. However, the methodology proposed was not based upon an analysis of the manpower needed to accomplish the required work but instead used a comparative methodology. The Monitor expressed concern that the proposed methodology would not adequately capture the actual workload necessary to complete this within the unique setting and practices of the IDOC.<sup>272</sup> The Monitor has also suggested consideration be given to use of telehealth technology to accomplish these encounters especially on weekends and at smaller facilities with relatively healthy populations and less frequent onsite provider presence.<sup>273</sup>

The date the patient was seen by a provider following emergent/urgent services is entered by only 10 of 19 sites that provided the log.<sup>274</sup> Of these only Menard's log documents that providers see patients upon return from an emergency room visit (or upon discharge from the hospital if admitted) within 48 hours. The records reviewed for this report did not consistently document the evaluation of a patient by a provider upon return to the facility<sup>275</sup> consistent with II.B.6.e. *Informed care for patients who return to IDOC facilities after being sent to an offsite service provider.*

**CONCLUSION**

Since the 6<sup>th</sup> Report IDOC has made progress toward compliance with the requirements of the Consent Decree for urgent emergent services. This progress includes efforts to standardize and obtain appropriate supplies and equipment to respond to medical emergencies, the development of policy and procedure to guide the delivery and oversight of urgent emergent services, and review of clinical care resulting in identifications of practices which should be improved. However, only the first step of Item 72 in the Implementation plan has been substantially accomplished to date. The Monitor has eliminated recommendations for this section which are now in the Implementation Plan.

**RECOMMENDATIONS:**

1. Prioritize implementation of the three draft policies and procedures D.01.01 Emergency Plans and Drills, E.08.01 Emergency Services and E.09.01 Emergency Response on the Facility after

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<sup>271</sup> See in particular the Monitor's redline and comments on E.09.01 Emergency Response on the Facility provided 9/12/2023.

<sup>272</sup> Monitor Response to JAA Proposal on Staffing Study, September 20, 2023

<sup>273</sup> Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys, March 13, 2023, page 98.

<sup>274</sup> In the Monitor's 5<sup>th</sup> report we noted that 18 facilities tracked this information, page 101. There are fewer facilities tracking this information 18 months later.

<sup>275</sup> Urgent emergent patient #1 was not seen by a provider after release from the hospital on 5/22/2023 with a diagnosis of exacerbation of multiple sclerosis. Urgent emergent patient #2 was not seen by a provider after release from the hospital on 5/30 following a seizure. Urgent emergent patient #3 was not seen by a provider after being sent to the ED for dialysis.

incorporating the Monitor's redline revisions.<sup>276</sup>

2. Address and implement improvements in urgent emergent health care in the Implementation Plan, Items 72 and 94.
3. Use the opportunities identified by the Morbidity and Mortality Committee to build the staff training program for emergency response and competency evaluation.
4. Data suggested to track on an onsite emergency response log should include the date, time and location of the emergency, the time and name of the first health care responder, the nature of the emergency, the patient's acuity, disposition, and date the response was reviewed by a supervisor.
5. The Monitor recommends that a column after discharge diagnosis be added to the offsite emergent/urgent services log to document the disposition. Documentation choices should include deceased, admitted to (name of hospital), transferred to (name of institution), released (date of release) etc.
6. The accuracy of the information documented in the log needs to be verified by an audit of patient records on a quarterly basis with corrective action as necessary until sustained performance is demonstrated.
7. Follow up appointments after patient's return from offsite emergency services or hospitalization should include the patient to review the findings and discuss any updates to the treatment plan. Consider using telehealth technology to accomplish these encounters especially on weekends and at smaller facilities with relatively healthy populations and less frequent onsite provider presence. A review of records without seeing the patient is not sufficient.

## Infirmary Care

*Addresses Items II.A.; II.B.1; II.B.6.k; III.I.1-5*

**II.A.** *Defendants shall implement sufficient measures, consistent with the needs of Class Members, to provide adequate medical and dental care to those incarcerated in the Illinois Department of Corrections with serious medical or dental needs. Defendants shall ensure the availability of necessary services, supports and other resources to meet those needs.*

**II.B.1.** *IDOC shall provide access to an appropriate level of primary, secondary, and tertiary care*

**II.B.6.k.** *IDOC agrees to implement changes in the following areas: Appropriate staffing, physical conditions, and scope of services for infirmary care;*

**III.I.1.** *A registered nurse will be readily available whenever an infirmary is occupied in the IDOC system.*

**III.I.2.** *At every facility regularly housing maximum security prisoners, there shall be at least one registered nurse assigned to the infirmary at all times, twenty-four (24) hours a day, seven (7) days a week.*

**III.I.3.** *All facilities shall employ at least one registered nurse on each shift. If a prisoner needs health care that exceeds the IDOC infirmary capabilities, then the prisoner shall be referred to an offsite service provider or a hospital.*

**III.I.4.** *All infirmaries shall have necessary access to security staff at all times.*

**III.I.5.** *All infirmaries and HCUs shall have sufficient and properly sanitized bedding and linens.*

**OVERALL COMPLIANCE RATING:** Noncompliant

### FINDINGS:

The Monitor requested the following information from IDOC:

- Any workload or other measures used to determine the number of staff positions required. If IDOC is not

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<sup>276</sup> If substantive redline revisions made by the Monitor are incorporated by IDOC into finalized policies and procedures five of the Monitor's recommendations would be eliminated (3,4,6,7,8).

tracking workload; provide whatever information is available for this item.

- For providers, the documentation of assignments for intake health assessments, infirmary rounds, urgent care clinic and chronic clinic for the of May 2022.
- Nurse assignment sheets. Provide daily assignment sheets used at the facility to assign nurse staff to their daily work. Daily assignment sheets for any 7 day period in May or June 2023 from NRC, Graham, Menard, Logan, Stateville, Centralia, and Pontiac.
- For each facility, a list of patients in the infirmary on April 30, 2023 to include the name, age, DOC#, diagnoses, and date of admission to the infirmary. This should be provided on an excel spreadsheet.<sup>277</sup>

#### **II.B.6.k. Infirmary Care: Appropriate Staffing, Physical Conditions, and Scope of Services**

The Implementation Plan which was filed with the Court 8/1/2023 specifies changes to infirmary services in item 71 specifically to *Set forth guidelines and benchmarks related to infirmary care. Additional steps to improve access to quality of care provided in infirmaries include:*

1. *Assess utilization of infirmary beds to include reasons for non-medical admissions, the prevalence, and reasons for lengths of stay longer than 7 days, reasons for readmissions to the infirmary in less than 30 days.*
2. *Solicit from facility HCUAs and Medical Directors information and data on backlogs for infirmary care to include procedures that must be completed in-cell, use of alternative placements such as Specialized Housing Unit or Residential Treatment Unit admissions that are delayed due to lack of beds, prolonged hospitalizations due to lack of infirmary capacity. This information could be solicited using focus groups with a skilled facilitator.*
3. *Define the purpose of infirmary care and the scope of services to be provided in statewide policy based upon the data collected on utilization in 2 & 3. Policy monitor gave draft language*
4. *Determine the number of beds needed to provide the defined scope of service.*
5. *Establish the staffing and other resources needed to operate each infirmary according to the scope of service, number, and type of infirmary beds.*
6. *Define the responsibilities of staff assigned to provide infirmary care, including correctional officers. Generic PDs [position descriptions]*
7. *Provide staff education to increase capacity to manage emerging areas of concern (aging, dementia, mobility impairment etc.).*
8. *Develop programmatic methods to manage infirmary services to include:*
  - a. *Daily huddle or rounds by physician and nurse.*
  - b. *Utilization review and approval.*
  - c. *Treatment plans.*
  - d. *Case management.*
  - e. *Programming.*
9. *Establish procedures for infirmary care.*
10. *Develop reporting requirements and establish tools to monitor performance.*

***Proposed End Date: February 2024***

With regard to the steps listed above, there has been no assessment of infirmary bed utilization or backlogs or barriers to access of infirmary beds yet. IDOC *has* developed a draft policy and procedure on Infirmary Care

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<sup>277</sup> Monitor's documentation request dated 8/4/2023, items 14, 40, 43, 54, 77. IDOC provided copies of a proposal for a staffing methodology, but no workload measures have yet been used to determine staffing. Assignment sheets for physicians, nurse practitioners, and physician's assistants were provided by all but one facility. Nurse assignment sheets were sent from each of the seven facilities listed above. With the exception of Logan's, the assignment sheets do not indicate the credential of the nurse(s) assigned to the infirmary. All but one facility sent the list of patients in the infirmary with information as requested and was very useful in the Monitor's review.

(F.04.01). The Monitor provided redline revisions and comments on the draft suggesting additions that define scope of services, add procedures, and establish requirements for monitoring and reporting on infirm care consistent with tasks 3, 8, 9 and 10 of item 71 above. The number of infirm beds that are needed can be determined once the scope of service has been defined, as well as the staffing and support resources necessary. Defining the responsibilities of staff assigned to infirm care, including correctional officers has not been accomplished yet. Position descriptions provided so far, for the Monitor's review, are generic and not specific to any particular post assignment. No particular education has been provided to enhance staff performance in areas that are especially important in the care of infirm patients, such as fall prevention, mobility impairment, dysphagia and other topics suggested above.

IDOC has initiated work on item 71 but has a significant way to go before it can be considered accomplished. The proposed February 2024 end date is not realistic and should be considered in the context of the timeframe needed to accomplish the evaluation of physical space and the assessment of the aged, infirm, and disabled.

Charts reviewed in preparation of the 7<sup>th</sup> Report depict the same problems with clinical care and support services for patients needing infirm care that have been discussed in previous reports.<sup>278</sup> These problems include failure to provide clinical care that is appropriate and responsive to the patient's medical needs<sup>279</sup> and unsafe practices that put patients at risk of adverse events.

As an example, one chart reviewed was a 62 year old who expired in April 2023. He had been diagnosed with cirrhosis of the liver and had esophageal varices that had been banded, hyponatremia, anemia, and portal hypertension. Beginning in 2020 he began having paracentesis for ascites. He was admitted to the infirm in March 2023; at that time, he was deconditioned and hypotensive. He was constipated and was treated with Colace. Nursing staff did not contact a provider until the patient became confused. The provider failed to anticipate the risk of severe constipation in cirrhotic patients. It was not until lab work returned in high ammonia levels that lactulose was prescribed. There was no monitoring of the patient's bowel movements or proactive management of the patient's symptoms. During his infirm stay he developed pressure ulcers. While dressing changes were ordered, no other measures were taken to reduce pressure or prevent further skin deterioration. No workup was initiated to establish the reason for his confusion or to determine if there were other contributing factors that were treatable. Paracentesis was the only measure used to address his condition; no changes were made to his plan of care as he progressively worsened, except to increase the frequency of paracentesis.<sup>280</sup>

There were numerous patients whose charts were reviewed who were not monitored by nursing or had abnormal vital signs with no recheck or other action taken<sup>281</sup>, indwelling urinary catheters that were problematic,<sup>282</sup> developed pressure sores,<sup>283</sup> or fell<sup>284</sup>. These are problems primarily in the provision of nursing care, which includes advocacy for the patient's wellbeing. One example was a 64 year old with a cognitive disorder, multiple chronic conditions including diabetes, COPD, coronary artery disease, etc. whose death in March 2023 was a result of a brain hemorrhage that occurred when he fell to the floor. In the last year of his life, he experienced a fall nearly every other week. He became increasingly confused, aggressive and noncompliant refusing even assistance with hygiene. No steps were taken to develop a plan that would address the deterioration in his

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<sup>278</sup> Health Care Monitor 4th Report Lippert v Jeffreys (September 16, 2021) pages 123-130; Health Care Monitor 5th Report Lippert v Jeffreys (July 22, 2022) pages 111-112; Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys, March 13, 2023, pages 104 - 108.

<sup>279</sup> Infirm patients # 5-12.

<sup>280</sup> These changes might have included adjustments to diuretics, diet, sodium etc. Infirm patient # 5.

<sup>281</sup> Infirm patients # 7, 8, 9, 11, 13.

<sup>282</sup> Infirm patients # 6, 10, 15, 17 were patients for whom the reason was documented for use of a catheter, or the intervention was not medically indicated or was not cared for properly and the patient experienced infection.

<sup>283</sup> Infirm patients # 5, 6, 7, 17, 18, 19.

<sup>284</sup> Infirm patients # 13, 14, 15, 20, 21.

condition.

In the last report we discussed two instances of patients who ingested cleaning products and the lack of inventory control and inappropriate steps taken after ingestion to care for the patients.<sup>285</sup> Among the records available for this report was a patient who was in the infirmary primarily because of a cognitive disorder, thought to be dementia. He also had hypertension, atrial fibrillation, congestive heart failure, prostatic hypertrophy, and seborrheic dermatitis. He drank some form of lotion during his infirmary stay and the plan of care was only to monitor his condition. As stated in the last report, this is considered an adverse event and should have been reported as such. In addition, the Material Safety Data Sheet (MSDS) should be obtained, and Poison Control contacted. There was no documentation that either was done.<sup>286</sup>

The Monitor reviewed the information provided by facilities about patients in the infirmary on April 30, 2023, which included the name, age, DOC#, diagnoses, and date of admission to the infirmary. On that day 68% of the infirmary beds available statewide were filled, however nine facilities were more than 80% filled with three having no beds available.<sup>287</sup> Of those facilities that provided the patient's admission date, two thirds had been in the infirmary for more than 30 days. Nearly a third of the patients had occupied an infirmary bed for a year or more. Every time an infirmary bed is occupied by a long stay patient that bed is offline for anyone else who may need it. Until IDOC manages the utilization of these beds access to infirmary level care will diminish over time.<sup>288</sup>

The Monitor rounded on all the patients in the infirmary during the site visit to Graham in July with the infirmary nurse. Two of the patients were in the infirmary simply because they had insulin pumps which are considered a security issue.<sup>289</sup> One of these men stated that he had been in the infirmary 117 days. Another patient had been in the infirmary for eight years because he is on an oxygen concentrator.<sup>290</sup> A fourth man was in the infirmary because his wrist was cased, also a security issue.<sup>291</sup> These are examples of persons taking up infirmary bed space who should be housed in a setting other than an infirmary.

### **Appropriate Physical Conditions for Infirmary Care**

The Monitor has found the space to provide needed services and programs for infirmary patients to be inadequate at all facilities site visited so far.<sup>292</sup> Graham was visited by the Monitor team during this report period and the space and programming for infirmary patients found inadequate as well. The nursing station is not functional and there is no space for examination or treatment on the unit. There are curtains between the beds in the six-bed rooms for visual privacy but there is no auditory privacy. Clinical rounds cannot be done in these rooms and any assessments or treatments would lack auditory privacy. The examination and treatment rooms in the clinic can be used to see infirmary patients but this would require scheduling and there is not enough space in the clinic either.

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<sup>285</sup> Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys, March 13, 2023, page 106.

<sup>286</sup> Infirmary patient # 13.

<sup>287</sup> Facilities filling more than 80% of the infirmary beds on that day were Big Muddy, Centralia, Hill, Lincoln, Logan, Pinckneyville, Shawnee, Sheridan, and Western.

<sup>288</sup> This same information was collected for 9/30/2022 and evaluated for the Monitor's 6<sup>th</sup> Report. The percentage of patients in an infirmary bed longer than 30 days at that time was 44% and the percentage occupying an infirmary bed longer than a year was 22%. Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys, March 13, 2023, page 101.

<sup>289</sup> Infirmary patients # 1, 2. A member of the OHS staff was on these rounds and shared plans to address the security problem by implementing different technology to track the need for insulin.

<sup>290</sup> Infirmary patient # 3

<sup>291</sup> Infirmary patient # 4

<sup>292</sup> Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys, March 13, 2023, page 57. These are Dixon, Lincoln, Logan, Robinson, and Shawnee.



Patients do not have a call system. Instead, patients are to bang on the window of the cell to summon help. Patients are not within sight or sound of the nurse assigned to the infirmary. Officers roam the area, and the workstation provides direct sight to all of the rooms except the first six-bed room. However, if a patient was unable to summon help for themselves, they would have to ask another patient to bang on the window. The method infirmary patients request attention is dangerous and needs improvement.

The six-bed rooms are not suited for delivery of infirmary care, especially for long stay patients. Other than a television and their personal belongings (books, tablets etc.) there is no equipment or supplies to support social interaction or leisure activity.

No additional information has been provided about the scope of services and structure of the new facility planned for Joliet, Illinois despite repeated inquiries from the Monitor. This facility was originally to have included 50-52 new medical beds.

## **Appropriate Staffing for Infirmary Care**

### **Physician Staffing**

There has been no workload analysis to determine the number of staff needed to adequately care for patients needing infirmary level care.<sup>293</sup> The Monitor reviewed the assignments of providers in May 2023 that were sent by 27 facilities to evaluate infirmary staffing. There are four facilities with more than 20 beds in the infirmary; Dixon, Menard, Stateville and Graham. Three of the facilities assign either a physician, physician's assistant, or an advanced practice nurse to the infirmary every weekday.<sup>294</sup> At Stateville a physician is assigned to the infirmary four days each week. No onsite provider is available in the infirmary on weekends. Menard with the second largest infirmary assigns the provider responsibility for urgent care as well as the infirmary.

There are nine facilities with 15 to 20 infirmary beds of which six routinely only assign infirmary rounds once a week, which means admission notes and provider rounds will not be completed per the timeframes in the Administrative Directive.<sup>295</sup> At five of these facilities the provider is also responsible for urgent care encounters and in some cases chronic care as well. At only two facilities is the provider assigned solely to infirmary care.

At the remaining facilities, those with less than 15 infirmary beds the provider assigned to the infirmary is also responsible for urgent care and chronic care. It appears that whatever provider is scheduled at the facility that day is responsible for all aspects of provider-driven care.

In addition to the numbers of provider positions being insufficient, 33% of physician positions and 18% of nurse practitioner/physician assistant positions are vacant.<sup>296</sup> This means that infirmary patients are more likely to be cared for by nurse practitioners or physician assistants which the Monitor believes is inappropriate. While some provider coverage is obtained via locum tenens or other type of contract it is not sufficient, particularly when managing the care of patients with complex medical problems who require care in the infirmary setting.

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<sup>293</sup> Step 5 of item 71 in the Implementation Plan with an expected end date of February 2024.

<sup>294</sup> Dixon, Menard, and Graham.

<sup>295</sup> Administrative Directive 04.03.120 currently requires documentation by the admitting provider within 48 hours and three days a week thereafter for patients admitted for acute care which is defined as any patient with rapid onset of symptoms of short durations, patients being treated for acute illnesses, and post-operative patients.

<sup>296</sup> Information provided by the vendor in response to the Monitor's document request # 12 allocated positions with vacancies, 6.30.2023. The vendor has 33.47 allotted physician positions of which 11.17 are vacant (33%). The vendor also has 48.5 allotted positions for a physician's assistant or nurse practitioner, of which 8.65 are vacant (18%).

One of the charts reviewed for this report provides an example of the consequences of inadequate provider staffing.<sup>297</sup> A 68 year old with COPD, chronic leukopenia and thrombocytopenia, hypertension, and cirrhosis. He was sent to the emergency room in August 2022 with pitting edema of the lower extremities and elevated TSH and D-dimer. He was returned to the institution that same day with orders for Lasix, daily weights, and oxygen. The recommendation was to see his primary provider in a day or two and to repeat lab work. This visit never happened. Subsequently he continued to be short of breath, need oxygen and had edema of his lower legs. He had low blood pressure which was not addressed except in November 2022 he was urged to increase his intake of salt and water despite have edema of the legs of unknown etiology. A nurse referred the patient to the doctor again in January 2023 for the edema but he was not seen for this problem for 19 days. At this encounter the dose of Lasix was increased and lab work ordered. At no point until his death in March 2023 was the reason for the edema in his lower legs worked up and his chronic disease conditions were not managed. This is a facility lacking a medical director and without regular primary care coverage.

In previous reports the Monitor has recommended that all providers have access to UpToDate® an online medical reference, which was reported in the past to have been made available by the vendor at all IDOC sites.<sup>298</sup> However interviews with medical staff at Graham reported that no reference material is provided except what they bring in themselves and that it can only be accessed in their office, not the exam room. Based on mortality reviews, providers caring for patients in the infirmary did not always know how to manage patient conditions, failed to understand drug-drug interactions, etc. For this reason, the Monitor continues to recommend that providers be provided with access to this reference *in each of the exam rooms*. Additional decision support material should be considered in the development of the standardized list of equipment to be available in every health care unit.<sup>299</sup>

The Monitor has found that patients in the infirmary were poorly managed by providers in every report so far. The Morbidity and Mortality Review Committee initiated by OHS in June 2022 also has identified a significant number of opportunities for improving medical care of patients in the infirmary. OHS has begun to act on these findings initiating projects but these have not yet included consideration of the staffing needed to provide adequate medical care for infirmary patients.

### **Registered Nurse Staffing**

The Monitor has information on the nursing coverage for nine of the IDOC infirmaries.<sup>300</sup> Stateville, with an infirmary of 25 beds and NRC with an infirmary of 12 beds are the only facilities that regularly assign two nurses to the infirmary from 7 am to 11 pm. Dixon, with the largest infirmary, staffs a single nurse on each shift. Based upon the snapshot infirmary census on 4/30/2023 the acuity of patients at Stateville and Dixon are similar.<sup>301</sup> Pontiac with an infirmary the same size as NRC only staffs the infirmary with one nurse each shift. Lincoln, the only minimum facility reviewed thus far and with less than 10 infirmary beds, does not assign a registered nurse to the infirmary but responsibility for infirmary care is one of the duties of nurses working the shift.<sup>302</sup> We know that nurse assistant positions have been allocated to the staffing mix, but it is not clear what assignments they

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<sup>297</sup> Infirmary patient # 7.

<sup>298</sup> Health Care Monitor 2nd Report Lippert v. Jeffreys, August 6, 2020, page 106, Health Care Monitor 3<sup>rd</sup> Report Lippert v Jeffreys, February 15, 2021, page 98; Health Care Monitor 4th Report, Lippert v Jeffreys, September 16, 2021, page 133; Health Care Monitor 5<sup>th</sup> Report, Lippert v Jeffreys, June 22, 2022, pages 115-116; Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys, March 13, 2023, page 110.

<sup>299</sup> Implementation Plan, item # 54.

<sup>300</sup> This information is derived from site visits to Graham, Dixon, Shawnee, Logan, Lincoln and from the nurse assignment sheets provided by Stateville, NRC, Centralia, and Pontiac. Information provided by Menard and Graham was not useable because the nurses are employed by IDOC rather than the vendor. IDOC sent no information in response to this request.

<sup>301</sup> Comparisons included the percentage of infirmary beds occupied, patients over 50 years old, patients over 65 years old, acute patients, patients admitted more than 30 days ago, patients admitted more than a year ago.

<sup>302</sup> Health Care Monitor 2nd Report Lippert v. Jeffreys, August 6, 2020, page 103.

have.<sup>303</sup> There has been no staffing analysis to establish the number and types of nursing positions that are necessary to provide nursing care for patients in the infirmaries at IDOC facilities but this step has been included in item 71 of the Implementation Plan.

IDOC did not provide any information on allocated nursing positions and whether they were filled or not for this report, as they have in the past, so it is not possible to ascertain the adequacy of staffing in the infirmaries. In previous reports the Monitor has commented that facilities do not have enough filled positions to cover the infirmary without use of overtime or agency personnel.<sup>304</sup> This would still be the case based upon the more limited data set provided by the vendor on filled and vacant nursing positions as of 6/30/2023. At that time more than 70% of allocated registered nurse and licensed practical nurse positions were vacant.<sup>305</sup> Inadequate nursing coverage in the infirmary is a function of not having enough of the right type of positions to meet patient needs as well as high numbers of vacant positions.

With regard to the Consent Decree IDOC has provided no proof of practice to show compliance with **III.I.1. A registered nurse will be readily available whenever an infirmary is occupied in the IDOC system** or **III.I.3. All facilities shall employ at least one registered nurse on each shift. If a prisoner needs health care that exceeds the IDOC infirmary capabilities, then the prisoner shall be referred to an offsite service provider or a hospital.** Nursing assignments at the time of the Monitor's site visits to Logan, Lincoln, Shawnee, Dixon, and Graham demonstrate compliance with these two requirements of the Consent Decree. The Monitor has not site visited the maximum security facilities and the data provided by IDOC is not sufficient to consider **III.I.2.** compliant.<sup>306</sup> Suggested revisions to the draft policy and procedure on Infirmary Level Care include the staffing requirements from the Consent Decree and a method to report compliance.

### **Ancillary and Support Personnel**

IDOC has 5.45 FTE physical therapists and 10.7 FTE physical therapy assistants allocated. Of these all but 0.9 FTEs physical therapist positions have been filled and all but three of the physical therapy assistants are filled.<sup>307</sup> As discussed in the 5<sup>th</sup> Report there are still many facilities with no physical therapy positions so there remain many patients who do not have access to this service.<sup>308</sup>

Physical therapy services at Graham CC were initiated in the fall of 2022. These staff see patients in the infirmary and have reached out to engage the elderly population in HU 10. Physical therapy sessions, not conducted on the infirmary are conducted in the gymnasium. The current physical therapy location is inadequate, lacks privacy and a way to secure equipment, is inefficient because only a limited number of patients can be treated at a time, and is woefully under equipped with devices/therapy equipment. IDOC must identify a more professional space for PT services or upgrade the space in the gym.

Physical therapy services were identified as problematic in three of the death records reviewed. Two of the three

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<sup>303</sup> The assignments sheets from Stateville are the only ones that indicate one nurse assistant is assigned to the infirmary each shift. See the Monitor's 6<sup>th</sup> report Dixon also assigns one nurse assistant to the infirmary each shift, page 109.

<sup>304</sup> Health Care Monitor 2nd Report Lippert v. Jeffreys, August 6, 2020, page 103, Health Care Monitor 3<sup>rd</sup> Report Lippert v Jeffreys, February 15, 2021, page 96; Health Care Monitor 4th Report, Lippert v Jeffreys, September 16, 2021, page 131; Health Care Monitor 5<sup>th</sup> Report, Lippert v Jeffreys, June 22, 2022, page 114; Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys, March 13, 2023, page 109.

<sup>305</sup> Of 263 LPN positions, 199 were vacant (76%). Of 221.4 registered nurse positions 161.4 were vacant (73%).

<sup>306</sup> *At every facility regularly housing maximum security prisoners, there shall be at least one registered nurse assigned to the infirmary at all times, twenty-four (24) hours a day, seven (7) days a week .*

<sup>307</sup> This is an improvement since the Monitor's 6<sup>th</sup> Report when 5.5 FTE physical therapy assistant positions were vacant.

<sup>308</sup> Health Care Monitor 5th Report Lippert v Jeffreys (July 22, 2022) pages 114-115. There are eight facilities with a population greater than 900 according to the IDOC Quarterly Report, October 1, 2023 or over 11,000 individuals who do not have access to onsite physical therapy services by virtue of their facility assignment.

facilities that housed these patients have no physical therapy staff allocated.<sup>309</sup>

The Monitor strongly recommends focusing on filling the remaining vacant physical therapy positions and assessing the actual need of patients for access to physical therapy at all facilities but particularly at facilities with populations of 900 or more.

#### **III.I.4 Access to Security Staff in the Infirmery**

Graham provided the following documentation of compliance with III.I.4. Five correctional officer posts are assigned to the HCU. One of these, post 635, is assigned to the infirmary. Additional officers are assigned to monitor when patients are in the infirmary on crisis watch. We observed at least two correctional officers in the infirmary at all times during the site visit. We also were provided with a month of staffing sheets that show a correctional officer assigned to post 635 all shifts from 6/12/2023 – 7/12/2023. We observed no delays in access to patients during the site visit and there was no indication of such in the material reviewed. III.I.4, access to security staff at all times in the infirmary, is met. Compliance with the requirement for access to security staff has been evident at each of the sites visited by the Monitor thus far.<sup>310</sup> Suggested revisions to the draft policy and procedure on Infirmery Level Care include language regarding security coverage and a method to report compliance with III.I.4.

#### **III.I.5 Bedding and Linens**

The Consent Decree requires that all infirmaries and health care units shall have sufficient and properly sanitized bedding and linen for the infirmary. In the last report the Monitor reviewed procedures for sanitizing infirmary bedding and linens submitted by three facilities. Each of the procedures addressed only the handling of laundry soiled with blood or other body fluids in conformance with AD 04.03.116. None of the procedures sent, defined the amount of clean linen to have on hand, how it is transported and received, how it is stored, or how laundry is handled once it has been used, if not contaminated with blood or other body fluids, how it is laundered etc.<sup>311</sup>

At Graham clean linens are provided by the nurse admitting the patient for infirmary care. After that linens are washed by porters on the unit. Each individual's linens are laundered separately four days a week. We were not provided with instructions for how laundry is done on the unit and presume they don't exist given that we were provided other information on the subject of sanitation in the HCU.<sup>312</sup> Any linen contaminated with blood, urine, or feces is placed into a biohazard bag and laundered by the institution laundry. When a patient is discharged from the infirmary the linens are returned to the HCU. Clean linens are ordered from the facility warehouse as the supply is depleted. Clean linens are transported in special bags marked as clean linen and are folded and stored on a covered linen cart in central supply. We did not check the supply of clean linens but noted no absence of clean and appropriate linens during infirmary rounds. Graham was in partial compliance with III.I.5. of the Consent Decree requires that "*All infirmaries and HCU's shall have sufficient and properly sanitized bedding and linens.*" Procedures for sanitizing linens need to provide more detailed steps to prevent transmission of infection during routine handling and laundering of bedding and linen used in the infirmary and these steps monitored for compliance.

The Monitor commented in September 2023 on draft policy and procedure F.04.01 Infirmery Services that a

<sup>309</sup> Mortality review patients # 13, 15, 21. These facilities are Vandalia and Danville.

<sup>310</sup> Robinson, Sheridan, Shawnee, Logan, Pontiac, Lincoln, Lawrence, Dixon, and Graham.

<sup>311</sup> Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys, March 13, 2023, page 111.

<sup>312</sup> The institution procedure on Infirmery Linens only states that "Infirmery linen will be laundered at the Health Care Unit (excluding blankets) unless there is a possibility of contamination; i.e., isolation, bodily fluid spills etc.

separate policy and procedure on sanitizing and handling of bedding and linens used in the infirmary needs to be developed. References from the Centers for Disease Control and Prevention for handling linens in health care settings were suggested as resources to develop a procedure for the inventory, storage, handling, and laundering of all linens used in the health care setting not just those that are contaminated with blood or other body fluids.<sup>313</sup> Such a policy and procedure has yet to be developed by OHS.

**II.B.1.** *IDOC shall provide access to an appropriate level of primary, secondary, and tertiary care*

IDOC has made a significant commitment in the Implementation Plan to the needs of the aged, infirm, and disabled populations for appropriate housing, programming, and health care. The narrative section of the Implementation Plan states that IDOC will ***“Hire a qualified consultant to quantify the numbers of aged, infirm, and disabled, to determine gradations of need of the population, to identify appropriate housing and management options for this population and to produce a report of findings and recommendations.”***<sup>314</sup>

The narrative further states that the Department will ***“evaluate the health care needs of the aging, infirm, and disabled populations housed in IDOC facilities. IDOC will seek assistance from the Illinois Department of Aging or a qualified consultant to develop a survey to quantify the numbers of these population groups within IDOC, and assess the health care and health-care-related housing needs of these populations. IDOC will develop options and recommendations to address the clinical care need gaps and clinical-care-related housing need gaps identified in the survey. IDOC will take appropriate actions to correct gaps in housing and clinical care needs of these populations.”***<sup>315</sup>

***“IDOC is committed to ensuring appropriate housing for the aged, infirm, and disabled populations including those with memory deficits, disabilities, and those in need of assistance with activities of daily living. Approximately 20% of inmates housed in IDOC are over 50 years of age. This population has considerably greater health needs and presents difficulties with respect to housing. However, there is uncertainty with respect to the scope of need for this population. For that reason, IDOC will hire a qualified consultant to develop a questionnaire based on the Illinois Department of Aging determination of need survey that is required of all persons entering a nursing home. This assessment of needs will result in a report with recommendations to form the basis for the development of action steps to provide appropriate resources, programming, and housing for the aged, infirm, and those with disabilities or those needing assistance with activities of daily living. The report would also provide guidance on the numbers of aged who have disabilities, memory deficits or other assistance needs that would provide data for a subsequent plan on how to best provide for these individuals. The analysis and development of the action plan will be performed in consultation with the Monitor.”***<sup>316</sup>

This evaluation and development of recommendations to address deficiencies that impact the health and physical safety of the aged, infirm, and/or disabled takes place over the next calendar year via six steps outlined in the Implementation Plan which are copied below. The Monitor has not been informed that any of this work has begun. Findings from the Morbidity and Mortality Committee confirm the need for IDOC to follow through with the

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<sup>313</sup> [Laundry | Background | Environmental Guidelines | Guidelines Library | Infection Control | CDC](#) and [Appendix D: Linen and Laundry Management | Environmental Cleaning in Resource Limited Settings \(RLS\) | Healthcare-Associated Infections \(HAI\) | CDC](#). Search on the CDC website for each of these items for guidance.

<sup>314</sup> Implementation Plan narrative page 2.

<sup>315</sup> Implementation Plan narrative page 5.

<sup>316</sup> Implementation Plan narrative page 6.

following steps from the Implementation Plan.

- **Implementation Plan item 64: *Identify and hire a qualified consultant to survey the medical needs for aged/infirm/disabled persons incarcerated in the IDOC.***
  1. *Determine the data that is appropriate to describing the needs of this population.*
  2. *Define scope of review to include:*
    - a. *determining the population of persons with dementia, memory impairment, aged and in need of supportive housing, severe medical infirmities and disabilities requiring specialized medical housing;*
    - b. *describing and quantifying existing services, clinical care, and housing for this population and its appropriateness;*
    - c. *providing recommendations and options for adequately addressing needs of this population.*
  3. *Determine parties responsible for participation in the project and set dates and expectations for work product. May-23.*  
***Proposed End Date: December 2023***
  
- **Implementation Plan item 65: *Identify existing IDOC levels of care with corresponding housing and programming arrangements for the aged, infirm and disabled.***
  1. *This includes review of existing medical classification system for housing the aged/infirm/disabled.*
  2. *Identify a range of aged/infirm/disabled populations by functional status within each living arrangement. For example, general population, protected housing, infirmary, etc. The type of facility (minimum, medium, and maximum security) is to be identified.*
  3. *Describe existing practices to prepare for early parole release of the aged/infirm/disabled and any expansions of such under the Joe Coleman Medical Disability Act.*
  4. *Identify community resources available to aged/infirm/disabled incarcerated population, identifying Medicaid available resources and nursing home options for care at the end- stage of life.*  
***Proposed End Date: March 2024***
  
- **Implementation Plan item 66: *Assess medical needs of aged and infirm.***<sup>317</sup>
  1. *Convene a focus group of aged/infirm/disabled persons to identify issues with housing and programming unique to this population and their need for care.*
  2. *Determine process to survey aged/infirm/disabled persons. Interviews using telemedicine may be an option. This may require sample sized population depending on numbers.*
  3. *Survey to include level of care needed, cognitive survey Montreal Cognitive Assessment (MOCA or other similar survey instrument), clinical risk assessment, intensity of nursing care needed, functional capacity, proximity of facility to specialty services, need for specialty services.*
  4. *Consultation with a survey research group may be indicated.*
  5. *Perform record reviews of people surveyed. This may be a sample population of persons in various categories of nursing need and functional status. Record review is to determine medical needs, number and types of medications, need for specialty care, accommodations provided or needed, and need for*

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<sup>317</sup> OHS is in the process of developing a survey instrument to assess for dementia and other cognitive impairments during the intake health assessment. However, the survey instrument and methodology has not been shared with the Monitor for review and comment. The Monitor applauds the plan to assess for these disorders at intake but does not consider this assessment to be in completion of item 66 of the Implementation Plan.

*nursing care.*

***Proposed End Date: July 2024***

- **Implementation Plan item 67:** *Convene a focus group of facility staff to better understand medical needs for the aged and infirm. **Proposed End Date: July 2024***
  
- **Implementation Plan item 69:** *Based on surveys and data reviewed, complete a report of the aged/infirmary/disabled population to describe in various functional status cohorts the medical beds or special housing arrangements available for this population as well as the need for these based upon length of sentence, medical risks and conditions, nursing needs, functional capacity and disabilities, and need for specialty care of each group. Patterns of civilian care are to be used as a template to describe levels of care for a similar but incarcerated population. These are routine medical care, home nurse visit care, adult day care, elderly housing without assistance, assisted living, nursing home, skilled nursing home, and hospice. Develop housing and programming options for each group. **Proposed End Date: October 2024***
  
- **Implementation Plan item 70:** *Provide recommendations to address deficiencies identified in the study that impact the health and physical safety of the aged/infirmary/disabled to include options for addressing deficiencies in housing these populations and support for each level of care.*
  1. *Develop recommendations for modifications to housing and classification system for aged/infirmary/disabled population to ensure match of housing to functional need. These recommendations may include identification of new or renovated housing for this population.*
  2. *Provide housing recommendations to the Physical Plant Consultant to incorporate into the evaluation of space.*
  3. *Identify and develop additional resources to address needs for equipment, training, specialty consultation in the care of the aged/infirmary/disabled, and at the end-of-life (i.e., geriatrics, guardianship, dementia, medication management, rehabilitation, and activities of daily living).*
  4. *Work with Re-Entry Services and Parole Board to develop process to identify eligible persons and make requests for early medical release.*
  5. *Identify, develop, and implement a plan or policy and standardized procedures to address each recommendation.*
  6. *Develop interim processes for housing until capital improvements occur.*
  7. *Engage CDB in steps necessary to obtain approval and funding for necessary modifications. (IDOC Capital Projects) Initiate Jan-24, Complete Dec-25.*

***Proposed End Date: December 2025***

The completion of the steps outlined in the Implementation Plan IDOC will improve access to infirmary services and provide appropriate physical conditions for others who because of their physical or mental condition are not able to be housed elsewhere. These changes support compliance with II.B.1. The recommendations have been revised to reflect the commitments IDOC made in the Implementation Plan.

#### **RECOMMENDATIONS:**

1. Complete the work called out in the Implementation Plan items 64-68, 69-71 and the accompanying narrative as scheduled.
2. Finalize and implement the draft policy and procedure on Infirmary Care (F.04.01) once the Monitor's redline and comments are incorporated.
3. Fill allocated positions.
4. Evaluate the need for physical therapy services at each institution with an infirmary. The Monitor

continues to recommend that physical therapy services be provided at all facilities with infirmaries that house over 900 incarcerated persons.

5. Clarify whether infirmary care that will be provided at the renovated Joliet Treatment Center.
6. Increase access to Up-To-Date®. Additional decision support material should be considered in the development of the standardized list of equipment to be available in every health care unit.
7. Initiate the adverse event reporting system and include requirements to report falls, decubiti, and accidental ingestion of non-food products. Initiate facility specific improvement projects to address preventable injuries.
8. Develop procedures to establish inventory control of linen for the infirmary, direct the conditions and practices for transport and storage of clean line, and the handling and laundering of dirty linen that are in accordance with contemporary standards for control of transmissible diseases.
9. Utilize resources available at SIU and UIC to educate providers and nursing staff about managing the care of geriatric patients, palliative and end of life care, and preventing injury in the inpatient setting (fall prevention, skin care, infection associated with urinary catheters, PICC line care etc.).

## Specialty Consultation

**Addresses Items II.A; II.B.1; II.B.6.e; II.B.6.g; III.E.4; III.H.1-4**

**II.A.** Defendants shall implement sufficient measures, consistent with the needs of Class Members, to provide adequate medical and dental care to those incarcerated in the Illinois Department of Corrections with serious medical or dental needs. Defendants shall ensure the availability of necessary services, supports and other resources to meet those needs.

**II.B.1.** IDOC shall provide access to an appropriate level of primary, secondary, and tertiary care

**II.B.6.e.** IDOC agrees to implement changes in the following areas: Informed care for patients who return to IDOC facilities after being sent to an offsite service provider;

**II.B.6. g.** IDOC agrees to implement changes in the following areas: Timely access to diagnostic services and to appropriate specialty care;

**III.E.4.** The medical records staff shall track receipt of offsite medical providers' reports and ensure they are filed in the correct prisoner's medical records.

**III.H.1.** Medical staff shall make entries in a log, preferably electronic, to track the process for a prisoner to be scheduled to attend an offsite service, including when the appointment was made, the date the appointment is scheduled, when the prisoner was furloughed, and when the prisoner returned to the facility. This log shall be maintained by the HCUA.

**III.H.2.** Within three days of receiving the documentation from scheduled offsite services, the documentation will be reviewed by a medical provider. Routine follow-up appointments shall be conducted by facility medical staff no later than five (5) business days after a prisoner's return from an offsite service, and sooner if clinically indicated.

**III.H.3.** If a prisoner returns from an offsite visit without any medical documentation created by the offsite personnel, IDOC shall use best efforts to obtain the documentation as soon as possible. If it is not possible to obtain such documentation, staff shall record why it could not be obtained.

**III.H.4.** Provided that IDOC receives documentation from offsite clinicians, all medical appointments between a prisoner and an offsite clinician shall be documented in the prisoner's medical record, including any findings and proposed treatments.

**OVERALL COMPLIANCE RATING:** Noncompliance

**FINDINGS:**



A draft policy and procedure on specialty care and medical holds was provided to the Monitor who returned comments to IDOC in September, 2023. Review of comments is not completed, and a final policy and procedure has not yet been achieved.

Actual performance is still not in compliance with the Consent Decree items related to specialty care. This conclusion is based on numerous examples documented in SIU mortality reviews. The Monitor also reviewed the records of two patients who each had multiple consults. The findings from the review of the specialty care for these two patients coincide with the findings from the SIU mortality reviews.

1. **II.B.6.e: Informed care needs to occur post specialty visits.** Provider follow up after specialty consultations were not timely or did not occur at all. When a follow up visits did occur, there is no documented discussion with the patient to inform them of the updated plan of care. For example, one of the patients reviewed<sup>318</sup> was not seen after a cardiology appointment, and then was not seen timely for two additional specialty appointments.<sup>319</sup> Neither of the untimely follow ups document informing the patient of the updated plan of care.
2. **II.B.6.g. Timely access to diagnostic services or specialty care is not occurring.** Another patient<sup>320</sup> was seen by an ENT specialist for problems swallowing. A swallowing study was recommended. However, the patient died five months after the recommendation and the test had not been completed by that time.
3. **II.E.4. Medical records fail to track receipt of specialty reports.** The specialty care logs show that most facilities do not track receipt of specialty care reports. Any paperwork received with respect to a consultation is accepted as a report. Reports are still not the written reports from the consultant that the Monitor has indicated in previous reports are acceptable. There were multiple examples in mortality reviews of not receiving reports when patient wellbeing was compromised due to the lack of this information.
4. **III.H.1. IDOC still does not maintain a log consistent with requirements of the Consent Decree.**<sup>321</sup> The HCUA is to be responsible for maintaining the log but logs are maintained by the vendor. One patient<sup>322</sup> had inaccurately logged referrals on the 2<sup>nd</sup> quarter 2023 specialty care log. The first referral was to neurology. An LPN documented memory loss on 4/7/22. The patient was referred to a provider and seen on 4/22/22. The provider noted 1-2 years of memory loss and documented referral to neurology. However, the referral wasn't written for 13 days (5/5/22), when the patient was approved for neurology. The urgency of the consult wasn't documented. On 6/10/22, the scheduling clerk wrote that a message was left with the Neurology Institute for a consult. On 8/30/22, the scheduling clerk wrote a note that the appointment was scheduled. The 2<sup>nd</sup> quarter specialty care log documented that the patient was referred to neurology on 8/31/22 which is inaccurate as the patient was referred on 4/22/22. The patient had the neurology appointment on 9/8/22.

The patient also had cardioversion on 2/24/23 with a recommendation to return for follow up on 3/24/23. On 2/24/23, the day of the cardioversion, a provider documented that the patient had cardioversion and was to follow up with the cardiologist on 3/24/23; no referral or order was present in the record on this date. The log documented that the referral to cardiology was made 3/8/23 but there was no documented note by a provider on 3/8/23 and no referral form or order. On 3/18/23 a medical records note documented

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<sup>318</sup> Specialty patient #1

<sup>319</sup> This patient was not seen for five weeks after an ENT appointment, and not seen for nine weeks after a second cardiology appointment.

<sup>320</sup> Specialty patient #1

<sup>321</sup> The date of referral is not consistently the date that a provider referred the patient but the date that the scheduling clerk logs the referral.

<sup>322</sup> Specialty patient #2

that the clerk scheduled the follow up with cardiology. There was no evidence that a referral was made or order written. The referral date on the log was unrelated to any clinical event or to a provider order. What the log needs to reflect is the first date that a provider refers the patient to a consultant. It appeared that the scheduling clerk arranged this appointment without provider direction.

5. **III.H.2.** Review of the consultation within three days and a follow up with the patient within five days inconsistently occurs. The first patient<sup>323</sup> cited as an example in this section had a cardiology appointment on 5/25/22. A provider did not review the consult for 15 days after the specialty appointment (6/9/22) but never followed up with the patient to update the plan of care.
6. **III.H.3.** When the consultant report does not return with the patient a best effort is used to obtain the report. SIU mortality reviews gave examples of failure to obtain consultant reports. These failures are not tracked. There is no evidence documented in the patient's record or on the log of any action taken to obtain the report. Failure to obtain a formal written consultant report should be tracked. The Monitor suggests that this become a performance and outcome measure.
7. **III.H.4.** The medical record does not consistently document all specialty care appointments including recommended treatments in the medical record. The existing policy for specialty care is Administrative Directive 04.03.103 Offender Health Care Services. This policy does not require documentation of when a patient attends an offsite appointment. The draft policy D.04.01 that addresses specialty care will need to address this documentation requirement. In practice, documentation regarding whether a specialty appointment occurs varies considerably and appears optional as some facilities do not even document that a patient went to a specialty appointment. Many specialty visits are documented using the DOC 0090 Offender Health Status Transfer Summary form. Sometimes a nurse progress note is used. The DOC 0090 form is not an appropriate form for communicating with a consultant and needs to be discontinued as soon as feasible.

SIU mortality reviews document multiple instances where transfer of information to the consultant was deficient leaving the consultant without sufficient information to conduct the consultation. There were also information transfers back to the facility that resulted in failure to consider consultant recommendations. These communication errors need to be addressed by policy and corrected in a standardized manner.

**Implementation Plan item 52: *The process for specialty care should include:***

1. *Analysis of use of telemedicine and e-consult to improve access to specialists.*
2. *Analysis of whether additional equipment (telemedicine) or contracts (with university programs) might improve access to specialty care.*
3. *Analysis of primary care physicians referral patterns for specialty care and utilization of consultant services.*
4. *Analysis of receipt and timeliness of consultant reports, and whether facility providers take appropriate action, if necessary, on those reports.*
5. *Analysis of scheduling and tracking of specialty care to ensure whether scheduling is timely.*

***Proposed End Date: March 2024***

IDOC has not initiated an analysis of their specialty care in order to improve specialty care services as required by Implementation Plan item 52.

Opportunities for Improvement (OFI) in access to specialty care and other OFIs related to specialty care were one of the most frequently identified in SIU mortality reviews. These findings were similar to findings of the

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<sup>323</sup> Specialty patient #1

Monitor in prior reports. The OFIs related to specialty care should be the basis of an analysis of specialty care. IDOC should consider the following when performing an analysis of specialty care and when crafting corrective actions based on the OFIs.

1. A root cause should be sought for delays in referral to specialty care for a long-standing sign or symptom. For example, not referring to a gastroenterologist for abdominal pain, weight loss and blood in the stool. The root cause of failing to refer may be multi-faceted including the following.
  - a. There were multiple OFIs related to physician oversight, physician availability, and failure to recognize or address significant signs and symptoms. These types of OFIs relate, in part, to lack of physician staffing (resulting from insufficient budgeted physicians and from vacancies in budgeted positions) results in inattention to needs of the patient and failure of physician to provide oversight over non-physician clinicians and nurses. A workload staffing analysis of the need for physician positions would help significantly.
  - b. Prior utilization standards used by the vendor should not be used as standard of care.<sup>324</sup> Expectations of providers related to use of specialists may require re-orientation and training on current standards of care including, for example, obtaining timely colonoscopy for either colorectal cancer screening or abnormal gastrointestinal symptoms, baseline pulmonary function testing for chronic obstructive pulmonary disease, when to obtain physical therapy for infirmity patients, etc. These expectations should be accomplished by vendor Regional Medical Directors but in interviews with two Regional Medical Directors they did not take responsibility for the multiple findings of delayed access to specialty care and hospitalization. One of the Regional Medical Director believed that access to specialty care was comparable to the community<sup>325</sup> and another Regional Medical Director said he had not reviewed the SIU mortality reviews. If the vendor Regional Medical Directors cannot or will not create clinically appropriate expectations for referral, this should be accomplished by OHS. SIU mortality reviews identify many opportunities that call for improvement because the standard of care was not met.
2. There were multiple OFIs in SIU mortality reviews related to lack of coordination of specialty care including:
  - i. Information transfers to and from consultants at IDOC facilities including:
    - a. Failing to communicate existing problems of the patient to the consultant;
    - b. Failing to effectively communicate medications of the patient to the consultant and failing to evaluate new medication recommendations;
    - c. Failing to communicate end-of-life desires of the patient to the consultant;
  - ii. Failing to obtain consultant reports;
  - iii. Failure of IDOC to coordinate recommended follow up timely and failure of physicians to be aware of delayed consultations; and
  - iv. Failure to engage a physician in clinical decision making regarding significant changes in patient status.

These problems have multi-faceted causes that include staffing of multiple different types of staff (scheduling clerks, nurses, non-physician clinicians, and physician). They also involve the lack of coordination of various staff involved in the management of the patient. For that reason, the Monitor continues to recommend regular (weekly) huddles regarding patients needing or undergoing specialty consultation. This is in line with a primary care model of medical care which emphasizes team coordination of patient care. IDOC should consider development of a Primary

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<sup>324</sup> For example, the utilization standard of correcting only one cataract because vision in one eye is considered adequate or not correcting inguinal hernias.

<sup>325</sup> The Monitor disagrees with this assertion which is also belied by the innumerable OFIs related to specialty care identified by SIU in their mortality reviews.

Care Medical Home model of care<sup>326</sup> as it begins to hire additional staff in its staffing plan.

3. There is no physician oversight over the appropriateness of scheduling specialty appointments. Physicians must provide guidance to scheduling personnel about the expected timelines for obtaining consultation. Currently, scheduling is done in the absence of this guidance by staff who have not been informed of the clinical urgency of the appointment. This can be addressed in policy and procedure with attention to its implementation. Weekly huddles as suggested in item b. above is a method to address this problem.
4. The inappropriate<sup>327</sup> use of free-care at UIC and its attendant rationing results in significant delays for multiple patients particularly from Dixon, Stateville, Pontiac, and Sheridan.<sup>328</sup> This is a long-standing regional issue that results in significant delays at the four facilities utilizing UIC for specialty care. Benchmark timelines for referral must be established, which if UIC cannot meet would mandate use of another specialty consultant.
5. Authorization and scheduling inefficiencies result in delays. A process analysis of scheduling operations at all facilities should occur. There does not appear to be sufficient support staff to obtain records nor to track and schedule offsite appointments. The workload analysis should evaluate this. Standardized scheduling procedures should be established.
6. Evaluation of the effect of payment schedules for specialty care should be evaluated to ensure that reimbursement is not a barrier in accessing specialty care.
7. Failures to obtain, timely review, and take action on consultant recommendations is a pervasive problem. Currently, this is significantly affected by physician staffing issues. In addition, the policy and procedure being drafted now needs to include expectations for providers in this area.
8. IDOC fails to use tracking data in logs to identify access issues with specialty care. Tracking logs are not yet completed in a standardized manner and are not maintained under direction of the HCUA of the facility. The vendor maintains these logs which vary from facility to facility. These data are maintained on spreadsheets at every facility visited, but definitions of data (e.g., what constitutes a consultant report or what the referral date is) do not exist. Data is mostly only used by the scheduling clerk with respect to scheduling. Data is not used to monitor access, delays in care, or services or facilities that need attention. This data should be standardized and used to monitor care. Some of the data obtained on these logs should be performance and outcome measures (e.g., receipt of reports and consultations that are delayed).

We carefully reviewed SIU mortality reviews and agree with their multiple findings related to specialty care. There is a significant amount of useful information in these reviews.

In summary, IDOC has drafted and the Monitor has reviewed and commented on a policy on specialty care but this policy is not yet completed. IDOC has not consistently provided timely nor appropriate access to specialty care or specialty diagnostic testing (II.B.1, II.B.6.g.) which results in inadequate care (II.A.). Proof of practice regarding access to specialty consultation has been provided through SIU mortality reviews which have identified multiple deficiencies in specialty care. Analysis of specialty care opportunities for improvement and corrective actions to improve specialty care has not been initiated. Given the drafting of the specialty care policy and initiation of mortality reviews that identified deficiencies in access to specialty care, continued noncompliance is warranted.

## **RECOMMENDATIONS:**

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<sup>326</sup> See for example the Agency for Healthcare Research and Quality discussion at <https://www.ahrq.gov/ncepcr/research/care-coordination/pcmh/define.html>

<sup>327</sup> The term “inappropriate” is used because in many cases, the urgency of the appointment is not considered for patients especially at Dixon, Stateville and Pontiac. The available appointment date for elective care at UIC is often considerably beyond the expectation for standard of care. Despite this, scheduling at UIC is continued despite the potential harm to the patient.

<sup>328</sup> This is the Monitor’s opinion based on experience gained from site visits to Stateville and Dixon and from record reviews.

1. OFIs related to specialty care should be used to analyze and correct deficiencies in specialty care.
2. The workload analysis of physicians should include whether the number of budgeted physicians is sufficient to address clinical needs including coordinating and managing patients with specialty care needs.
3. IDOC needs to closely examine those OFIs in mortality reviews that result in failing to timely work up significant symptoms and signs to the extent that these failures are the result of utilization practices.
4. A root cause analysis needs to be done to identify why existing practices result in communication errors with consultants. Corrective actions to streamline and reduce errors in communication between consultants and practitioners should be established in policy and procedure.
5. Institute a required huddle between providers, the offsite scheduling clerk and the chronic disease nurse to discuss all new referrals with expected timelines; recently returned consultations to include follow up; discuss report availability and review; and update on all pending reports, pending consults that exceed expected timeframes, and any other specialty care question impacting clinical care.
6. IDOC should evaluate adequacy of transportation vehicles and transportation officers to ensure that sufficient officers and vehicles are available to ensure inmates have access to timely specialty care appointments.
7. When specialty care appointments to UIC or any other consultant are delayed, alternate local appointments must be used.
8. Reimbursement rates for specialty care should be evaluated to determine if the rates are a barrier for the delays in care.
9. IDOC should consider using a primary care medical home model of care as a methodology to improve coordination of care.
10. IDOC should expand the utilization of telehealth with UIC or other academic centers to increase access to specialty care.<sup>329</sup>
11. IDOC should also begin to explore initiation of specialty e-consults<sup>330</sup> and advice without the need for appointments.

### **Specialty Referral Oversight Review**

#### ***Addresses III.H.5***

**III.H.5.** *Within six (6) months after the Preliminary Approval Date of this Decree [July 2019] or until Defendants are able to fill both Deputy Chief of Health Services positions, they will make reasonable efforts to contract with an outside provider to conduct oversight review in instances where the medical vendor has denied any recommendations or taken more than five (5) business days to render a decision, including cases in which an alternative treatment plan has been mandated in lieu of the recommendation and cases in which the recommendation has not been accepted and more information is required. If no contract with an outside provider is reached, then the Monitor or his or her consultants shall conduct oversight review in instances where the medical vendor has denied any recommendation or taken more than five (5) business days to render a decision, including cases in which an alternative treatment plan has been mandated in lieu of the recommendation and cases in which the recommendation has not been accepted and more information is required. Once Defendants have filled both Deputy Chief positions, the Deputy Chiefs will replace any outside provider, the Monitor or his or her consultants to conduct oversight review in the instances described in this paragraph. (see Specialty Care Section)*

### **OVERALL COMPLIANCE RATING: Substantial Compliance**

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<sup>329</sup> UIC currently provides telehealth care and consultation for HIV, Hepatitis B and C, and the management of uncontrolled and difficult to control diabetes.

<sup>330</sup> E-consults are emails to a specialist for advice or a brief consultation.

## **FINDINGS:**

IDOC no longer requires a utilization review of specialty referrals. Therefore, this provision is found compliant.

## **RECOMMENDATIONS:**

1. The termination of the collegial review must also pertain to referrals for subcontracted onsite ultrasonography services.
2. IDOC must immediately develop a tracking system to ensure that the vendor's demand for a summary of clinical information on the Special Services Referral and Report form does not result in administrative denials of providers' referrals for specialty consultation, diagnostic testing, and procedures.
3. The IDOC must conduct a review of the vendor's policies, practices, and guidelines that affect patient-inmates' access to medically necessary consultation, testing, and procedures and eliminate, with input from the monitor, those guidelines that restrict access to medically necessary clinical services. Examples of current restrictive vendor practices include limiting cataract surgery to only one eye, categorizing ostomy reversal surgery as an elective, and others.

## **Hospital Care**

### ***Addresses Items II.A; II.B.1; III.G.4***

**II.A.** *Defendants shall implement sufficient measures, consistent with the needs of Class Members, to provide adequate medical and dental care to those incarcerated in the Illinois Department of Corrections with serious medical or dental needs. Defendants shall ensure the availability of necessary services, supports and other resources to meet those needs.*

**II.B.1.** *IDOC shall provide access to an appropriate level of primary, secondary, and tertiary care*

**III.G.4.** *Facility medical staff shall ensure that a prisoner is seen by a Medical Provider or clinician within 48 hours after returning from an offsite emergency service. If the Medical Provider is not a clinician, the Medical Provider shall promptly review the offsite documentation, if obtained, with a clinician and the clinician shall implement necessary treatment.*

## **OVERALL COMPLIANCE RATING: Noncompliance**

## **FINDINGS:**

SIU mortality reviews had multiple findings of delayed hospitalization. These are abundant material from which to derive corrective actions. The Monitor has reviewed these mortality reviews. The Monitor also reviewed two patient deaths to describe the kinds of issues still unresolved.

On record reviews, one patient,<sup>331</sup> had metastatic prostate cancer, hydronephrosis, diabetes, hypertension, COPD, a ventriculoperitoneal shunt from prior traumatic brain injury with subsequent dementia. He also had a urethral stent inserted in 2021 and in early 2022 the UIC urologist recommended removal and replacement. This was done on 1/28/22. The patient left the UIC hospital with instructions to return to the urology clinic in three months. An appointment was not made. There was no evidence that the hospital recommendations were reviewed and a follow up appointment was not made.

The day following the procedure the patient, at one o'clock in the morning, said he could not urinate and told the nurse to insert a catheter. Though the patient had just had a urological procedure, the nurse did what the patient

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<sup>331</sup> Hospital care patient #1

asked without consulting a provider, Later that morning, the patient again couldn't urinate. A nurse obtained a provider order to perform a straight catheterization. A few hours after the straight catheterization, the patient was still having pain and was sent to a hospital in Joliet. There was no communication with the urologist from UIC who placed the stent. The nurse writing the IDOC form 0090 Transfer Summary wrote that the patient has renal stones, prostate biopsy and hydronephrosis which was inaccurate. The patient had metastatic prostate cancer with a recent L renal stent placed for hydronephrosis. The information the hospital received upon the patient's arrival was that he had a recent prostate biopsy and was unable to urinate. This was inaccurate. The hospitalist was unaware that a stent had just been place. A Foley catheter was placed with instructions to remove it in five to seven days.

Upon return to the prison, the patient was not evaluated by a provider for eight days. The provider did not appreciate the hospital instructions to remove the Foley in five to seven days and it remained in place for months. This placed the patient at risk for infection.

Three months later, the patient became confused and disoriented so he was sent to a hospital in Joliet where a urinary tract infection and pyelonephritis were diagnosed. No one in the hospital questioned why the Foley catheter was in place and presumed it was necessary. A new Foley catheter was inserted. After a week in the intensive care unit the patient was discharged on 4/8/22. The recommendation after hospitalization, months earlier, for the urethral stent was to return to UIC urology in three months. This was due but the recommendation was not acted on without any explanation.

The patient wasn't seen after discharge from the hospital for two weeks (4/21/22) when a provider noted dementia, metastatic prostate cancer, post-urethral stent and persistent subdural from prior traumatic brain injury. The patient had tachycardia with skipped beats. The provider considered but did not order an electrocardiogram. Two days later the patient fell and was found lying on the floor. The blood pressure was 177/128 with a heart rate of 177. A subsequent blood pressure was 66/48. The patient died upon arrival to the hospital from pulmonary embolism. Whether the "skipped beats" experienced by the patient two days previous was atrial fibrillation is unknown as the hospital record was not obtained by the prison health program.

The failure to timely review the patient's hospital report after the urethral stent on 1/28/22 meant that the patient missed the recommended follow up with the urologist at UIC. The lack of follow up after the Foley catheter insertion resulted in unnecessary long-term use of a Foley catheter that led to urosepsis and another hospitalization. The lack of follow up by a provider post-hospitalization is likely a staffing deficiency.

Another patient,<sup>332</sup> had multiple medical conditions including asthma, hypertension, dyslipidemia, and chronic kidney disease due to his hypertension. The patient went to a kidney doctor at UIC who recommended a follow up in two months. This follow up appointment was made and took place.

The patient had shortness of breath for over two months without provider evaluation. He was seen by nurses four times and referred twice to a provider but not seen. Medical records appear missing from the record<sup>333</sup> but the patient was eventually sent to a hospital. The hospital record was found in the record and showed that the patient had pneumonia with very severe heart failure. A temporary defibrillator was placed with instructions to have the patient return in three months to evaluate whether a permanent defibrillator should be inserted. An outpatient cardiac MRI was also recommended in the interim. A nurse practitioner evaluated the patient post hospitalization but did not document review of the hospital record. The provider did document that the patient was recovering from community acquired pneumonia and heart failure and ordered a follow up chest x-ray which was not found

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<sup>332</sup> Hospital care patient #2

<sup>333</sup> This was from Stateville where the medical records are not appropriately managed.

in the record. A subsequent note documented that the patient had pericardial effusion. The MRI and cardiology follow up were not scheduled<sup>334</sup>. The first physician note for this patient post-hospitalization was nine days after discharge. The doctor documented that the patient had heart failure and had a temporary defibrillator. The plan of care was to use the temporary defibrillator for a few months and then reassess. The follow up with cardiology and the cardiac MRI were not acknowledged as recommendations and a referral was not made at that time.

The patient returned to nephrology at UIC for follow up as recommended. The nephrologist recommended a two month follow up but this recommendation was not followed. The offsite tracking log did not contain a follow up referral and the patient became lost to follow up.

This patient was on the infirmary at Stateville. There was no evidence in the record of a chronic care visit for the year of available record. As well, infirmary notes do not include assessments and plans of care for all of the patient's medical conditions. The patient's nephrology appointment was lost to follow up. The chronic kidney disease, dyslipidemia, asthma, hypertension, and even heart failure were not routinely assessed with a plan of care. There was one note over the year that documented his diseases (chronic kidney disease, hypertension, anemia, asthma, increased lipids, and hyperparathyroidism) as problems but these problems were not assessed nor was a plan of care evident for each problem. This physician appeared to be backtracking and reviewed the prior hospitalization two months ago for heart failure and documented the recommendation for a cardiac MRI and cardiology follow up. This physician referred the patient to cardiology two months after the recommendation was made. This referral was found in the specialty care log two months after the recommendation was made. Care appeared episodic and infrequent likely due to physician staffing issues.

The patient experienced increasing shortness of breath; saying to nurses at times that he couldn't breathe. On 10/5/22, a physician documented that the patient was coughing and had chest pain with a blood pressure of 86/61, pulse of 102 and a fever (100.1) with an oxygen saturation of 93%. The patient had labored breathing and 1-2+ pitting edema of the lower extremities.

Using the community acquired pneumonia severity index<sup>335</sup>, this patient with known heart failure and chronic kidney disease had a 9% risk of mortality and should have been hospitalized. This patient should have had an urgent evaluation with blood tests (blood count, metabolic panel, BNP test, COVID test), chest x-ray and CT of chest, electrocardiogram, blood cultures and evaluation for pneumonia. He should have been sent to a hospital as Stateville had no capacity for urgent radiologic or laboratory testing.

Instead, the physician completed an electrocardiogram and documented that he would wait for an x-ray report that was performed the day before. The doctor ordered a seven day course of empiric antibiotics and oxygen to keep the saturation above 93%. There was no documented follow up by this physician for six days when decongestants were added. At this visit the patient's vital signs were not obtained nor was an oxygen saturation obtained. The x-ray was not documented as reviewed and the patient was not evaluated for exacerbation of his heart failure which should have been the dominant concern. The physician next saw this patient three days later. Vital signs were not done but the doctor wrote that vital signs were stable except that the oxygen saturation was 92% which is low. The patient was maintained on continuous oxygen but was not tested for COVID, and treatment of his heart failure was not advanced by addition of diuretic. Whether the patient had pneumonia was based on a guess. No laboratory tests were ordered. This is unsafe and clinically inappropriate care.

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<sup>334</sup> Neither the follow up with cardiology nor the outpatient MRI were in the specialty tracking log for three months after the hospitalization.

<sup>335</sup> This calculator found in UpToDate, is a measure of the severity of risk for pneumonia and mortality to assess whether a patient with suspected pneumonia warrants hospitalization or can be managed as an outpatient.



The patient's follow up cardiology visit was with UIC on 10/17/22. Yet IDOC did not provide the UIC cardiologist with the medical records from the hospital in Joliet where the temporary defibrillator was placed. The cardiologist without benefit of prior records started over and recommended an echocardiogram. Depending on the results of the echocardiogram, a cardiac MRI would be considered. The cardiologist wrote that an implanted defibrillator would be a benefit if the echocardiogram showed depressed heart function. The cardiologist took a history that the patient had shortness of breath lying flat and shortness of breath on exertion. He recommended increasing the diuretic and follow up in a month. The recommendation for echocardiogram was not on the specialty care log and was not addressed.

There were no nursing notes or physician notes from 10/18/22 until 10/24/22. On 10/25/22, a doctor wrote a very brief note stating that the patient complained of leg swelling that was getting worse over the past two weeks. There was no examination and insufficient history of the leg swelling and whether it affected both legs or just one leg. Without history or examination, the doctor ordered another diuretic (Aldactone) and documented he would consider compression stockings if the swelling persisted. Later that same day, a nurse documented that the patient couldn't breathe and was found kneeling on the floor with his chest on the bed. He was described as gasping for air. A doctor was called, and the patient was sent to the hospital where he died the following day. The autopsy showed a right leg deep vein thrombosis with bilateral extensive pulmonary emboli which were documented as the cause of death.

In summary of this patient's care, physician evaluations were episodic and hospital and offsite medical consultations were not carefully reviewed. The patient was lost to follow up for his nephrology appointment. The heart failure hospitalization report was not initially reviewed carefully and the recommended follow up was not ordered for almost two months. The patient was not monitored in the infirmary for his chronic conditions and there was no consistent assessment and plan. This is likely due to insufficient physician staffing. Care was episodic. The patient had symptoms and signs of advancing heart failure on 10/5/22 which should have resulted in hospitalization due to high risk of mortality but instead was managed with empiric treatment without diagnostic testing. Laboratory and radiologic testing needed urgently was not done. The patient was sent to a cardiologist at UIC rather than the cardiologist from Joliet who performed initial diagnostic testing and placed the temporary defibrillator. IDOC did not send the UIC cardiologist reports of the testing performed in Joliet nor had IDOC performed the diagnostic test (cardiac MRI) recommended by the Joliet cardiologist. This delayed care for this patient as it required repeating previous testing. A day before death, when the patient complained of leg swelling, the doctor ordered empiric therapy (diuretic) without an adequate history or any physical examination. Lack of attention to details of care for the patient led to these deficiencies and point to significant lack of physician staffing. The deficiencies also point to lack of support staff to obtain records, manage offsite referrals appropriately, and perform diagnostic tests (in this case radiology testing) timely.

In summary, IDOC, through the SIU mortality reviews, have provided multiple examples to demonstrate its status with respect to the Consent Decree requirements for tertiary care. No analysis or corrective actions have yet been initiated on these findings. The Monitor's record reviews continue to show lack of timely or effective follow up of hospital recommendations and lack of timely access to hospitalization. Physician staffing and support staff to track specialty care and obtain records are likely the reasons for these deficiencies. Based on the SIU mortality reviews and failure to initiate corrective actions, a noncompliance rating continues to be warranted.

#### **RECOMMENDATIONS:**

1. Providers must continue orders promptly after hospitalization or document why recommendations will not be continued. Immediately upon return from hospitalization, nurses must consult with providers regarding recommended hospital orders. Within 2 days a provider must revise the therapeutic plan of the patient consistent with the hospital findings and recommendations. The provider must discuss the revised plan and how it will be implemented with the patient.

2. As part of the audit system, IDOC needs to evaluate whether the process of chronic care management results in preventable hospitalization. The audit system must also evaluate all provisions of the Consent Decree including II.A., II.B.1., and III.G.4. If systemic problems are identified these should be corrected through the quality improvement programs.
3. The statewide quality unit should perform a process analysis to determine why hospitalization is delayed for patients found in mortality reviews. Problems identified need to be corrected through the quality improvement program.

## Preventive Services

### *Addresses items III.M.1.a-d*

**III.M.1.a.** *Defendants or their contracted vendor(s) shall ensure that all prisoners will be offered an annual influenza vaccination.*

**III. M.1.b.** *Defendants or their contracted vendor(s) shall ensure that all prisoners with chronic diseases will be offered the required immunizations as established by the Federal Bureau of Prisons.*

**III.M.1.c.** *All prisoners ages 50-75 will be offered annual colorectal cancer screening and PSA testing, unless the Department and the Monitor determine that such testing is no longer recommended.*

**III.M.1.d.** *All female prisoners age 45 or older will be offered a baseline mammogram screen, then every 24 months thereafter unless more frequent screening is clinically indicated, unless the Department and the Monitor determine that such testing is no longer recommended.*

### **OVERALL COMPLIANCE:** Partial Compliance

The partial compliance rating took into consideration IDOC's decision to use the CDC Adult Immunization and United States Preventive Services Task Force (USPSTF) A and B prevention screening recommendations, the near finalization of the Preventive Services and Periodic Health and Immunization policies, the ongoing and progressing access to recommended adult vaccines many of which were not available prior to the Consent Decree, the auditing of influenza and pneumococcal vaccination and colorectal cancer screening (fecal immunochemical test (FIT) testing) as performance and clinical outcome measures, the continued practice of offering screening for breast and cervical cancers and HPV immunization to at-risk incarcerated females, the annual provision of influenza vaccination, and the ongoing availability of updated COVID vaccines.

**FINDINGS:** The Monitor requested eleven documents for the 7<sup>th</sup> Report's section on Preventive Services. Seven of these documents were either completely or partially received.<sup>336</sup> Two requests concerning logs or tracking mechanisms verifying the offering and provision of immunizations and routine health maintenance (RHM)/cancer screenings were not provided. IDOC has communicated that there is very limited data tracking of immunizations and RHM/cancer screenings. This makes it difficult to verify compliance.

The Consent Decree requires that IDOC is to produce an annual report based on data and information sufficient to verify compliance. IDOC has previously asserted compliance with III.M.1.a. but provided no systemic data for verification. Neither does the IDOC/SIU audit of select performance and clinical outcome measures provide verification of compliance with this provision. IDOC must provide comprehensive data to demonstrate its compliance with this element of the Consent Decree.

### **Influenza Vaccinations**

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<sup>336</sup> IDOC provided a link to one request about the facility-by-facility age breakdown of the incarcerated population.

**III.M.1.a** *Defendants or their contracted vendor(s) shall ensure that all prisoners will be offered an annual influenza vaccination*

**Overall compliance:** Partial Compliance

**Findings:** The rating of partial compliance is based on the consistent communication from clinical staff that influenza vaccination event days are held annually in October-December at all IDOC facilities, previous documentation of the substantial volume of influenza vaccines that were delivered by the Boswell Pharmacy to all IDOC sites, review of the databases of multiple medical charts, and review of the seven facilities that reported influenza vaccination at their monthly CQI committee meetings. IDOC still needs to gather facility by facility data on the number and percentage of the population offered, accepted, and refused influenza vaccination.

The influenza season begins annually around September and continues into the late winter and early spring of the following year. Influenza vaccinations are generally offered in flu-shot event days from September to December. As reported in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup>, and 6<sup>th</sup> Court Reports the Monitor is aware that influenza vaccination is annually offered over a few days in the early to mid-fall to many of the IDOC patient population at all correctional centers<sup>337</sup>. Review of facility CQI minutes from September 2022 through June 2023 identified only four sites<sup>338</sup> with cumulative population of 4,410 that reported 3,441 flu shots offered (78% of estimated population) and 1,222 (36% of those offered) administered. Three additional sites<sup>339</sup> (combined population 3,365) did not report on shots offered but noted that 1,345 flu shots were given. If the acceptance for these three sites was approximately 40% then 3,400 (approaching 100%) were offered the flu shot. The remaining twenty-three facilities did not report data on influenza vaccination. IDOC has reported no standardized systemwide data to the Monitor on influenza vaccinations offered, accepted, or refused during the last four years. SIU reported FY23 4<sup>th</sup> quarter audit results for influenza vaccination were based on review of ten randomly selected charts at each facility. Fourteen (50%) of 28 facilities had greater than or equal to 70% inmates vaccinated.

For the current report (7<sup>th</sup>) the monitor also reviewed the Database sheet in the medical record of ten facilities to evaluate the offering and administration of 2022-2023 seasonal flu vaccine (see table below).

Influenza Vaccination Offered and Administered at Ten Correctional Centers Based on Record Reviews*				
Fall 2022 - Winter 2023				
# Eligible	# Offered	# Administered	# Refused	No Documentation of Offer or Refusal
43	22 (51%)	20 (47%)	2 (5%)	21 (49%)
East Moline, Graham, Hill, Jacksonville, Lawrence, Lincoln, Pinckneyville, Shawnee, Vandalia, and Taylorville				

Review of multiple medical records verified that many but not all patients had documentation in the database that they had been offered influenza vaccines. Access to influenza vaccination is available at all facilities but is not yet tracked based on the requirement of the Consent Decree to **offer** influenza vaccination to all incarcerated persons. Tracking needs to include all influenza vaccinations offered, refused, and administered. IDOC must begin this effort now and not wait for implementation of the electronic record. The failure to gather basic influenza

<sup>337</sup> The IDOC performance and outcome measure audits gathered by SIU includes a sample of ten records at each site quarterly of how many persons *received* influenza vaccine but did not show how many persons were offered the vaccine which is required by the Consent Decree. Statewide their sample for FY23 2<sup>nd</sup> Quarter showed 45% of charts reviewed demonstrated vaccination.

<sup>338</sup> Jacksonville, Menard, Taylorville, and Vienna reported flu shots ordered and accepted.

<sup>339</sup> Dixon, Hill, and Kewanee reported only the number of flu shots administered.

vaccination data creates a barrier for IDOC to monitor the quality of preventive care delivered in the IDOC.<sup>340</sup> Because of the historically high rate of refusal of vaccination, IDOC needs to focus educational efforts to increase the acceptance rate of influenza vaccine. The IDOC quality improvement program initially chose the administration of influenza vaccination as a performance and outcome measure and has recently communicated that the data on influenza vaccination now includes the cumulative number offered and administered.<sup>341</sup> The Monitor is supportive of this decision but recommends that SIU report separately the number and percent of influenza vaccinations offered and administered.

**Recommendations:**

1. IDOC must track and report annual influenza vaccination rates including the number and percentage of eligible patients who are offered, administered, and refused vaccination.
2. IDOC should institute an annual health information campaign to educate the incarcerated population about the health benefits of the annual influenza vaccine and the COVID-19 vaccine.

**Adult Immunizations**

**III.M.1.b** *Defendants or their contracted vendor(s) shall ensure that all prisoners with chronic diseases will be offered the required immunizations as established by the Federal Bureau of Prisons.*

**OVERALL COMPLIANCE RATINGS:** Partial compliance

The rating of partial compliance is based on the volume of vaccines being ordered from IDOC's pharmacy vendor, the assignment of the Infectious Diseases Coordinator as the leader of immunization program, the ongoing HPV vaccination in the two female facilities, the initiation of performance and clinical outcome audits of pneumococcal and influenza vaccination, and the incorporation of the Center for Disease Control Advisory Committee on Immunization Practices guidelines in the nearly finalized Immunization policy. Aggregate data on the offering, administration, and refusal of recommended vaccines, tracking of the percentage of eligible incarcerated persons who have been offered vaccination, and the focused efforts on educating staff on the prevention of disease with adult vaccinations are required to approach substantial compliance.

**Implementation Plan Items Addressing Immunizations**

**Implementation Plan item 26:** *Finalize and disseminate immunization and routine health maintenance (RHM) and cancer screening policies, procedures, and guidelines using the Center for Disease Control (CDC) adult immunization guidelines and United States Preventive Services Task Force (USPSTF). Proposed End Date: July 2023*

**Findings:** IDOC has submitted a draft policy G.09.01 Immunizations. The Monitor has reviewed this draft and forwarded input to the IDOC.<sup>342</sup> The CDC Adult Immunization guidelines have been incorporated into this policy. Finalized versions of this policy has not yet been received by the Monitor. This draft policy is not yet implemented and needs to be updated to include the current CDC Adult Immunization guidelines for pneumococcal vaccination. **Based on the draft of a policy, IDOC is partially compliant with Implementation Plan item 26.**

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<sup>340</sup> It also prevents verification of compliance with the Consent Decree.

<sup>341</sup> OHS-Monitor Monthly Call 10/19/23: The measuring of influenza vaccination by IDOC's partner SIU Office of Correctional Medicine was expanded to include both the offering and administration. The audit data for the 4<sup>th</sup> Quarter 2023 showed that 60% were offered influenza vaccination. In future audits, the Monitor recommends that SIU report separately the number offered and the number accepted.

<sup>342</sup> The Monitor's input on G.09.01 was returned to IDOC on 7/12/23.

**Implementation Plan item 27:** *Identify and finalize a mechanism to track immunizations and routine health maintenance (RHM) and cancer screening information until EHR is fully implemented. The mechanism will track and report both the volume of specific vaccines offered, administered, and refused per facility and the percentage of eligible patients who have been offered, accepted, and refused specific vaccinations and routine health maintenance/cancer screenings. IDOC must implement an interval immunization and RHM/cancer screening tracking system prior to the full implementation of the EHR. Proposed End Date: December 2023*

**Findings:** IDOC has communicated that a systemwide mechanism to track immunizations or RHM/cancer screening has not yet been developed. IDOC stated that it only tracks the number of individual patient and stock vaccine orders dispensed by its mail order pharmacy, Boswell Pharmacy Services (see table below). It is encouraging to see the volume of immunizations being ordered by IDOC providers, but pharmacy vaccine orders especially stock orders do not definitively equate to the volume of vaccines actually administered. Still, based on dispensing data there are indications that vaccinations are becoming more accessible in the IDOC. However, accessibility still needs to be improved and IDOC needs to verify actual administration of vaccination. As also noted in the table below, there is a wide variation between the thirty IDOC facilities in the ordering of vaccines. IDOC needs to investigate the reasons for this variation.

Adult Immunization Individual Doses And Stock Doses Ordered from Boswell 11/1/19 to 8/31/23								
Facility	Pneumococcal 23	Pneumococcal 13	RZV Shingles	HPV	Hepatitis B	Hepatitis A	Meningococcus ACWY	Meningococcus B
BMR	256	31	703	1	0	0	2	0
CENTRALIA	145	0	225	3	3	0	0	0
DANVILLE	94	4	63	0	0	0	21	0
DECATUR	92	0	170	149	11	6	0	0
DIXON	56	32	234	6	2	0	0	0
EAST MOLINE	86	15	140	2	0	0	3	2
JITC/ELGIN	10	1	2	0	2	2	0	0
GRAHAM	121	53	149	1	3	0	2	0
HILL	324	36	712	0	0	0	6	0
IRCC	175	21	217	0	0	0	0	0
JACKSONVILLE	238	57	66	5	12	0	0	0
JTC	36	0	9	0	0	0	0	0
KEWANEE	87	12	85	2	0	0	0	0
LAWRENCE	127	10	86	4	0	0	0	0
LINCOLN	75	201	126	0	0	0	0	0
LOGAN	131	12	544	520	0	0	0	0
MENARD	69	21	163	3	0	0	0	0
MURPHYSBORO	38	0	67	0	0	0	0	0
NRC	21	1	0	0	0	0	1	1
PINCKNEYVILLE	57	180	633	0	0	0	0	0
PONTIAC	72	2	124	0	0	0	0	0
ROBINSON	113	0	95	0	0	0	0	0
SHAWNEE	246	7	113	0	0	0	0	0
SHERIDAN	115	0	5	0	12	2	2	0
SOUTHWESTERN	4	0	6	0	6	4	0	0
STATEVILLE	49	12	68	0	3	3	3	2
TAYLORVILLE	71	0	471	0	0	0	0	0
VANDALIA	57	2	31	0	0	0	0	0
VIENNA	66	11	159	0	5	63	0	0
WESTERN	130	0	210	1	2	2	0	0
<b>Total</b>	<b>3161</b>	<b>721</b>	<b>5676</b>	<b>697</b>	<b>61</b>	<b>82</b>	<b>40</b>	<b>5</b>

There also is a dearth of vaccines ordered for hepatitis A and B, Meningococcus, and HPV for eligible<sup>343</sup> males. Over the last four years, of the thirty IDOC facilities, seven (23%) ordered hepatitis A vaccines, 11 (37%) ordered Hepatitis B vaccines, eight (27%) ordered Meningococcal ACWY vaccines, and 10 (36%) of the twenty-eight male facilities ordered HPV vaccines. Further emphasis must be directed at increasing the number of at-risk men and women who are offered these important immunizations. Failure to provide nationally recommended vaccines to the incarcerated population is a missed opportunity to prevent infection and cancers in the IDOC and ultimately in all communities in Illinois.

The CDC has recommended onetime universal hepatitis B screening of adults aged 18 years and older<sup>344</sup> and routine hepatitis B vaccination for all individuals 19 years through 59 years and for individuals with known risk factors (which include chronic liver disease, HIV infection, sexual exposure risk, current or recent injection drug

<sup>343</sup> All IDOC males aged 26 or younger are eligible to receive the HPV vaccine services.

<sup>344</sup> Conn EE, et al. Screening and testing for hepatitis B virus infection, CDC Recommendations 2023, *MMWR* published online March 10, 2023

use, **and incarceration**) regardless of age.<sup>345</sup> As shown in the Boswell pharmacy data in the table above, hepatitis B vaccines are infrequently ordered. IDOC is missing a significant opportunity to prevent or diminish the transmission and morbidity and mortality of hepatitis B infection in the prison and in the community by not routinely testing all new admissions and offering opt-out hepatitis B vaccination to all incarcerated individuals in the IDOC. The California Correctional Health Care Services dashboard reported in October 2022 that, using an opt-out strategy, 98% of new individuals arriving at the 34 state prisons have received hepatitis B screening.<sup>346</sup> IDOC should strongly consider testing all new admission for hepatitis B immunity and vaccinating those who are not immune.

IDPH has declared that “individuals in correctional settings...are at risk for becoming sick with hepatitis A due to the close living quarters” and has recommended that all inmates and correctional staff be vaccinated with hepatitis A vaccine. IDPH made special mention of the need to vaccinate kitchen staff and food handlers in correctional facilities because they can cause and further spread outbreaks of hepatitis A.<sup>347</sup>

IDOC’s draft but not finalized Immunization policy (G.09.01) states (V.F.1-2) the following:

1. “Hepatitis A vaccine will be offered to patients with end stage liver disease, chronic viral hepatitis or HIV who are not immune...
2. Hepatitis A vaccine will be offered to all porters and hospice workers have risk of exposure to fecal wastes.”

IDOC currently only offers hepatitis B vaccination to the porters (and hospice workers)<sup>348</sup> even though porters are listed in this directive as being in the highest risk category for “daily and direct daily contact with blood or other potentially infectious body fluids.” The Monitor team has interviewed hospice workers who related that they have undressed and bathed infirmity patients with fecal incontinence and observed porters cleaning soiled beds of patients in the infirmity and cleaning walls and floors smeared with feces in mental health crisis rooms. Review of systemwide vaccine orders filled by Boswell Pharmacy Services from November 2019 through August 2023 (34 month period) documented that only seven correctional facilities<sup>349</sup> ordered hepatitis A vaccines. The quantity of hepatitis A is grossly insufficient to meet the vaccination needs of the inmate porters let alone to vaccinate incarcerated persons with active liver disease or cirrhosis who do not have immunity against hepatitis A. IDOC has provided no additional systemwide about information that inmate workers have been vaccinated for hepatitis A. IDOC needs to finalize the draft Immunization policy and train staff on the importance of providing hepatitis A vaccination to inmate workers (porters, hospice workers, food handlers) at risk for exposure to fecal-oral transmitted pathogens.<sup>350</sup>

The Monitor reviewed the databases, problem lists, and annual health assessments of forty-three males with chronic illnesses and/or 65 years or older to identify the documentation of the offering, administration, and refusal of adult immunizations. The results of this audit are shown below.

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<sup>345</sup> CDC Recommended Adult Immunization Schedule, United States, 2023

<sup>346</sup> So S, Terrault N, Conners EE. Universal Adult Hepatitis C Screening and Vaccination as the Path to Elimination, *JAMA*. May 16, 2023;329(19) 1639-1640.

<sup>347</sup> IDPH website: Preventing Hepatitis A Outbreaks in Jails

<sup>348</sup> IDOC Administrative Directive 04.03.116, Bloodborne Pathogens

<sup>349</sup> Only Decatur, JITC/Elgin, Sheridan, Southwestern, Stateville, Vienna, and Western ordered Hep A vaccines in the last 34 months

<sup>350</sup> This recommendation has been made in the Medical Monitor’s 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup>, and 6<sup>th</sup> Court Reports.

Immunizations Offered and Administered at 10 Male IDOC Facilities*				
43 charts reviewed				
Vaccine	# Eligible	# Offered	# Administered	# Refused
Influenza	43	22 (51%)	20 (47%)	2 (5%)
Pneumococcal	39	16 (41%)	15 (39%)	1 (3%)
RZV (Shingles)	36	13 (36%)	12 (33%)	1 (3%)
HPV	4	0 (0%)	0 (0%)	NA
COVID**	37	28 (76%)	27 (73%)	1 (3%)
Diphtheria, Tetanus, Pertussis (tDAP)	37	17 (30%)	16 (25%)	1 (5%)
* East Moline, Graham, Hill, Jacksonville, Lawrence, Lincoln, Pinckneyville, Shawnee,				
** Offered included any documentation in the chart that the vaccine was offered, refused, or administered.				

Although a few facilities have initiated logs of patients receiving or scheduled to receive specific vaccinations, none of these logs track the number of individuals who are eligible to receive vaccines.<sup>351</sup> In conjunction with SIU Office of Correctional Medicine (SIUOCM), performance and outcome measures for influenza and pneumococcal vaccinations have been initiated with quarterly auditing of ten medical records per facility for each of these two measures. SIU has only recently begun to audit and cumulatively report both the offering and the acceptance data for these two performance measures at each facility. The actual percentage of eligible patients at each facility who are offered and receive these vaccines and tests is not yet being measured. **IDOC is not compliant with Implementation Plan item 27.**

**Implementation Plan item 28:** *Track adult immunization and RHM/cancer screening acceptance rates. Proposed End Date: December 2023*

**Findings:** As noted in Implementation Plan item 27, IDOC currently does not have a systemwide mechanism to track adult immunization acceptance rates. For the past 12 months IDOC, in collaboration with SIUOCM, has quarterly audited 10 charts per facility to assess the acceptance of influenza and pneumococcal vaccines. In the last quarter (4<sup>th</sup> quarter 2023) the audit began reporting the combined<sup>352</sup> total of vaccinations offered, accepted, and refused. It is appropriate and useful for IDOC to measure the number/percentage of the ten individuals per facility offered these vaccines. However, it is also an important clinical outcome measure (and requirement of the Implementation Plan) to report the number who accept the vaccination so that action can be taken to improve low acceptance rates. **IDOC is not compliant with the first requirement of Implementation Plan item 28.**

**Implementation Plan item 28 (continued)** *Develop and implement an interval immunization and RHM/cancer tracking solution using an electronic database (see #27.) Possible solutions for immunization tracking include open source relational database software, the Illinois Comprehensive Automated Immunization Registry I-CARE or similar database.*

<sup>351</sup> Logs of HPV vaccination have been presented in the past from the female facilities Decatur CC and Logan CC.

<sup>352</sup> Number reported is cumulative



**Findings:** As noted in the 6<sup>th</sup> Court Report IDPH has instituted I-CARE<sup>353</sup> to confirm individual vaccination history. This State of Illinois I-CARE registry of vaccinations should be used by IDOC to verify vaccination status on all new admissions to the IDOC and should be used by nursing personnel to verify vaccination status. IDOC has voiced interest in utilizing the I-CARE vaccination database but due to certain logistical issues, has not yet been able to achieve sufficient access to I-CARE. A substitute for I-CARE has not been developed. **IDOC is not compliant with the second requirement of Implementation Plan item 28.**

**Implementation Plan item 28 (continued)**

1. *Complete immunization policy and procedures revision to include:*
  - a. *Primary responsibility for the systemwide immunization program will be under the system's Infectious Disease Coordinator.*

**Findings:** The IDOC Infectious Disease Coordinator has stated that the immunization program is a responsibility of the Infection Control program.<sup>354</sup> However, neither IDOC policy G.01.01 Infection Control nor policy G.09.01 Immunization state who is to direct the immunization program. According to the position description, the Infectious Disease Coordinator supervises no one so it is unclear how the Infectious Disease Coordinator has primary responsibility for the immunization program. In practice, the immunization program is dependent on HCUs who can optionally assign or not assign nurses to work on immunization efforts. As a result, the immunization program can only be implemented to the extent the HCUs assign staff to conduct immunizations. According to the table of organization, the Infection Control Coordinator has no line authority to give assignments to assigned or dedicated nurses who perform infection control duties. As a result, although the Infectious Disease Coordinator states that he is responsible for the immunization program, he lacks authority by policy and by his position description to implement the program. **IDOC noncompliant with Implementation Plan item 28.1.a.**

- (Implementation Plan item 28 continued)** 1. *Complete immunization policy and procedures revision to include:*
- b. *Designated infection control nurses will coordinate the facility's immunization program and will have dotted line reporting to the system's Infectious Disease Coordinator.*

**Findings:** The draft Infection Control policy states that "...each facility has one dedicated position assigned as the facility Infection Control Nurse who responds to the Agency Infectious Disease Coordinator for all matters related to infection control."<sup>355</sup> If the facility infection control positions are *dedicated* to infection control, they should be supervised by the Infection Control Coordinator and they should have no other assignments other than infection control. The policy is written as if the facility Infection Control nurse can have multiple assignments other than infection control. Despite this draft policy, IDOC has communicated to the Monitor that there are currently no facility nurses fully dedicated to infection control duties and some facilities do not even have a part-time designated infection control nurse. At facilities with nurses assigned to infection control duties, the actual infection control duties being performed are very limited and the infection control nurses are also assigned to other non-infection control tasks. The Infectious Disease Coordinator stated that the existing infection control nurses do report to him for infection control issues but this "reporting" relationship appears to be a consulting relationship. The Infection Control Coordinator added that there is no formal reporting

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<sup>353</sup> The IDOC website at <https://dph.illinois.gov/topics-services/prevention-wellness/immunization/icare> states the following. "I-CARE, or Illinois Comprehensive Automated Immunization Registry Exchange is a web-based immunization record-sharing application developed by the Illinois Department of Health (IDPH). The application allows public and private healthcare providers to share the immunization records of Illinois residents with other physicians statewide".

<sup>354</sup> Interview with Infectious Disease Coordinator, 9/13/2023

<sup>355</sup> Draft Infection Control policy, G.09.01

relationship<sup>356</sup>. **IDOC is not compliant with Implementation Plan item 28.1.b**

**(Implementation Plan item 28 continued).** 1. *Complete immunization policy and procedures revision to include:*  
c. *Modification that allows nurses, acting under protocol, to immunize patients.*

**Findings:** The draft Immunization policy (G.09.01) states that “Vaccines will only be given on the order of an appropriately licensed health provider or under the guidelines of approved treatment protocols”. The Monitor was not provided a protocol giving nurses ability to immunize patients. IDOC has voiced support in previous reports including the 6<sup>th</sup> Court Report for this modification of nursing responsibilities.<sup>357</sup> The Monitor has repeatedly recommended to IDOC that the management of the immunization program at facilities be placed under the control of nursing with a single nurse at each site who directs and manages the program under standing orders approved by IDOC physician leaders and the Infectious Disease Coordinator. This is a common practice in public and private health care systems throughout the USA and, essentially, is already the practice for the offering and administration of influenza and COVID vaccines in the IDOC. Nursing staff at Decatur CC have reportedly been **trained in soliciting and** documenting vaccine information.<sup>358</sup> Both female facilities, Decatur CC and Logan CC have also implemented HPV vaccination programs for women twenty-six years of age or younger. Placing the immunization program under the umbrella of nurse leadership offers IDOC the best option for successfully providing recommended adult immunizations to the IDOC population. No recent information about progress toward systemwide implementation of this modification has been provided to the Monitor. IDOC needs to create a policy that codifies that nurses can immunize patients based on protocol including the current practices of nurses vaccinating for HPV vaccination at Logan and Decatur CCs, the annual influenza vaccine events, and the ongoing provision of COVID vaccination. **IDOC is partially compliant with Implementation Plan item 28.1.c.**

**(Implementation Plan item 28 continued)** *Complete immunization policy and procedures revision to include:*  
d. *Annual health evaluation update of immunization and RHM/cancer screening status and offering of necessary immunizations and screenings at chronic care and specialty clinic visits, annual and biannual health visits, and regular vaccination/RHM/cancer screening events.*

**Findings:** The draft Immunization policy (G.09.01) states, “At each clinic visit, the Master Problem List should be reviewed, and any vaccine that is due should be offered and administered upon consent unless contraindicated at that time”. This could be more specific to state chronic clinic, specialty care, and biannual health visits. As written, this implies at every nurse or physician sick call a vaccination history must be taken. This may be excessive.

This draft policy has not yet been approved or implemented. But current practice shows that immunization is not offered or updated at chronic clinics, specialty care follow up or biannual health visits.

The Monitor has not gathered or tabulated data or been provided data on whether immunization status is reviewed and offered at “every clinic visit” as noted in the draft Immunization policy. However, based on medical records provided for this Court Report, the Monitor has noted that immunizations histories are not consistently documented and immunizations<sup>359</sup> are inconsistently ordered and offered during annual periodic health assessments and examinations and are rarely offered at chronic care visits. There is notable facility to

<sup>356</sup> Interview with Infectious Disease Coordinator, 9/13/2023

<sup>357</sup> In accord with practice guidelines and protocol, outpatient nurses in public community centers commonly coordinate and administer adult vaccinations.

<sup>358</sup> Decatur CC Continuous Quality Improvement Minutes, September 2020

<sup>359</sup> Recombinant Zoster Vaccine (shingles, pneumococcal vaccine, and Diphtheria Tetanus (DT)/tetanus Diphtheria Acellular Pertussis (tDAP) were the occasionally ordered during annual health assessments. HPV is offered at the female facilities during mass vaccine events. HPV is rarely offered at male facilities to eligible men  $\leq 26$  years of age.

facility variation in the completion of the immunization histories at chronic care visits and during intake screenings.

**IDOC is partially compliant with Implementation Plan 28.1.d.**

**(Implementation Plan item 28 continued)** *1. Complete immunization policy and procedures revision to include:*

- e. ***Reception and classification centers will solicit and record immunization and RHM/cancer screening status and will offer and track required vaccinations and RHM/cancer screenings as part of the intake admission process.***

**Findings:** The draft Immunization policy (G.09.01) states (IV.B.) the following :

“Vaccination history of each patient shall be assessed on intake during receiving screening by a nurse. The vaccine history is documented on the vaccination history form. If this information is absent at the time of the provider’s health assessment and physical exam, the provider will refer the patient to the infection control nurse to take and document the immunization history. The Illinois Comprehensive Automated Immunization Registry Exchange (I-CARE) should be consulted as needed to identify and verify a patient’s immunization history.”

This policy statement is satisfactory.

In practice, limited data was provided on the completion of immunization histories and the offering of indicated vaccinations during intake health screenings at Reception and Classification Centers. On the few Reception and Classification intake health assessments forms included with the medical records provided to assess preventive services, the immunization history forms were frequently not completed and required immunizations were not offered. As documented in the Medical Reception section of this report, two of the four Reception and Classification Centers inconsistently documented immunization history during in the intake screening.<sup>360</sup> With exception of COVID immunization and influenza vaccination during the influenza season,<sup>361</sup> there is very limited data that any needed routine adult vaccinations are offered during the intake screening and health assessment process.<sup>362</sup> The largest Reception and Classification Center (NRC) is not being audited by SIU for any of the twelve performance and clinical outcome measures including influenza and pneumococcal immunizations. NRC should be included in the systemwide audit of performance and clinical outcome measures.

**IDOC is partially compliant with Implementation Plan item 28.1.e. on the basis of an appropriate draft policy.**

**(Implementation Plan item 28 continued).** *Complete immunization policy and procedures revision to include:*

- f. ***Immunization and RHM/cancer screening data will be reported regularly at the monthly facility QI meetings and at the systemwide Quality Council meetings.***

**Findings:** The draft Immunization policy (G.09.01) does not address reporting of immunization data at facility quality meetings or at the systemwide Quality Council meetings. The draft Quality Improvement Program policy

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<sup>360</sup> Logan and NRC inconsistently documented immunization histories, Graham and Menard were more consistent in documented the immunization histories on new admissions to the IDOC. See Medical Reception section

<sup>361</sup> Based on communication with OHS, the Monitor is aware that COVID immunization and influenza vaccination (during the flu season) are being offered to new admissions at all intake centers, Graham, Logan, Menard and NRC. This offering is inconsistently documented.

<sup>362</sup> The Reception and Classification Center at Menard has offered hepatitis A and B vaccines but no other needed vaccines were documented as being offered at any of the four IDOC Intake Centers, See Medical Reception section.

(A.06.01) states that facility “minutes and reports by the facility shall conform to the format and distribution established by SLQC [system leadership quality council]”. This does not include specifics regarding what is to be reported. The SLQC meeting minutes of December, 2022 include a discussion regarding a list of data to be tracked by the facility. No further information on a standardized data report has been provided.

Based on the review of September 2022 through June 2023 monthly quality QI meeting minutes, there is limited reporting of immunizations during facility QI meetings. Data that is reported is not standardized. Seven<sup>363</sup> (23%) of thirty sites reported influenza vaccination data, four<sup>364</sup> (13%) reported COVID vaccine administration, and one<sup>365</sup> (3.3%) noted HPV vaccination numbers in QI minutes.

Hill CC was the only correctional center that provided monthly data to its QI Committee meeting on the administration of influenza, tetanus, pneumococcal, RZV (shingles), and Hepatitis B vaccinations (see table below). The vaccination reporting at Hill CC could serve as a model for tracking the administration of immunizations in the IDOC pending the installation of the electronic health record provided they included those eligible, offered, refused, and administered the vaccines. The Monitor recommends that additional vaccines including COVID, Hepatitis A, HPV, and meningococcal vaccinations be added to those tracked at Hill CC.

Hill Correctional Center Monthly Vaccination Reports in CQI Minutes June-December 2022					
Date	Influenza	Tetanus	Pneumococcal	RZV (shingles)	Hepatitis B
Jun-22	0	4	3	42	0
Jul-22	0	13	16	3	7
Aug-22	0	24	7	4	0
Sep-22	0	33	8	19	1
Oct-22	0	26	11	49	1
Nov-22	645	20	5	20	2
Dec-22	1	12	2	3	5
<b>Total</b>	<b>646</b>	<b>132</b>	<b>52</b>	<b>140</b>	<b>16</b>

The System Quality Council minutes<sup>366</sup> indicate that Q2 2023 and Q3 2023 performance and clinical outcome measures which include the data on influenza and pneumococcal vaccination audits were reviewed. The Council also discussed the creation of a tracking mechanism to identify vaccines being offered. The Monitor has not seen evidence that more comprehensive immunization data has been regularly reported at System Quality Council meetings.

**Based on lack of a policy related to CQI reporting of immunization data and the documented lack of systemwide reporting of immunization data at facility monthly QI Committee meetings, IDOC is not compliant with Implementation 28.1.f.**

**(Implementation Plan item 28 continued).**

2. *Ensure that the implementation of the electronic health record includes requirements to track and automatically report immunization and RHM/cancer screening data.*

<sup>363</sup> Dixon, Hill, Jacksonville, Kewanee, Menard, Taylorville, Vienna

<sup>364</sup> Jacksonville, Logan, Menard, Vienna

<sup>365</sup> Logan CC

<sup>366</sup> System Quality Council Meeting minutes 6/28/23

**Findings:** Given that IDOC has not yet finalized the selection of an electronic medical record vendor, this task of Implementation Plan item 28.6 has not yet been acted upon. IDOC has voiced a commitment to electronically gather ongoing data about numerous aspects of health care delivery including immunizations. **This task has thus not been rated.**

(Implementation Plan item 28 continued)

3. *Select a reputable database to assess immunization and RHM/cancer screening status at intake and update immunizations/RHM/cancer screenings prior to conclusion of the intake process.*

**Findings:** Draft Immunization policy G.09.01 requires in section IV.B. that an immunization history utilizing the ICARE software be used to obtain vaccination history at intake. Draft policy E.05.01 Intersystem Receiving Screening also directs use of ICARE software. Both policies direct that vaccinations are to be updated at the intake physical examination. These draft policies have not yet been approved or implemented. Using ICARE would be consistent with the Implementation Plan requirement but IDOC has had difficulty accessing this service.

Pending the implementation of an electronic health record, IDOC has developed standardized immunization history forms that were verified during chart reviews as being utilized, albeit inconsistently, in Reception and Classification intake health assessments, periodic health assessments, and chronic care visits. No data was provided to verify the recommended vaccinations, besides influenza and COVID vaccines, were actually being offered while new admissions were housed in intake housing at Reception and Classification Centers. **IDOC does have draft policy that is satisfactory for this item but the policy has not yet been implemented. Inmates do not have their vaccination status updated in intake. Implementation Plan item 28.3 is therefore partially compliant.**

(Implementation Plan item 28 continued).

4. *Institute statewide training of nurses on safe immunization practices and update immunization procedures and select RHM/cancer screenings.*

**Findings:** The Monitor has not yet received documentation of the statewide nurse training on safe immunizations practices and updated immunization procedures. **This item has thus not been rated.**

**Implementation Plan item 56** requires that: *OHS will ensure all routine health maintenance/cancer screenings and adult immunizations as respectively recommended by USPSTF (A and B recommendations) and CDC are being offered to all at risk patients*

IDOC does not ensure that all CDC recommended immunizations are offered to at risk patients. Evidence showing partial implementation of the immunization program is provided in discussions in Implementation Plan item 28 above.

As noted in the 5<sup>th</sup> and 6<sup>th</sup> Reports, vaccination practice is proceeding with considerable variation. An effective immunization program would standardize the process, create effective policy, ensure appropriate forms were in place with staff training on use of the forms, assign specific personnel and ensure there were sufficient staff to carry out the policy, ensure sufficient supplies were present where they need to be, train staff on the policy and use of equipment and supplies, ensure that tracking mechanisms are effective and in place, establish timelines for implementation and ensure that all facilities have implemented appropriately, and to reflect on an ongoing basis as to the effectiveness of the implementation. Most of these elements are not evident at this moment. It is encouraging to the Monitor that OHS has hired a fulltime Infectious Diseases Coordinator who has energetically begun to address systemwide issues in the immunization program. An Implementation Plan project manager and

likely additional staff are needed to organize and manage the support system for this program.

The Monitor has repeatedly discussed with IDOC that the management of the Immunization Program be placed under the control of nursing with a single nurse who directs and manages the program under standing orders approved by IDOC clinical leaders. See discussion about this recommendation and its rationale in the preceding section about findings for Implementation Plan item 28.1.b. To date, no IDOC facilities have a fulltime infection control nurse and some do not even have a dedicated parttime infection control nurse who can assist with the management of the immunization program.

Since the beginning of the Consent Decree, IDOC has not reported data on the vaccinations given or vaccination rates; it only provides lists of dispensed stock and individually ordered patient-specific vaccinations. As noted in the 4<sup>th</sup>, 5<sup>th</sup>, and 6<sup>th</sup> Court Reports, OHS has appropriately expanded access to nationally recommended adult vaccines for the IDOC population and there is evidence that the medical providers at some IDOC correctional centers have begun to order some of these vaccinations for their patient populations. However, the IDOC population is still under-vaccinated for many CDC-recommended adult immunizations. IDOC needs to finalize its policy and procedure and implement it to ensure that vaccinations are offered to all eligible at-risk candidates. **Implementation Plan item 56 is partially compliant.**

Implementation Plan 56 subitems related to immunization include 56.1, 56.2, 56.3, 56.7, and 56.8. Item 56.2, is addressed in discussion on Implementation Plan items 27 and 28 above. Item 56.8 is addressed in discussion on Implementation Plan item 28.f. above. The remainder are addressed below.

**Implementation Plan 56.1, *Train healthcare staff on new immunizations and cancer screening policies.***

IDOC has not addressed training of staff on immunizations. Its policy has not been completed and therefore is not yet implemented. Training should occur with the implementation of the policy. **Item 56.1 is noncompliant.**

**Implementation Plan 56.3, *Develop mechanism to audit compliance with immunization and cancer screening policies.***

The policy on immunization has not been finalized. IDOC has not established an audit process for this item. SIU's limited tracking of performance and outcome measures does not constitute an audit.

**Implementation Plan item 56.3 is noncompliant.**

**Implementation Plan 56.7, *OHS will establish a method of documenting screenings and immunizations in the medical Record.***

There is no standard method to document immunizations in the paper medical record. Some vaccinations are documented on the Database, some are documented on progress notes, and some are documented on orders. A standardized method of documenting vaccinations needs to be developed. With implementation of the new electronic record, IDOC needs to ensure that a standardized method of documenting vaccination is created.

**Implementation Plan item 56.7. is noncompliant.**

**Recommendations**

1. Address and implement recommendations concerning immunizations that are noted in Implementation Plan Items 26, 27, 28, and 56
2. The structure of the vaccination program should be rolled out with standardized practices, staffing, equipment, supplies, and training. See Implementation Plan 56.4

3. The Immunization Program should be placed under the administrative umbrella of nursing leadership and managed by each facility's infection control nurse or a dedicated immunization nurse using approved standing orders to administer recommended adult immunizations. Also see Implementation Plan item 28.1.b and c.
4. The new EMR vendor should incorporate data points and clinical prompts which electronically remind, record, track, and report all adult immunizations offered, administered, and refused and the identified clinical indication (age, clinical condition, etc.)
5. HPV immunization must be offered to all incarcerated women **and men** 26 years of age or younger.
6. IDOC should initiate a universal Hepatitis B vaccination program preferably in conjunction with opt-testing with a triple panel (HBsAg, antibody to HBsAg, and total antibody to hepatitis B core antigen.<sup>367</sup>
7. The database and Immunization, Screenings, and Exam tracking table in the **paper** medical record must accurately document all vaccinations that are offered, administered and refused.
8. The IDOC immunization guidelines must be reviewed and updated as needed to assure that updates to Center for Disease Control recommendations for adult immunizations are expeditiously incorporated into the IDOC guidelines. IDOC's current guidelines for pneumococcal vaccination are already outdated.

### **Cancer and Routine Health Maintenance Screening**

**III.M.1.c.** *All prisoners ages 50-75 will be offered annual colorectal cancer screening and PSA testing, unless the Department and the Monitor determine that such testing is no longer recommended.*

### **OVERALL COMPLIANCE RATING: Partial Compliance**

The rating of partial compliance is very tentatively continued due to progress being made in the measurement and increased offering of nationally recommended colorectal cancer screening tests. However, the lack of any data that screening for prostate cancer, lung cancer, and abdominal aortic aneurysm is being performed puts IDOC in jeopardy of being non-compliant with Consent Decree III.M.1.c.

### **Annual Colorectal Cancer Screening**

**Compliance rating:** Partial compliance

The determination of this rating for colorectal screening was based on the following.

1. Chart and document review that indicate an increased, albeit slowly implemented and not yet at goal, utilization of FIT testing;
2. The decision of IDOC to incorporate the USPSTF A and B recommendations for colorectal cancer screening;
3. The selection of the offering and provision of FIT testing as a systemwide performance and outcome measure;
4. The decision to further study the reasons that the provision of screening of colorectal screening has not met IDOC's goals; and
5. Initiation of a comprehensive log that tracks colorectal screening at one facility<sup>368</sup> that could be used as a model for systemwide use and development of an electronic tracking process.

Since the Consent Decree was signed the United States Preventive Services Task Force (USPSTF) has lowered the age when colorectal screening should begin in asymptomatic, low risk individuals from 50 to 45 years of age.

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<sup>367</sup> IDOC's draft Policy B.01.01 Preventive Service and Periodic Health Assessment has included Hepatitis B screening and vaccination in its screening/vaccination recommendations.

<sup>368</sup> Keweenaw CC Colon Screen Tracking Log with data from 12/31/2022 through 7/20/2023, Logan CC also had a colorectal cancer screening log that was provided to the Monitor in late 2021; an updated log was not provided for this Report.

In its draft of the Preventive Service and Periodic Health Assessment Policy, IDOC has appropriately modified the age to begin colorectal cancer screening to 45 years.<sup>369</sup>

Thirty medical records from 10 IDOC facilities were reviewed with respect to colorectal cancer screening. The results of the Monitor's audit are shown in the table below.

Colorectal Cancer Screening						
Review of Medical Records from Ten IDOC Facilities						
Appropriate Screening			Inappropriate Screening			
				Offered Rectal Exam with Single Guaiac		
# Eligible	# Colonoscopy	# FIT test	Stool Guaiac x3	Accepted Rectal Exam with Guaiac	Refused Rectal Exam with Guaiac	
30	2 (7%)	10(33%)	3(10%)	2(7%)	13 (43%)	

In the above table only 12 (40%) of the 30 patients eligible for colorectal cancer screening<sup>370</sup> were screened using a nationally recommended screening test (colonoscopy, fecal immunochemical test (FIT)). Three individuals were screened by testing three stool cards for the presence of blood; this screening modality is no longer recommended by the United States Preventive Services Taskforce (USPSTF). Fifteen incarcerated persons were offered to have a rectal exam to gather a fecal sample for a single hemoccult test; 13 men refused the rectal exam and two men accepted this screening. Performing a rectal exam and testing a single stool specimen for blood has been not recommended as a screening test for colorectal cancer for the last 15-20 years. Eighteen (60%) individuals in this audit were either not screened or were screened by invalid testing modalities. The IDOC has appropriately recommended FIT testing as the screening test for colorectal cancer in all of its thirty facilities.<sup>371</sup> The failure to offer a nationally recommended screening test for colorectal cancer was witnessed during Monitor's facility visits as recently as 6/29/2023, over two years after IDOC had disseminated updated guidelines directing the utilization of FIT testing.<sup>372</sup> The vendor Regional Medical Directors must assist in this IDOC implementation plan in order to make progress toward compliance.

IDOC provided tracking logs for colon cancer screening from Kewanee CC and East Moline CC. The tracking log for Kewanee is shown below.

Kewanee CC Colon Cancer Screening (FIT) Scheduling and Tracking Spreadsheet December 12, 2022 to July 20, 2023				
FIT Test Offered	Performed	Refused	Blank	Next Annual Test Scheduled
47	21 (45%)	24 (51%)	2 (4%)	47 (100%)

<sup>369</sup> B.01.01 Preventive Service and Periodic Assessment Policy Draft April 2023 colorectal is to be offered to individuals age 45 to 75 years.

<sup>370</sup> USPSTF 2023 recommends screening for colorectal cancer in adults aged 45 to 49 years (Grade B recommendation) and aged 50 to 70 years (Grade A recommendation).

<sup>371</sup> Administrative Directive IDOC Immunization and Cancer/Preventive Screening Programs January 2021 and Draft Preventive Service and Periodic Health Assessment Policy B.0.01 April 2023

<sup>372</sup> Administrative Directive IDOC Immunization and Cancer/Preventive Screening Programs January 2021



Kewanee CC, population 222 men<sup>373</sup>, utilizes a log to record and track colorectal screening that includes the patient's name, IDOC #, age, date of birth, test to be performed, date offered, date performed or refused, and the date of next annual screening. Kewanee did not provide data on the number of men aged 45 to 75 years who would be eligible for colorectal screening. This is the first facility to utilize a comprehensive colon cancer screening log that has been provided to the Monitor. IDOC should consider implementing this log in all of its thirty centers. The high refusal rate (51%) needs to be evaluated by the facility's quality improvement committee in conjunction with IDOC System Quality Council which is collaborating with SIU to audit colorectal screening in all IDOC facilities. IDOC has selected colorectal screening as a performance and clinical outcome measure that will be studied to identify opportunities to improve both the offering and patient acceptance of this non-invasive colorectal screening test. It was noted on the Kewanee log that 10 (21%) of individuals offered screening were 44 years of age or younger (range 40-44 years old). IDOC should investigate why incarcerated men at this facility are beginning to be screened at a younger age than recommended by the USPSTF.

The East Moline colorectal cancer screening log is shown below.

East Moline CC Colon Cancer Screening (FIT) Scheduling and Tracking Spreadsheet June, 2022 to August 2022				
FIT Test Offered	Accepted	Refused	Paroled/ Discharged	Date Next Scheduled
33	20 (61%)	11 (33%)	2 (6%)	Not Listed

East Moline CC utilizes an *Annual Physicals* scheduling log that records the patient's name, IDOC number, FIT test accepted/refused, (routine) lab date, date physical exam (PE) scheduled, and date PE completed. This log does not document the date that the FIT test was given to the patient or the date the test was completed. Providers appear to enter a checkmark in the FIT column when the test is accepted and a dash mark when the test is refused. It is less informative about the provision of colorectal screening than the log utilized by Kewanee CC. East Moline also has a high refusal rate (33%) for this non-invasive colorectal screening test that needs to be evaluated by the facility and system quality improvement committees.

IDOC, in collaboration with SIU, has chosen to audit the percentage of ten individuals in each of the 30 IDOC facilities who have received a recommended screening test for colorectal cancer. This audit is performed quarterly. After four quarters of auditing, the numbers of individuals screened are less than optimal.<sup>374</sup> OHS has decided to investigate and identify barriers to the offering and acceptance of colorectal screening.

The Monitor strongly supports this decision to study and improve colorectal cancer screening in the IDOC.

### Prostate Cancer Screening

**Compliance rating:** Non-compliance

The Monitor has found no evidence nor was provided any data that IDOC providers are adhering to the USPSTF guidelines (Grade C<sup>375</sup>) concerning prostate cancer screening. The January 2021 IDOC Administrative Directive

<sup>373</sup> IDOC population by facility November 2022

<sup>374</sup> Performance and Clinical Outcome Measure Colon Cancer Screening FY 2023 Quarter 4

<sup>375</sup> USPSTF Grade C definition: "The USPSTF recommends selective offering or providing this service to individual patients based on professional judgement and patient preferences. There is at least moderate certainty that the net benefit is small." Grade A "...net benefit is substantial, Grade B "...net benefit is moderate"

on Immunization and Cancer/Preventive Screening Programs and the draft policy B.01.01 Preventive Service and Periodic Health Assessment direct that facilities follow USPSTF recommendations. The current USPSTF recommendation for prostate cancer screening is a C recommendation for men 55-69 years of age and a D recommendation for men 70 years of age and older. The C recommendation is that prostate cancer screening is to be an individual decision based on discussion between a physician and the patient. The physician is recommended to discuss benefits and harms of screening and to discuss that a small potential benefit of reducing death from prostate cancer exists but the harms are that many men will experience potential complications from procedures attendant to false positive tests including incontinence and erectile dysfunction. The Monitor recommends that the policy direct only A and B recommendations be followed. There is no A or B recommendation to support routine prostate cancer screening. However, it may be reasonable for the OHS leadership to educate the clinical staff about the USPSTF C recommendation for prostate cancer screening.

To evaluate the current procedure used in the IDOC to screen men for prostate cancer, the Monitor reviewed 37 medical records from ten correctional centers. Twenty-two men were eligible for prostate cancer screening based on their ages between 55 and 69 years. Results of that review are shown below.

Prostate Cancer Screening				
Review of Medical Records from Ten IDOC Facilities				
# Eligible	Discussion Pros/Cons of PSA Testing	Digital Rectal Exam Done	Rectal Refused	No Data
22	0 (0%)	5 (23%)	13 (59%)	4 (18%)

**The United States Preventive Services Task Force (USPSTF) recommends that men aged 55 to 69 years discuss the possible benefits and harms of prostate-specific antigen (PSA) screening with their health providers and make an individual decision about whether to get screening. Men who do not express a preference for PSA testing should not be screened. This a Grade C recommendation.** Audit of the medical records of 22 men between the ages of 55 to 69 years revealed that none had documentation in the medical record that the harms and benefits of PSA screening were discussed with them. Although the performance of a digital rectal exam (DRE) is no longer a recommended screening test for prostate cancer, 18 (82%) of the 22 men were offered rectal exams; 5 received a rectal exam and 13 refused this exam. An additional four men whose age exceeded 69 years (range 72 to 83 years) were not candidates for prostate screening but nonetheless were offered rectal exam screening for prostate cancer. Three of these non-eligible patients refused the rectal exam and one accepted the exam.

A provider at one facility<sup>376</sup> communicated to the Monitor that they continue to offer rectal exams to screen for prostate cancer, in part, because the IDOC physical exam form still contains a line where “rectal exam” is listed and providers feel that this mandates them to do this procedure. If this outdated form contributes to the continuation of this antiquated practice, then all providers should be re-educated and the form should be revised. The January 2021 IDOC Administrative Directive Immunization and Cancer/Preventive Screening Programs is in full accord with the USPSTF Grade C prostate screening recommendation. IDOC’s April 2023 draft Policy and Procedure B.01.01 Preventive Service and Periodic Health Assessment currently does include the USPSTF Grade C recommendation on prostate screening. It is evident that USPSTF Grade C recommendation is not being implemented in the IDOC. The IDOC must discontinue the utilization of the outdated and ineffective digital rectal examination as a screening test for prostate cancer.

<sup>376</sup> Interview at Graham CC in July 17-19 2023

## **Mammography Screening**

### ***Addresses items III.M.1.d***

**III.M.1.d.** *All female prisoners age 45 or older will be offered a baseline mammogram screen, then every 24 months thereafter unless more frequent screening is clinically indicated, unless the Department and the Monitor determine that such testing is no longer recommended.*

### **OVERALL COMPLIANCE RATING: Substantial Compliance**

Substantial compliance

### **Findings:**

#### **Breast and Cervical Cancer Screening**

Normal mammograms are to be repeated every 2 years on women between 50 and 75 years of age; normal PAP smears are to be done every 3-5 years in females between 21 and 65 years of age based on age and results of HPV cultures.<sup>377</sup> Abnormal mammograms and PAP smears require more frequent imaging and testing.

Three documents were to evaluate progress toward completion of this task in the Consent Decree. One document received contained nine medical records with mammogram and PAP data from Decatur CC that had already been received and reported in the 6<sup>th</sup> Court Report. This document was not used. The second document provided medical records of ten new admissions to the Logan Reception and Classification Center. The third document contained a spread sheet with all mammograms scheduled from 10/23/2022 to 7/21/2023 at Logan CC. The second and third documents were used as evidence in this report.

Nine (90%) of the ten intake health records of women being admitted to Logan had documentation that they had been offered pap smear testing for cervical cancer.<sup>378</sup> Five additional medical records of the Logan CC patients (54 to 64 years of age) documented that all five had been offered pap smear testing; four had accepted the screening and had results in the chart verifying that they had been screened for cervical cancer within the last 13 months (10/16/22 to 6/2/23). One patient refused cervical cancer screening.

Four of the ten records received from Logan had documentation that the women at were offered mammography screening. Two refused the mammograms. Two accepted the screening. One woman had a previous mammogram on 8/10/21 and on 2/7/23, 16 months later, had a repeat mammogram. The result was BIRADS 2<sup>379</sup>, benign findings with a repeat mammogram recommended to be done in one year. The other patient who accepted the mammogram had a previous mammogram on 8/10/21 which showed focal asymmetry in the left breast. This abnormal screening resulted in a repeat mammogram and an ultrasound on 1/4/23 which were both normal with the recommendation to repeat the mammogram in six months. On 7/7/23 follow-up mammogram was completed and read as BIRADS 1<sup>380</sup>. This patient with an initial abnormal mammogram was appropriately managed by Logan CC.

The third document was a mammography scheduling log that provided evidence on mammography screening at Logan CC. The data on this log is presented on the table below.

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<sup>377</sup> United States Preventive Task Force reviewed 2/9/23 and IDOC Draft Administrative Directive January 2021. The Consent Decree III.N.1.d states that mammography is to start at the age of 45 is not in align with the USPSTF recommendations to start breast cancer screening at age 50 years.

<sup>378</sup> See Medical Reception section of this report for additional information.

<sup>379</sup> Breast Imaging Reporting and Data System (BIRADS) Category 2 is consistent with benign findings.

<sup>380</sup> BIRADS 1 indicates a fully negative study

Mammography Screening Scheduling Log from Logan CC. 10/23/22 to 6/21/23												
On Schedule Log at Logan	Released or Transferred from Logan Before Mammography Completed				Completed Mammography at Logan			Mammography Not Completed at Logan				
	Total Released or Transferred	Paroled	Transferred to Decatur	Transferred to Transition Center	Total Remaining at Logan	Completed at Logan	Completed at a Medical Center	No Show for Mammography	On Crisis Watch and Unable to Screen	Refused	Ultrasound Needed Prior to Mammography	
	54	9 (17%)	44 (81%)	1 (2%)	228	157 (69%)	9 (4%)	21 (9%)	3 (1%)	37 (16%)	1 (0.4%)	
						166 (73%)			62 (27%)			
282	54 (19%)								228 (81%)			

Two hundred and eighty two women were on the mammography scheduling log. Fifty-four women were released, transferred to Decatur or to a transition center before the test could be completed. The 44 (77%) who transferred to Decatur, had no information whether these women received mammography screening or whether their transfer summary documented need to complete mammography screening at Decatur. Information about whether the transfer summary included information that they have not yet had mammography should be included on the log. Of the remaining 228 women on the mammography scheduling log who remained at Logan, information was not available whether they were all offered mammograms. The Monitor presumed they were all offered screening. Of these 228 women, 166 (73%) had mammograms completed, which is slightly below the score of 85% of women receiving mammography based on a review of the ongoing data being gathered by SIU on women having had a mammograms within the last two years at Logan CC and Decatur CC (85%).<sup>381</sup> Twenty-one women (9%) scheduled for mammograms at Logan CC between 10/23/22 and 6/21/23 were listed as “no shows”. IDOC needs to investigate this group to determine the reasons for “no shows” including possible failure of security to move the individuals to the health care unit for the procedure or women who refused mammograms but were not brought to HCU to sign a refusal form as per IDOC practice. IDOC did not provide information about whether the “no shows” were rescheduled for breast cancer screening.

As noted in previous Reports, randomly chosen chart reviews during a site visit<sup>382</sup> and non-randomly selected medical records provided to the Monitor for previous Court Reports revealed that women were being regularly screened for breast and cervical cancers.<sup>383</sup>

As previously discussed in the previous four Court Reports, the data of mammogram screenings and PAPs only reported the volume of screening tests performed; they did not indicate the percentage of eligible women who were offered, accepted, and refused these screenings.

IDOC needs to track these two cancer screening modalities based on the percentage of eligible women who are offered, received, and refused testing within the established timeframes. This data should be reported to the CQI committees and corrective action taken as indicated. There is evidence that mammograms and PAP tests are being regularly performed at both female institutions. However, more robust data and tracking to assure that all eligible women are being testing in accord with nationally cancer screening standards needs to be established.

### Recommendations:

1. Monitor and report the offering, provision, and refusal of breast and cervical cancer screening to the facility Quality Improvement Committees.
2. Report Women’s health data based on the percentage of eligible incarcerated women who receive breast and cervical cancer screenings within the nationally established time intervals.

<sup>381</sup> Clinical Quality Measures 4th Quarter 2023: 85% of ten randomly chosen charts at Decatur CC and Logan CC had received at least one mammogram in the previous two years.

<sup>382</sup> Logan CC site visits 2/25-26/2020

<sup>383</sup> 4<sup>th</sup>, 5<sup>th</sup>, and 6<sup>th</sup> Court Reports

**Implementation Plan items addressing RHM/cancer screening.**

**Implementation Plan item 26:** *Finalize and disseminate immunization and routine health maintenance (RHM) and cancer screening policies, procedures, and guidelines using the Center for Disease Control (CDC) adult immunization guidelines and United States Preventive Services Task Force (USPSTF). Proposed End Date: July 2023*

**Findings:** IDOC has also submitted a draft of the B.01.01 Preventive Care and Periodic Health Assessment policy which addresses RHM and cancer screening. The Monitor team has reviewed this draft and has forwarded input to the IDOC.<sup>384</sup> Finalized versions of this policy have not yet been received by the Monitor. This draft is also not yet been approved or implemented. **Based on the draft of these policies, IDOC is partially compliant with Implementation Plan item 26. This policy needs to be implemented.**

**Implementation Plan item 27:** *Identify and finalize a mechanism to track immunizations and routine health maintenance (RHM) and cancer screening information until EHR is fully implemented. The mechanism will track and report both the volume of specific vaccines offered, administered, and refused per facility and the percentage of eligible patients who have been offered, accepted, and refused specific vaccinations and routine health maintenance/cancer screenings. IDOC must implement an interval immunization and RHM/cancer screening tracking system prior to the full implementation of the EHR. Proposed End Date: December 2023*

**Findings:** IDOC has communicated that a mechanism to track RHM and cancer screenings systemwide has not yet been developed. Although a few facilities have initiated logs of patients either receiving or scheduled to receive select RHM/cancer screenings, none of these logs track the number of patients who are eligible to receive RHM/cancer screenings or the number offered, administered, and refused screening tests.<sup>385</sup> In conjunction with SIU, performance and outcome measures for colorectal cancer screening have been initiated but have only recently begun to track both the offering and administration rates at each facility. The actual percentage of eligible patients who are offered and receive colorectal and mammography testing is not being measured. The completion date for this Implementation Plan item of December of 2023 will not be met. **To date IDOC is not compliant with Implementation Plan item 27.**

**Implementation Plan item 28:** *Track adult immunization and RHM/cancer screening acceptance rates. Develop and implement an interval immunization and RHM/cancer tracking solution using an electronic database (see #27.) Possible solutions for immunization tracking include open source relational database software, the Illinois Comprehensive Automated Immunization Registry I-CARE or similar database. Proposed End Date: December 2023*

**Findings:** As noted in Implementation Plan item 27, IDOC currently does not have a systemwide mechanism to track RHM/cancer screening. The proposed end date for Item 28 of the Implementation Plan including subitems 1-4 below is December 2023. These items will not be accomplished by December 2023. **IDOC is not compliant with Implementation Plan item 28.**

**(Implementation Plan item 28 continued)** *Complete immunization policy and procedures revision to include:*  
*d. Annual health evaluation update of immunization and RHM/cancer screening status and offering*

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<sup>384</sup> Monitor's limited revisions to the 2<sup>nd</sup> draft of B.01.01 were returned to IDOC on 5/19/23.

<sup>385</sup> Logs of colorectal cancer screening were provided for East Moline and Kewanee, mammography screening logs were provided for Logan CC, HPV vaccination logs have been presented in the past from Decatur and Logan CC's

*of necessary immunizations and screenings at chronic care and specialty clinic visits, annual and biannual health visits, and regular vaccination/RHM/cancer screening events.*

**Findings:** Policy B.01.01 Preventive Service and Periodic Health Assessment directs that nursing will interview all patients to determine their need for screenings in accordance with the United States Preventive Health Services Task Force. The policy specifically calls out screening for colon cancer, lung cancer, abdominal aortic aneurysm, and breast and cervical cancer for females.

This draft policy has not yet been approved or implemented. Current practice shows that RHM/cancer screening is not offered or updated at chronic clinics, specialty care follow up or biannual health visits.

The Monitor has not gathered or tabulated data or been provided data on whether RHM/cancer screening is reviewed and offered at chronic care and specialty clinic visits, annual and biannual health visits and RHM/cancer screening events. However, based on medical records provided for this Court Report, the Monitor has noted that RHM/cancer screenings are inconsistently offered and ordered during annual periodic health assessments and examinations and are rarely offered at chronic care visits. There is notable facility to facility variation in the completion of the RHM/cancer screenings.

Policy for RHM/cancer screening at annual health updates is present but proof of practice is not provided for implementation of the policies. **IDOC is noncompliant with Implementation Plan 28.1.d.**<sup>386</sup>

**(Implementation Plan item 28 continued)** *I. Complete immunization policy and procedures revision to include:*  
*e. Reception and classification centers will solicit and record immunization and RHM/cancer screening status and will offer and track required vaccinations and RHM/cancer screenings as part of the intake admission process.*

**Findings:** Draft policy B.01.01 Preventive Service and Periodic Health Assessment in section III states that a baseline health assessment is to occur at intake for all individuals 45 years of age or older. This health assessment is to include cancer prevention. However, the 45 years of age limit, in this policy, fails to include cervical cancer screening for females. Cervical cancer screening already occurs at female intake so IDOC should ensure the current practice is established in policy. This policy is not yet approved or implemented.

No data was provided on the completion of RHM/cancer screening histories and the offering of indicated screenings during intake health screenings at Reception and Classification Centers. On the few Reception and Classification intake health assessments forms included with the medical records provided to assess preventive services, the status of RHM/cancer screening was frequently not completed and recommended RHM/Cancer screenings were not offered. Data based on the review of multiple intake screening records and reported in the Medical Reception of this Report verified that new admissions identified as candidates for lung cancer and colorectal cancer screenings were not offered these indicated screenings.<sup>387</sup> IDOC's largest Reception and Classification Center (NRC) is not audited for any of the twelve performance and clinical outcome measures including colorectal cancer screening. **IDOC is noncompliant with Implementation Plan item 28.1.e. Policy is drafted but not approved or implemented.**

**(Implementation Plan item 28 continued).** *Complete immunization policy and procedures revision to include:*

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<sup>386</sup> As noted in III.M.1.d, the offering of breast and cervical cancer screening is performed at the two female facilities. This aspect of cancer screening in the IDOC is in substantial compliance.

<sup>387</sup> See Medical Reception section of this Report for additional information

- f. *Immunization and RHM/cancer screening data will be reported regularly at the monthly facility QI meetings and at the systemwide Quality Council meetings.*

**Findings:** The draft Preventive Service and Periodic Health Assessment policy (B.01.01) does not address reporting of RHM/cancer screening data at facility quality meetings or at the systemwide Quality Council meetings. The draft Quality Improvement policy (A.06.01) states that facility “minutes and reports by the facility shall conform to the format and distribution established by SLQC [system leadership quality council]”. This does not include specifics regarding what is to be reported. The SLQC meeting minutes of December, 2022 include a discussion regarding a list of data to be tracked by the facility. No further information on a standardized data report has been provided.

Based on the review of September 2022 through June 2023 monthly quality QI meeting minutes, there is limited reporting of RHM/cancer screening during facility QI meetings. Review of System Quality Council meeting minutes<sup>388</sup> did not identify any reporting of RHM/cancer screening data. However, based on communication at monthly OHS-Monitor conference calls, it has been reported that OHS has discussed the results of the quarterly performance and clinical outcome data gathered by SIU concerning breast cancer and colorectal screening and a decision has been made to investigate the colorectal screening program and to identify opportunities to enhance the rates of colorectal cancer screening in the IDOC. **IDOC lacks policy and procedure on CQI reporting for RHM/cancer screening but has reported SIU audits for vaccinations and cancer screening at the SLQC and is developing corrective actions on cancer screening. Because of this IDOC is partially compliant with Implementation Plan item 28.1.f.**

(Implementation Plan item 28 continued).

2. *Ensure that the implementation of the electronic health record includes requirements to track and automatically report immunization and RHM/cancer screening data.*

**Findings:** Given that IDOC has not yet finalized the selection of an electronic medical record vendor, this task of Implementation Plan item 28.6 has not yet been acted upon. IDOC has voiced a commitment to electronically gather ongoing data about numerous aspects of health care delivery including immunizations. **This task has thus not been rated.**

(Implementation Plan item 28 continued)

3. *Select a reputable database to assess immunization and RHM/cancer screening status at intake and update immunizations/RHM/cancer screenings prior to conclusion of the intake process.*

**Findings:** IDOC has not identified or implemented a database to assess RHM/cancer screening status on new admissions to the Reception and Classification centers and has provided no data that IDOC updates RHM/cancer screenings prior to transferring new admissions to their “home” correctional center. The largest Reception and Classification Center (NRC) is not being audited by SIU for any of the twelve performance and clinical outcome measures including FIT colorectal cancer screening. This suggests that NRC is not offering needed RHM/cancer screening to new admissions. IDOC draft policy G.09.01 Preventive Service and Periodic Health Assessment requires a nurse at intake to perform a baseline health assessment to include RHM/cancer screening elements. This policy is not yet approved or implemented but would be an appropriate practice. IDOC should implement this policy and develop a process to track cancer screening efforts. **IDOC does have draft policy that addresses this item but the policy has not yet been implemented. Implementation Plan item 28.3 is therefore partially compliant.**

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<sup>388</sup> System Quality Council minutes: 9/8/22, 12/13/22, 3/29/23, 6/28/23

(Implementation Plan item 28 continued).

4. *Institute statewide training of nurses on safe immunization practices and update immunization procedures and select RHM/cancer screenings.*

*Proposed End Date: December 2023*

**Findings:** IDOC has not provided data on the statewide training of nurses (and other clinical staff) for selected RHM/cancer screenings. IDOC has also not provided to the Monitor information as to which staff are performing the point-of-care FIT screening for colorectal screening. This item will not be accomplished by December 2023 as IDOC has not yet completed policy on immunization and RHM/cancer screening. Once those policies are completed, the Monitor expects training will be initiated. **This item has thus not been rated.**

**Implementation Plan item 56** requires that: *OHS will ensure all routine health maintenance/cancer screenings and adult immunizations as respectively recommended by USPSTF (A and B recommendations) and CDC are being offered to all at risk patients*

**Findings:** USPSTF recommendations for routine health and cancer screening<sup>389</sup> are addressed in IDOC draft policy B.01.01 Preventive Service and Periodic Health Assessment. But this policy is not yet completed or accepted and implementation has not yet begun.

Though the policy is not yet complete, practices of IDOC regarding specific recommendations of the USPSTF (excluding colorectal cancer screening which is addressed above) are addressed here.

### Documentation of Tobacco Use

#### Criteria Needed to Determine Candidates for Lung Cancer and AAA Screening

Review of intake screening forms, annual medical histories, chronic care visits from multiple medical records identified a consistent lack of adequate documentation of a history of tobacco use, the years of smoking, the packs/day history, the pack years smoked, and whether the patient had stopped smoking for 15 years or longer. Absence of comprehensive data on tobacco usage is a barrier to identifying which individuals should be screened for lung cancer and abdominal aortic aneurysm (AAA). IDOC needs to address this gap in gathering pertinent medical histories so that USPSTF guidelines and the IDOC Preventive Service and Periodic Health Assessment<sup>390</sup> policy for identifying eligible candidates for lung cancer and AAA screening can be implemented. Thirty seven records were reviewed related to smoking history. A table of that review is shown below.

History of Tobacco Use										
Information Needed to Determine Eligibility for Abdominal Aortic Aneurysm and Lung Cancer Screening										
Number of charts reviewed	Tobacco Use			Packs/Day documented		Years of smoking documented		Pack pers years smoked documented		Not smoking for ≥ last 15 years documented
	Yes	No	Not Noted	Yes	No	Yes	No	Yes	No	
37	12 (32.5%)	9 (24.5%)	16 (43%)	4 (33%)	8 (67%)	3 (25%)	9 (75%)	2 (17%)	10 (83%)	0 (0%)

Forty-three percent of the 37 charts reviewed did not document whether the patient had or had not used tobacco. Of the twelve individuals with a documented history of tobacco use, only 4 (33%) noted the number of packs of cigarettes smoked per day, 3 (25%) documented the number of years that the patient had smoked, 2 (17%) recorded data that allowed pack years to be calculated, and zero (0%) noted whether the patient had stopped

<sup>389</sup> The USPSTF recommendations for immunization are to follow the Center for Disease Control Advisory Committee on Immunization Practices (ACIP) which is being done by IDOC.

<sup>390</sup> IDOC Policy B.01.01 Preventive Service and Periodic Health Assessment draft April 2023



smoking for 15 years or longer. The lack of comprehensive data on the use of tobacco cripples the identification of individuals who qualify for screening for lung cancer and AAA. Moreover, smoking is a major cardiovascular risk and is important to identify with respect to primary and secondary cardiovascular prevention.

### Lung Cancer Screening

The Monitor has found no evidence nor was provided any data that IDOC providers are adhering to the USPSTF guidelines, the January 2021 IDOC Administrative Directive on Immunization and Cancer/Preventive Screening Programs, or the IDOC draft Preventive Service and Periodic Health Assessment Policy concerning screening for lung cancer. A review of 37 charts from ten male facilities<sup>391</sup> identified twenty-nine individuals aged 50 to 80 years which defines the age criteria for lung cancer screening. The follow table is based on that review.

Lung Cancer Screening							
Age Criteria Met	Tobacco User Documented	Packs/Day Documented	Years Smoked Documented	Pack/Years Documented	Years Since Patient Smoked	Lung CT Scan Ordered	Data on Tobacco Use Not Provided
29	11 (38%)	4 (37%)	2 (18%)	2 (18%)	0 (0%)	0/2 (0%)	14/29 (48%)

The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit smoking within last fifteen years.<sup>392</sup> A history of smoking was noted for only eleven (38%) of the 29 patients between the ages of 50 to 80. Of these eleven men with a history of tobacco use, the data needed to calculate pack-years was documented on only 2 (18% of the 11 smokers) individuals and thus only these two men were eligible for lung cancer screening. Neither of these two had documentation in the records provided that low-dose lung CT had been ordered. A history of smoking or non-smoking was not provided in 14 of the 29 medical records. Since the Reception and Classification centers and these ten correctional centers did not consistently document the history of tobacco use.<sup>393</sup> The Monitor (and the IDOC) are not able to identify patients eligible for low-dose lung CT screening. IDOC must incorporate the data elements required to identify eligibility for lung cancer screening into both intake screenings and annual/biannual medical histories. IDOC and the medical vendor need to re-educate and monitor providers' compliance with the lung cancer screening criteria and recommendations of the USPSTF.

### Abdominal Aortic Aneurysm (AAA) Screening

The Monitor has found no evidence and was not provided any data that IDOC providers are adhering to the USPSTF guidelines, the January 2021 IDOC Administrative Directive on Immunization and Cancer/Preventive Screening Programs, or the IDOC draft Preventive Service and Periodic Health Assessment Policy concerning screening for abdominal aortic aneurysm (AAA). Thirty-seven records were reviewed for AAA screening. The following table shows the results of that review.

<sup>391</sup> The thirty-seven medical records were reviewed from East Moline, Graham, Hill, Jacksonville, Lawrence, Lincoln, Pinckneyville, Shawnee, Taylorville, and Vandalia correctional centers

<sup>392</sup> On 11/1/23, it was announced in the media that the American Cancer Society has recommended to delete the USPSTF guideline to "not to screen individuals who have quit smoking only within the last fifteen years". The USPSTF recommendation not to screen individuals who have stopped for 15 years or longer is still the gold standard for the United States and the IDOC.

<sup>393</sup> Tobacco history needs to include the packs smoked per day, the years smoked, the pack-years of smoking and the number of years since the individual ceased smoking.

Abdominal Aortic Aneurysm (AAA) Screening*				
Age and Male Criteria Met	Tobacco Use Criteria Met	Data on Tobacco Use Not Provided	Non-Smoker	AAA Ultrasound Performed
15	5 (33%)	5 (33%)	5 (33%)	0/5 (0%)

\* 37 medical records were reviewed from East Moline, Graham, Hill, Jacksonville, Lawrence, Lincoln, Pinckneyville, Shawnee, Taylorville, and Vandalia Correctional Centers

The USPSTF recommends that all males ages 65 to 75 years **who have ever used tobacco** have a one-time ultrasound (US) of the abdominal aorta to identify the presence of a potential life-threatening aneurysm. The IDOC has included this USPSTF screening recommendation for AAA screening into its Preventive Service and Periodic Health Assessment Policy.<sup>394</sup> Zero of the five men eligible (see above table) for AAA screening received the recommended ultrasound or had documentation that the ultrasound had been ordered. The eligibility of five additional individuals who met the age criteria but could not be determined eligible for screening because there was no documentation in the annual physical examination and medical histories that the individual had ever smoked. The monitor team has not to date identified any AAA ultrasound screenings being performed in IDOC during the team's onsite inspections at eight male correctional centers.<sup>395</sup> IDOC and the medical vendor needs to re-educate providers and monitor the compliance with the USPSTF guidelines concerning screening for AAA.

### Hepatocellular Cancer (HCC) Screening

The standard of care for screening for hepatocellular carcinoma is to perform surveillance screening with ultrasound with or without alpha fetoprotein every six months in patients with cirrhosis.<sup>396</sup> UpToDate also recommends inclusion of hepatitis C patients without cirrhosis but with advanced fibrosis. The Monitor has identified no systemwide evidence of this screening being performed on high risk incarcerated persons or data being reported in facility QI minutes. In the 5<sup>th</sup> Report, only two of IDOC's thirty correctional facilities provided data in their Chronic Care Rosters indicating that liver ultrasonography screening is being performed on small numbers of patients with hepatitis C; this data is not presented to the facilities' monthly quality improvement minutes.<sup>397</sup> The Monitor reviewed seven medical records from four different facilities of patients who had been treated for active hepatitis C. The records provided were incomplete which made it difficult to assess compliance with the recommended six monthly HCC ultrasound (US) screening.<sup>398</sup>

Lung cancer, colorectal cancer, and hepatocellular carcinoma are the three leading causes of cancer mortality in the IDOC.<sup>399</sup> These three cancers can be diagnosed and treated at an earlier stage with effective screening programs and can even be prevented or cured if detected in an early or precancerous stage. IDOC needs to more aggressively develop and track the effectiveness of its cancer/preventive screening program. Effective cancer and

<sup>394</sup> IDOC draft policy B.01.01

<sup>395</sup> The Monitor has done onsite inspections at Dixon, Graham, Lawrence, Lincoln, Pontiac, Robinson, Shawnee, and Sheridan correctional centers since the signing of the Lippert Consent Decree.

<sup>396</sup> Diagnosis, Staging, and Management of Hepatocellular Carcinoma: 2018 Practice Guidance by the American Association of the Study of Liver Diseases as found at [https://www.aasld.org/sites/default/files/2022-06/AASLD\\_2018\\_HCC\\_Guidance\\_on\\_Diagnosis%2C\\_Staging\\_and\\_Management\\_hep\\_29913.pdf](https://www.aasld.org/sites/default/files/2022-06/AASLD_2018_HCC_Guidance_on_Diagnosis%2C_Staging_and_Management_hep_29913.pdf)

<sup>397</sup> 5<sup>th</sup> Report or in 2022 2<sup>nd</sup> and 3<sup>rd</sup> quarter CQI reports

Dixon CC chronic care roster listed 8 patients (6 with treated hepatitis C and 2 with "cirrhosis") who were to receive semi-annual liver sonography (US) screening for hepatocellular carcinoma; three had liver US done in 2021 with the next US to be done in early 2022. One other unidentified correctional facility's chronic care roster listed one patient with treated hepatitis C who required every 6 month liver US screening. This data was provided to Monitor on 3/28/22

<sup>398</sup> The records of two patients were insufficient to ascertain if liver US screening was being performed. One patient had an initial US but the report was not provided; he refused a repeat US. One patient diagnosed with HCC was treated with chemo-thromboembolism and follow up care and tests were being done at UIC. Three other patients had received US screening in 2023 but only one patient had documentation previous US (9/21/21, 9/9/22, and 4/23/23).

<sup>399</sup> 2017-2022 IDOC mortality spread sheets.

RHM screening in the IDOC for at-risk incarcerated persons has the potential to positively impact on avoidable morbidity and mortality. **Implementation Plan item 56: following USPSTF guidance for RHM/cancer screening is noncompliant.**

Implementation Plan item 56 also includes eight steps in order to implement the immunization and cancer screening programs. Each of them are discussed below.

**Implementation item 56.1, *Train healthcare staff on new immunizations and cancer screening policies.***

IDOC drafted and the Monitor has responded with comments to policy B.01.01 Preventive Service and Periodic Health Assessment, Training on this policy will presumably ensue following final approval. **This task has not been rated.**

**Implementation item 56.2, *Develop or implement an interval immunization and cancer screening tracking solution until EHR implementation as described above in Task 28.***

As noted in Item 27, IDOC has not yet developed or implemented a systemwide process to track RHM/cancer screenings pending the installation of an EHR. **IDOC is non-compliant with Implementation Plan item 56.2.**

**Implementation item 56.3, *Develop mechanism to audit compliance with immunization and cancer screening policies.***

IDOC's efforts to audit are not based on a standardized process nor are they based on audit requirements of II.B.9 for a comprehensive audit. IDOC's efforts are incremental and optionally enacted facility by facility. IDOC has designed and begun to utilize a specific form to document point-of-care FIT screening for colorectal cancer. This form will be filed in the lab section; it is unclear if the result will also be documented in the database where some RHM/cancer screenings and immunizations are documented. For the last four quarters, IDOC in collaboration with SIU has been randomly auditing ten medical records of eligible individuals per facility to assess compliance with breast cancer screening (female centers Decatur CC and Logan CC) and with colorectal cancer screening using FIT testing (29 facilities, NRC is not being audited). Colorectal cancer screening logs from two male facilities, Kewanee CC and East Moline CC, were provided to the Monitor for this Report and are used to track colorectal screenings. Logan CC provided a comprehensive log of breast cancer screening performed from 10/23/22 through 6/21/23. No data has been provided on IDOC's compliance with prostate cancer, lung cancer screening, hepatocellular cancer (HCC) screening in patients with advanced fibrosis/cirrhosis of the liver, and abdominal aortic aneurysm (AAA) screening. **IDOC is partially compliant with Implementation Plan item 56.3.**

**Implementation item 56.4, *Evaluate facilities to determine readiness (equipment, supplies, and staff) to complete cancer screenings.***

The Monitor has not received any reports or data on the readiness of each facility to complete cancer screenings. Staffing deficiencies impair progress at all facilities. Significant facility-to-facility variability in the use of FIT testing to screen for colorectal cancer suggests multiple deficiencies including: test kits are not available, inadequate education of the clinical staff, or lack of training for completion of the FIT, or all of these potential gaps. IDOC has chosen to focus on colorectal cancer screening with the goal of increasing access to colorectal cancer screening but a standardized plan to implement colorectal cancer has not been provided. **IDOC is currently not non-compliant with Implementation 56. 4.**

**Implementation item 56.5, OHS will identify the health care staff personnel responsible for screenings.**

Until staffing improves IDOC will be challenged to effectively implement any new programs. The Monitor has not received any reports or data on which health care staff will be completing or tracking cancer screenings. **This task has not been rated.**

**Implementation item 56.6, OHS will identify barriers to obtaining appointments for offsite screening.**

IDOC has not provided any information or data on barriers to scheduling offsite screenings for cancer. IDOC needs to monitor and identify any barriers to timely scheduling of colonoscopy for follow-up of abnormal colorectal screening tests, obtaining appointments to low dose lung CAT scans for lung cancer screening, and the scheduling of onsite or offsite ultrasonography for Abdominal Aortic Aneurysm (AAA) screening. To date the monitor team has identified very few if any individuals who have been scheduled for lung cancer and AAA screenings. **This item is not yet rated.**

**Implementation item 56.7, OHS will establish a method of documenting screenings and immunizations in the medical Record.**

During review of medical records, the Monitor noted no standardization in the medical record for the location of orders for cancer screening, verification of completion, and review of the result of screening tests or the location where results are filed. This creates difficulty for OHS and the Monitor to assess compliance with RHM/cancer screenings. **IDOC is non-compliant with Implementation Plan item 56.7.**

**Implementation item 56.8, OHS will direct all facilities to report routine health maintenance/cancer screenings and adult immunizations data to monthly facility QI meetings and system Quality Council meetings as detailed above in Tasks 27 and 28.**

Facilities optionally report data in facility Quality Improvement Meeting minutes and if reported, the format is not standardized. With respect to health maintenance and cancer screening data, OHS has not established standardized data definitions to be reported at CQI meetings or to the System Leadership Quality Council. The Monitor has identified limited reporting of RHM/cancer screening data at monthly facility QI meetings. Review of System Quality Council meeting minutes<sup>400</sup> did not identify any reporting of RHM/cancer screening data<sup>401</sup>. In the September 2022 SLQC minutes, a proposed action was to compile a list of data to be tracked by facilities, but the Monitor has received no further information.

SIU reports quarterly performance and outcome data in a standardized format which does contain some cancer screening data for selected items but this data does not include the eligible population as part of their data and only includes a sample population for a selected number of RHM/cancer screenings. **IDOC is partially compliant with Implementation Plan item 56.8.**

The proposed completion date for Implementation Plan item 56 including subitems 1-8 is March 2024, which is an unrealistic expectation especially since policy for routine health maintenance, cancer screening, and

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<sup>400</sup> System Quality Council minutes: 9/8/22, 12/13/22, 3/29/23, 6/28/23

<sup>401</sup> Based on communication at monthly OHS-Monitor conference calls, it has been reported that OHS has discussed the results of the quarterly performance and clinical outcome data gathered by SIU concerning breast cancer and colorectal screening and a decision has been made to investigate the colorectal screening program and to identify opportunities to enhance the rates of colorectal cancer screening in the IDOC. However, there is no formal reporting of RHM/cancer screening data.

immunization are not yet finalized. Once policy is completed the implementation will be challenging because there is no lead individual responsible for the implementation and because of the significant lack of staffing.

### **Recommendations:**

1. The IDOC Routine Health Maintenance (RHM)/cancer screening program guidelines must be reviewed and updated as needed to assure that updates to United States Preventive Services Taskforce recommendations for routine health maintenance and cancer screening are expeditiously incorporated into the IDOC guidelines.
2. The database and Immunization, Screenings, and Exam tracking table in the paper medical record must accurately document all RHM tests, cancer screenings, and exams that are offered, performed, and refused.
3. The IDOC should track and report facility specific data on the percentage of eligible men and women who are current with all nationally recommended cancer and routine health maintenance screening standards.
4. The IDOC should continue to incorporate all the A and B recommendations of the USPSTF into the draft Preventive Service and Periodic Health Assessment<sup>402</sup> policy and should maintain the Grade C prostate cancer screening recommendation in this policy.
5. The IDOC should provide ongoing education to nurses and providers on the nationally recommended preventive screening standards.
6. The wording of III.M.1. (c) in the Consent Decree should be modified so that the PSA testing recommendation is aligned with the prostate screening Grade C recommendation of the USPTF. PSA testing is now recommended to be discussed with men ages 55-69 and colorectal cancer offered to individuals ages 45 to 75 years.
7. IDOC must immediately discontinue the outdated and not recommended use of digital rectal exams with the collection of a single stool guaiac test as screening tests for prostate cancer and colorectal cancer. IDOC should delete "rectal exam" from the physical examination form and educate providers on when a rectal examination is indicated.
8. IDOC should solicit and accurately document in the medical record an individual's history of tobacco use including the number of years smoked and the number of packs smoked per day. If the patient has quit smoking, the number of years since tobacco use has been discontinued should be documented in the database so that IDOC staff can determine eligibility for lung cancer screening. Determination of eligibility for onetime AAA screening for men ages 65 to 75 years requires documented history that they had a history of tobacco smoking.
9. IDOC should add Hepatocellular Cancer (HCC) screening to the draft Preventive Services and Periodic Health Assessment policy B.01.01 as a recommended liver cancer screening for individuals with advanced liver fibrosis/cirrhosis.
10. The new EMR vendor should incorporate data points and clinical prompts which electronically remind, record, track, and report all RHM/cancer screenings offered, administered, and refused and the identified clinical indication (age, clinical condition, etc.)

## **Pharmacy and Medication Administration**

***Addresses items II.A; II.B.1; II.B.6.c; II.B.6.d;***

***II.A. Defendants shall implement sufficient measures, consistent with the needs of Class Members, to provide adequate medical and dental care to those incarcerated in the Illinois Department of Corrections with serious***

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<sup>402</sup> Draft B.01.01 Preventive Service and Periodic Health Assessment policy

medical or dental needs. Defendants shall ensure the availability of necessary services, supports and other resources to meet those needs.

**II.B.1.** IDOC shall provide access to an appropriate level of primary, secondary, and tertiary care.

**II.B.6.c.** IDOC agrees to implement changes in the following areas: Medication administration records-both for directly administered medications and KOP.

**II.B.6.d.** IDOC agrees to implement changes in the following areas: Medication refusals;

## **OVERALL COMPLIANCE RATING: Noncompliance**

### **FINDINGS:**

Pharmacy inspection reports and any medication administration audits that are completed each month by the consulting pharmacist for each facility were requested by the Monitor to review in preparation of this report.<sup>403</sup> The IDOC did not provide these documents. There are 19 facilities which report some information about pharmacy services in the monthly quality improvement committee meeting minutes. These reports may include the findings of the pharmacy inspection and sometimes medication errors that took place during the reporting period. The information discussed is considerably more detailed when the pharmacist attends the meeting. The Monitor reviewed pharmacy services and medication administration during the site visit to Graham CC that took place 7/17-7/19/2023 and reviewed medical records for this report.

The Defendants Implementation Plan<sup>404</sup> includes two process improvement projects, one on medication management that lists eight targets and another on chronic disease management which supports providers' evaluation of medication compliance and current medications at chronic clinic visits.<sup>405</sup> Monitoring of medication adherence is one of the Implementation Plan items in the steps for implementation of the electronic health record.<sup>406</sup> Finally the Implementation Plan addresses medication safety as part of several items (adverse event reporting, training, and process improvement projects).<sup>407</sup>

Another two drafts of policies and procedures pertaining to pharmacy and medication management were received from OHS to review.<sup>408</sup> The Monitor has suggested on two occasions that the drafts of any policy on pharmaceutical operations would benefit from the review and expert advice of an experienced pharmacist who is familiar with Illinois state and federal law.<sup>409</sup> This would seem to be an appropriate project in which to involve the Director of Pharmacy Standards & Operations, SIU Office of Correctional Medicine but that does not appear to have taken place. The Monitor expects to provide feedback on these two drafts in the near future and hopefully by then, this expertise will have been sought. Other than the draft policies there is no significant forward progress with regard to compliance with II.B.6.c and II.B.6.d.

The Implementation Plan commits IDOC to complete four **process improvement projects**, one of which is **medication administration**.<sup>410</sup> The project will employ process analysts to systematically map all steps and procedures of medication administration; analyze input, process, and output using root cause analysis; determine

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<sup>403</sup> Monitor's document request, dated 8/4/2023, item 92.

<sup>404</sup> Defendant's Implementation Plan, Lippert Consent Decree, Case: 1:10 -cv-04603, Document #:1688 Filed 8/1/23.

<sup>405</sup> Items 54 (14), 55.

<sup>406</sup> Item 29.

<sup>407</sup> Items 7 (3), 36, 50, 51.

<sup>408</sup> D.02.01 Pharmaceutical Operations received 6/23/2023 and C.06.01 Medication Administration/Delivery, Count Process, and Training received 8/23/2023. The Monitor provided feedback on two earlier policies in February 2022. See page 146 of the Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys, March 13, 2023.

<sup>409</sup> Email from Mike Puisis to Janette Candido dated 2/25/2022. OHS-Monitor Monthly Call, 10/18/2023.

<sup>410</sup> See item 51 of the Defendants' Implementation Plan for the general plan for four process analyses. The specific process analysis for medication management is Implementation Plan item 55.

the desired output; make the process more efficient, with fewer errors, and in line with the movement towards compliance with the Consent Decree.

**Proposed End Date: January 2024**

The Monitor's last report noted that SIU had initiated an evaluation of medication management which included visits to two facilities and development of a survey questionnaire.<sup>411</sup> In June of 2022 SIU also hired a pharmacist to serve as Director of Pharmacy Standards & Operations for the Office of Correctional Medicine.<sup>412</sup> The Monitor inquired in June 2023 on the status of this project and were told that SIU was working on a final version which would be available by the next meeting.<sup>413</sup> No further information has been provided by SIU or IDOC about the evaluation of medication management or the results of the survey. There is no evidence that the expertise of a process analyst has been obtained for such a project but according to the proposed end date IDOC has until January 2024 to accomplish this.

The steps for the process improvement project on medication administration are listed in item 55 of the Defendants' Implementation Plan as follows: ***The process improvement for medication management will address:***

1. *The use of two-part patient identification with the medication administration record.*
2. *The use of a pharmacy generated label to be placed on the MAR after the script has been profiled by the pharmacist and elimination of hand written orders transcribed onto the MAR.*
3. *Documenting on the medication administration record at the time medication is administered.*
4. *Administration of medication directly from pharmacy-dispensed, patient-specific unit dose containers.*
5. *Development of workflows for medications which are issued to patients to self-administer (KOP) and those administered to patients by a nurse (DOT) to be finalized in standardized statewide policy and procedure.*
6. *Elimination of medication discontinuity that occurs as a result of the non-formulary request and prescription renewal processes.*
7. *Pharmacy initiated consultation with providers regarding polypharmacy and prescribing patterns.*
8. *Expanded use of pharmacists to work with providers in managing chronic conditions, as is done now in the HIV clinic medication.*

**Proposed End Date: February 2024**

The process improvement project is to be completed a month after it is initiated. There was no evidence that action has been taken on steps 1 – 7 of item 55. The diabetic clinic initiated with UIC as a pilot project in the Northern Region is an instance the Monitor is aware of that involves expanded use of pharmacists to work with providers in managing chronic conditions as described in step 8 of item 55 in the Implementation Plan. OHS is in the process of expanding the scope of the diabetic project to include the entire state. HIV and hepatitis C care conducted via telemedicine by UIC faculty also makes use of a clinical pharmacist.

As mentioned previously OHS has drafted a policy and procedure on medication administration which is with the Monitor for review. However, it was drafted without having completed workflows described in step 5 of item 55 in the Implementation Plan for how nurse administered and Keep on Person (KOP) medications are to be distributed to patients.

Completing workflows is important because medication administration has many components and responsible parties. During site visits to facilities the primary objection about administering medication directly from patient

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<sup>411</sup> Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys, March 13, 2023, page 146.

<sup>412</sup> Email from Kelly Presley dated 5/19/2022.

<sup>413</sup> OHS-Monitor Monthly Call, 6/15/2023. This would have been July or August of 2023.

specific packages and contemporaneous charting of administration there is not enough time given the availability of custody staff to provide security. The safety of medication administration cannot be compromised because of insufficient staffing, including correctional officers.

Currently, the Chief Administrative Officer determines the times that medication is administered based upon the operational needs of the facility. At Graham CC, for example, medication is administered at 4 am, 1 pm, and 7 pm. Medication times should be based upon the dosing needed to maintain an appropriate concentration of the drug in the body, not convenience.<sup>414</sup> The 4 am and 7 pm times are too far apart and too close for twice a day doses. The 1 pm and 7 pm times are too close for three times a day doses. With regard to insulin, it needs to be given no more than 30 minutes before a meal. We heard from diabetics while at Graham that they were fearful of taking insulin because meals were not always available soon enough to prevent hypoglycemia. By completing workflows, facilitated by a process analyst the health care staff and custody operations staff confer and devise operational schedules that are not contradictory to the purpose of treatments orders.<sup>415</sup>

There is as yet no guidance on how nursing staff are to verify that they have the right patient and the correct medications before administering each dose of medication. When medications to be given are not reconciled with patient identification and the medication administration record (MAR) errors occur that can compromise patient safety.<sup>416</sup>

At present, a pharmacy generated medication administration record is printed once a month. However, if a new medication is ordered, or the order of an existing medication is changed, the practice is for the new order to be transcribed in handwriting to the MAR. There are a number of problems that occur when the system relies on transcription by human beings. These include the failure to transcribe the new order and making an error in the transcription. Other poor practices observed in the MARS of patients in the IDOC are nurses who fail to include all of the information required to make the order complete (name of prescriber, start and stop date, dose, route, allergies etc.) and crossing through the old order and writing the new order over the crossed out information. Both practices contribute to avoidable medication errors and the latter is illegal.

The Implementation Plan item 55 step 2 would limit handwritten transcription of all but stat or urgent orders by having the pharmacy generate a label directly from the order that has been entered into the patient profile that can be sent to the facility with the blister package and put on the MAR when the medication has been received from the pharmacy. At present the Monitor has not been informed of any efforts made to accomplish this step.<sup>417</sup>

Contemporaneous documentation of patients' receipt of medication<sup>418</sup> continues to be problematic as evidenced by review of the pharmacists' audits of the medication record, medication errors described in the minutes of CQI meetings and review of patient records. During the site visit to Graham Correctional Center, we observed preparations for medication administration. Nurse administered medications are stored in a large medication cart. Each patient has a multi-dose blister card with their name and the required prescription information (name of drug, dose, etc.). The nurse takes the medication out of the patient specific blister card and puts it in a paper

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<sup>414</sup> Twice a day means that medication is provided every 12 hours, every day means every 24 hours. Three times a day means that medication is administered every eight hours and so forth. Medication times need to coincide with the number of hours needed between doses to maintain the therapeutic benefit.

<sup>415</sup> [https://www.ismp.org/resources/guidelines-timely-medication-administration-response-cms-30-minute-rule#:~:text=Medications%20administered%20more%20frequently%20than%20every%204%20hours%20\(e.g.%2C%20q1h,for%20every%203%20hours%20dosing\).](https://www.ismp.org/resources/guidelines-timely-medication-administration-response-cms-30-minute-rule#:~:text=Medications%20administered%20more%20frequently%20than%20every%204%20hours%20(e.g.%2C%20q1h,for%20every%203%20hours%20dosing).)

<sup>416</sup> See step 1 of item 55.

<sup>417</sup> See step 2 of item 55.

<sup>418</sup> See step 3 of item 55.



envelope with any other medications the patient takes at the same time. Each medication is to be written as ordered on the outside of the envelope. The envelopes are placed on a shelf in the medication room until patients appear for medication line.<sup>419</sup> Once all medications have been administered the nurse uses the envelopes to document administration on the MAR. The envelopes are used over and over again for the same patient.

KOP medications are given to the patient when their name is called at medication line. The entire blister card is given to the patient, and they are responsible for taking the medication on their own as ordered. The MAR is to be initialed on the date the card is given to the patient and the quantity written and circled. Medication is taken to patients who are housed in Reception and Classification (intake) and Restrictive Housing (segregation). Officers bring patients out of the cell to administer medication in a room at the end of each cell block. We did not observe medication administration in these units.

Reviewing the MARs at Graham there was one patient who did not receive the morning dose of medications most days in July<sup>420</sup>. We checked another ten patients with medications administered in the morning and found each had missed at least eight of 17 possible doses in July based upon documentation on the MAR.<sup>421</sup> We were told that this was a failure by the nurse on duty to document administration. This is a *serious* problem and was not identified in any CQI minutes, audit findings or other monitoring records. There was one report by the pharmacist of inconsistent dose documentation in December 2022 that was reported in CQI, but nothing was done in follow up. No medication errors have been reported since September 2022.

Step 6 of item 55 in the Implementation Plan is to eliminate medication discontinuity that occurs as a result of the non-formulary request and prescription renewal processes. There is ample evidence that medication discontinuity continues to be a problem in the care of patients in IDOC facilities.

While at Graham CC, two individuals in custody complained<sup>422</sup> of not getting prescribed medication while we toured the housing units. Upon review of the orders for each individual and the MAR; the complaint of each was validated.<sup>423</sup> One individual<sup>424</sup> was on a medication that required non-formulary approval and the approval had run out. The dates that non-formulary requests run out do not coincide with stop dates for the medication. The need for non-formulary renewals is not tracked and as a result patients with a valid order will stop receiving the medication until non-formulary approval is once again obtained.

The second patient<sup>425</sup> had an order for a medication written two weeks earlier that had not been delivered. The pharmacy subcontract vendor, Boswell, had no record of the order. Miscommunication between the ordering provider (facility HCU) and the dispensing pharmacy (Boswell) is a frequent reason for discontinuity in medication. At Graham, 21 orders sent the Friday before (7/14/2023) were not filled. The notices received from Boswell were reviewed the following Tuesday by the Monitor. Four required a non-formulary approval first, one had no drug allergy handwritten on the script, two were without a corresponding order, and for 14 the copy of the

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<sup>419</sup> See step 4 of item 55.

<sup>420</sup> Pharmacy services patient # 1

<sup>421</sup> Pharmacy Services patients # 2-11.

<sup>422</sup> Medications is the second most frequent complaint filed at Graham. Medication grievances represent 16% of all medical grievances received at Graham in April, May, and June 2023. This information is a tabulation of medical grievances by type from the grievance logs we were provided at the site visit.

<sup>423</sup> See step 6, item 55.

<sup>424</sup> Pharmacy services patient # 12 was prescribed Trileptal – all entries on the July MAR were marked with a 6 indicating the drug was not available. The pharmacy tech indicated that this was because a non-formulary approval was needed. The MAR for this patient also shows that many am doses were not documented in July.

<sup>425</sup> Pharmacy services patient #13. The MAR for this patient also shows that many am doses were not documented in July.

order was too light to read.<sup>426</sup> Every one of these causes a delay in patient treatment that is preventable with the proper policies, equipment, and support. An electronic health record with provider order entry would eliminate all except the delays necessitated by the nonformulary approval process but these could be reviewed more quickly.

Another patient with known seizure disorder did not receive Depakote for four days upon admission to Graham.<sup>427</sup> On the fourth day he started having seizures and was sent to the emergency room. Six hours later he returned to the facility and was placed back in population. He did not receive Depakote after his return to the facility and three days later he had seizures again.<sup>428</sup> As illustrated by this example transitions of care (discharge from a prison infirmary to a housing unit) are well known to put patients at risk for disruptions in continuity of care.

Lack of meaningful participation by the pharmacy in identifying problems with prescribed medications and consulting with prescribers to achieve more effective treatment has been identified as a problem since the 3<sup>rd</sup> report.<sup>429</sup> Step 8 of item 55 in the Implementation Plan is *Pharmacy initiated consultation with providers regarding polypharmacy and prescribing patterns*. Other than the diabetic and HIV/hepatitis C clinics operated by UIC this step has not been accomplished yet by IDOC.

As an example, one patient whose chart was reviewed this report period was seen in chronic clinic for high blood lipids, diabetes, and hypertension. He also was being treated, presumably for gout, with indomethacin and allopurinol which were “Keep on Person”.<sup>430</sup> Indomethacin should be used for the shortest duration of time and at the lowest possible dose. Yet in his case, indomethacin was distributed to him month after month. Use of this medication should be avoided in persons at risk for gastrointestinal disease. This patient also had recent anemia, with a positive FIT test. Endoscopy showed gastritis with H pylori, intestinal metaplasia consistent with Barrett’s esophagus and three small colon tubular adenomas. This patient was also taking prescribed aspirin which singly and in combination with indomethacin put him at significant risk for gastrointestinal bleeding. This patient should have been monitored more closely but at a minimum the pharmacist should have questioned the continuous dosing with indomethacin and its combination with aspirin as contraindicated.

Another patient whose chart was reviewed during this report period was followed in chronic clinic for diabetes and hypertension. He also had a CPAP machine, presumably for sleep apnea.<sup>431</sup> At the time of his chronic clinic visit in June 2023 he was taking 70/30 insulin, glipizide 20mg twice a day, pioglitazone 45mg/d, and metformin 850mg three times a day. This combination of medications to manage diabetes is highly questionable. One of these medications, pioglitazone, is associated with weight gain, leg edema, exacerbation of heart failure, and this patient was morbidly obese.<sup>432</sup> This individual’s diabetes was poorly controlled based upon a hemoglobin A1c of 10.1%. This patient would benefit from consultation with an endocrinologist and a consulting pharmacist.

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<sup>426</sup> The pharmacy tech gives the stack of problem notifications to the doctor who is to go through them, write out non-formulary requests, consider ordering another drug if it is out of stock, handwriting the allergy on the script, and making existing orders darker so they can be read by the pharmacy. The discussion of this problem during the site visit was more about who was to blame than identifying structural solutions (like getting rid of a fax machine that doesn’t work).

<sup>427</sup> Pharmacy services patient # 14.

<sup>428</sup> He missed two days of Depakote to be taken twice a day or four doses.

<sup>429</sup> Health Care Monitor 3<sup>rd</sup> Report Lippert v Jeffreys (February 15, 2021) page 125; Health Care Monitor 4<sup>th</sup> Report Lippert v Jeffreys (September 16, 2021) page 162; Health Care Monitor 5th Report Lippert v Jeffreys (July 27, 2022) page 146; Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys, March 13, 2023, page 150.

<sup>430</sup> Pharmacy services patient # 15. Gout was not listed on his problem list and the reason for indomethacin and allopurinol not documented in the prescription for either medication.

<sup>431</sup> Pharmacy services patient # 16. The diagnosis associated with use of the CPAP machine was not on the problem list.

<sup>432</sup> This medication also has a black box warning about the risk of bladder cancer. This patient weighed 350 pounds.

The findings from the Morbidity and Mortality Committee similarly identify instances when medications were prescribed that were not appropriate treatment for the patient. IDOC should identify the means to increase meaningful communication with dispensing pharmacists about medication contraindications and use the minutes of the M & M committee to identify trends in prescribing treatment that would benefit from pharmacist consultation.<sup>433</sup> The Monitor was told that the pharmacist employed by the Office of Correctional Medicine would join the Morbidity and Mortality Committee and should be engaged to provide substantive expertise in addressing the tasks in the Implementation Plan relating to pharmaceutical operations and medication management.<sup>434</sup>

Item 55 of the Implementation Plan will likely not be accomplished by the proposed end date of February 2024 based upon the progress to date. Implementation of an electronic health record with automated provider order entry and medication administration record will eliminate many potential sources of error and should simplify manual processes that exist currently to manage medication treatment. However, IDOC should not wait for the electronic record to begin this process improvement project, in particular the use of a process analyst to develop the workflows for medication ordering, administration and delivery of medication and contemporaneous documentation. Increasing pharmacy communication and collaboration is also not dependent upon the electronic record and should be pursued by IDOC.

The Consent Decree requires changes in how medication refusals are managed.<sup>435</sup> The steps to do this are listed in item 29 of Defendant's Implementation Plan: ***Develop a mechanism to notify providers of instances of medication non-adherence within the EHR.***

1. *Establish policy and standardized procedures to support patient adherence with prescribed medications.*
  - a. *Define which medications are to be monitored for non-adherence.*
  - b. *Define the frequency for monitoring medication adherence.*
  - c. *Determine how providers are notified.*
  - d. *Define the expectations of providers when notified of non-adherence and steps to be considered to improve adherence including timeframes for action.*
  - e. *Establish the factors to be addressed in documentation by providers of efforts to address adherence.*
  - f. *Develop an audit tool or other tracking mechanism to account for the efforts and outcomes in addressing medication non-adherence.*
  - g. *Inform staff of expectations and methods to address nonadherence and implement policy and procedure.*
  - h. *Track implementation progress and compliance.*
2. *Establish the process within the EHR to accomplish notification and documentation of provider actions in response to notification of nonadherence.*
  - a. *Determine how the EHR will distinguish medications that are to be monitored.*
  - b. *Determine where the information to be monitored resides in the EHR (i.e., MAR).*
  - c. *Identify the mechanism used to determine the frequency adherence is monitored and the means to identify when provider notification should take place.*
  - d. *Determine how providers are notified of non-adherence (message, establish a task for chart review or patient appointment).*
  - e. *Develop documentation template for providers to review nonadherence, meet with the patient to*

<sup>433</sup> The Monitor suggests consultation on psychotropic medications, geriatric patients, and other patients with complex comorbidities.

<sup>434</sup> Monitor interview with the Executive Director, Office of Correctional Medicine, SIU on 10/18/2023.

<sup>435</sup> II.B.6.d. IDOC agrees to implement changes in the following areas: Medication refusals;

*discuss, actions taken to address patient concerns, and education or counseling provided.*

f. *Implement automated methods to monitor and report nonadherence.*

g. *Monitor accuracy and timeliness of automated review and notification processes.*

**Proposed End Date: August 2024**

IDOC does not have a system wide electronic health record selected at the time this report was written. It will be some considerable time before the electronic record will be implemented. The IDOC to its credit, however, has initiated work to make changes in how medication refusals and medication nonadherence is handled. The Monitor agrees that this can be accomplished independent of the implementation of an electronic health record. IDOC has developed two draft policies and procedures. The first concerns patient rights to refuse treatment<sup>436</sup> and the second describes how patient adherence with prescribed medication is monitored and interventions to assist nonadherent patients to become compliant.<sup>437</sup> Both drafts are being reviewed by the Monitor currently.

From chart review it is apparent that medication records are not reviewed by providers or adherence summarized and providers do not address adherence during important patient-provider encounters such as chronic clinic or infirmary rounds.<sup>438</sup> One patient whose record was reviewed for this report was 63 years old. He had a medical history of asthma, hypertension, unstable thyroid, hepatitis C with possible varices, CHF, spinal stenosis, restrictive airway disease, pulmonary fibrosis, hypoalbuminemia, protein gap, neutropenia, and thrombocytopenia.<sup>439</sup> This multi-problem patient was taking a thyroid replacement medication. The provider increased the patient's dose of this medication because his TSH level was elevated. This change was made without reviewing the MAR for adherence or discussing with the patient whether it was being taken correctly. The danger with this is if the patient not taking the medication and then becomes more adherent the increased dose may lead to adverse effects.

At a minimum, the provider should have a copy of the most recent MAR to review at the time of any provider appointment. In the absence of this, the provider should have a summary of medication adherence provided in advance of the appointment. As suggested in the last report making this happen now would be a simple step to better inform providers and is an example of a simple step that can be taken to improve patient care.

The Implementation Plan requires *training of nursing staff* in clinical practices including *medication administration*.<sup>440</sup> This was to be completed by September 2023. No evidence of training in medication administration was provided except assertions by nurses that they be granted privileges to administer medication used by Lawrence and Sheridan.<sup>441</sup> There was no training curriculum provided nor is there any evidence that nurses knowledge, skill, or competency administering medication was evaluated. The findings from Mortality and Morbidity Reviews, as well the Pharmacy Inspection Reports should inform the development of the curriculum to train nurses in medication administration. We suggest emphasis be placed on patient safety and

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<sup>436</sup> I.01.01 received by the Monitor 6/23/2023.

<sup>437</sup> C.06.01 received by the Monitor 8/23/2023.

<sup>438</sup> See item 54 (step 14) of the Implementation Plan: Ensure the availability of providers to review medication compliance and current medications at chronic care visits. Pharmacy services patient # 17 was on antirejection medication after kidney transplant that was not monitored. C10214 was prescribed multiple inhalers, including a steroid yet had low peak expiratory flow. The frequency and technique for use of inhalers was not reviewed by the provider during chronic care visits. Pharmacy services patient # 18 was taking medication to treat hypertension. He also had ESRD. Medication compliance was not addressed during CC visits and blood pressure was not intermittently monitored. He was hospitalized with both hyper and hypotension.

<sup>439</sup> Pharmacy services patient # 19.

<sup>440</sup> Implementation Plan item 7: *Develop written procedures for expectation of training to include: 3) Clinical practice training and updates (e.g., provider training on asthma management, nurse training on vital sign assessment, medication administration, nurse training on use of a point of care device, etc.);*

<sup>441</sup> Material provided in response to Monitor's document request, dated 8/4/2023, item 51. The requirement for this training is included in the draft of policy C.06.01.

advocacy, medication reconciliation, standards of practice for “as needed” medication, communication with providers regarding orders and order clarification, patient education about medications, factors that influence adherence, and techniques to support patient adherence with medications.

There are two items in the Implementation Plan that concern *quality and patient safety* that *specifically call out medication management*. These are:

- Item 36 to establish a patient safety program which includes *safety initiatives to reduce medication errors*. ***Proposed End Date: November 2023***
- Item 50 to *train facility quality improvement* coordinators on *reporting and remediating adverse events focused on medication errors and polypharmacy*. ***Proposed End Date: December 2023***

IDOC has indicated that neither item has been completed yet.<sup>442</sup> A method to receive adverse event reports has been developed but not yet implemented. IDOC reported that they have initiated training through the Institute for Healthcare Improvement for HCUA and members of the OHS staff which includes several modules related to patient safety.<sup>443</sup> The following recommendations have been modified from earlier reports to eliminate those which are now included in the Implementation Plan.

## RECOMMENDATIONS:

1. Move forward with the Implementation Plan items 7 (step 3), 29, 36, 51, 54 (step 14), and 55 pertaining to medication management that are discussed in this section.
2. The process improvement project called out in item 55 of the Implementation Plan should include representatives of prison operations and map out responsibilities for custody assistance and maintenance of the equipment and the physical plant.
3. The pharmacist employed by the Office of Correctional Medicine should be engaged to provide substantive expertise in addressing the tasks in the Implementation Plan relating to pharmaceutical operations and medication management.
4. Establish expectations for the vendor’s pharmacy to identify, communicate directly and document this communication of drug-drug interactions, medication combinations to avoid, drug warnings and contraindications with prescribing providers. The pharmacy should also assist providers in evaluation of polypharmacy.
5. Identify additional topics related to pharmaceutical management that need to be addressed in policy and procedure. Most state correctional systems have more than two directives on this subject. Examples of topics to consider are provider orders, controlled substance accountability, maintenance of the formulary and nonformulary requests, inventory control etc.
6. Develop a workload driven staffing standard to account for the nursing staff necessary to carry out orders for medication treatment.
7. Eliminate expiration of non-formulary requests once approved. Investigate other reasons for medication discontinuity and develop solutions to eliminate these.
8. Implement computerized physician order entry (CPOE) and automate the MAR early in the implementation of the electronic health record. Develop automated reports of patients with medication orders which expire in the next seven days and notification to providers of non-adherence.
9. Establish the expectation that each medication order include the reason the medication was prescribed.
10. Provide a copy of the current and preceding month of medication records (MARs) to the provider to review at any chronic care or scheduled follow up appointment.

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<sup>442</sup> Interview with OSH on 8/11/23 regarding the CQI program.

<sup>443</sup> Email from Special Litigation Counsel dated 10/16/2023.

11. Establish an observational tool to be used by nursing supervisors to monitor compliance with medication administration procedures and include this study on the CQI calendar.

## Discharge Planning

### **Addresses Items II.B.5; II.B.6.s; II.B.6.t;**

**II.B.5.** *Continuity of care and medication from the community and back to the community is also important in ensuring adequate health care.*

**II.B.6.s.** *IDOC agrees to implement changes in the following areas: Summarizing essential health information for patient and anticipated community providers; and*

**II.B.6.t.** *IDOC agrees to implement changes in the following areas: Upon release, providing bridge medications for two weeks along with a prescription for two more weeks and the option for one refill, if medically appropriate.*

### **OVERALL COMPLIANCE RATING:** Partial Compliance

### **FINDINGS:**

The following are the documents requested from IDOC by the Monitor to evaluate compliance with requirements for discharge planning contained in the Consent Decree:

- Any new or revised audit instrument developed by defendants to self-monitor performance.
- Updated list of all implemented policies since beginning of Consent Decree with date of implementation.
- Provide discharge planning records for 10 individuals in chronic care clinics, released from Big Muddy, Illinois River, Dixon, Jacksonville, Logan, Menard, Pinckneyville, and Robinson, in the month of March 2023. Discharge documents requested include pre-discharge planning notes, discharge summary, receipt for medication, prescription for refill of medication, any documents accompanying the discharge summary, progress notes by physician or other health care staff related to the discharge.<sup>444</sup>

The Monitor reviewed five additional records of persons discharged during a site visit to Graham Correctional Center July 17-19, 2023. Finally, monthly reports and other correspondence provided to the Monitor for the time period this report covers were reviewed.

The Implementation Plan finalized with the Court August 1, 2023, contains two tasks to carry out the changes called for in the Consent Decree to ensure continuity of care and medication back to the community. The first is task 31 to **ensure all traditional releases receive a Medical Discharge Summary**. This task has a **proposed end date of September 2023**. There are six subtasks which are listed here:

1. *Process mapping should be used to define the steps necessary to plan for continuity of care upon “traditional” release to the community. These steps include defining the clinician’s review of patient needs in preparation for release, need for pre-arranged follow up care, handoff communication, provision of materials and supplies needed to continue care (medication, dressings, etc.), availability of records, preventive care, and post release communication.*
2. *Review NCCHC E -10 Discharge Planning and ensure that the process includes identification of patients who need arrangements or referrals for follow up and assistance with application for health*

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<sup>444</sup> Monitor’s documentation request dated 8/4/2023, items 24, 39 and 93. Defendants submitted no audit or performance outcome measures relating to discharge planning. A list of policies that have been implemented was not provided. The Monitor has provided input to IDOC on a draft policy and procedure for Discharge Planning E.01.01. Discharge planning records were provided by Dixon (6), IRCC (4), Menard (7), Robinson (1). Pinckneyville CC only sent records of medication received upon discharge, but no other information and so was considered non-responsive. Big Muddy, Jacksonville, and Logan sent none of the requested records.

*insurance.*

3. *Define responsible parties, timeframes and develop tools used to complete each step in discharge planning.*
4. *Develop and implement via policy and procedure that describes the steps of discharge planning, responsible parties, timeframes, and tools, including a standardized list of health care information to be provided to all discharges. Information will include: Diagnoses and active problem list, current medications, immunizations and screening, summary of recent medical care (clinic and specialist care), copies of pertinent diagnostic and laboratory reports, copies of pertinent specialty consultations, and instructions for follow-up and community health care resources.*
5. *Establish metrics and methods for reporting discharge planning encounters as a proportion of all discharges.*
6. *Establish tools to evaluate the process and outcomes of discharge planning and include in calendar of performance monitoring.*

The Monitor has been provided with no information to ascertain if process mapping was used to define how continuity of care upon release to the community would take place as listed in subitem 1 above. IDOC did provide two draft policies in March 2023 regarding continuity of care and medications at the time of discharge. The monitor provided recommendations and feedback on these drafts a month later. IDOC combined the two policies into one as recommended by the Monitor and provided a second draft for review. The Monitor provided comments on the second draft in July 2023. The area still needing resolution concerns the role of providers in establishing recommendations for follow up care and determining what medications the patient will be discharged with. This work is consistent with that required by subtasks 3 and 4 of task 31 above. The draft policy does reference *NCCHC E -10 Discharge Planning* and has steps to identify patients who need arrangements made or referrals for follow up of serious medical, dental, or mental health needs that is called for in subtask 2. The reporting of discharge planning metrics has been suggested in the policy revisions suggested by the Monitor and if accepted by IDOC would be consistent with subtask 5. In May 2023 the Monitor provided IDOC with examples for the comprehensive audit that included the audit of discharge planning which is consistent with the process currently used by the Monitor to evaluate compliance with the consent decree. While there has been general discussion about the comprehensive audit generally no specific work has been completed, to the Monitor's knowledge, of any tool to monitor discharge planning.

The other task in the Implementation Plan is item 32: ***Ensure appropriate discharge medication is provided at the time of discharge.*** *All discharges currently receive a 2 week supply of medication and a prescription for an additional 2 weeks of medication with one refill. HIV patients receive a 30 day supply of HIV medication upon discharge. The Proposed End Date: July 2023.*

1. *Survey each facility to determine:*
  - a. *Who determines what medications are provided at the time of release?*
  - b. *How discharge medications are obtained?*
  - c. *Who prepares medications for discharge and how is the task completed?*
  - d. *Does a clinician review and determine what medications the patient is to be provided in advance of the release? If so, when does this take place and how is it documented?*
2. *Establish and implement policy and procedure defining the process for clinician review of medications in advance of release, the process for procuring and packaging these medications, the methods used to provide them to the patient and how a two week refill is accomplished.*
3. *Establish methods to account for and document provision of discharge medication and compliance with written directives.*

Since the policy and procedure for discharge planning E.01.01 has yet to be finalized this task has not yet been completed. The Monitor's suggested revisions were made with the intention to accomplish subtasks 2 and 3 of

this item, however at the time this section of the report was written IDOC has not indicated whether these revisions are acceptable. The Monitor has not been provided with the results of the survey described in subtask 1; it is in the implementation plan as a means to inform policy makers of current practice and to serve as a foundation for identifying necessary changes to comply with the consent decree. It may not be necessary if implementation of policy and procedure achieves the necessary changes.

The following are the results of the Monitor's review of discharge records from Dixon, Illinois River Correctional Center, Menard, and Robinson. All of the 18 records reviewed were for persons who had chronic medical and or mental illnesses. Of these, 12 (67%) had documentation of discharge planning in advance of the release date. At Dixon these were completed two to three weeks in advance of the release date, while at Menard they were completed three to five months before the release date and were more often not up to date at the time of release. There is no consistency in how pre-release planning is documented.

All but six patients received a copy of a discharge summary. However, the information on the discharge summary was too general to be useful to the patient in following up with a provider in the community. All these patients had chronic illnesses but the information on the discharge summary was not specific about the illness or the patient's status. Patients were described as having asthma without any information about severity, last exacerbation, triggers, peak flow etc. or as being a diabetic without specifying the type, last available HbA1c, eye exam etc. This was universally true in all the review of all documents sent. For one patient with hyperlipidemia<sup>445</sup>, discharge summary documented elevated triglycerides and cholesterol and yet no specific lab values are recorded, and a copy of the lab was not included with the discharge paperwork. The same with another patient whose discharge summary documents mild splenomegaly<sup>446</sup> but provides no specific results, its significance in light of the patient's conditions, or a copy of the lab itself. In other instances, the discharge summary states that no current lab information was available. Patients were on medications for conditions which should have been listed on the discharge summary and were not.<sup>447</sup> Thus the discharge summary is a rote transcription of available information rather than a thoughtful description of the patient and their condition at the time of pending discharge.

Only 12 of the 18 charts gave information about tuberculosis screening; correct documentation of the results of tuberculin testing (date of the test and results in millimeters) was present in only 7 of the 12 discharge summaries (58%). Two patients were followed in TB clinic in the months preceding discharge and yet no information was provided about their status or referral to the county health department for follow up on the discharge summary (prophylaxis, lab results).<sup>448</sup>

Seventeen of 18 patients were offered HIV testing. However, at Menard these tests are offered months in advance of release which defeats their intended purpose of preventing transmission upon return to the community. Six patients accepted the offer of HIV testing (35%) although there was not always documentation that it had been completed prior to release. We continue to note wide variation in acceptance rates for HIV testing upon release. Review of the minutes of the CQI meetings at facilities in 2023 show consistent acceptance rates of 0% at Dixon, Graham, JTC, Sheridan, and Vandalia. While other facilities acceptance is much higher (Big Muddy over 50%, Centralia 46%, Menard 78%, Pontiac 66%). At some point the variation in HIV test acceptance at time of release should be an area of inquiry for possible improvement.

Neither a complete vaccination history nor recommendations for future vaccines were documented on any of the discharge summaries. Several of the patients, based upon the notes from the last chronic clinic visit, should have

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<sup>445</sup> Discharge planning patient #10

<sup>446</sup> Discharge planning patient #7

<sup>447</sup> Discharge planning patients #5 & #9.

<sup>448</sup> Discharge planning patients #4 & #6



received preventive screening (EKG, colorectal cancer screening, eye exam) or had vaccines recommended. This information is not accounted for on the discharge summary and results in poor hand off to the next provider. No patient had specific recommendations for follow up.

During the site visit to Graham (7/17-7/19/2023) five records of discharged patients were selected randomly from a list of discharges in the previous three months and reviewed. Three of the five had a completed discharge summary filed in the record.<sup>449</sup> These were completed three days before release for two of the individuals, the third was completed the same day as release. One individual did not have a discharge summary and should have because he had screened positive on the tuberculin test and had paralysis of the left arm.<sup>450</sup>

The results of tuberculosis screening were only listed on one of the discharge summaries and none of the summaries included vaccinations or preventive health screening that had been completed. The three persons who received a medical discharge summary were offered HIV testing on release.<sup>451</sup>

With regard to continuity of medication called for in II.B.6.t of the 18 records reviewed from Dixon, IRCC, Menard, and Robinson, 17 patients were prescribed medications but at the time of discharge only 11 signed receipts (65%) for medication at the time of discharge. There were notes on several indicating that the patient left without picking up the medication. Neither the discharge summary nor the medication receipt consistently document the dose, frequency, and route. This information is important to convey to subsequent providers as well as the patient. Furthermore, without this information, it is not possible to determine if the person received a sufficient quantity at release.

The Consent Decree II.B.6.t stipulates that persons be provided access to 42 days of medications after release.<sup>452</sup> Facility practices vary with regard to supplying medication at discharge. Three of four patients discharged from Dixon received medication. Two of these patients received 30 days of medication without any refills. The third received 30 days of Ultram, Buspar, Remeron, Norvasc, Colace and iron and a prescription for 14 days of each. At IRCC two of three patients documented as receiving medication received a 30 day supply. The third patient appears to have taken what had been distributed as “Keep on Person” a few days earlier. At Menard four of five patients received a 14 day supply of discharge medication of which three received a prescription as well. The fifth patient received 30 days of medication and no prescription.

Of the five records reviewed during the Graham site visit two were individuals receiving treatment at the time of release.<sup>453</sup> One person was being treated for a psychiatric disorder, hypertension, and an enlarged prostate.<sup>454</sup> The problem list did not include any psychiatric diagnoses. No recent labs were provided, and the only recommendation was to “seek care by self”. This individual did not receive any of the three psychotropic medications that were prescribed. Only two doses of medication for hypertension and 18 days of medication for prostate enlargement were provided at release. This patient received no prescriptions either. The second patient was HIV positive and receiving a daily dose of Biktarvy; he also was HCV positive.<sup>455</sup> The problem list does

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<sup>449</sup> Discharge planning patients #19, #20, and #21.

<sup>450</sup> Discharge planning patient #22 should have had a discharge summary that included the date and size of the positive tuberculosis screening test, results of symptom screening, chest x-ray, pertinent labs, and any prophylactic treatment considered. The discharge summary should also have indicated if the individual had any assistive devices, limitations on activities of daily living, and any rehabilitation recommendations.

<sup>451</sup> Discharge planning patient #20 was positive for HIV and receiving treatment and was offered an HIV test at release. This indicates that discharge planning is a rote task and not individualized to the needs of the patient.

<sup>452</sup> A 14 day supply, plus a script for 14 days with one renewal of 14 days, if medically appropriate.

<sup>453</sup> Discharge planning patients #20 & #21

<sup>454</sup> Discharge planning patient #21

<sup>455</sup> Discharge planning patient #20

not list HCV. Recent labs and HIV clinic notes were not provided. No paperwork for Ryan White funds or other HIV release planning was in the record and there was no date listed for follow up in the community. It is documented that he received 81 tablets of Biktarvy at release, but no dosing instructions were listed. If a conventional dose was prescribed this would be 81 days of medication, well more than the Consent Decree specifies. There is no evidence that a provider was involved in any aspect of discharge planning for either of these individuals, released from Graham CC.

The proposed end dates for the two Implementation Plan items are past due and yet the policy and practices of the IDOC with regard to discharge planning for the purposes of continuity of medical care upon return to the community are *unchanged*.<sup>456</sup> IDOC has yet to finalize policy and procedure for discharge planning. There is considerable variation among facilities in the documentation and practice of discharge planning. There is almost no evidence of provider<sup>457</sup> involvement in discharge planning or clinical review of need for medications or referral. Medical summaries are incomplete or inaccurate, information about tuberculosis screening is incomplete, vaccination status or risk/age-based health screenings or recommendations, and the status and control of chronic disease and other information from the most recent chronic disease clinic was not included in the discharge summary. While medication is provided to many persons being released, these practices lack consistency and there is no assessment of individuals' knowledge and ability to manage the medication regime that is prescribed at discharge. HIV testing is not always offered or documented as offered before release.

## RECOMMENDATIONS:

1. Revise the proposed end dates for Implementation Plan tasks 31 and 32 to reflect the time estimated as necessary to complete them.
2. Confirm the parties responsible for each of the items in the Implementation Plan.
3. Consider requesting consultation from the SIU pharmacist to standardize the process for determining medication to be provided at discharge, including documentation thereof.
4. Consider adopting (with some revision) the pre-discharge planning worksheet that was cited in the 3rd Report as used at Lawrence CC.<sup>458</sup> and incorporate it into the policy and procedure. The worksheet has a place for physician and psychiatry signature and the entry of information into the Offender Tracking System (OTS) about release needs. The form could be improved to document separate review by both mental health and medical clinicians. Use of this worksheet should initiate a referral to the responsible medical and mental health clinician to review the patient chart and see the person as necessary to make determinations about medical and mental health referrals to the community.

## Infection Control

### *Addresses items II.A; III.J.1; III.J.2*

**II.A.** *Defendants shall implement sufficient measures, consistent with the needs of Class Members, to provide adequate medical and dental care to those incarcerated in the Illinois Department of Corrections with serious medical or dental needs. Defendants shall ensure the availability of necessary services, supports and other resources to meet those needs.*

**II.B.3.** *IDOC must also provide enough trained clinical staff, adequate facilities, and oversight by qualified professionals, as well as sufficient administrative staff.*

**III.J.1.** *IDOC shall create and staff a statewide position of Communicable and Infectious Diseases*

<sup>456</sup> Health Care Monitor 3<sup>rd</sup> Report Lippert v Jeffreys (February 15, 2021) pages 127-131; Health Care Monitor 4<sup>th</sup> Report, Lippert v Jeffreys (September 16, 2021) page 164-166; Health Care Monitor 5<sup>th</sup> Report, Lippert v Jeffreys (June 22, 2022) pages 149 – 152, Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys, March 13, 2023, pages 150-154.

<sup>457</sup> Specifically, physician, nurse practitioner, or physician's assistant.

<sup>458</sup> Health Care Monitor 3<sup>rd</sup> Report Lippert v Jeffreys (February 15, 2021) page 130.

*Coordinator. This position shall be filled within fifteen (15) months of the Preliminary Approval of this Decree [June 2020].*

**III.J.2.** *Facility staff shall monitor the negative air pressure in occupied respiratory isolation rooms which shall be documented each day they are occupied by prisoners needing negative pressure. If unoccupied, they shall be monitored once each week. Facility staff shall report such data to the Communicable and Infectious Diseases Coordinator on a monthly basis.*

**OVERALL COMPLIANCE RATING:** Partial Compliance

**FINDINGS:**

The Monitor requested eleven documents concerning aspects of the Infection Control Program and IDOC provided, in whole or part, information on all eleven requests. The Monitor team also obtained updated information and filled in data not provided in the document request about the infection control program during a productive and informative conference call with the OHS Infectious Disease Coordinator.<sup>459</sup>

**Implementation Plan narrative page 2:** *Another initial focus of OHS is to institute the following structural components to its health care program: Implement an infection control program sufficient to provide surveillance, prevention and control of communicable disease.*

As noted in the 6<sup>th</sup> Court Report an infection control program is an essential component of any correctional medical program and will be necessary for IDOC to establish in order to comply with II.A and II.B.3 of the Consent Decree.<sup>460</sup>

IDOC has made progress addressing some of the infrastructure and activities of an infection control program including the management of COVID infection which has now moved into an endemic phase with diminished hospitalizations and deaths. The position of Infectious Disease Coordinator has been permanently filled. IDOC has established and maintained a consulting relationship with IDPH which initially focused on COVID-19 issues but has now been expanded to address infectious diseases and public health issues in the congregate living environments such as the IDOC facilities. IDOC has drafted Infection Control and Immunization policies and developed forms to standardize the immunization and infectious disease histories and the reporting of infectious diseases in the IDOC. The Coordinator has begun to make presentations at the quarterly Office of Health Services (OHS) meetings on infection control related topics. IDOC has continued to treat and cure an increased number of incarcerated individuals with hepatitis C infection at quadruple the pre-Consent Decree rate.

However other key aspects of the infection control program have not yet been addressed or implemented.

**III.J.1.** *IDOC shall create and staff a statewide position of Communicable and Infectious Diseases Coordinator. This position shall be filled within fifteen (15) months of the Preliminary Approval of this Decree [June 2020].*

In May of 2020 IDOC temporarily filled the position of Infectious Disease Coordinator with a registered nurse (RN) who was the Health Care Unit Administrator at Stateville CC. The position description<sup>461</sup> included the following job prerequisites: licensure as an RN, master's degree in Public Health preferred, three years of progressively responsible nursing experience with two of these years in infection control, certification in Infection

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<sup>459</sup> 9/13/23 Interview with Infectious Diseases Coordinator

<sup>460</sup> The National Commission on Correctional Health Care (NCCHC) standard P-B-02 Infectious Disease Prevention and Control is an essential standard. It states, "There is a comprehensive institutional program that includes surveillance, prevention, and control of communicable disease".

<sup>461</sup> Central Management Services, Position Description, Infectious Diseases Coordinator, number 37015-29-02-800-41-01

Prevention and Control or eligibility for certification at the time of hire preferred. Besides being an RN, the acting coordinator did not meet any of these criteria. The Monitor advised the IDOC in the 3<sup>rd</sup>-6<sup>th</sup> Court Reports that, at a minimum, in addition to infection control experience, the acting coordinator should obtain certification by the Certification Board of Infection Control and Epidemiology.

During the last three years, the acting Infectious Disease Coordinator was responsible for operational aspects of the COVID pandemic, expanded access to treatment for hepatitis C, supervised elements of the IDOC immunization program, and standardized the facility Monthly Infection Control Report. The acting Coordinator presented Infection Control reports at the last three OHS Quarterly Meetings<sup>462</sup> including updates on OHS' revised COVID-19 policy, the revised Monthly Infection Control Report, hepatitis C treatment data, hepatitis C medication delivery process improvements, and the interpretation of IGRA tuberculosis blood testing. The acting coordinator has now met the prerequisite requirement of having obtaining at least two years of experience engaged with infection control.

On June 1, 2023, the acting coordinator was chosen to permanently fill the position of Infectious Diseases Coordinator. In alignment with the recommendation of the Monitor team, the coordinator has enrolled in a 26 week online program offered by the Association for Professionals in Infection Control and Epidemiology which will prepare him to take examination to be Certified in Infection Control and Prevention (CIC).<sup>463</sup> At the time of the writing of this Report, he is now in the 14<sup>th</sup>-15<sup>th</sup> week of the program.<sup>464</sup> With the infection control experiences to date and certification in Infection Control and Epidemiology, the current Infectious Diseases Coordinator will be better prepared and trained to develop the IDOC infection control program. **IDOC is partially compliant with Consent Decree III.J.3, II.B.3, and the Implementation Plan narrative page 4.**

**Implementation Plan narrative page 4:** *In addition to adding a full time Infectious Disease Coordinator, IDOC currently will establish an Infection Control program. Currently IDOC collaborates with the Illinois Department of Public Health ("IDPH"). This arrangement allows IDPH to provide consultation and guidance with respect to infection control policy on immunization, screening, and other public health matters. IDOC will formalize that relationship to ensure that IDOC has assigned consultation time with an infectious disease physician to help guide and develop their infection control program. If IDPH is unable to provide that service, a university program should be involved. If that is not possible, IDOC should hire an infectious disease physician for this purpose.*

In early response to the COVID-19 pandemic, Illinois Department of Public Health (IDPH) assigned a public health physician to serve as IDPH's liaison with the OHS/IDOC. This physician worked closely with OHS concerning the implementation of COVID prevention, vaccination, and treatment programs in the IDOC. This IDPH consultant also advised and discussed with IDOC other preventive diseases and public health measures. The IDPH-IDOC relationship was never codified in a formal document.

It has been recently communicated to the Monitor<sup>465</sup> that a new physician has been assigned as IDPH's liaison with OHS/IDOC. This physician will be in charge of infection control issues in Illinois's congregate living sites which **include all IDOC facilities**. IDPH has divided Illinois into six regions each staffed by an IDPH infection control RN who will interact with congregate living and IDOC sites assisting with outbreaks and infectious diseases. Each regional IDPH nurse will provide supervision concerning infection control issues and address gaps

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<sup>462</sup> OHS Quarterly Meetings, 12/14/22, 3/29/23, 6/28/23

<sup>463</sup> The Certification examination is offered by the Certification Board of the Infection Control and Epidemiology.

<sup>464</sup> Communicated to Monitor team during 9/13/23 phone interview of OHS Communicable and Infectious Diseases Coordinator.

<sup>465</sup> OHS-Monitor Monthly Call 9/21/23

in processes and preventive measures. The Monitor has been advised that a written agreement has been completed. The agreement which formalizes the public health relationship between IDPH and OHS/IDOC has not yet been shared with the Monitor.<sup>466</sup>

Although the IDPH relationship is a valuable public health consultative resource, it is the responsibility of IDOC to build and maintain the infrastructure of its infection control program. It continues to be the Monitor's recommendation that IDOC also establish a consultative relationship with an academic center for infectious disease specialty consultation to advise facility physicians on the treatment of individual patients. **IDOC is partially compliant with Implementation Plan narrative page 4 as it pertains to formalizing its relationship with IDPH.**

**Implementation Plan item 30: *Develop an infection control program which includes: Proposed End Date: November 2023***

As noted, provided above in III.J.1, IDOC has initiated a number of activities that are needed for a systemwide Infection Control Program. However much more needs to be done to establish an effective program.<sup>467</sup>

IDOC should consider adding regional infection control coordinators to provide systemwide wide direction at the facility level and interact with the IDPH's regional infection control nurses. A successful infection control program will need data analysts to collect, manage and analyze surveillance and incidence health data for a functioning infection control program. Data analysts will be invaluable in mining infectious disease and infection control data from the forthcoming electronic medical record for surveillance but also for quality improvement activities. Until IDOC hires trained and qualified nurses to fill infection control positions in most of its thirty correctional facilities, a budgeted or contracted infection control trainer will be needed to train existing nurses in the performance of infection control activities. As of the writing of this Report, there have been no regularly scheduled systemwide meetings where the Infectious Diseases Coordinator updated facility infection control nurses on infection control issues or for discussion among facilities about infection control activities.

IDOC does not currently have any fulltime dedicated infection control nurses. A number of facilities do not have even a nurse assigned parttime to infection control. IDOC needs but does not have a working job description for its facility infection control nurses. The nurses assigned to infection control duties are not trained to do the duties of an infection control nurse. Without properly trained facility infection control nurses, IDOC will only have a piecemeal and inadequate infection control program.

The reporting relationship between the Infectious Diseases Coordinator and the facility infection control nurses needs to be clearly defined. The OHS table of organization needs to the document, at a minimum, a dotted line reporting relationship between the Infectious Diseases Coordinator and facility infection control nurses. A clear infection control chain of command is important to the development of standardized Infection Control program in the IDOC.

As reported in the 6<sup>th</sup> Report, the infection control information reported at the monthly quality improvement committee are not actionable and result in limited, if any, discussion, analysis and corrective action. An example of a missed opportunity is the low volume of patients with hepatitis C treatment being treated at an IDOC facility with nearly 2,000 incarcerated men and a clinic roster of 50-70 patients with hepatitis C<sup>468</sup>. This facility has

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<sup>466</sup> OHS-Monitor monthly call 9/21/23

<sup>467</sup> More detailed information is provided in Implementation Plan items 8, 30.1 – 30.6, 30.8, 57, 57.1-57.4, 58.a-58.d, 59, and Consent Decree III.J.2 of this Infection Control section

<sup>468</sup> Pinckneyville CC

treated only three patients in the last three years. This facility also inconsistently submits hepatitis C clinic activity in its monthly CQI minutes. Both the remarkably low rate of HCV treated patients and the failure to report HCV clinic activities in the facility CQI minutes should have been studied and corrective action taken, if so warranted.

The monitor has previously recommended that the monthly facility Safety and Sanitation rounds include the inspection of potential risks for exposure of inmates and staff to infectious diseases. These risks include mold in showers, vermin/roaches/flea infestations, non-functioning washers and dryers in the housing units, birds in cafeterias and housing areas, and the testing of water for legionella bacteria. The Infection Control Program needs to work with the IDOC leadership to expand the Safety and Sanitation inspection tool/check list to include these and other preventable infectious disease risks. This recommendation has not yet been acted upon.

The immunization program is now a responsibility of the Infection Control Program. The Monitor has repeatedly recommended that it be placed under the umbrella of the nursing and managed by the facility infection control nurse. Nurses trained in immunizations and guided by treatment guidelines, standing orders, or protocols offer IDOC the optimal opportunity to administer indicated immunizations to the incarcerated population. This has been shown to be effective with IDOC's annual influenza vaccination events and with the ongoing provision of COVID-19 immunizations which are managed by nurses under physician-approved standing orders. Pilot programs to administer Human Papilloma Virus (HPV) vaccine to eligible females at the Decatur and Logan Correctional Centers have shown that the nurse-led immunization programs are successful. OHS needs to place responsibility for the provision of routine immunizations under the management of each facility's infection control nurse.

IDOC received a significant grant from the Department of Justice/Center for Disease Control (CDC) to enhance pandemic staffing, plan for response to future pandemics, and potentially strengthen IDOC's infection control efforts.<sup>469</sup> The Monitor understood this to be an opportunity to use some of these grant resources to establish a systemwide, functioning infection control program that would protect the health of the incarcerated population and the IDOC staff.<sup>470</sup> However, based on discussions with IDOC it is unlikely that this grant funding will be readily available to hire additional staff to solidify the infection control program and instead will be used to purchase supplies and equipment. **IDOC is partially compliant with Implementation Plan item 30.**

**Implementation Plan item 30.1** *Sufficient personnel within OHS who are appropriately qualified in communicable diseases and infection control to provide agency wide direction and to carry out these directions reliably at the facility level. (Agency Medical Director) Proposed End Date November-2023*

The Infectious Diseases Coordinator is currently the only OHS employee of the Infection Control Program. This individual is fully focused on addressing infection control issues and identifying the needed infrastructure for an Infection Control Program that would adequately serve IDOC's 27,000 incarcerated individuals and staff at its thirty facilities. Additional personnel being considered include three regional infection control coordinators, data analysts to organize and analyze data, infection control experts to train facility infection control nurses, and an infectious disease consulting physician. To date there has been no action to add or assign additional personnel needed to provide agency wide direction and to carry out these directions **reliably** at the facility level. **IDOC is not compliant with Implementation Plan item 30.1**

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<sup>469</sup> IDOC was awarded a \$7 million grant from the Department of Justice/ Centers for Disease Control to enhance pandemic staffing, plan for response to future pandemics, and strengthen IDOC's infection control efforts, page 153 Monitor's 5<sup>th</sup> Report, Lippert v Jeffreys (June 22, 2022) page 154.

<sup>470</sup> At a minimum, IDOC should use funds to hire an infectious disease physician who would have dual responsibilities for infection control in IDOC yet be on staff with IDPH. This person should guide development of an infection control manual, assist in development of policy, develop surveillance strategies, and lead the infection control program.

**Implementation Plan item 30.2** *Develop written guidelines on all operational aspects of infection control in facilities (i.e., education, exposure control, vaccination, monitoring and surveillance, prevention and treatment, outbreak investigation, policy enforcement). (Infectious Disease Coordinator) Proposed End Date November-2023*

IDOC has drafted but not finalized 20 policies that guide the operations of the Infection Control Program including:

- G.01.01 Infection Control Program,
- G.02.01 Disease Reporting,
- G.03.01 Facility Infection Control,
- G.04.01 Infection Control Committee
- G.05.01 Employee TB Testing,
- G.06.01 Prevention of Hepatitis B in Employees,
- G.07.01 Medical Management of Infectious Exposure,
- G.09.01 Immunizations,
- G.10.01 Standard Precautions,
- G.11.01 Transmission Based Precautions,
- G.12.01 Handwashing,
- G.13.01 Medical Supply Decontamination,
- G.14.01 Disposal of Sharps, Needles, and Syringes,
- G.15.01 Special (Medical) Waste Management,
- G.16.01 Patient Blood Borne Infections Exposure,
- G.17.01 Personal Protective Equipment & Other Supplies,
- G.18.01 Instrument Sterilization,
- G.20.01 Barber and Beauty Shop Personnel,
- G.21.01 Food Handlers,
- G.22.01 Health Care Unit Safety and Sanitation.

In addition to the above list, nine policies and procedures have been developed for infection control in the dental clinic. The Monitor has provided input on most of these policies. IDOC has stated that their goal is to finalize most, if not all, of the policies in January 2024.<sup>471</sup>

It was communicated that OHS is planning to develop an infection control manual but would not start working on this manual until the infection control policies are finalized.<sup>472</sup> Given the large volume of revised policies and procedures, IDOC will need to initiate extensive, statewide training of all pertinent staff on the updated policies. **IDOC is partially compliant with Implementation Plan item 30.2.**

**Implementation Plan 30.3** *Establish surveillance report format to be used to analyze and report on infection control in CQI meetings at the facility and agency level. (Infectious Disease Coordinator) Proposed End date: November-2023*

IDOC has developed a **Monthly Infection Control Report** that was implemented in March 2023 at all facilities. The form is to be completed by each facility and sent to the Infectious Diseases Coordinator. The report contains

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<sup>471</sup> IDOC communicated this at the 10/19/23 and 11/16/23 OSH-Monitor conference calls.

<sup>472</sup> 9/13/23 conference call with the OHS Communicable and Infectious Diseases Coordinator. At this same meeting the Monitor team advised that the manual and policies be available electronically with links to current best practices to keep staff abreast of changes and to minimize the need to modify the written policies and manual.

data on new cases<sup>473</sup>, evaluation processes, and utilization data for the hepatitis C clinic. The data gathered was described as raw data that would not meet the definition of surveillance data. The reports being submitted and the data being reported are inconsistently completed. The use of this form was reported to have helped to identify an increase in syphilis cases at Receptions and Classification centers and to track the treatment and communication to IDPH. The initiation of the Monthly Infection Control Report is new and still being refined. **Given the recent introduction of the Monthly Infection Control Report a rating of compliance has not been determined for Implementation Plan item 30.3.**

**Implementation Plan 30.4** *Work with data personnel to develop methodology to acquire data for surveillance reports manually to begin and eventually within the EHR (Infectious Disease Coordinator) Proposed End Date: November-2023* *Erroneously listed as task 30.5 in the approved Implementation Plan.*)

IDOC is considering adding data analysts to the OHS team that would assist the Infection Control Program's efforts to both acquire and analyze data. At the time of writing this report, there has been no communication to the Monitor that data analysts have been assigned to the Infection Control Program. **IDOC is not compliant with Implementation Plan item 30.4.**

**Implementation Plan 30.5.** *Establish reporting methodology to document enforcement of each item in the Consent Decree relating to infection control (III.I.5; III.J.2-3) as well as any called out in written guidelines #2 above. (Infectious Disease Coordinator) Proposed End Date: November-2023. (Erroneously listed as task 30.6 in the approved Implementation Plan.)*

This Implementation Plan item has not yet been addressed. **IDOC is not compliant with Implementation Plan item 30.5 (erroneously listed in the approved Implementation Plan as 30.6)**

**Implementation Plan 30.6** *Establish statewide infection control meetings of infection control personnel. (Infectious Disease Coordinator) Proposed End Date: November- 2023 (Erroneously listed as task 30.7 in the approved Implementation Plan.)*

IDOC has plans to create an Agency Infection Control Committee to oversee the system's Infection Control Program. The draft of Policy G.04.01 Infection Control Committee has received the input of the Monitor but has not yet been finalized. The draft policy outlines the multi-disciplinary membership of this committee that will meet no less than quarterly to provide direction to the Infection Control Program, establish annual goals and objectives endorsed by the System Quality Council, review and analyze monthly facility reports on infection control data, plan for response to public health emergencies and disasters, and other activities. This committee has not yet been formed. To date, there also has not been any statewide infection control meetings of infection control personnel which the Monitor assumes would include all facility infection control nurses. **IDOC is not compliant with Implementation Plan 30.6.**

**Implementation Plan item 8:** *Have dedicated staff for infection control nurse, at each facility. Proposed End Date: January 2024* As noted in the 6<sup>th</sup> Report, IDOC Staffing Analyses submitted to date have not identified positions designated for infection control at the institutions.<sup>474</sup> This is in spite of recommendations from the Monitor to do so since the 2<sup>nd</sup> report.<sup>475</sup> The IDOC has previously indicated an intention to assign existing

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<sup>473</sup> New cases to be reported on the Monthly Infection Control Report include tuberculosis (active and latent), HIV/AIDS disease, hepatitis A, B, and C, STDs, MRSA, hygiene related conditions (fleas, lice, fungal infections, scabies, etc.), bloodborne exposures of staff and incarcerated persons, influenza, and COVID-19.

<sup>474</sup> Staffing Analysis Illinois Department of Corrections Office of Health Services, Lippert Consent Decree 11/23/19, 6/18/20, 12/15/20, 5/3/21, 7/7/202, 8/17/21, 3/12/22, 9/22/22.

<sup>475</sup> Health Care Monitor 2<sup>nd</sup> Report Lippert v. Jeffreys, August 6, 2020, page 131.



personnel to be responsible for coordinating infection control in the draft implementation plan.<sup>476</sup> This intention will only continue IDOC's practice of assigning staff duties for which they are not appropriately trained, contrary to II.B.3. It has been recently communicated to the Monitor that there are no nurses fully dedicated to infection control duties.<sup>477</sup> Almost all nurses assigned some infection control responsibilities are also assigned to other non-infection control duties. Both registered nurses (RN) and licensed practical nurses (LPN) are currently assigned to infection control duties.

At this time the actual duties performed by the infection control nurse are very limited. There are currently no specific qualifications required of RNs or LPN's assigned to infection control tasks and there is no additional, uniform training on infection control for these nurses.

The Monitor has indicated that nurses selected for infection control positions must have qualifications and training pertinent to infection control. Although the draft Infection Control policy G.01.01 states that "the Infection Control Program is coordinated and managed by the Agency Infection Control Coordinator" and "the facility infection control nurse who reports to the Agency Infection Control Coordinator for all matters related to infection control", the position description<sup>478</sup> does not indicate that the Coordinator supervises anyone so it is unclear whether the Coordinator has direct responsibility for the activities of the infection control nurses. IDOC needs to create at least a dotted line relationship in the OSH table of organization between the Infectious Diseases Coordinator and the facility infection control nurses. **IDOC is not compliant with Implementation Plan item 8.**

**Implementation Plan 57:** *Replace tuberculosis skin testing (TST) with Interferon-Gamma Release Assays (IGRA) blood testing. Proposed End Date: December 2023.*

IDOC has only initiated IGRA blood testing in its four Reception and Classification Centers.<sup>479</sup> To date there has not been any timeline established to replace TB skin tests with IGRA blood testing in the remaining twenty-six IDOC correctional centers. **IDOC is in partial compliance with Implementation Plan item 57.**

**Implementation Plan item 57.1:** *IDOC replaced tuberculosis skin testing with updated IGRA blood testing at R & C facilities as of October 2021. IDOC is in substantial compliance with Implementation Plan item 57.1.*

**Implementation Plan item 57.2:** *Establish written guidance for initial and subsequent screening for tuberculosis infection including the frequency, methods, timeframes, responsible parties, and reporting. Proposed End date December 2023*

The draft policy Infection Control Program G.01.01.II.a,b,c, d, e addresses some elements of a tuberculosis screening, treatment, and monitoring program for the incarcerated population and staff. Guidelines for reporting of TB are not addressed in this policy. However, the recently initiated Monthly Infection Control Report does identify eight tuberculosis data points that are to be collected and reported to the OHS.<sup>480</sup> **IDOC**

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<sup>476</sup> IDOC Implementation Plan: Hiring Process, Task 4., Submitted to the Court on December 30, 2021.

<sup>477</sup> Monitor team interview of Communicable and Infectious Diseases Coordinator on 9/13/23

<sup>478</sup> Central Management Services (CMS) Position Description. Infectious Diseases Coordinator, position number 37015-29-02-80-41-01

<sup>479</sup> Graham, Logan, Menard, and NRC R+C's now use IGRA testing to screen for TB.

<sup>480</sup> Monthly TB Data 1) # active TB cases, 2) # with positive IGRA or TST, 3) # on prophylaxis treatment, 4) # of TST conversions from negative to positive, 5) # IGRA or TSTs placed due to contact investigation or signs/symptoms, 6) # CXR done to rule out TB, 7) # completed prophylaxis this month, 8) annual employee TB testing completed (summary report)

**is partially compliant with Implementation Plan item 57.2**

**Implementation Plan item 57.3:** *Establish a plan and implement finalized program which replaces TST with IGRA screening for tuberculosis infection statewide. Proposed End date December 2023*

When the Interferon Gamma Release Assay (IGRA<sup>481</sup>) blood test was initiated<sup>482</sup> in lieu of tuberculosis skin test (TST) at the four IDOC Reception and Classification Centers, the reaction of the intake staff was very supportive. At that time IDOC stated that the cost-benefit of the IGRA test was being evaluated.<sup>483</sup> The Monitor was recently informed that IDOC has been in communication with UIC medical center about increasing the use of IGRA TB testing at all the other IDOC facilities.<sup>484</sup> As noted in the 6<sup>th</sup> Report switching all IDOC facilities to IGRA testing would increase diagnostic accuracy, eliminate human error in reading the TST, minimize the risk of accidental needle sticks to staff, and free up nursing time for other duties. IDOC has not provided the Monitor with any concrete plan or timeline to expand the use of IGRA TB screening into other IDOC facilities. **IDOC is not in compliance with Implementation Plan item 57.3.**

**Implementation Plan item 57.4:** *Use reporting metrics to monitor progress with implementation and to evaluate the effectiveness of the tuberculosis screening program. Proposed End date December 2023*

As noted in Implementation Plan item 30.4, the addition of data analysts to assist the Infection Control Program with the acquisition and analysis of data has not, to date, been acted upon. The new Monthly Infection Control Report has only been in use for a few months and is not fully implemented. This report provides only raw data and has not yet been used to evaluate the effectiveness of the TB screening program. IDOC has previously reported that TST positivity rates were not being tracked.<sup>485</sup> **IDOC is not in compliance with Implementation Plan item 57.4.**

**Implementation Plan item 58:** *Increase access to HCV treatment.*

Since June 2021 the annual volume of treated IDOC patients for hepatitis C has nearly quadrupled – see the table below. This is a notable accomplishment which puts IDOC in alignment with the National Hepatitis C Elimination Program.<sup>486</sup> IDOC continues on a path to actually eliminate active hepatitis C infection in the IDOC. The increasing elimination of active hepatitis C has a positive impact on the present and future health of the incarcerated population and will decrease the risk of transmission of hepatitis C in the IDOC and ultimately in the communities of Illinois.

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<sup>481</sup> The brand name used in IDOC is QuantiFERON.

<sup>482</sup> October 2021

<sup>483</sup> OHS-Monitor Monthly Conference call 4/28/22

<sup>484</sup> Interview with Communicable and Infectious Diseases Coordinator 9/13/23

<sup>485</sup> OHS-Monitor Monthly Conference call 4/28/22

<sup>486</sup> Fleurence RL, Collins F, A National Hepatitis Elimination Program in the United States, A Historic Opportunity: JAMA. April 18, 2023; 329 (15): 1251-52

IDOC Hepatitis C Treatment Feb 2018 through November 10, 2023	
Year	Number Treated
2018	79
2019	82
2020	98
2021	246
2022	348
2023	311*
<b>Total</b>	<b>1164</b>
* Through 11/10/23	

However, there are notable variations in the number of patients treated in different facilities.<sup>487</sup> This may be due to inadequate staffing, lack of staff education, or the absence of an organized systemwide and facility infection control program (see Implementation Plan item 58.d for further details). It is again the Monitor's firm opinion that the lack of dedicated infection control nurses at each facility significantly contributes to the failure of many sites to refer HCV patients for treatment. This needs to be monitored and addressed by the Infection Control Program.

With the initiation of a Monthly Infection Control Report (see Implementation Plan item 58.c.), IDOC has taken steps to develop a systemwide, standardized internal surveillance system to track infectious diseases including HCV infection and treatment. The utilization of this new report has not yet been consistently implemented in all facilities. It is anticipated that this revised report will standardize data and make it possible to know the true percentage of untreated HCV patients as well as the number of HCV patients who have been treated at each facility and in the IDOC system.<sup>488</sup>

IDOC still needs to develop and implement a protocol or guideline to direct and track ongoing liver ultrasound screening for hepatocellular cancer of treated or untreated HCV patients with advanced liver fibrosis and cirrhosis. This screening is currently recommended to be performed every 6 months for patients with higher levels of liver fibrosis.

**Implementation Plan item 58.a:** *Revise the Hepatitis C treatment protocol following consultation with the Monitor and the UIC Hepatitis C Telemedicine Clinic. Proposed End Date: March 2022*

IDOC in collaboration with the UIC Hepatitis C Telehealth clinic revised the Screening and Treatment of Hepatitis C Guidelines in March 2021 and significantly expanded the number of Hepatitis C patients who were eligible for treatment. **IDOC is in substantial compliance with Implementation Plan item 58.a.**

**Implementation Plan item 58.b:** *Disseminate, educate, and implement the revised Hepatitis C Treatment guidelines at all IDOC facilities. Proposed End Date: August 2023*

IDOC began disseminating and educating clinical staff about the revised treatment guidelines in early-mid 2021. The Monitor first noted the increase in patients receiving Hepatitis C treatment during the June 21-23, 2021 site

<sup>487</sup> See table in implementation Plan 58.d. titled Hepatitis C Treated Patients by Facility 2021-2023 (through 11/10/23), Ranking by # Hep C Patients Treated.

<sup>488</sup> Some facilities have previously have kept successfully treated HCV patients on the HCV clinic roster; others have discharged treated patients with follow-up in their chronic care clinics for those patients who require semiannual HCC screening. Some facilities have kept treated patients in their clinic but have not consistently reported the number of treated patients maintained on the HCV clinic roster.

visit at Shawnee CC. However, the Infection Control Program needs to monitor and address the notable variations among facilities in the number of patients treated. **The rating of only partial compliance with Implementation Plan item 58.b is based on the variation of treatment at different facilities.**

**Implementation Plan item 58.c:** *Standardize Hepatitis C Clinic monthly facility reporting tables to include a. total HC patients, b. # pts on treatment, c. # pts refused tx, d. # awaiting tx, e.# ineligible for tx. and report HC clinic data to facilities' monthly QI meetings. Proposed End Date: August 2023.*

The recently implemented Monthly Infection Control Report lists eight data points that facilities are to track and report on the Hepatitis C Virus (HCV) clinic: a. total # of HCV patients in the HCV clinic, b. # currently receiving treatment, c. # completed treatment, d. # referred to UIC Telehealth HCV clinic and pending treatment, e. # refused treatment, f. # of patients with contraindication for treatment (liver cirrhosis/adenocarcinoma/liver transplant).The Monitor recommends that the report also document the total # of untreated patients on this monthly report.

**The contraindications to HCV treatment listed in sub-item f. of the Monthly Infection Control Report are not in alignment with current standards of care which indicate that successful treatment of HCV has improved morbidity and mortality of patients with compensated and decompensated liver failure, liver cancer (HCC), liver cancer awaiting liver transplantation, and post-liver transplantation.**<sup>489</sup> Beside the logistical contraindication of an out date of less than six months required to complete the requisite lab and diagnostic workup, referral to UIC HCV Telehealth for their evaluation and decision to treat, and the completion of the 12 week course of treatment, there are few absolute contraindication to HCV treatment. IDOC should rewrite sub-item f. in consultation with the UIC HCV specialists.

As noted in the 6<sup>th</sup> Report the Monitor continues to recommend performance measures and an outcomes dashboard to measure hepatitis C treatment. This dashboard or its equivalent should include the number of HCV patients treated over a specified time period in the numerator and the total number of untreated HCV patients over the same time period in the denominator. The number of untreated HCV patients should be separately tracked on a dashboard and would permit staff to see whether the number decreases consistently over time. IDOC has yet to develop performance measures and outcome studies that are satisfactory to the Monitor.<sup>490</sup> **IDOC is in partial compliance with Implementation Plan item 58.c.**

**Implementation Plan item 58.d:** *Review and tabulate on a quarterly basis the UIC HCV telehealth's spread sheet of IDOC HC patients started on treatment. Based on this data identify facilities that are not expeditiously referring active HC patients for treatment. Proposed End Date: September 2023*

IDOC has begun to regularly review the UIC telehealth HCV treatment spread sheet which lists the date treatment started, name, IDOC number, DOB, facility, fibrosis level, and medications for each patient approved by UIC and started on HCV treatment.<sup>491</sup> The Infectious Diseases Coordinator has intermittently provided the Monitor with updates on the volume of patients initiating HCV treatment and the percentage of each level of fibrosis for these newly treated patients.

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<sup>489</sup> Colombo M, Sirin CB, Chopra S, Robson KM. Patient Evaluation and Selection for Antiviral Therapy for Chronic hepatitis C Infection, Special Situations. UpToDate, 10/31/22 with literature review current through October 2023.

<sup>490</sup> Monitor's Letter on IDOC Quality Audit and Outcomes and Performance Measures sent by email 11/19/2022. See also the discussion of Outcome and Performance Measurement Results in this report.

<sup>491</sup> Communicable and Infection Diseases Coordinator regularly sends the Monitor cumulative data on the number of individuals and fibrosis levels for each treatment batch.

<b>Number of Hepatitis C Patients Treated by Facility 2021-2023*</b>					
<b>Ranked by Number of Patients Treated</b>					
<b>Facility</b>	<b>Number Treated in 2021</b>	<b>Number Treated in 2022</b>	<b>Number Treated in 2023</b>	<b>Total Treated</b>	<b>Population**</b>
Shawnee	42	41	24	107	1508
Sheridan	37	37	26	100	1036
Lincoln	11	28	28	67	654
Decatur	25	22	13	60	327
Jacksonville	7	29	24	60	937
Logan	7	28	24	59	1070
Menard	18	12	12	42	1917
Danville	2	25	13	40	1591
Dixon	28	4	7	39	1449
IRCC	1	12	22	35	1670
Robinson	8	18	8	34	933
Vandalia	9	15	9	33	534
Graham	8	5	16	29	1691
Vienna	0	6	22	28	698
East Moline	11	8	7	26	491
Lawrence	6	11	8	25	677
BMRCC	0	6	14	20	1148
Western	2	4	11	17	1731
Centralia	12	2	1	15	1281
Southwestern	1	5	6	12	605
Stateville	1	11	0	12	615
Hill	4	4	3	11	1194
Kewanee	2	7	1	10	179
Taylorville	1	0	7	8	1091
Pontiac	2	3	2	7	630
JTC	0	1	2	3	163
Pinckneyville	0	2	1	3	1858
NRC	1	1	0	2	1312
JITC/Elgin	0	0	0	0	15
Murphysboro	0	0	0	0	179
<b>Total</b>	<b>246</b>	<b>347</b>	<b>311</b>	<b>904</b>	<b>29184</b>
* Through 11/10/23					
** Population from IDOC website from 6/30/23					

As seen in the above table, IDOC continues to treat a notable number of HCV patients.

However, the facility-by-facility variation in the number of HCV patients who have been treated continues to be sizable. Six facilities housing 20% of IDOC population has each treated 59 or more HCV patients accounting for 453 (50%) of the 904 individuals receiving HCV treatment in IDOC over the last three years. Twelve (43%) of 28 sites treated  $\leq 20$  HCV patients over the last 35 months.<sup>492</sup> Three of these are smaller small facilities (JTC, Kewanee, Southwestern) and NRC has high turnover as an intake center. However, Big Muddy River (BMR), Centralia, Hill, Pinckneyville, Pontiac, Stateville, Taylorville, and Western CCs are large facilities. Why, for example, has Pinckneyville CC with nearly 2,000 incarcerated individuals treated, on average, only one HCV patient a year for the past three years? This variation in access to HCV treatment needs to be continually monitored and addressed. The quality improvement program and the infection control coordinator should investigate whether systemic or operational barriers to treatment exist. Any identifiable systemic barriers to treatment need to be corrected. **IDOC is partially compliant with Implementation Plan item 58.d.**

**Implementation Plan item 59:** *Increase access to HCV treatment for individuals with F0 and F1 fibrosis levels.*  
**Proposed End Date: August 2023**

The January 2019 revised HCV Guidelines allowed treatment referral for patients with fibrosis scores of F2<sup>493</sup> not just patients with F3 and F4 fibrosis. In March 2021 these guidelines were again modified to include consideration of persons with fibrosis scores of F0 and F1 for Hepatitis C Virus (HCV) treatment. This progression can be seen in the following table.

Fibroscan Scores of Treated Hepatitis C Patients 2017-2023 (through 11/1/23)					
Year	F0/F1	F2	F3	F4	Total
2017	0	0	1	1	2
2018	5	9	18	35	67
2019	3	35	25	19	82
2020	2	37	23	36	98
2021	119	72	21	30	242*
2022	247	56	25	20	348
2023	234	39	24	13	310 **
<b>Total</b>	<b>610 (53%)</b>	<b>248 (22%)</b>	<b>137 (12%)</b>	<b>154 (13%)</b>	<b>1149</b>
*Information of 4 fibroscans not provided.					
** 1 fibroscan unreadable due to obesity					

Prior to 2019, HCV treatment had been limited in the IDOC to incarcerated persons with more advanced levels (F3, F4) of fibrosis. Although patients with higher levels of liver fibrosis are appropriately given priority for treatment, IDOC now refers all patients including all five levels of fibrosis scores (F0, F1, F2, F3, F4)<sup>494</sup> who have completed prerequisite tests to UIC Hepatitis Telehealth clinic where the prioritization for treatment is determined. Making all levels of fibrosis eligible for treatment has expedited and expanded the provision of HCV treatment. HCV treatment is not inexpensive but delaying curative treatment until the liver has become increasingly cirrhotic is clinically unacceptable and is not cost effective. The treatment and management of the clinical complications of advanced liver cirrhosis are expensive and significantly more costly than early curative treatment HCV. IDOC's development of a systemwide HCV identification and treatment program is fully aligned

<sup>492</sup> Two small facilities (JITC/Elgin and Murphysboro) with zero treated HCV patients were excluded from this calculation.

<sup>493</sup> Previous HCV guidelines predominantly treated only HCV patients with more advanced fibrosis scores (F3, F4).

<sup>494</sup> F0:no fibrosis, F1:portal fibrosis without septa, F2: portal fibrosis with few septa, F3: numerous septa without cirrhosis, F4: cirrhosis. The higher the score the worse the fibrosis (scarring) of the liver.

with the nation's efforts to eliminate hepatitis C.<sup>495</sup> **IDOC is substantially compliant with Implementation Plan 59.**

**III.J.2.** *Facility staff shall monitor the negative air pressure in occupied respiratory isolation rooms which shall be documented each day they are occupied by prisoners needing negative pressure. If unoccupied, they shall be monitored once each week. Facility staff shall report such data to the Communicable and Infectious Diseases Coordinator on a monthly basis.*

Twenty-six IDOC facilities<sup>496</sup> have infirmaries with negative pressure rooms, however, only 17 facilities reported in their June 2023 CQI minutes on the status of negative pressure rooms. Five facilities<sup>497</sup> have not reported negative pressure monitoring results in the last nineteen months and three<sup>498</sup> of these have not reported results since the initiation of the Consent Decree.<sup>499</sup> The reporting done is quite limited and generally does not comment on the test used, the correlation of the tissue test with the control panel, and the room number.

During the Monitor's site visit to Graham CC in July 2023 all three negative pressure rooms in the infirmary failed the tissue test even though the pressure gauges for each room indicated that the units were properly functioning. CQI reports from Graham had consistently reported negative pressure rooms as fully operational. The engineering staff was called and fixed the problem in two of the three rooms. The Graham clinical leadership was advised by the Monitor not to use the third room as respiratory isolation room and to verify the electronic gauge results by doing the tissue paper test as well.

To date the Monitor team has inspected the isolation rooms during site visits to eight correctional centers and identified non-functional negative pressure units and/or defective monitoring gauges at four facilities.<sup>500</sup> The staff and clinical leadership at these four sites were not aware that their units were not operational. None were performing tissue tests to verify the functionality of their negative pressure units. Only two of the twenty-six facilities with isolation rooms documented in their June 2023 CQI minutes that tissue testing was being performed to verify negative airflow.<sup>501</sup>

The draft Infection Control Program policy notes that "A standardized methodology is established...to regularly monitor negative pressure in respiratory isolation rooms...(and) reporting these results monthly to the Agency Infectious Disease Coordinator and follow-up on necessary repairs,"<sup>502</sup> (and) the ...Agency Coordinator develops procedures...and Facility Infection Control Coordinators implements those procedures (and) participates in Safety and Sanitation monthly rounds , monitoring and tracking infection control related matters including: monitoring negative pressure rooms."<sup>503</sup> Based on the review CQI minutes and the site visit to Graham, the policy and procedure addressing the monitoring of negative pressure units has not yet been implemented.

IDOC provided the Monitor in March 2021 a copy of the Airborne Infection Control Room Operation and Training document which detailed guidelines concerning the operation and monitoring of negative units in isolation rooms which included documented checks for correct airflow direction by "observing toilet papers being drawn underneath and around doors or other openings into the room" and "electronic monitor alarms should be

<sup>495</sup> R. Fleurence, F.Collins: National Hepatitis C Elimination Program in the United States. *JAMA*. April 18, 2023;329 (15) 1251-52. doi:10.1001/jama.2023.3692

<sup>496</sup> Elgin/JITC, Joliet Treatment Center, Murphysboro, and Vienna CC do not have infirmaries or negative pressure rooms.

<sup>497</sup> Danville, NRC, Pinckneyville, Robinson, and Taylorville did not report negative pressure testing since 12/2021.

<sup>498</sup> Danville, NRC, Pinckneyville have never recorded negative pressure testing the Consent Decree was signed.

<sup>499</sup> The Monitor tracks whether negative pressure testing has been reported in every 3<sup>rd</sup> to 6<sup>th</sup> CQI minutes for each correctional facility.

<sup>500</sup> Dixon, Logan, Graham, and Robinson CC's had non-functional negative pressure units

<sup>501</sup> Hill CC (tissue test) and Lawrence CC (airflow and alarm test) June 2023 CQI minutes

<sup>502</sup> Infection Control Program draft policy G.01.01.IX page 2

<sup>503</sup> Infection Control Program draft policy G.01.01 procedure II and II.v. page 4

tested at least semiannually or per manufacturer recommendations.”<sup>504</sup> Based on the Monitor’s review of the CQI minutes and site inspections there has not been systemwide implementation of the guidelines in this email. The newly appointed Infectious Diseases Coordinator has communicated the need to verify the reading on a control panel using an airflow testing methodology such as tissue paper testing.<sup>505</sup>

The Monitor continues to recommend that a negative pressure reporting log be established and submitted by each facility along with the other Lippert reports. The log should indicate the status of each negative pressure room, the type of check that was done, the correlation of the tissue test with the control panel, the completion of an alarm test in rooms with control panels, the date and person completing the check, and the results. These results should be reported in the facility CQI meeting minutes and forwarded to the Agency Infectious Diseases Coordinator noting any corrective action needed and taken. The reliability of the information on the log will then have to be verified by periodic inspection at the facility. This recommendation has been made by the Monitor since the 3<sup>rd</sup> Report. The failure to regularly monitor and report on the functionality of the negative pressure rooms puts staff, patients, and others at risk of exposure to contagious airborne illnesses. **IDOC is non-complaint with Consent Decree III.J.2**

### **COVID-19 Infection**

IDOC/OHS leadership developed an effective collaboration with IDPH during the COVID-19 pandemic that addressed the utilization of masks, quarantine, restricted internal and external movement, vaccination of incarcerated persons and clinical and correctional staff, limited visitation and volunteer activities, and extensive surveillance testing of staff and the incarcerated population. The primary vaccination rates for staff and incarcerated persons were ultimately comparable to the rates in the State of Illinois. As the pandemic waned in the early 2023 and COVID-related hospitalizations and deaths abated, many of the pandemic restrictions, in consultation with IDPH, have been lifted. In mid-July 2023, surveillance testing of asymptomatic staff and the incarcerated was discontinued, length of quarantine time decreased, and mandatory use of masks ended. IDOC now only tests symptomatic patients. Masks are available for voluntary usage and is encouraged for high risk individuals. Mandatory vaccination of staff has ended but staff are encouraged to stay current with the COVID vaccinations. Primary and updated boosters continue to be offered to the incarcerated. However, acceptance rates are low but comparable to the community vaccination rates for the updated boosters of 10-11%.<sup>506</sup> New admissions to the Reception and Classification are tested for COVID and isolated as needed. All new admissions are offered COVID vaccination.

There is the potential for more lethal COVID-19 mutations that could put the incarcerated persons and staff in the congregate living settings of the IDOC at risk for future outbreaks of COVID-19. The Infectious Diseases Coordinator in consultation with IDPH must be prepared to expeditiously reinstitute the COVID -19 plan developed during the pandemic. The Infectious Diseases Coordinator has developed a Facility Monthly Infection Control Report form that include monitoring the incidence of new cases of COVID-19 and COVID-related hospitalizations and deaths.<sup>507</sup> This data will hopefully provide an early warning of an outbreak in the IDOC. The Monitor is fully supportive of the decision to continue to monitor the incidence of new COVID-19 cases in the IDOC.

### **Conclusion**

<sup>504</sup> Email Communication IDOC legal counsel to Monitor March 17, 2021 titled *Airborne Infection Control (AIC) Room Operation and Testing*.

<sup>505</sup> Monitor team Interview with Communicable and Infectious Diseases Coordinator on 9/13/23

<sup>506</sup> Correctional Staff has an updated booster vaccination rate of 18% (2,199 staff received bivalent COVID-19 vaccine out of 12,404 total staff). This data was provided to the Monitor on 8/30/23

<sup>507</sup> Monthly Infection Control Report Number 16: COVID-19 data traced: a. # patients diagnosed with COVID in the month, b. # of patients treated with COVID-19 antivirals, c. # of hospitalizations with COVID-19, and d. # of deaths due to COVID-19.



**The Monitor continues the rating of partial compliance on Infection Control based on:**

1) the selection of a permanent Infectious Disease Coordinator who is enrolled in a training program that will result in eligibility to take the certification exam in Infection Control and Epidemiology 2) the continued monitoring of new COVID-19 cases and ongoing offering of primary and updated COVID vaccines, 3) the continued relationship with UIC Medical Center Telehealth HCV program that has significantly increased treatment to incarcerated individuals with active HCV, 4) the drafting of Infection Control and Immunization policies (approval pending), 5) the continuation of a consultative relationship with IDPH that is now expanded to include all public health issues in the congregate living setting, and 6) the continued effort to increase the offering and provision of adult immunizations.

However, as noted in the 6<sup>th</sup> Report, IDOC still has not addressed the most substantive requirements of the Consent Decree and the Monitor's recommendations regarding each of these. Substantial compliance will not be achieved until the IDOC has provided proof of practice that it has:

- A comprehensive, system wide infection control program.
- Implemented infection control policy with standardized methods of surveillance and infection control activities.
- Trained, qualified and credentialed personnel in the roles of statewide infection control coordinator and facility infection control coordinators.
- Effective monitoring of all negative pressure isolation rooms and timely identification and correction of malfunction.
- Reliable and valid data on infection control activity to include immunizations rates, annual HCV treatment rates, and immunization of inmate workers and volunteers at risk of body fluid exposure.
- Demonstrated identification and follow through on opportunities for improvement in infection control.

Those recommendations made previously which are now in the Implementation plan have been deleted.

**RECOMMENDATIONS:**

1. Address the recommendations cited in Consent Decree II.A, II.B.3, III.J.1, III.J.2., Implementation Plan narrative pages 2 and 4, and Implementation Plan items 8, 30, 30.1-6, 57, 57.1-4, 58.a-d, and 59
2. Ensure the statewide infection control coordinator obtains and maintains certification in infection prevention and control through the Certification Board of Infection Control and Epidemiology.
3. IDOC should consider hiring or contracting with an infectious disease specialist or academic center to consult with IDOC physicians concerning the treatment of individual patients with complicated infectious diseases or treatments.
4. Maintain the COVID-19 vaccination program that provides systemwide education on the value of COVID-19 vaccination and offers initial and ongoing vaccination for men and women incarcerated in the IDOC.
5. Place the provision of adult immunizations under the management of facility infection control nurse and DON using approved standing orders, treatment guideline, or protocols.
6. Ensure that quality improvement activity identifies infection control and prevention opportunities for improvement and takes steps to ensure that improvements occur.
7. Weekly tissue paper testing of the isolation rooms should be conducted to verify operability of the monitoring gauge and that these units are always operational.
8. Revise the Safety and Sanitation or regular other inspections of infirmaries and housing unit to identify potential public health and infection control risks (infestations, rodents, molds, etc.)
9. Provide both hepatitis A and hepatitis B vaccinations to inmate workers who have risks of exposure to

blood and fecal borne pathogens and to inmate kitchen workers.

10. Track and provide detailed reports on the offering and provision of nationally recommended adult immunizations including the percentage of eligible candidates who have been offered and received the required immunizations at each site.

## Dental Care

### Dental Staffing

#### *Addresses II.B.3*

**II.B.3.** *IDOC must also provide enough trained clinical staff, adequate facilities, and oversight by qualified professionals, as well as sufficient administrative staff.*

**OVERALL COMPLIANCE RATING:** Partial Compliance

### FINDINGS:

This section will examine the current staffing of the Department of Corrections (DOC) dental program, focusing on clinical staffing (dentists and hygienists) as well as administrative staffing. The Monitor asked for a list of allocated positions at each facility by position type with vacancies. IDOC was only able to send the vendor positions. State positions were unable to be obtained.

**Implementation Plan item 81:** *Hire a Chief of Dental Health Services.*

#### *Chief of Oral Health Services*

As noted in the 6<sup>th</sup> Monitor's Report IDOC hired an administrative dentist responsible for the statewide program. A Chief of Oral Health Services was hired in February of 2021. IDOC remains in compliance with this aspect of the Implantation Plan.

#### *Hygienists*

There were 20.25 vendor hygienist positions for the 30 IDOC facilities with three (15%) vacancies. Excluding Murphysboro (which uses Pinckneyville for dental services) six facilities (20%) lacked a vendor hygienist.<sup>508</sup> Jacksonville and Menard had state dental hygienists, based on the September 2022 staffing grid provided by IDOC, but IDOC did not provide State positions for this report so it is unclear if these positions are still filled. JTC, NRC, Vienna, and Western, with a combined population of 3635 have no budgeted hygienists. The following table gives the populations of facilities without dental hygiene services.

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<sup>508</sup> JTC (which does not have a dental clinic), Jacksonville, Menard, NRC, Vienna, and Western

Facilities without Budgeted Dental Hygienists	
Facility	Population
Joliet Inpatient Treatment Center	15
Murphysboro	179
NRC	1312
Vienna	698
Western	1731
Total	3935

The existing staffing arrangement employed by IDOC is unclear. The deployment of hygienists lacks consistency and does not follow a standardized pattern. For instance, at Hill Correction Center, which houses 1,194 inmates, there is a part-time hygienist (0.5 FTE) assigned. In contrast, Southwestern Illinois Correctional Center, with a population of 605 inmates, has a full-time hygienist (1 FTE), while Western Correctional Center, with a population of 1700 inmates, lacks a dental hygienist. Similarly, Logan Correctional Center, accommodating 1,070 inmates, is allocated 2 full-time dental hygienists.

Hygiene support is not evenly distributed throughout the entire enterprise. The existing staffing arrangement creates significant gaps in the program, occasionally resulting in facilities being overstaffed. It is recommended that IDOC conduct a statewide analysis of dental hygiene assets to assess staffing levels at different facility types. A staffing ratio should be established for IDOC dental clinics that will ensure compliance with the decree. The current staffing pattern leaves Western Correctional Center, Vienna Correctional Center, and Northern Reception and Classification Center with no hygiene support. Just these facilities alone account for a little over 10% of the statewide population.

Two small facilities (JITC and Murphysboro) do not have dental units. Murphysboro patients are seen at Pinckneyville but JITC patients do not have access to hygiene services. Three facilities (NRC, Vienna, and Western with 3741 inmates) do not have hygiene services and no budgeted hygienists. Twenty-five of 30 facilities have hygiene services. Of the 25 facilities with hygiene services only 19 have their entire budgeted dental hygiene positions filled. There are 18.25 working hygienists<sup>509</sup> for 29,212 inmates or one hygienist for every 1600 inmates. A workload analysis should be performed to determine how many hygienists are needed to perform routine hygiene and pre-procedure hygiene. The Monitor continues to recommend that *all* IDOC facilities with dental suites should have a dental hygienist on the dental team. The following table shows the current status of dental hygiene in IDOC facilities.

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<sup>509</sup> Budgeted hygienists minus vacant hygienists equals working hygienists.

<b>Dental Hygiene Services in IDOC</b>					
<b>Facility</b>	<b>23-May</b>	<b>2023 June</b>	<b>2023 June</b>	<b>2023 June</b>	<b>2023 June</b>
	<b>Dental Cleanings</b>	<b>Budgeted FTEs</b>	<b>Vacancy</b>	<b>Working Hygienists</b>	<b>Census June 2023</b>
<b>BMR</b>	54	1	0	1	1148
<b>Centralia</b>	58	1	0	1	1281
<b>Danville</b>	39	1	1	0	1591
<b>Decatur</b>	0	0.5	0.5	0	327
<b>Dixon</b>	No Data	1	0	1	1449
<b>East Moline</b>	No Data	0.5	0.5	0	491
<b>JITC/Elgin</b>	No dental unit	No dental unit	No dental unit	0	15
<b>Graham</b>	No Data	1	0	1	1691
<b>Hill</b>	55	0.5	0	0.5	1194
<b>Illinois River CC</b>	26	1	0.5	0.5	1698
<b>Jacksonville</b>	0	1 (State)**	1	0	937
<b>Joliet Treatment Center</b>	11	0.25	0	0.25	163
<b>Kewanee</b>	23	0.5	0	0.5	179
<b>Lawrence</b>	No Data	1	0	1	677
<b>Lincoln</b>	29	1	0	1	654
<b>Logan</b>	No Data	2	0	2	1070
<b>Menard</b>	52	1 (State)**	0	1	1917
<b>Murphysboro</b>	No dental unit	No dental unit	No dental unit	0	179
<b>NRC</b>	No Data	0	0	0	1312
<b>Pinckneyville</b>	72	1	0	1	1858
<b>Pontiac</b>	43	1	0	1	630
<b>Robinson</b>	No Data	0.5	0	0.5	933
<b>Shawnee</b>	0	1	0	1	1508
<b>Sheridan</b>	No Data	0.5	0.5	0	1036
<b>Southwestern</b>	36	1	0	1	605
<b>Stateville</b>	No Data	1	0	1	615
<b>Taylorville***</b>	91	1	0	1	1091
<b>Vandalia</b>	56	1	0	1	534
<b>Vienna</b>	0	0	0	0	698
<b>Western</b>	No Data	0	0	0	1731
<b>Sites w Hygiene Support</b>		<b>23/28 sites</b>			
<b>TOTALS</b>		<b>22.25</b>	<b>4.0 (18%)</b>	<b>18.25</b>	<b>29212</b>

\*The census used in this review was obtained from the IDOC's official Internet webpage

\*\* IDOC did not provide State positions for this report. Two facilities (Jacksonville and Menard) had state dental hygienists based on a May 2021 State staffing grid. No official staffing information has been provided since.

\*\*It was unclear whether these were actual cleanings or some other type of encounter.

### Dentists

Twenty-eight IDOC correctional centers have onsite dental suites and services.<sup>510</sup> As can be seen from the graph below, at the inception of the Consent Decree, there were 24.2 working dentist. The number of working dentists has decreased from 24.2 in 2019 to 20.8 in 2023. Working dental staff is deteriorating even as budgeted staff are increasing.

Dentists from 2019 to 2023												
	Nov-19				Sep-22				Aug-23			
	Budgeted	Vacant	Vacancy Rate	Total Working	Budgeted	Vacant	Vacancy Rate	Total Working	Budgeted	Vacant	Vacancy Rate	Total Working
<b>State</b>	2	1		1	1	0		1	1*	0*		1*
<b>Vendor</b>	28.7	5.5		23.2	35.15	15.35		19.8	35.15	15.35		19.80
<b>Total</b>	30.7	6.2	21%	<b>24.2</b>	36.15	15.35	42%	<b>20.8</b>	36.15	15.35	42%	<b>20.8</b>

\* State did not provide staffing data so September 2023 data used

Budgeted dentist positions range from 0.25 FTE to 3.0 FTE at the twenty-eight sites.<sup>511</sup> Thirteen<sup>512</sup> facilities have greater than 1.0 FTE budgeted dentist positions.<sup>513</sup> There are 36.15 dentists of which 15.35 (42%) are vacant. The vacancy rate is the same as from the last report. Ten facilities are staffed as they were budgeted.<sup>514</sup> Six facilities<sup>515</sup> have vacant dental positions. Eighteen facilities<sup>516</sup> have less than their budgeted staff. Using June 2023 population statistics, 18,848 individuals at 18 facilities have no dedicated dentist coverage or are understaffed due to dentist vacancies; this puts 63% of IDOC patient-inmates at clear risk for limited, if any access to dental services. If all dentist positions were filled, there would be one dentist for every 821 inmates. But given existing staffing there is one dentist for every 1,466 inmates. There is no sign of improvement as both the absolute number of dentists and the vacancy rate is deteriorating. Following the Monitor's 6th report issuance, there has been no change in dental vacancies. A comprehensive analysis should be conducted to determine the underlying reasons for the attrition of dental personnel. In this endeavor, conducting exit surveys appears to be a prudent course of action, as it may provide valuable insights.

The CQI minutes indicate an effort to hire dentists on an "as needed" basis for dental coverage. However, it is challenging to ascertain who delivers this coverage and the total number of FTE (Full-Time Equivalent) hours allocated to each facility. The situation becomes unclear regarding whether institution dentists are covering multiple facilities or part-time dentists are being contracted through a vendor, as implied by the Monitor's report of the most recent site visit<sup>517</sup> and a staffing document.<sup>518</sup>

<sup>510</sup> Two small IDOC correctional centers, Elgin and Murphysboro do not have onsite dental services.

<sup>511</sup> 9/12/22 IDOC Staffing Update

<sup>512</sup> This includes Stateville, but the Monitor is unsure if this position is still allocated as no State staffing statistics were provided. If the Stateville dentist position was eliminated the vacancy rate is slightly higher (44 vs.42%). If the Stateville position is still allocated and filled the vacancy rate is the same (42%). If the Stateville position is still allocated but not filled the vacancy rate is higher (45% vs 42%)

<sup>513</sup> IDOC Staffing Analysis 9/12/22 and 10/19/22 Medical Providers Table: Budgeted dentist staffing greater than 1.0 FTE: Dixon 1.4, Graham CC 1.6, Lawrence CC 1.5, Logan CC 2.0, Menard 3.0, NRC 1.6, Pinckneyville CC 2.25, Shawnee CC 1.4, Sheridan CC 1.5, and Vandalia CC 1.5.

<sup>514</sup> East Moline, IRCC, JTC, NRC, Pontiac, Sheridan, Southwestern, Stateville, Taylorville, and Western.

<sup>515</sup> BMRCC, Graham, Hill, Jacksonville, Shawnee, and Vandalia

<sup>516</sup> BMRCC, Centralia, Danville, Decatur, Dixon, Graham, Hill, Jacksonville, Kewanee, Lawrence, Lincoln, Logan, Menard, Pinckneyville, Robinson, Shawnee, Vandalia, and Vienna.

<sup>517</sup> Graham CC Site Visit 7/17-19/2023

<sup>518</sup> Revised Lippert Report Yellow Spreadsheet February 2023

As previously noted in the Monitor's 6th report, it remains extremely difficult to approximate the extent of "as needed" dentist coverage to address the significant dentist staffing gaps. During the Monitor team's recent site visit to Graham CC,<sup>519</sup> it was discovered that the full-time dentist retired at the end of June. A part-time dentist from Logan CC is currently providing coverage at Graham CC until the full-time dentist position is filled. This part-time dentist works one day per week (0.2 FTE) on Thursdays, primarily focusing on intake dental exams, 30-day assessments, treatment plans (especially for inmates being transferred to other facilities), and handling some dental emergencies such as pain and extractions. A second dentist occasionally fills in on Saturdays or Sundays, focusing on dental fillings.

#### *Dental Assistants*

There are almost nine more budgeted dental assistants and almost 16 more working dental assistants than dentists. As the table below shows, while budgeted dental assistants increased by one position, the working number of dental assistants decreased by approximately one position. The dental assistant vacancy rate has increased from 15% to 19%.

	Nov-19				Sep-22				Aug-23			
	Budgeted	Vacant	Vacancy Rate	Total Working	Budgeted	Vacant	Vacancy Rate	Total Working	Budgeted	Vacant	Vacancy Rate	Total Working
<b>State</b>	8	2		6	8	2		6	8*	2*		6*
<b>Vendor</b>	35.55	4.4		31.15	36.9	5.5		31.4	36.9	8.5		28.4
<b>Total</b>	43.55	6.4	15%	<b>37.15</b>	44.9	7.5	16%	<b>37.4</b>	44.9	8.5	19%	<b>36.4</b>

\* State did not provide staffing data so September 2023 data used

Due to the significant staffing shortages, there are significant delays in receiving routine dental care. The waiting list for fillings has an 11-month wait time, and there is a backlog of 130 individuals who have been waiting for six months to get on the list. Additionally, 56 patients are waiting for dentures, with a six-month wait but no backlog for denture waiting list placements. Fortunately, no individuals are waiting or backlogged for extractions. These findings are reported in the 2 Quarter Graham CQI minutes.

#### **RECOMMENDATIONS:**

- 1. Conduct Statewide Analysis:** It is recommended that the Department of Corrections (DOC) initiates a comprehensive statewide analysis of dental hygiene assets. This analysis should focus on evaluating staffing levels at various facility types to identify gaps and discrepancies. By understanding the distribution of hygiene support, the DOC can implement a more equitable and efficient staffing arrangement.
- 2. Establish Staffing Ratio:** To address the current inconsistency in hygiene support, it is advisable to establish a standardized staffing ratio for DOC dental clinics. This ratio should be designed to ensure compliance with the consent decree and the overall needs of the facilities. Implementing a clear staffing guideline will help in achieving a more balanced distribution of hygiene support and prevent instances of overstaffing.
- 3. Ensure Adequate Dental Hygienist Staffing:** Address the shortage of dental hygienists by filling the vacancies at facilities lacking hygienists. All DOC facilities with dental suites should have a dental hygienist on the dental team to enhance patient care.

<sup>519</sup> Graham CC Site Visit 7/17-19/2023 1,691 Census. CC 1324 and RCC 367

4. **Address Dentist Vacancies:** Expeditiously recruit and hire dentists to fill all current and ongoing dentist vacancies.
5. **Comprehensive Analysis of Vacancy Causes:** Conduct a thorough analysis to identify the root causes of attrition and vacancies among dental personnel (Dentists).
6. **Staffing Analysis:** Evaluate the dentist staffing at each IDOC facility with onsite dental services to ensure that the FTE dentist staffing is in accord with each facility's average daily census and dental care needs of its incarcerated population.
7. **Ensure Emergency Dental Services:** Continue to provide emergency dental services and those essential dental services during this staffing shortage.

## Dental Documentation

Addresses item III.K.1; III.K.11; III.K.12

**III.K.1.** *All dental personnel shall use the Subjective Objective Assessment Plan ("SOAP") format to document urgent and emergency care.*

**III.K.11.** *Each prisoner shall have a documented dental health history section in their dental record.*

**III.K.12.** *Dental personnel shall document in the dental record whenever they identify a patient's dental issue and dental personnel shall provide for proper dental care and treatment.*

**OVERALL COMPLIANCE RATING:** Partial compliance

## FINDINGS:

The Monitor assessed this section using dental peer reviews, urgent care dental, comprehensive dental care, prosthetic dental care, intake (initial examination), and dental extraction records.

The analysis of dentist peer reviews from 2022 and 2023 revealed a moderate to high level of compliance, with 76% adherence to the SOAP (Subjective, Objective, Assessment, Plan) format. When reviewing urgent care records for the utilization of the SOAP format, the Monitor observed that 60% of the records (6 out of 10) followed the SOAP format. However, only half of these records (three out of six) used the SOAP notation correctly. The following is an example of a SOAP note not annotated appropriately.<sup>520</sup>

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<sup>520</sup> Patient #1

<b>SUBJECTIVE:</b>
Dr. RDH and DA present on HU for dental sick call
<b>OBJECTIVE:</b>
pain on LL side
<b>ASSESSMENT:</b>
Dr. [REDACTED] educated on active infection coming from 19/20 area
<b>PLAN:</b>
RX Amox 500 mg take 4 tabs for 7 days until gone
Schedule for extractions
<b>EDUCATION:</b>
patient educated on PLAN
<b>CO-PAY:</b>
<input type="checkbox"/> \$5.00 Co-pay

The "Subjective" section of a SOAP note is meant to capture the patient's description of their complaint. However, the provider in this case mentioned the presence of the doctor, hygienist, and dental assistant in the health services unit that day instead. The "Objective" notation should document objective and measurable data related to the patient's oral health, such as findings from a dental examination, X-rays, measurements of oral conditions, and any other clinical information that is observable and quantifiable. Instead, the provider enters the patient's "Subjective" complaint of pain on the lower left side. An "Assessment" is made when the dentist offers their professional assessment /diagnosis based on subjective and objective information. It typically includes the provider's impressions, conclusions, and differential diagnoses. In this case, the provider makes a diagnosis of an active infection without the benefit of objective data or intra-oral X-rays. The type of infection (odontogenic vs. periodontal) is not specified, yet the patient is scheduled for extractions. It is important to note that a clear and precise diagnosis is necessary for appropriate treatment planning and patient care.

The purpose of a SOAP note is to provide a structured and systematic method for the dentist to document and communicate essential information about a patient's condition and urgent/emergency treatment. A key factor contributing to the poor quality of the example note is that it's being authored by someone other than the dentist. The responsibility for creating clinical notes should squarely belong to the dentist and should not be delegated to a dental assistant, dental hygienist, or any other staff member.

A dentist at Western employed a stamp in lieu of writing a comprehensive SOAP note.<sup>521</sup> This stamp merely indicated "EMERGENCY" care without offering meaningful information regarding the patient's presenting complaint, as shown below. Using a stamp that says "EMERGENCY" with very little clinical content doesn't provide the necessary details for comprehensive documentation. A SOAP note should have been entered after the record was stamped.

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<sup>521</sup> Patient #2



Date	Service Rendered	D.D.S. Signature
6-21-23 2P	EMERGENCY	
	Pt E multiply abscess	
	Transfer soon	
	Clindamycin 150mg q 30T tid	

Nineteen out of twenty records showed that a health history was obtained during the intake screening, indicating a 95% compliance rate. Only one record lacked a completed health history. This observation aligns with the Wexford peer review instrument (PR 001C) findings, which assesses whether medical histories are reviewed. In the peer review analysis, three out of 21 dentists did not review health histories, resulting in an 85% compliance rate, which means that health histories were there for the dentist to review.

However, it was noted that many health histories were not updated when treatment planned for comprehensive care. Eight of the 23 comprehensive care records (35%) showed updated health histories.

Generally, the reviewed records adequately document the patient's dental issues and provide appropriate care. To ensure consistency and accuracy, the Monitor will need to check the written dental requests onsite and cross-reference them with dental records to confirm that dental issues are consistently recorded and appropriately addressed.

#### RECOMMENDATIONS:

- 1. Enhance SOAP Format Compliance:** To ensure consistent and structured documentation, all dental providers should adhere to the SOAP (Subjective, Objective, Assessment, Plan) format when creating urgent care notes. This format should be used uniformly across dental records.
- 2. Proper Authorship of Clinical Notes:** Clinical notes should be authored by the attending provider to ensure accuracy and comprehensiveness. This responsibility should not be delegated.
- 3. Education and Training:** Offer additional training to dentists on properly utilizing the SOAP format and the importance of clear, accurate, and objective documentation. Ensure that they understand the distinctions between subjective and objective data.
- 4. Review of Health Histories:** Reinforce the importance of reviewing patient health histories before treatment. This process should be consistent among all dentists. Ensure that health histories are updated, particularly when planning comprehensive care.

#### Dental Extractions

Addresses item III.K.10.a; III.K.10.b; III.K.10.c

**III.K.10.a.** *Diagnostic radiographs shall be taken before every extraction*

**III.K.10.b.** *The diagnosis and reason for extraction shall be fully documented prior to the extraction*

**III.K.10.c.** *A prisoner shall consent in writing once for every extraction done at one particular time. In instances where a prisoner lacks decision making capacity the Department will follow the Illinois Health Care Surrogate Act. In the event a prisoner verbally consents to an extraction, but refuses to consent in writing, dental personnel shall contemporaneously document such verbal consent in the prisoner's dental record.*

**OVERALL COMPLIANCE RATING:** Partial compliance

#### FINDINGS:

In this section, the Monitor assessed site visit<sup>522</sup> findings and dental records for patients who had dental extractions, comprehensive care, and urgent dental procedures. During this evaluation, the Monitor accepted panoramic and intra-oral films up to one year old for assessment. However, it should be noted that if the patient had recently experienced trauma, < one year, the expectation is a new radiograph will be made.

While the Monitor has accepted X-rays that were made up to one year, it is not clear if this was the intent of decree. If the intent of the decree is for all dentists to make an immediate x-ray before an extraction IDOC will fall very short of meeting compliance. Further discussion will need to be made to determine the standard of care in regard to extractions and if the word “before” means immediately, 3 months, 6 months, or a year before and extraction. The onsite evaluation<sup>523</sup> of nine patient records conducted by the Monitor revealed that all patients undergoing extractions had preoperative X-rays. These X-rays were taken within 3 to 10 months before the extractions.

The analysis of twelve extraction records revealed low compliance regarding the performance of diagnostic X-rays before extractions. Only four out of twelve records (33.3%) indicated that a current preoperative radiograph (< one year) had been made. Five records had X-rays outside the date range (370 days to 954 days).<sup>524</sup> Three records did not have any documentation that an X-ray was made.<sup>525</sup>

An additional nine records from the review of comprehensive and prosthetic care folders were evaluated for the presence of a preoperative radiograph before an extraction. Only three of nine patient records detailing extractions indicated preoperative radiographs were made<sup>526</sup>, resulting in a 33% compliance rate.<sup>527</sup> It is possible that the dentists and their staff conducted preoperative X-rays but failed to document this step in the patient records. However, the Monitor does not have physical access to the records or to the actual X-rays; this analysis relies solely on clinical notes entered into the record. A recommended practice for all providers is to document in the patient record that they have made an X-ray.

The Monitor noted the absence of specific directives from IDOC that would clarify the timing requirements for these X-rays. It is recommended to take X-rays closer to the extraction date to ensure that the dentist has the most current information about the tooth, bone structure, and potential complications, especially in acute situations. This practice helps make well-informed decisions and ensure the extraction procedure's safety and effectiveness.

There was a high level of compliance in documenting the reasons for extraction. Eight out of ten reviewed records included a documented diagnosis or reason for the extraction. This was consistently observed throughout the records reviewed by the Monitor.

The Monitor reviewed ten dental records from the Extraction Folder (provided by IDOC) to investigate the completion of dental consents before extractions. A consent form was provided with every one of these records, resulting in a 100% compliance rate. A similar rate of compliance for obtaining consent was noted by the Monitor at the Graham site visit. Eight out of nine records reviewed revealed a compliance of 89%.

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<sup>522</sup> Graham CC Site Visit 7/17-19/2023

<sup>523</sup> Graham CC Site Visit 7/17-19/2023

<sup>524</sup> Patients #1 - #5

<sup>525</sup> Patients #6 - #8

<sup>526</sup> Credit for an X-ray was given if the dentist indicated that an X-ray was reviewed.

<sup>527</sup> Records for patients #9 - #14 did not document that preoperative radiographs were made or reviewed.

The Monitor extended the review to encompass an additional nine records of patients undergoing extractions during comprehensive routine care, with a specific focus on evaluating the documentation of consent. Although these records were not accompanied with consent forms, it was noted that four (44%) of nine records indicate that consent was obtained.<sup>528</sup> It is unclear whether the providers forgot to document that consent was obtained or if they failed to obtain it.

Documenting that informed consent was obtained becomes particularly critical when using paper records, as consent forms can become separated from the dental record, potentially causing issues with tracking and maintaining a complete patient history.

## RECOMMENDATIONS

1. **Low Compliance with Preoperative X-rays:** It's clear from the analysis that there is a low level of compliance with conducting preoperative X-rays before dental extractions. Preoperative X-rays must be made for patient safety and treatment planning. Dentists should consistently follow this practice to ensure they understand the patient's dental condition before proceeding with an extraction.
2. **Documentation of X-ray Reviews:** The Monitor recommends better documentation practices to ensure that X-rays are taken, reviewed, and considered in the extraction procedure. Dentists must document in their clinical notes that they have made or reviewed a current X-ray.
3. **Consent Forms:** It is essential to consistently document that informed consent was obtained in the patient's record. IDOC may want to consider developing a standardized and easily identifiable section within the paper dental record for informed consent. This section should indicate where the consent form should be attached.
4. **Guidance For X-rays:** The Chief of Oral Health Services at IDOC should establish guidance concerning the timing requirements for X-rays, especially regarding extractions. This guidance can help ensure dental staff have clear protocols when determining when to take X-rays in preparation for various dental procedures.

## Dental Support (Equipment and Policies)

### *Addresses items III.K.4-5; III.K.13*

**III.K.4.** IDOC shall implement policies that require routine disinfection of all dental examination areas.

**III.K.5.** IDOC shall implement policies regarding proper radiology hygiene including using a lead apron with thyroid collar, and posting radiological hazard signs in the areas where x-rays are taken.

**III.K.13.** IDOC shall conduct annual surveys to evaluate dental equipment and to determine whether the equipment needs to be repaired or replaced. Any equipment identified as needing repair or replacement will be repaired or replaced.

**OVERALL COMPLIANCE RATING:** Partial Compliance

## FINDINGS:

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<sup>528</sup> Records for patients #2, #7, #8, #9, and #10 did not document a consent

In the previous Monitor's 6<sup>th</sup> report,<sup>529</sup> it was observed that the IDOC Administrative Directive (04.03.102) did not address routine disinfection of all dental examination areas, the utilization of lead aprons with thyroid collars, or the posting of radiological hazard signs in areas where x-rays are taken.

#### *Routine Disinfection*

IDOC is making significant progress in addressing disinfection and infection control. IDOC submitted a draft Infection Control Program policy. The Monitor submitted comments prior to the Monitor's Dental Consultant being hired. He will review this policy and provide comments related to dental issues to IDOC.

#### *Thyroid Collars*

**Implementation Plan item 84: *Ensure all facilities have lead radiation aprons with thyroid collars for patient protection during X-rays.***

1. *Procure sufficient leaded aprons with thyroid collars so that each dental suite has a dedicated thyroid collar that is stored in the dental area.*

***Proposed End Date: July 2023***

IDOC is making strides forward in ensuring that all facilities have thyroid shielding. The recent site visit to Graham noted that the dental clinic had a leaded apron with a thyroid collar. Furthermore, during a WebEx meeting with the Chief of Dental Health Services, the Monitor was informed that every facility had acquired thyroid collars.<sup>530</sup> The Monitor indicated that the standard of care concerning the use of thyroid collars is evolving.<sup>531</sup> The Monitor referenced guidance from the American Academy of Oral and Maxillofacial Radiology, which states:

*'On the basis of radiation doses from contemporaneous maxillofacial imaging, the committee considered that the risks from thyroid cancer are negligible and recommends that thyroid shielding not be used during intraoral, panoramic, cephalometric, and cone-beam computed tomographic imaging.'*

It was acknowledged that further discussions regarding thyroid collars will depend on the State Dental Board's adoption of these recommendations. However, it was emphasized that until clarification and adoption occurs, the expectations outlined in the consent decree regarding using thyroid collars remain in force<sup>532</sup>.

#### *Radiological Hazard Signs*

No information was received regarding Radiological Hazard signage in dental clinics to warn individuals that they are entering an area where X-rays are being made. It is unclear regarding the status of Radiological Hazard Signs statewide.

#### *Dental Equipment*

**Implementation Plan item 85: *Create a standardized list of all medical equipment required in each dental operator in the IDOC and develop an instrument for an annual dental survey of dental equipment at every clinic.***

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<sup>529</sup> Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys March 13, 2023 Page 176

<sup>530</sup> WebEx Meeting with the Chief of Oral Health Services September 25, 2023

<sup>531</sup> JADA 2023;154(9):826-835 <https://doi.org/10.1016/j.adaj.2023.06.015>

<sup>532</sup> It is not clear if regulatory bodies or authorities will define contemporaneous maxillofacial imaging. For example, does contemporaneous maxillofacial imaging mean that older X-ray units may have to meet a state or federal requirement?

1. *Contract with a professional evaluator (e.g., Henry Schein) of dental suite equipment to create a standardized list of dental equipment required in all dental operatories in the IDOC.*
2. *Develop an instrument to perform an initial and thereafter annual survey of presence, functionality, and calibration status (if required) of dental equipment in every IDOC dental suite. A record or log of the dates and findings of annual dental equipment surveys are to be maintained.*
3. *Dental operatory equipment that is missing, broken, or defective must be replaced. Work orders or fiscal requests must be tracked and regularly reported to the facility QI meeting until repairs are completed or new equipment is installed.*
4. *Each dental unit needs to track the last servicing or calibration and keep a record or log of servicing and calibrations which generally should be done at least annually.*
5. *Each facility's documentation of servicing, calibration, needed repairs and replacements, and the turnaround time of work and purchase orders are reported annually to the system's Quality Council. The annual independent audit would determine whether this survey of dental equipment was done and whether appropriate action was taken.*

***Proposed End Date: August 2023***

The Monitor received submissions from twenty-three facilities<sup>533</sup> regarding dental equipment, but these submissions lack standardization. As noted in the Monitor's 6th report, some reports detail only 4-7 different dental apparatuses' presence and condition,<sup>534</sup> while others provide more comprehensive information, including the quantity of drills and handpieces. Many facilities have contracted with external vendors for equipment maintenance and inspection; however, the equipment surveyed varies between vendors.<sup>535</sup> Some vendors inspect compressors and vacuums, while others do not. All vendors evaluate electrical equipment, but there is inconsistency in the equipment surveys, even when the same contractor is used across different facilities.

Among the 23 facilities, 11 perform yearly inspections of their dental equipment, and they do so with the assistance of biomedical contractors.<sup>536</sup> Meanwhile, one facility only conducts surveys when their equipment needs repair on an as-needed basis.<sup>537</sup> It's worth noting that in some instances, inspections are carried out locally within the facility without the involvement of external contractors. However, there's some uncertainty about who is responsible for these internal reviews, and it's unclear whether these individuals have the necessary technical or electrical expertise to effectively evaluate the equipment.<sup>538</sup>

At the writing of this section of the report, IDOC has not yet provided the Monitor with a comprehensive systemwide survey for auditing dental equipment's presence and operational status. Repair and/or replacement requests have been submitted for a sterilizer and an amalgam separator.<sup>539</sup> Additionally, one facility has initiated the procurement process for a dental chair and the maintenance and repair of an X-ray machine and film processors.<sup>540</sup> However, the available data lacks consistency in documenting when defective equipment was identified, when work orders were submitted and approved, and when the equipment was ultimately repaired or replaced.

As emphasized in the Monitor's 6th report, the DOC must develop a standardized equipment audit tool. This audit needs to be more robust than the cursory audit performed by SIU as this audit does not go in depth to review

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<sup>533</sup> IDOC folder 102 Dental equipment

<sup>534</sup> Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys March 13, 2023 Page 176

<sup>535</sup> Denman Biomedical Services, Henry Schein Services and Repairs, ClinTech, and IEMA

<sup>536</sup> Vienna, Southwestern, Sheridan, Shawnee, Robinson, Pinckneyville, Kewanee, Danville, Centralia, Big Muddy, and East Moline.

<sup>537</sup> Menard

<sup>538</sup> Western Illinois, Hill, Illinois River, and Lincoln

<sup>539</sup> Vienna

<sup>540</sup> Graham

equipment such as compressors, vacuum pumps, and amalgamators.<sup>541</sup> This audit instrument should generate site-specific lists detailing the quantity of dental devices, instruments, and equipment required at each facility. Moreover, it should facilitate annual surveys and reports to identify variances between equipment volume and the quantity needed for each facility.

#### *Dental Space*

In the 6th report from the Monitor, it was highlighted that there hasn't been any evidence of standardized, comprehensive, yearly surveys being conducted to assess dental facilities and equipment throughout the organization. It's essential to stress that the initiation of a survey should not be delayed while waiting for the DOC to bring in consultants to perform a broader evaluation of clinical spaces.

Furthermore, the Monitor has yet to receive specific information regarding the number of dental chairs available within the DOC. This raises concerns about how it might affect dental hygiene and services at various locations. Conducting such a survey is vital to ensure the safety and effective functioning of the dental program.

#### *Spore Testing*

A review of Quarter 2, 2023 CQI (Continuous Quality Improvement) reports was conducted to assess whether facilities were spore-testing autoclaves. Twenty-six CQI meeting minutes were reviewed, with three omitted due to a lack of evidence of dental presence or corrupted files.<sup>542</sup> Forty-seven percent of the facilities (11 out of 23) did not document spore testing results in their CQI minutes.<sup>543</sup>

Of the facilities that recorded spore testing, five indicated that it was conducted on a weekly basis.<sup>544</sup> However, discrepancies were observed, such as in the case of Graham, where spore testing was reported to be performed weekly, but the Monitor observed documentation that it occurred every two weeks.<sup>545,546</sup> A similar finding was highlighted in a CQI PowerPoint from Shawnee. In January, April, May, and June of 2023, spore testing was conducted twice for the month and only once in February. These findings highlight inconsistencies in the frequency of autoclave testing, which is inadequate for ensuring effective sterilization. According to the Centers for Disease Control, spore testing should be conducted on each sterilizer at least weekly.

*"A spore test should be used on each sterilizer at least weekly. Users should follow the manufacturer's directions for how to place the biological indicator in the sterilizer. A spore test should also be used for every load with an implantable device. Ideally, implantable items should not be used until they test negative."*<sup>547</sup>

The reporting of spore testing is inconsistent in facility CQI minutes, and there is a lack of a mechanism or protocol for systemwide monitoring and reporting. Minimum elements for reporting spore testing should include the date of the spore test, an indication of whether a control was run, and the test's disposition (positive/negative). Any deviation from weekly testing should be accompanied by an explanation.

The Special Litigation Counsel provided a late submission for the Monitor regarding Dental Unit Overview.<sup>548</sup> This document, created by SIU, provides a quarterly summary of dental units, including spore testing. An

<sup>541</sup> SIU Dental Unit Overview

<sup>542</sup> JTC Inpatient, Lawrence, and Western respectively.

<sup>543</sup> Southwestern, Sheridan, Shawnee, Lincoln, Kewanee, JTC, Illinois River, Graham, East Moline, Decatur, and Centralia

<sup>544</sup> Southwestern, Lincoln, Illinois River, Graham, and Decatur

<sup>545</sup> CQI minutes Monthly Quality Improvement Meeting and Administrative Review Graham Month: June2023

<sup>546</sup> Monitor site visit to Graham July 2023

<sup>547</sup> <https://www.cdc.gov/oralhealth/infectioncontrol/faqs/monitoring.html>

<sup>548</sup> E-mail from Special Litigation Counsel October 29, 2023

examination of the spore testing for the 4th quarter of FY 2023 reveals that seven facilities failed to submit reports on spore testing. Unfortunately, this non-compliance was also noted in the CQI minutes.

When facilities neglect to report spore testing, a zero-tolerance approach to non-compliance should be adopted. It is crucial for all facilities to submit statistical data on sterilization because a malfunctioning autoclave poses a public health risk. The Monitor strongly advises the Chief of Oral Health Services to directly contact these facilities and ensure that any outstanding questions are addressed to the satisfaction of the SIU.

#### *Therapeutic Treatment Plan and X-rays*

Implementation Plan item 54: ***This process improvement for chronic care should address:***

1. *That a therapeutic dental plan is made at the conclusion of the intake dental examination.*
2. *That dental x-rays are digitalized and organized in a picture archiving and communication system (PACS).*

The therapeutic dental plan (after intake examinations) is discussed in the Comprehensive Dental Care Section and will not be discussed in this section. Regarding the digitalization of X-rays, the dental Monitor contacted the Chief of Oral Health Services to ascertain progress in fulfilling this directive. In an email response<sup>549</sup>, the Chief of Oral Health Services mentioned that only the female facilities (Logan and Decatur) and one male facility (Dixon), currently possess the capability to digitize radiographs. The remaining facilities within the Illinois Department of Corrections (IDOC) will be addressed at a later date, possibly when an Electronic Health Record (EHR) is initiated. In anticipation of an EHR the Monitor strongly recommends that IDOC start the procurement process of purchasing digital X-ray units or the equipment needed to convert celluloid films into a digital format.

#### **RECOMMENDATIONS:**

1. **Radiological Hazard Signs:** IDOC should immediately conduct a comprehensive assessment of radiological hazard signage in all dental clinics across the organization to ensure compliance with safety regulations. This assessment should involve verifying the presence, visibility, and condition of Radiological Hazard Signs in each clinic and implementing necessary corrective actions to ensure clear and effective signage statewide.
2. **Standardize Equipment Monitoring and Reporting:** IDOC should implement standardized protocols and reporting procedures for dental equipment monitoring across all facilities. This should include uniform reporting templates and guidelines for documenting equipment defects, repair orders, and replacements. Templates should include the date when broken dental equipment is identified, the work order or ASR submitted, the work order or ASR approved, the purchase order approved, and the date equipment is repaired or replaced.
3. **Spore Testing Compliance:** Ensure that all dental autoclaves undergo spore testing as per the recommended frequency, at least weekly, in accordance with the Centers for Disease Control (CDC) guidelines.
4. **Spore Testing Documentation:** Establish precise documentation requirements for spore testing reports, including the testing date, **whether controls were run**, and the test results (positive/negative). Any deviations from weekly testing should be accompanied by explanations.

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<sup>549</sup> Email received from the Chief of Oral Health programs on December 6, 2023.

5. **Continuous Quality Improvement (CQI):** Encourage facilities to incorporate spore testing and equipment monitoring into their CQI processes, ensuring that these essential aspects of infection control and equipment functionality are regularly reviewed and improved.
6. **Reporting Mechanism:** Develop a standardized systemwide monitoring and reporting mechanism for spore testing and dental equipment assessments. This should include regular reporting intervals and mandatory reporting of testing and assessment results.
7. **Standardized Dental Space Survey Implementation:** Establish a protocol for conducting standardized, annual dental space and equipment surveys in all DOC facilities. Ensure that these surveys become a routine practice to monitor the status and functionality of dental programs.
8. **Conversion of Digital X-rays:** Ensure a standardized and comprehensive approach to digitalizing X-rays across all facilities, the dental Monitor recommends that the Illinois Department of Corrections (IDOC) establish a clear timeline and strategy for extending the digitalization capability to facilities beyond Logan, Decatur, and Dixon.

## Dental Access

*Addresses items II.B.6.h; III.K.2*

**II.B.6. h.** IDOC agrees to implement changes in the following areas: Dental care access and preventative dental care;

**III.K.2.** Each facility's orientation manual shall include instructions regarding how prisoners can access dental care at that facility

**OVERALL COMPLIANCE RATING:** Noncompliance

## FINDINGS:

**Implementation Plan item 87:** *Review and revise orientation manual for individuals in custody on access to dental care. The orientation manual should include information on the dental services provided in the IDOC, directions on how to submit requests for routine and urgent dental care, including dental cleanings, education on dental hygiene and dental self-care. Proposed End Date: November 2023*

Dentist vacancies, along with some dental hygienist vacancies, are currently the primary contributing factor to decreased access to dental services in the IDOC. Dentist and hygienist vacancies will be addressed in the dental staffing section of this report. Access to dental hygiene services will be addressed in the dental hygiene section.

In order to review access to care the Monitor reviewed waiting list and backlog data. The dental services sections of the 2nd quarter 2023 CQI Minutes were examined to ascertain access and backlogs of care. There is an absence of standardization in reporting dental statistics throughout the organization. Some facilities report the number of inmates on the waiting list and the backlog,<sup>550</sup> while others document wait times in months.<sup>551</sup> However, it is essential to highlight that significant delays in routine care were reported at several facilities, indicating extended wait times.

Additionally, some facilities did not provide information about backlogs or waiting lists. It remains unclear whether these omissions were intentional or if these facilities simply did not have waiting lists or backlogs. To effectively evaluate and manage a program, it is essential to collect data consistently. The Chief of Oral Health

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<sup>550</sup> Southwestern, Sheridan, Hill and Vandalia (as examples)

<sup>551</sup> Centralia and Graham



Services should establish a standardized format for reporting statistics in CQI minutes. This standard format will ensure that data is collected and presented consistently, making assessing and managing the program's performance easier.

Five orientation manuals were submitted for review in this report.<sup>552</sup> Each manual underwent a review to assess whether it contained explicit instructions on accessing dental services for routine care and provided guidance for patients seeking dental care in emergencies, such as dental abscesses, acute pain, or oral-facial trauma.

Out of the five manuals, the Monitor determined that only two provided instructions to patients on accessing dental care. The Murphysboro manual indicated inmates could sign up and report to dental services for scheduled dental appointments. In contrast, the Kewanee manual instructed patients to submit a written request using Form DOC 286.

The Joliet Inpatient manual mentioned medical staff being available to address urgent care needs, but it did not specifically mention dental emergencies or provide guidance on accessing routine dental care. It remains unclear whether the staff accepts dental concerns and refers patients accordingly. Further clarification is needed since this facility doesn't have a dental clinic.

The Jacksonville and Hill orientation manuals presented challenges due to the absence of a table of contents. Additionally, neither of these manuals addressed access to routine dental care or provided instructions on how to engage health services staff for urgent dental care needs. The Jackson orientation manual mentioned that patients could submit a slip for new dental concerns, but this wording suggests episodic rather than routine care. Conversely, the Hill orientation manual did not mention dental care in the Health Care Unit section, failing to meet the necessary criteria of the Decree.

Of the reviewed manuals, only the Kewanee orientation manual addressed how patients could access emergency care. Kewanee patients can sign up for dental sick call for toothaches and active infections. Although it is recognized that IDOC faces challenges in maintaining adequate dental staffing, it is crucial to have contingency plans in place to address emergent dental needs.

In situations where a dentist is not available, patients should be promptly directed to a physician who can offer antibiotics and palliative medications to manage their condition until they can receive treatment from a dentist. This approach ensures patients receive appropriate care, even without immediate dental resources.

In light of Implementation Plan Item 87, which instructs IDOC to incorporate information regarding dental services, directions for requesting routine and urgent dental care, dental cleanings, and education on dental hygiene and self-care, it is evident that the current orientation manuals do not fully align with the Decree's requirements. Each of the submitted orientation manuals must undergo expansion to include a section that addresses the elements outlined in Implementation Plan item 87. This expansion is necessary to ensure compliance with the Decree and to provide inmates with the required information and access to dental services and care. More importantly, **all facilities** are required to have orientation manuals that advise patients about oral health care access and services.

The last Monitor's report stated that the instruction concerning repairing or replacing broken prostheses (dentures, bridges) is a barrier to needed dental care and may jeopardize the health of the involved patients. The Monitor recommended that IDOC re-evaluate this policy. When the Monitor inquired about an update regarding the policy, the Special Litigation Counsel provided a revision which stated "Individuals in custody shall not be required to pay to repair or replace dental prosthetics unless restitution is recommended by the Adjustment

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<sup>552</sup> Murphysboro, Kewanee, Joliet, Jacksonville, and Hill

Committee pursuant to Departmental Rule 504.140. In no circumstances will dental prosthetics be denied due to monies owed as restitution or otherwise."<sup>553</sup> This recommendation is now remedied through a statewide request of variance; the Monitor will continue to examine for compliance.

The dental needs of incarcerated populations are extensive, and, at this time, primarily due to dentist vacancies, these needs are not consistently met in all correctional centers in the IDOC.

IDOC must expeditiously recruit and hire dentists to address the lengthy waiting times and hefty backlogs and provide reasonable access to the full range of dental services in the Illinois prison system. Given the high dentist vacancy rates and lengthy waits for dental services in the IDOC, an overall compliance rating for dental care access has been assessed to be non-compliant.

#### **RECOMMENDATIONS:**

1. **Prioritization of Care:** Initiate planning on prioritizing and addressing the dental care backlog during current staff shortages.
2. **Standardize Reporting Format:** Standardize the data on the waiting times and backlogs for dental services and report this data in the CQI meeting minutes at all IDOC facilities with dental suites.
3. **Orientation Manuals:** Revise the submitted manuals and prepare orientation manuals that encompass instructions on accessing dental care at all IDOC facilities.
4. **Expand Current Orientation Manuals:** Standardize and enhance orientation manuals across all facilities to provide clear and comprehensive instructions for patients accessing dental services for routine and emergency care while ensuring alignment with Decree criteria for consistent and effective communication.

**Document and Monitor Disruptions to Care:** Monitor and report data on cancellations, restrictions, and rescheduling of offsite and on-campus health care services due to lockdowns and shortage of correctional staff.

#### **Dental Intake**

##### ***Addresses items III.K.3***

**III.K.3.** *IDOC shall implement screening dental examinations at the reception centers, which shall include and document an intra- and extra-oral soft tissue examination.*

**III.K.11.** *Each prisoner shall have a documented dental history section in their dental record.*

**OVERALL COMPLIANCE RATING:** Partial Compliance

#### **FINDINGS:**

**Implementation Plan item 88:** *Develop a standardized protocol for patient treatment at the reception center to ensure:*

1. *Panorex X-rays will be performed on all new admissions to the IDOC.*
2. *Intake screening dental examinations at the reception centers shall include intra- and extra-oral tissue examination.*
3. *Chronic and acute illnesses and dental conditions are listed on a problem list.*
4. *Problem lists are completed by providers.*
5. *Medical and dental history and physical exams are completed.*
6. *Patients receive initial medical and dental treatment plans and timely referrals for evaluation and*

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<sup>553</sup> Illinois Department Of Corrections Statewide Request For Variance 5/23/23

*development of comprehensive medical and dental treatment plans based on acuity.*

**Proposed End Date: November 2023**

**Implementation Plan item 54: *This process improvement for chronic care should address:***

*9. That a therapeutic dental plan is made at the conclusion of the intake dental examination*

**Proposed End Date: March 2024**

For this review, the Monitor referred to Implementation Plan item 88, which requires IDOC to develop a "protocol" for patient treatment at reception centers. Subsumed in this section are the basic requirements of a "screening examination." They include but are not limited to intra and extra-oral tissue exams, panoramic X-rays, medical and dental health history, and a requirement to establish treatment plans. The Monitor also used conditions from IDOC's Administrative Directive 04.03.102 to determine compliance with their policy.<sup>554</sup>

In this review, 20 patient records of inmates were examined. Three inmates were released from IDOC custody, and it was not possible to obtain their admission dates from the IDOC Internet site.

The following criteria were assessed by the Monitor:

1. Was a panoramic X-ray taken?
2. Were preliminary treatment plans established?
3. Were medical and dental health histories recorded?
4. Was an APHA classification (prioritization) assigned?
5. Was a hard tissue examination documented?
6. Was a soft tissue examination documented?
7. Was an extra oral examination documented?
8. Were oral hygiene instructions provided?
9. Were the dental examinations conducted within ten days of admission<sup>555</sup>?
10. Are comprehensive dental treatment plans established?

With respect to treatment plans, Implementation Plan item 88 specifies that a treatment plan is to be created during the initial dental encounter and then expanded upon based on the severity (acuity) of the case. This process entails an initial examination that should result in a preliminary treatment plan.<sup>556</sup> Subsequently, a more comprehensive treatment plan should be developed. What is most confounding, regarding IDOC's intake dental examination, is that a periodontal screening is not performed. This is a community standard and a correctional dental standard as well.<sup>557</sup>

Another confusing matter is IDOC's use of the words "complete dental examination" in Administrative Directive 04.03.102.<sup>558</sup> If the word complete is synonymous with comprehensive then there is a problem. The current practice among IDOC dentists does not align with the American Dental Association's definition of a

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<sup>554</sup> Initial examination within ten working days after admission to a reception and classification center or to a facility designated by the Director . . . , each offender shall receive a complete dental examination by a dentist. Charting of the oral cavity and categorization of status or treatment needs in accordance with the American Public Health Association's priorities.

<sup>555</sup> 17 records were used for this part of the review (3 inmates were released from custody)

<sup>556</sup> This preliminary treatment plan is referred to as a "therapeutic plan" by the Chief of Oral Health Services. E-mail exchange December 5, 2023.

<sup>557</sup> Adult Correctional Institutions Fifth Edition (American Correctional Association) 5-ACI-6A-19 page 178.

<sup>558</sup> Administrative Directive 04.03.102 referencing Initial Examinations page 2

comprehensive dental examination. The American Dental Association's definition requires that a comprehensive dental examination necessitates additional data collection and assessments, including periodontal probing, intra-oral radiographs (bite-wing and periapical films), evaluation of existing prosthetics, and an assessment of occlusal relationships.<sup>559</sup>

The Monitor acknowledges the efforts of the Chief of Oral Health Services to address Comprehensive Dental Treatment Planning (CDTP). The Monitor has reviewed the initial draft proposal for CDTP, but it's essential to emphasize that, for this review, IDOC dentists are not currently establishing a "comprehensive" dental treatment plan at the Reception Centers. At best, IDOC dentists are developing a partial treatment plan based on the limited data collected during the initial examination. The absence of a periodontal screening renders even the preliminary (therapeutic) plan insufficient. Since the dentists at reception centers are tasked with formulating comprehensive medical and dental treatment plans based on acuity, it is evident that IDOC dentists are not meeting compliance standards in creating satisfactory preliminary or comprehensive treatment plans.

The cumulative data from these chart reviews are presented in the table below.

<b>Dental Screening at Reception Centers: Review of 20* Records</b>		
<b>Screening Activity</b>	<b>Number</b>	<b>Percent</b>
Panoramic X-ray Taken	14	70%
Initial Examination within 10 Days	15**	88%
Health History Complete	19	95%
Soft Tissue Examination Recorded	2	13%
Hard Tissue Examination Recorded	18	90%
*2 records from Logan; 7 from NRC; 6 from Graham; and 5 from Menard.		
** 15 out of 17 were compliant.		

Fifteen records revealed that inmates received an initial examination within 15 days of admission for 88% compliance.<sup>560</sup> Seven records indicated patients received their examinations on the same day as admission.<sup>561</sup> Two records were not compliant, with dental examinations occurring 11 and 12 days after admission to the Reception Centers.

Patient records documented 70% compliance among the dental teams in making a panoramic X-ray at the initial dental examination. For patient records from Menard, they simply use a stamp that says "RC Exam." If the record does not indicate that a panoramic film was made, the Monitor cannot provide credit for this aspect of care. It is not clear if a panoramic X-ray was made and simply not recorded. It is important to note that Implementation Plan item 88 requires that the panoramic film be made at the Reception Centers and not at the patient's final designation as indicated in the Administrative Directive. Future site visits will involve the Monitor's review of panoramic X-rays to determine if the images are of diagnostic quality.

<sup>559</sup> CDT 2022 Current Dental Terminology, American Dental Association page 4

<sup>560</sup> Note the dates of Admission were obtained for 17 records. 15 records were in compliance.

<sup>561</sup> For this review patients from NRC received their examinations the same day as their admission.

Nineteen out of twenty records, accompanied by the DOC 0422 form, indicated that a health history was obtained at the intake screening. One record had a partially completed health history. The Monitor found the dental and medical history documented on the DOC 0422 form was inadequate.

The documentation of medical and dental histories on DOC 0422 is insufficient<sup>562</sup>. It does not provide the dentist with the necessary information about the patient's oral and overall health, potentially leading to a lack of context when making treatment decisions. Inadequate documentation of a patient's medical history can have legal and ethical implications, particularly if complications arise during treatment due to a lack of information. Various standardized templates are utilized within the profession, such as those in private offices, dental schools, the Department of Defense, the Veterans Administration, and the Federal Bureau of Prisons.

Of the 20 dental records reviewed, 18 revealed that a hard tissue examination was performed (90% compliance rate). However, only two records<sup>563</sup> (10%) reviewed documented a soft tissue examination or an oral cancer screening (10% compliance). No records showed that an extra-oral examination (0%) had been performed.

These deficiencies of poor health histories and no documentation of extra-oral and intra-oral examinations were previously noted in expert reports in 2014 and 2018.<sup>564,565</sup> A quote from the 2014 report stated: "Rather egregious deficiencies were observed at the NRC during the screening exam. The exam was extremely cursory and did not include an adequate head and neck and soft tissue examination. The health history was sketchy and poorly documented."

It is unclear to the Monitor why an oral cancer screening examination and a periodontal assessment were not included in the screening. Oral cancer screenings should be a high priority given that inmates often have health histories of substance abuse (alcohol and tobacco), which places these patients at a higher risk for developing oral cancer.<sup>566</sup> For this reason, the first oral cancer screening should happen at intake and not at the biennial examination.

One of the most concerning issues is the lack of periodontal assessment for inmates. Without a periodontal assessment, conducting a meaningful oral health evaluation during screening or creating effective treatment plans is impossible. Assessments need not be time-consuming and can involve the measurement of periodontal probing depths of index teeth. The Community Periodontal Index (CPI)<sup>567</sup> is utilized by the Federal Bureau of Prisons and the Indian Health Service as a standard periodontal assessment tool for evaluating an individual's gum health. It is a quick and straightforward method for dental professionals to assess a patient's gum health and identify potential signs of periodontal diseases, such as gingivitis or periodontitis. An alternative screening assessment is the Periodontal Screening and Recording (PSR), which the American Dental Association and the

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<sup>562</sup> The Monitor concurs with IDOC in their policy draft (**G.19.01**) . . . "A thorough health history shall be compiled for all patients, including inquiry into latex sensitivity and other allergies is mandatory before initiating any dental examination or treatment procedure."

<sup>563</sup> These records were from Logan

<sup>564</sup> Final Report of the Court Appointed Expert (December of 2014) page 38

<sup>565</sup> Statewide Summary Report Including Review of Statewide Leadership and Overview of Major Services Report of the 2nd Court Appointed Expert Lippert v. Godinez (October 2018) page 108

<sup>566</sup> <https://www.mayoclinic.org/diseases-conditions/mouth-cancer/symptoms-causes/syc-20350997>

<sup>567</sup> [https://www.ihs.gov/doh/documents/periodo/Protocol%20-](https://www.ihs.gov/doh/documents/periodo/Protocol%20-%20IHS%20Community%20Periodontal%20Index%20(CPI)%20Guide.pdf)

[%20IHS%20Community%20Periodontal%20Index%20\(CPI\)%20Guide.pdf](https://www.ihs.gov/doh/documents/periodo/Protocol%20-%20IHS%20Community%20Periodontal%20Index%20(CPI)%20Guide.pdf)

Academy of Periodontology for general dentists introduced. Like the CPI, it is easy to perform and takes only a few minutes. In this screening assessment, the provider probes each tooth and assigns a numerical value (0-4) for each sextant.<sup>568</sup> The PSR system is designed to be an efficient and effective way for general dentists to screen for periodontal disease and determine whether a patient requires more in-depth periodontal assessment and treatment. It helps streamline the evaluation process and is particularly useful for busy dental practices where time is limited.

Upon collecting all dental documentation and charting, the status and treatment needs should be classified using the American Public Health Association (APHA) prioritization of dental patients.<sup>569</sup> Thirteen out of the 20 records reviewed were assigned an APHA prioritization. However, the Monitor observed that most dentists didn't complete the APHA section on form DOC 0422. It should be noted that chronic periodontitis is often categorized in class II of the APHA categorization system.

However, due to the absence of periodontal assessments, all APHA prioritizations and treatment plans generated during intake screenings or for routine care are considered inadequate. Conducting a periodontal assessment is the standard of care in both private practice and institutional dentistry.

#### **RECOMMENDATIONS:**

1. **Monitoring and CQI:** Monitor, report, and document key elements of the dental intake screening processes in the facilities' monthly CQI meeting
2. **Panoramic X-rays:** Ensure that panoramic X-rays are consistently taken during the initial dental examination for all inmates at Reception Centers, as required by Implementation Plan item 88. The DOC should establish protocols and processes to ensure the consistent recording and maintenance of these X-rays.
3. **Periodontal Assessment:** Implement a standardized periodontal assessment protocol, such as the Community Periodontal Index (CPI), for all inmates during dental screenings. This will allow for the comprehensive evaluation of gum health, early detection of periodontal diseases, and the development of effective treatment plans aligning with best practices in oral healthcare.
4. **Intraoral and Extraoral Tissue Examination:** Ensure that all dental professionals conduct a thorough soft tissue examination and an oral cancer screening during the initial examination. Oral cancer screenings should be a priority, particularly for inmates with a history of substance abuse. Expand the IDOC dental form (DOC 0422) to include an area to document soft tissue examination.
5. **Comprehensive Dental Examination:** These examinations must align with the American Dental Association's definition of a comprehensive dental examination. This should involve additional data collection, such as periodontal probing, intraoral radiographs, evaluation of existing prosthetics, and an assessment of occlusal relationships. IDOC should provide clear guidance to dentists on what is expected in a comprehensive examination.
6. **APHA Prioritization:** Ensure that all dental professionals complete the APHA section on form DOC 0422 and assign APHA prioritization for patients.

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<sup>568</sup> Stefanac, S. J., & Nesbit, S. P. (2007). *Treatment Planning in Dentistry* (2nd ed.), Page 14. Publisher Mosby

<sup>569</sup> APHA dental patient categorizations: I. Emergency Treatment. II.-IV decreasing levels of dental urgency, V. Radiological absence of caries and lack of clinically visible gingival lesions, VI. No symptoms of apparent need for dental treatment.

## Dental Hygiene

*Addresses III.K.7; III.K.8;*

**III.K.7.** *Dental hygiene care and oral health instructions shall be provided as part of the treatment process.*

**III.K.8.** *Routine and regular dental cleanings shall be provided to all prisoners at every IDOC facility. Cleanings shall take place at least once every two years, or as otherwise medically indicated.*

### **OVERALL COMPLIANCE RATING:** Partial Compliance

#### **FINDINGS:**

To review this section, dental hygiene vacancy data, and SIU continuous quality improvement findings were utilized. Additionally, the records of inmates receiving comprehensive dental care, partial dentures, and initial examinations were used.

During the Graham site visit conducted by the Monitor in July 2023, the dental hygienist reported a reduction in her daily schedule from six appointments to five. This reduction resulted from a dentist's unavailability to provide approval or referral for cleanings. The vacancies in dentist positions at Graham CC and other correctional centers directly impact dental hygiene productivity, as they limit the pool of patients available for dental hygienists.

Dental cleaning logs or daily log reports were not provided; therefore, it is impossible to determine how many patients were rescheduled, refused care, were no-shows, and had no escorts. In lieu of log reports, the Monitor used 2<sup>nd</sup> Quarter 2023 CQI minutes and CQI presentations to obtain dental hygiene (cleaning) statistics.

Dental treatment planning is a multi-phase process, as described by Stefanic and Nesbit.<sup>570</sup> These phases are broken out into the Systemic, Acute, Disease Control, Definitive Treatment, and Maintenance phases. Before proceeding to the Definitive Treatment phase, which involves restorations and prosthetics, it is essential to evaluate patients' periodontal health. The oral tissues must be healthy before initiating a removable prosthodontic restoration. Therefore, dental hygiene appointments should occur before fabricating a prosthetic and performing general restorative procedures.

For this review, we examined the records of 17 patients receiving restorative care (fillings) or partial dentures. The objective was to determine whether the dental team had assessed the periodontal status, provided oral hygiene or periodontal therapy, and given oral hygiene instructions before fabricating a removable prosthetic or restorative care.

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<sup>570</sup> Stefanac, S. J., & Nesbit, S. P. (2007). *Treatment Planning in Dentistry* (2nd ed.), Page 59. Publisher Mosby

<b>Provision of Periodontal Status, Oral Hygiene or Periodontal Therapy and Oral Hygiene Instruction (OHI) Prior to Fabrication of Removable Prosthetic or Restorative Care in Record Reviews of 17 Patients</b>					
<b>Facility</b>	<b>Periodontal Assessment</b>	<b>Hygiene Appointment Done Before Dental Procedure*</b>	<b>Hygiene Appointment Done Before, During or After Dental Procedure</b>	<b>OHI</b>	<b>Notes</b>
Taylorville	No	No	Yes	No	Oral hygiene is provided after or during the
Stateville	No	Yes	Yes	Yes	Lower Removable Partial Denture
Stateville	No	No	No	No	Upper and Lower Removable Partial Denture
Stateville	No	No	Yes	No	Oral hygiene provided after or during the
PNKCC	No	No	No	No	Lower Removable Partial Denture
PNKCC	No	No	No	No	Upper Removable Partial Denture
Stateville	No	No	No	No	Restorative Care
Stateville	No	No	No	No	Restorative Care and Removable Partial Denture
Stateville	No	No	No	No	Extractions
Stateville	Attempt Made	N/A	NA	NA	Refusal of care x 2
Stateville	No	Yes	Yes	Yes	Restorative Care
Pontiac	No	Yes	Yes	Yes	Restorative Care
Pontiac	Yes	Yes	Yes	Yes	Restorative Care
Pontiac	No	Yes	Yes	Yes	Restorative Care
Pontiac	No	No	No	No	Treatment plan to extract a tooth and then deliver a removable partial denture on same
Pontiac	No	Yes	Yes	Yes	Restorative Care
Taylorville	No	No	Yes	No	Oral hygiene provided after or during the prosthetic appointments
*Standard of Care is for dental hygiene to be performed prior to a dental procedure not during or after the procedure					

Out of the 17 dental records, one record revealed that the facility had extended two separate offers for an oral hygiene appointment to the inmate, both of which were declined by the patient. In the remaining 16 patient records, there was one documented assessment of the periodontal condition through probing. Only one dentist conducted probing, prompted by concerns regarding tooth mobility.

Furthermore, a subset of six records, constituting 37.5% of the total, indicated that oral hygiene appointments (dental cleaning) were provided before initiating prosthetic and restorative therapy. Three patients received oral



hygiene appointments either during or after receiving restorative or prosthetic care.<sup>571</sup> Seven patients were not provided a dental cleaning before restorative or prosthetic services.<sup>572</sup>

When patients received dental cleanings, they were all provided oral health instructions (OHI). OHI was provided during initial intake examinations, with a 100% compliance rate. Evidence also suggests that some dentists offered follow-up OHI after procedures.

One significant challenge faced by the Monitor in this evaluation is the lack of uniformity in data collection and reporting practices. The Clinical Quality Improvement (CQI) meeting minutes on dental hygiene exhibit a broad spectrum, ranging from no data being reported to highly detailed reports. For effective program management, it is essential to consistently measure production statistics and report them in CQI minutes, adhering to monthly or quarterly schedules for communication with the Chief of Oral Health Services.

In the Monitor's sixth report, a key recommendation was proposed, emphasizing the prioritization of promoting the submission of statistical data from facilities through the utilization of the "Daily Dental Report."<sup>573</sup> This recommendation merits attention from the service vendor (Wexford) and the Chief of Oral Health Services, underlining the importance of standardizing data collection and reporting protocols. It is essential to recognize that effective program management relies on measuring and analyzing data accurately. Without proper measurement, appropriate management becomes a challenge.

The Monitor received SIU performance and outcome measures for three quarters (1<sup>st</sup>, 2<sup>nd</sup>, and 4<sup>th</sup>) for 2023<sup>574</sup>, which assess the percentages of patients who have had a dental visit, including examinations and cleanings, within the last two years. The target compliance goal is set at 90%. The table below give SIU audit results for the two year dental visit.

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<sup>571</sup> Patients #1- #3

<sup>572</sup> Patients #4- #10

<sup>573</sup> Page 184. "The Daily Dental Report is very comprehensive and should be used at all IDOC centers with dental services."

<sup>574</sup> The Monitor does not have the 3<sup>rd</sup> quarter data.

<b>SIU Performance and Outcome Data on Dental Visits Every Two Years<sup>1</sup></b>			
	<b>1st Quarter 2023</b>	<b>2nd Quarter 2023</b>	<b>4th Quarter 2023</b>
Number of Facilities with 0% Score	3 <sup>2</sup>	3 <sup>3</sup>	0
Number of Facilities with 90% Score and at Goal	2 <sup>4</sup>	1 <sup>5</sup>	1 <sup>6</sup>
Number of Facilities with 100% Score <sup>7</sup>	3 <sup>8</sup>	0	0
Statewide Average Score	46%	40%	41%
<sup>1</sup> This is presumed to be the dental hygiene visit.			
<sup>2</sup> Dixon, Jacksonville, and Vienna			
<sup>3</sup> Decatur, Murphysboro, and Western			
<sup>4</sup> Lawrence, Southwestern CC			
<sup>5</sup> Sheridan			
<sup>6</sup> Vandalia			
<sup>7</sup> None of the three facilities scoring 100% in the 1st quarter scored greater than 41% in the 2nd and 4th quarters.			
<sup>8</sup> Joliet Treatment Center, Lincoln, and Robinson			

SIU's metric has set a threshold for facilities to attain 90% compliance, meaning that 90% of the inmate population at each facility should have a dental hygiene appointment (teeth cleaning) every two years. However, SIU reports that the overall compliance with this goal across all facilities averages only 42%<sup>575</sup>. In simpler terms, this indicates that just 42% of the inmate population statewide is receiving dental cleanings once every two years. As previously indicated, only one facility has met this requirement.

The Monitor is uncertain about the frequency of dental cleanings, specifically whether they occur every two years. The Monitor contends that this figure (40%) is overestimated. The existing metric includes any dental visit, not just examinations and cleanings. In its current form, if a patient visits the dental clinic for reasons other than a cleaning or examination, that visit contributes to the goal.

To align with the Court's requirements and ensure compliance with the decree, the goal should be rephrased to reflect the stipulated criteria accurately as was originally agreed upon and by approved by IDOC Office of Health Services, System Leadership Council June 9, 2022 (see below).

<sup>575</sup> The average of statewide percentages of completion of a dental appointment every two years for quarters 1, 2, and 4 of SIU clinical performance reviews.

Domain	Effectiveness of Care – Prevention & Screening	
Measure	Dental Cleaning	
Definition	Percentage of patients who had a dental cleaning within the last 2 years.	
Denominator	The number of patients in custody who are eligible for dental cleaning.	
Numerator	The number of patients from the denominator who received at least one dental cleaning in the last 2 years.	
Rate Calculation	Statewide: Percentage is the sum of the numerators divided by the sum of the denominators multiplied by 100.  Institution: Percentage is the numerator divided by the denominator multiplied by 100.	
Data Source(s)	Electronic Health Records Paper health records Institution list of all individuals in custody for more than 24 months.	
Reporting Frequency	Quarterly	
Background	Healthcare services clinical quality measure improvement objective: By June 30, 2023, 90% (HEDIS Medicaid = 42.8) or more of all eligible patients will receive a dental cleaning every two years.	
Goal/Ranking	High $\geq$ 90%	
	Moderate 75% - 89%	
	Low $\leq$ 74%	
Comments	IDOC AD 04.03.102 = dental cleaning every two years	

The process of collecting this metric needs clarification for the Monitor. Additionally, it's important to note that any assertion linking or comparing this metric to a HEDIS measure is inaccurate. According to The National Committee for Quality Assurance, "At this time, there are no HEDIS measures specific to oral health in members 21 years of age and older."<sup>576</sup> The current HEDIS metric only measures **Annual Dental Visits (ADV)**<sup>577</sup> for pediatric populations. Moreover, it doesn't measure hygiene appointments.

#### RECOMMENDATIONS:

1. **Ensure Adequate Dental Hygienist Staffing:** Address the shortage of dental hygienists by filling the vacancies at facilities lacking hygienists. All DOC facilities with dental suites should have a dental hygienist on the dental team to enhance patient care.
2. **Optimize Dental Appointment Scheduling:** Coordinate schedules between dental hygienists and dentists to ensure patients receive the appropriate dental cleanings and preventive care. Efforts should be made to minimize delays in dental cleaning appointments.
3. **Explore Dental Board Waiver:** The Chief of Oral Health Services should inquire with the State Dental Board about obtaining a waiver allowing dental hygienists to perform specific procedures without direct supervision or collaboration with a dentist. This could help enhance efficiency in dental care delivery.
4. **Follow Comprehensive Treatment Planning:** Implement a comprehensive treatment planning process that follows the phases of dental care, including Systemic, Acute, Disease Control, Definitive Treatment, and Maintenance. This approach ensures that periodontal health is assessed before initiating restorative and prosthetic treatments.

<sup>576</sup> Email correspondence on September 20, 2023 between the dental Monitor and NCQA

<sup>577</sup> Bolded for emphasis

5. **Standardize Periodontal Assessment:** Ensure that the periodontal condition of patients is consistently assessed through probing before proceeding with prosthetic or restorative care. Periodontal health is a critical factor in the success of these treatments.
6. **Revise SIU Compliance Goals:** Reevaluate the compliance goals for dental cleanings to align with the stipulated criteria in the Court's requirements. The current metric, which includes any dental visit, should be revised to reflect compliance regarding biennial examinations and cleanings.
7. **Standardize Data Collection and Reporting:** Implement consistent data collection and reporting standards across all facilities. Encourage facilities to submit production statistics using the "Daily Dental Report" to ensure that program management is based on reliable data. Monthly reports should be generated, collated quarterly, provided at CQI meetings, and reported to the Chief of Oral Health Services.
8. **Reporting Data for CQI Minutes:** Monitor and report data from the facility CQI committee meetings on cancellations, restrictions, and rescheduling of dentist and dental hygienist appointments due to lockdowns and lack of escorts caused by a shortage of correctional officers.

## Comprehensive Dental Care

### *Addresses item III.K.6; III.K.10.a-b; III.K.12*

**III.K.6.** *Routine comprehensive dental care shall be provided through comprehensive examinations and treatment plans and will be documented in the prisoners' dental charts.*

**III.K.10.a.** *Diagnostic radiographs shall be taken before every extraction.*

**III.K.10.b.** *The diagnosis and reason for extraction shall be fully documented prior to the extraction.*

**OVERALL COMPLIANCE RATING:** Partial compliance

## FINDINGS:

In this section, the Monitor conducted a review of patient records for inmates who were undergoing comprehensive dental care (including patients receiving prosthetic care). The Monitor specifically looked into whether comprehensive dental examinations, including radiographs, were conducted as part of creating a treatment plan for routine dental care, including prosthetic procedures. Additionally, the Monitor evaluated whether dentists had documented the review or creation of an X-ray before the extraction of teeth.<sup>578,579</sup>

Due to the inconsistent methods of documenting treatment plans by dentists, some using APHA format, others utilizing graphic images, and still others writing their treatment plans within progress notes, the Monitor conducted a comprehensive search of all sections within the dental records for this specific documentation. The primary focus of this search was to ascertain whether any type of examination had been conducted before formulating a treatment plan.

A total of twenty-three dental records underwent review. Twelve records (52%) indicated that treatment plans had been established. Eight of the 23 records (35%) showed updated health histories. Seven records (30.4%) indicated an examination occurred before formulating a treatment plan; six provided evidence of X-rays being conducted in conjunction with the examination.

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<sup>578</sup> Lippert file 108 Dental Records routine care, filings, root canals, partials provided by IDOC

<sup>579</sup> Lippert file 106 Dental Charts – prostheses provided by IDOC

Due to the prevalence of extractions in routine records, the Monitor sought to determine if preoperative radiographs were taken before these extractions. Among the nine patient records that detailed extraction procedures, three documented preoperative radiographs prior to the extractions for 30% compliance.<sup>580</sup>

The Monitor is aware that the Chief of Oral Health Services has initiated the process of addressing Comprehensive Dental Treatment Planning (CDTP) through a draft policy document. During the Monitor's review of patient care records, it became evident that only partial examinations were being conducted. Out of twenty-two patient encounters, none included a periodontal assessment. The only instance where a dentist conducted a meaningful periodontal examination was when a patient had tooth mobility.

While the Monitor gave credit for treatment plans coinciding with or occurring near the biennial exam, many of these examinations were cursory. A comprehensive examination should involve a thorough review of health histories, taking radiographs, oral cancer/soft tissue examination, and evaluating the patient's periodontal status.

As mentioned earlier, the Monitor faced difficulties locating established treatment plans within the dental records, as treatment plans were spread across various sections. To simplify the process, the Monitor recommends that IDOC dentists either introduce a new DOC 0422 form or create a new comprehensive treatment plan form that includes sections for soft tissue examinations and periodontal status assessments. This form should explicitly state that it is to be filled out in conjunction with a comprehensive dental examination.

The Monitor also observed that routine care patient records from Pontiac were accompanied by forms that included a section for juveniles, which differed from the DOC 0422. Interestingly, these forms were left blank, with no health histories, hard tissue findings, or treatment plans recorded. It remains uncertain whether the facility forwarded outdated records or if Pontiac detains juvenile offenders. Nonetheless, it is important for all prisons that rely on written records use the same form to ensure consistency.

Additionally, the Monitor identified a problem where some providers used the SOAP format for all routine care entries. The SOAP format is typically utilized in medicine and dentistry for acute care.<sup>581</sup> It is unclear why a dental hygienist would use the SOAP format to document a patient encounter.

Reviewing records was difficult, given the different style entries in the progress notes. In some cases, the records were simply illegible. Often, providers used differing abbreviations for clinical notation. The Monitor recommends that the Chief of Oral Health Services consider meeting with several dentists in the field to address a standard approved list of abbreviations used in IDOC facilities.

## **RECOMMENDATIONS:**

1. **Standardized Treatment Plan Documentation:** Establish a standardized format for treatment plan documentation within the dental records. Whether it's a new form like DOC 0422 or an enhanced comprehensive treatment plan form, ensure consistency across all facilities. This form should explicitly require a comprehensive dental examination before treatment planning.

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<sup>580</sup> Findings also discussed in the extractions section of this report

<sup>581</sup> Stefanac, S. J., & Nesbit, S. P. (2007). *Treatment Planning in Dentistry* (2nd ed.), Page 134. Publisher Mosby

2. **Comprehensive Examination:** Emphasize the importance of comprehensive dental examinations before formulating treatment plans. This examination should include health history reviews, radiographs, oral cancer/soft tissue assessments, and evaluation of periodontal status.
3. **Periodontal Assessment:** Ensure that all dental patient encounters include a periodontal assessment. This assessment is critical for patient care and should be integrated into routine dental examinations.
4. **Preoperative Radiographs:** Encourage the use of preoperative radiographs before tooth extractions. Monitor compliance with this practice and provide training and resources to improve adherence.
5. **Consistency in Forms:** Ensure that all facilities, including Pontiac, use uniform forms for documenting patient records, with a focus on health histories, hard tissue findings, and treatment plans. This will enhance data consistency and record-keeping quality.
6. **Review the Use of SOAP Format:** Investigate and address the issue of some providers using the SOAP format for routine care entries. Ensure dental hygienists and other providers understand the appropriate documentation format for various patient encounters.

## Dental Training

**OVERALL COMPLIANCE RATING:** Partial Compliance

### FINDINGS:

**Implementation Plan task 92:** *Develop annual and new hire orientation training for dental staff. Training to include:*

1. *Dental records with comprehensive examinations, X Rays, and treatment plans.*
2. *Dental records with legible notation if EHR are not available. Notes should be standardized using an acceptable dental documentation format or template to include patient medical history and dental examination. (initial and updated).*
3. *Consent form for extractions (Current X-Ray taken prior to extraction must be present). Dental treatment remarks/complaint form.*
4. *Dental specialist referral form. Medical services request form. Dental laboratory form if necessary.*
5. *Patient education and oral hygiene completion form.*
6. *Dental Policies and Procedures.*
7. *Infection Control guidelines.*
8. *Identify who will provide the training and how the training will be done (in-person, zoom presentation, etc.), and where the documentation of training will be maintained.*
9. *An annual report covering training of dental staff will be provided to the IDOC Quality Council.*

This section will assess IDOCs progress on Implementation Plan task 92, which focuses on annual and new hire orientation training.

There is no evidence submitted indicating the existence of formal annual or new hire orientation training. Additionally, the Monitor did not review an annual report submitted to the DOC Quality Council (subsection #9). This does not necessarily mean that no mentoring occurs among dental staff; however, it is not a formalized process known to the Monitor.

The Chief of Oral Health Services is currently in the process of establishing Dental Policies and Procedures and Infection Control Guidelines. This suggests that Task 92 is evolving, and any changes will need to be addressed

on an annual basis. Therefore, the Monitor recommends that Dental Staff convene annually, either in person or online (e.g., Zoom).

The Monitor further recommends that the Chief of Oral Health Services establish a protocol for all new hires, including part-time employees. This protocol should outline expectations related to DOC policies and, more importantly, the stipulations outlined in the Decree and in the Implementation Plan task 92. It is recommended, that all orientation training must be documented and signed by both dental staff and the lead dentist providing the training.

#### **RECOMMENDATIONS:**

- 1. Formalize Annual and New Hire Orientation Training:** Develop and implement a formal annual and new hire orientation training program for dental staff within IDOC. Ensure that this program covers essential policies, procedures, and infection control guidelines.
- 2. Documentation and Reporting:** Establish a systematic method for documenting all aspects of the orientation training, including attendance, content covered, and signatures from both dental staff and the lead dentist providing the training.
- 3. Submission of Annual Report:** Institute an annual report on orientation training, which is submitted to the IDOC Quality Council (subsection #9).
- 4. Regular Convening of Dental Staff:** Encourage regular meetings of Dental Staff, either in person or through online platforms like Zoom, to discuss updates, changes, and any additional training needs. This will foster a collaborative and informed dental team.
- 5. Protocol for New Hires:** Develop and implement a comprehensive protocol for all new hires, including part-time employees, outlining expectations related to DOC policies. Emphasize the importance of compliance with the stipulations outlined in the Decree and the Implementation Plan for Task #92.
- 6. Training Oversight by Chief of Oral Health Services:** Task the Chief of Oral Health Services with the responsibility of overseeing the orientation training process. This includes ensuring that the established protocol is followed, and all training is in alignment with DOC policies and legal requirements.
- 7. Task 92 Compliance Monitoring:** Implement a system to monitor ongoing compliance with Task 92. Regularly assess the effectiveness of the orientation training program, making adjustments as necessary to address evolving needs and changes in dental policies.

## **Facility Internal Monitoring and Quality Improvement**

*Addresses item II.B.2; II.B.6.l; II.B.6.o; III.L.1.*

**II.B.2.** *IDOC shall require, inter alia, adequate qualified staff, adequate facilities, and the monitoring of health care by collecting and analyzing data to determine how well the system is providing care. This monitoring must include meaningful performance measurement, action plans, effective peer review, and as to any vendor, effective contractual oversight and contractual structures that incentivize providing adequate medical and dental care.*

**II.B.6.l.** *IDOC agrees to implement changes in the following areas: Effective quality assurance review;*

**II.B.6.o.** *IDOC agrees to implement changes in the following areas: Training on patient safety;*

**III.L.1.** *Pursuant to the existing contract between IDOC and the University of Illinois Chicago (UIC) College of Nursing, within fifteen (15) months of the Preliminary Approval Date [April 2020], UIC will advise IDOC on implementation of a comprehensive medical and dental Quality Improvement Program for all IDOC facilities, which program shall be implemented with input from the Monitor.*

**OVERALL COMPLIANCE RATING:** Noncompliance

**FINDINGS:**

Material requested by the Monitor to review facility quality improvement included:

- Quality Improvement meeting minutes for each facility for each month- as provided currently in IDOC quarterly submissions.<sup>582</sup>
- Any **facility** CQI or performance audits since 6<sup>th</sup> Court report with results of study, analysis, and corrective action.<sup>583</sup>
- Documentation of any facility-specific training since 6<sup>th</sup> Court report on CQI provided for each facility.<sup>584</sup>
- Any reports since 6<sup>th</sup> Court report of facility-specific analyses of process problems. If analysis was done but no report written, documentation of the analysis should be provided.<sup>585</sup>
- List and details of all identified deficiencies by facility and corrective actions directed by Systems Leadership Council to facilities for any reason.<sup>586</sup>
- Nursing personnel at each site assigned the duties of Quality Improvement listing their names, licensure (RN, LPN), percentage of time assigned to these duties.<sup>587</sup>

The Implementation Plan includes three items that are needed to achieve the changes expected by the Consent Decree. One of these is item 8: *Have **dedicated staff** for infection control nurse, chronic care nurse, and **quality improvement coordinators** at each facility. **Proposed End Date: January 2024.***

Currently no facility positions are dedicated to quality improvement. The Agency Medical Director has indicated that quality improvement is a responsibility of the HCUAs and that they are largely the ones doing this work now.<sup>588</sup> Only five facilities responded to the Monitor's request to identify who was responsible for quality improvement. At four of these facilities the HCUA or DON have this responsibility. The amount of time spent on quality improvement ranged from 10 to 75 percent.<sup>589</sup> The minutes of the June meeting of System Leadership Council document an intent to create these positions. The Implementation Plan has this identified for completion in January 2024.

The quality improvement coordinators need to be trained to carry out the QI plan and this is item 50 in the Implementation Plan: ***Train facility quality improvement coordinators.** A training procedure with training curriculum will be developed and implemented for QI coordinators and facility leadership. The initial focus of training will include initiating and implementing corrective actions based on deficiencies identified by the audit program. Later training features can include methodologies to identify and report process deficiencies. Other training can follow incrementally. See Task 44 item 3 above.*

*Training on patient safety will initially focus on how to report and remediate adverse events. Training will focus initially on falls, medication errors, polypharmacy, etc. The procedure and curriculum will be developed by*

<sup>582</sup> Monitor's documentation request dated 8/4/2023, item # 109. Eleven of 30 facilities did not provide QI meeting minutes for the period January through June 2023. Nine facilities provided no minutes for the entire 6 month period.

<sup>583</sup> Monitor's documentation request dated 8/4/2023, item # 110

<sup>584</sup> Monitor's documentation request dated 8/4/2023, item # 111

<sup>585</sup> Monitor's documentation request dated 8/4/2023, item # 112

<sup>586</sup> Monitor's documentation request dated 8/4/2023, item #22

<sup>587</sup> Monitor's documentation request dated 8/4/2023, item #44

<sup>588</sup> Interview 8/11/2023.

<sup>589</sup> Graham it is the HCUA (45%), Jacksonville it is the HCUA-acting (75%), JITC it is the HCUA (10%), and at Vienna it is the DON (10%).



*OHS/SIU using information from healthcare quality improvement entities, correctional health accreditation organizations, or academic centers. **Proposed End Date: December 2023***

The proposed completion date to have trained facility quality improvement coordinators precedes the establishment of these positions by one month. This is unfortunate and should be revised to reflect the availability of QI coordinators to more realistically complete training.

Training has been provided for OHS leadership and facility HCUs at the statewide quarterly Quality Improvement meetings. Since September 2023 training has included quality management generally, the OHS Quality Improvement Program, the performance measures selected for FY 2023, and three improvement initiatives.<sup>590</sup> The regional Health Services Coordinators received basic training in CQI and performance and outcome measures on May 31, 2023. Facilities were then invited to participate in Webex training on quality and attend a facilitated discussion about the performance and outcome measures for their facility during the month of June 2023. However, during the site visit to Graham in July 2023 the HCUA<sup>591</sup> did not mention training provided by OHS/SIU on quality and was uninformed about the results of performance and outcome audits.<sup>592</sup> No information has been provided about who attended or what was expected as a result of participation in this training provided by OHS/SIU.

IDOC has obtained access to 90 slots for training provided by the Institute for Healthcare Improvement (IHI). All of OHS, all HCUs and all Directors of Nursing are expected to complete this training. This training is intended as a baseline.<sup>593</sup> Topics concern both quality management and patient safety and include:

- Q101: Introduction to Health Care Improvement
- Q102: How to Improve with the Model for Improvement
- Q103: Testing and Measuring Changes with the PDSA Cycles
- Q104: Interpreting Data: Run Charts, Control Charts, and other Measurement Tools
- Q105: Leading Quality Improvement
- Q201: Planning for Spread: From Local Improvements to System-Wide Change
- Q202: Addressing Small Problems to Build Safer, more Reliable Systems

- PS101: Introduction to Patient Safety
- PS102: From Error to Harm
- PS103: Human Factors and Safety
- PS104: Teamwork and Communication
- PS105: Responding to Adverse Events
- PS201: Root Cause Analyses and Actions
- PS202: Achieving Tool Systems Safety
- PS203: Pursuing Professional Accountability and a Just Culture<sup>594</sup>

Except the Agency Medical Director and Deputies, no physician participation in the IHI training is expected, even though the draft QI plan lists the facility medical director as a member of the facility QI/QM committee. Physician

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<sup>590</sup> PowerPoint slides from the OHS quarterly quality improvement meetings dated December 13, 2022, March 2023, and June 2023. Minutes of the SLC dated 6/28/2023.

<sup>591</sup> The Regional Health Service Coordinator stated that this resulted from the HCUA being on sick leave during the period when training was provided.

<sup>592</sup> Notes from interview with HCUA at Graham Correctional Center 7/17/2023.

<sup>593</sup> Expected completion date was mid-September according to the Agency Medical Director. Notes from interview with the Agency Quality Improvement Coordinator on 8/11/2023.

<sup>594</sup> Email from IDOC Special Litigation Counsel dated 10/16/2023.

attendance at facility QI/QM meetings was reported at seven of 12 facilities who document attendance.<sup>595</sup> OHS should reconsider and make the IHI training available to facility medical directors who regularly attend facility QI/QM meetings. Alternatively, the vendor should enroll key personnel into this training.

In addition to the appointment of quality improvement coordinators at each facility and a plan to deliver training in quality and patient safety the Implementation Plan item 44 requires: ***IDOC will modify its CQI policy to change the current facility CQI programs to be more in line with Consent Decree requirements.***

1. *See Task 8 with respect to CQI coordinators.*
2. *Each facility CQI program will develop an annual CQI plan which is based on corrective actions related to its annual audit findings and findings on mortality reviews, summary adverse event reports, its summary of performance and outcome measures, and additional tasks deemed appropriate by the system leadership council. The annual plan will be approved by the Agency Medical Director and the System Leadership council.*
3. *Each facility CQI coordinator will have Institute for Healthcare Improvement (IHI) and/or six sigma training in addition to training provided by SIU.*
4. *The Quality Management Program will assign a statewide quality specialist to work with the facility CQI coordinator, HCUA, facility Medical Director and DON in implementing corrective actions in their annual plan and for mentoring on quality efforts in general.*
5. *IDOC will continue the practice of maintaining monthly CQI meeting minutes which will be assigned to the CQI coordinator and will be in a standardized format statewide.*

***Proposed End Date: September 2023***

Earlier paragraphs have discussed IDOC's obligation and progress with regard to the CQI coordinators and IHI training. The Agency Quality Improvement Coordinator and Agency Medical Director have said that facilities do not have CQI plans as of yet. The Implementation Plan states that these plans will be based upon "*corrective actions related to its annual audit findings and findings on mortality reviews, summary adverse event reports, its summary of performance and outcome measures...*". The Agency Medical Director has decided on corrective actions regarding vaccination, colorectal cancer screening, and sick call access based upon the results of performance and outcome measures.<sup>596</sup> However, review of the minutes of facility CQI meetings provide no evidence of the issuance of these corrective actions through June 2023. During the interview with the HCUA at Graham during the site visit in July 2023 she could only recall one direction for change received from OHS the past year and it did not concern the three issues the Agency Medical Director listed as corrective action. She did not recall receiving any direction for corrective action.<sup>597</sup>

SIU has created a position titled Quality Integrator which are part of the process revision team. Five of these positions have been established to consult with facilities. These positions could fulfill the functions described in subitem 4 to "*work with the facility in implementing corrective actions in their annual plan and for mentoring on quality efforts in general.*" However, at the time this section of the report was written only one of the five positions was filled.

Administrative Directive 04.03.125 Quality Improvement requires a monthly CQI meeting. The minutes of the June 2023 System Leadership Quality Council report revision of the AD and modification of the QI manual and plan. The Monitor was not provided the opportunity to review and comment on these revisions and had not received the revised documents at the time this section of the report was written.

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<sup>595</sup> Dixon, Jacksonville, NRC, Pontiac, Robinson, Shawnee, and Stateville.

<sup>596</sup> Notes from interview with the Agency Quality Improvement Coordinator on 8/11/2023.

<sup>597</sup> Notes from interview with HCUA at Graham CC on 7/17/2023. She recalled a directive concerning how grievances were to be categorized.

Actual practice is not in conformance with the Implementation Plan, item 44, subitem 5 “*maintaining monthly CQI meeting minutes which will be assigned to the CQI coordinator and will be in a standardized format statewide.*” Twelve of 30 facilities provided no QI minutes for the second quarter of 2023 (April through June 2023). Eighteen facilities provided minutes of quality meetings but only 10 facilities reported completion of a total of 23 quality improvement studies. The number of quality improvement studies completed is less than the number completed a year ago.<sup>598</sup> The minutes of the statewide Systems Leadership Council indicated that in March 2023 there was a moratorium on individual studies.<sup>599</sup> It is not clear what the expectations are for facility level quality improvement at this time.

The minutes of quality improvement meetings that took place at facilities from April through June 2023 were reviewed and the findings are no different from those described in the 6<sup>th</sup> report. To briefly summarize:

- results of quality improvement studies and performance audit are not reported, or findings discussed,
- when a problem was identified either no action was taken, or an ineffective action proposed (signing a memo),
- studies do not identify opportunities to improve the quality of patient care but focus solely on compliance with existing policy
- no standardization as to the topics addressed or the format for recording the review and discussion at CQI meetings.<sup>600</sup>

Of the three items in the Implementation Plan which address changes in facility quality improvement, no positions have been dedicated as quality improvement coordinators at the facilities and while some training has been initiated, it is taking place in the absence of quality improvement coordinators. Facilities have not been given the expectation to develop quality improvement plans and statewide specialists in quality improvement are not yet in place to assist facilities. Policy on quality improvement has not yet been finalized. Facility quality improvement meetings are not held consistently and the format varies widely.

## **RECOMMENDATIONS:**

1. Revise the proposed end dates in the Implementation Plan to reflect when the training of QI coordinators will be accomplished.
2. Revise the policy on CQI to be consistent with the Consent Decree and the finalized Implementation Plan.

## **Audits**

### ***Addresses item II.B.9***

**II.B.9.** *The implementation of this Agreement shall also include the design, with the assistance of the Monitor, of an audit function for IDOC’s quality assurance program which provides for independent review of all facilities’ quality assurance programs, either by the Office of Health Services or by another disinterested auditor.*

**OVERALL COMPLIANCE RATING:** Noncompliance

## **FINDINGS:**

**Implementation Plan narrative page 5:** *The quality improvement program will provide leadership and front-*

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<sup>598</sup> 18 of 30 facilities reported doing 40 CQI studies the first quarter of 2022. Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys, March 13, 2023, page 187.

<sup>599</sup> Minutes of System Leadership Council March 29, 2023.

<sup>600</sup> Health Care Monitor 6<sup>th</sup> Report Lippert v. Jeffreys, March 13, 2023, page 187-189.

line team training that will train facility leaders in quality improvement methodologies and give guidance on how to take corrective actions identified in audits.

**Implementation Plan item 43a:** *Develop an audit process number 7: A report will be delivered to the facility and system-wide quality committee and that committee will decide on corrective actions that the facility quality improvement program is to address. **Proposed End Date: March 2024***

Material requested by the Monitor to review the independent audit function of health care programs at facilities included:

- Any facility audits related to Consent Decree item II.B.9 (design of audit function for IDOC's QA program which provides for independent review of all facilities QA programs).<sup>601</sup>
- Any facility CQI or performance audits with results of study, analysis, and corrective action.<sup>602</sup>

No information was received by the Monitor about either of these requests. IDOC does not have an audit function that complies with the Consent Decree. See the section on Statewide Internal Monitoring and Quality Improvement, Audits for additional discussion related to the need for change in internal monitoring.

**RECOMMENDATIONS:** See the recommendations in the section on Statewide Internal Monitoring and Quality Improvement, Audits.

## **Performance and Outcome Measure Results**

### ***Addresses items II.B.7***

**II.B.7.** *The implementation of this Decree shall include the development and full implementation of a set of health care performance and outcome measures. Defendants and any vendor(s) employed by Defendants shall compile data to facilitate these measurements.*

**OVERALL COMPLIANCE RATING:** Partial compliance  
**FINDINGS:**

Material requested by the Monitor to review facility based performance and outcome measurements included:

- Any **facility** CQI or performance audits since 6<sup>th</sup> Court report with results of study, analysis, and corrective action.<sup>603</sup>

A set of 12 performance and outcome measures have been produced for each facility by SIU for three quarters. The Agency Quality Improvement Coordinator reported that the performance and outcome measures were discussed with facilities during a series of webinars in June.<sup>604</sup> Vandalia was the only facility to report the results of the SIU performance audit in the quality improvement minutes; there was no discussion or planning for improvement documented.<sup>605</sup> The HCUA interviewed during a site visit at Graham Correctional Center reported not having received any expectations to improve performance after Clinical Performance Review completed in

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<sup>601</sup> Monitor's documentation request dated 8/4/2023, item # 177

<sup>602</sup> Monitor's documentation request dated 8/4/2023, item # 174

<sup>603</sup> Monitor's documentation request dated 8/4/2023, item # 110.

<sup>604</sup> June 2023 CQI Facility Monthly Schedule, System Leadership Quality Council minutes dated 6/28/2023.

<sup>605</sup> CQI minutes June 2023.

May 2023.<sup>606</sup> The development and full implementation of a set of health care performance and outcome measures has yet to be accomplished at the facility level.

**RECOMMENDATIONS:** See recommendations made in Statewide Internal Monitoring and Quality Improvement, Performance and Outcome Measure Results.

### **Adverse Event and Incident Reporting Systems**

*Addresses Items II.B.6.m; II.B.6.n*

**II.B.6.m.** *IDOC agrees to implement changes in the following areas: Preventable adverse event reporting;*

**II.B.6.n.** *IDOC agrees to implement changes in the following areas: Action taken on reported errors (including near misses);*

**OVERALL COMPLIANCE RATING:** Noncompliance

### **FINDINGS:**

No information was received in response to the Monitor's request for

- Any documentation since 6<sup>th</sup> Court report of progress at a facility level toward an adverse event reporting system.<sup>607</sup>
- The list of grievances since 6<sup>th</sup> Court report related to medical and dental with the grievance number, date received, name and number of the offender, nature of the complaint, date of response. If unavailable, provide whatever IDOC tracks based on the list above.<sup>608</sup>

Minutes of the System Leadership Quality Council document that SIU has had methods to receive reports of adverse events via voice mail and email since October 1, 2022. Implementation is to occur when the QI policy, QI manual, and revised AD are distributed.<sup>609</sup> The Agency Quality Improvement Coordinator and Agency Medical Director confirmed that adverse event reporting has not yet started.<sup>610</sup>

**RECOMMENDATIONS:** See recommendation made in the section on Statewide Internal Monitoring and Quality Improvement, Adverse Event and Incident Reporting Systems.

### **Vendor Monitoring**

*Addresses II.B.2.*

**II.B.2.** *IDOC shall require, inter alia, adequate qualified staff, adequate facilities, and the monitoring of health care by collecting and analyzing data to determine how well the system is providing care. This monitoring must include meaningful performance measurement, action plans, effective peer review, and as to any vendor, effective contractual oversight and contractual structures that incentivize providing adequate medical and dental care.*

**OVERALL COMPLIANCE RATING:** Noncompliance

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<sup>606</sup> Notes from interview with HCUA at Graham CC on 7/17/2023. The HCUA recalled the performance audits taking place and that they had scored above average, yet the Clinical Performance Review document completed in May 2023. shows that Graham met the performance goal for only three of 11 applicable performance measures in the 4<sup>th</sup> quarter FY23.

<sup>607</sup> Monitor's documentation request dated 8/4/2023, item #113

<sup>608</sup> Monitor's documentation request dated 8/4/2023, item #114

<sup>609</sup> System Leadership Council minutes dated 9/8/2022, 12/13/2022, 3/29/2023, and 6/28/2023.

<sup>610</sup> Notes from interview with the Agency Quality Improvement Coordinator on 8/11/2023.

**FINDINGS:**

A vendor monitoring database was sent. See comments regarding it in the previous section of this report on Statewide Internal Monitoring and Quality Improvement, Vendor Monitoring.

**RECOMMENDATIONS:** See recommendations made in the section of this report on Statewide Internal Monitoring and Quality Improvement, Vendor Monitoring.

**Mortality Review**

*Addresses items II.B.6.i; III.M.2;*

*II.B.6.i. IDOC agrees to implement changes in the following areas: Morbidity and mortality review with action plans and follow-through;*

*III.M.2. Mortality reviews shall identify and refer deficiencies to appropriate IDOC staff, including those involved in the Quality Assurance audit function. If deficiencies are identified, corrective action will be taken. Corrective action will be subject to regular Quality Assurance review.*

**OVERALL COMPLIANCE RATING:** Noncompliance

**FINDINGS:**

Material requested by the Monitor to review facility-based mortality review included:

- Documentation of any facility-specific recommended corrective actions or discussions on deaths. This includes any corrective actions assigned by the system-wide quality committee with documentation of facility follow up.<sup>611</sup>

The Monitor has been provided with the minutes of the SIU Office of Correctional Medicine, Morbidity & Mortality Committee which reviewed 107 mortalities taking place in IDOC prisons.<sup>612</sup> Each mortality reviewed includes opportunities for improvement. The individual mortality reviews are sent to the IDOC Agency Quality Improvement Coordinator as well as the facility where the death took place. The recommendations are to be reviewed by the facility CQI committee and corrective action developed as a result; the regional Health Services Coordinators are to monitor follow up with facilities. The Agency Medical Director commented that facilities needed education in how to improve.<sup>613</sup> At the meeting of the System Leadership Quality Council in June 2023 the regional Health Services Coordinators were asked if the results of M & M reviews were discussed at facility CQI meetings. Two of three replied that there was no discussion of the results of M & M reviews at facility CQI meetings. None of the CQI minutes reviewed for this report reflect a discussion of the results of the SIU M & M Committee, in fact there is no acknowledgement SIU is doing these reviews.

It is evident that there is a process in place to review deaths and make recommendations for improvement. There is no evidence that these reviews have resulted in any action, follow up or corrective action.

**RECOMMENDATIONS:** See recommendations in the earlier section on Statewide Internal Monitoring and Quality Improvement, Mortality Review.

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<sup>611</sup> Monitor's documentation request dated 8/4/2023, item #115.

<sup>612</sup> Minutes from August 2022 through August 2023.

<sup>613</sup> Notes from interview with the Agency Quality Improvement Coordinator on 8/11/2023.