Health Care Monitor
9th 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.*

There have been personnel changes since the last report. The prior Monitor resigned and a new Monitor (Dr. Puisis) was chosen. There was a gap in monitoring for several months until contracts with the new Monitor and a new Consultant (Dr. Anandkumar) were completed. The Chief OHS resigned in July and IDOC appointed an Acting Chief (Dr. Conway). IDOC was unable to come to contract terms with their medical vendor (Wexford) and in June of 2025, selected a new vendor (Centurion). The latest information provided to the Monitor is that IDOC is still negotiating contract details and Centurion is working on an emergency contract.

Because of the impending end of the Consent Decree in less than four years, the Monitor submitted a Special Report on 9/11/25 to address six areas not in compliance that include potential budgetary or operational hurdles.[1] These must be addressed as soon as possible so IDOC can accomplish compliance within the deadline set for the Consent Decree. The Monitor asked that those authorized to make the necessary changes join the meet and confer. No senior leadership or organizational staff attended. The meet and confer included only six attorneys who offered no plans to resolve areas of noncompliance. IDOC sent a post-meeting letter to Plaintiffs and the Monitor stating their view that they are compliant in all areas cited in the Special Report and that no further action on their part was necessary to come into compliance. The IDOC response to the Special Report was inadequate.

The majority of material reviewed by the Monitor for this report was focused on the operation of the health care program from January through June of 2025. There has not been significant change in performance since the Monitor's last Report. The following key points are discussed in this report.

- After six months of the contract with Centurion, the Monitor has no credentialing data for any physicians and IDOC has not informed the Monitor that the new vendor has hired any physicians.
- Staffing data for this report was insufficient to make a comparison with the 2022 Staffing Analysis submitted to the Court. Staffing remains deficient based on record reviews, failure to implement policies, and a variety of staff comments.[2] IDOC needs to standardized staffing data to allow for comparison with the 2022 Court-filed staffing analysis. A separate report should be used to report data on additional hours worked.
- IDOC now prohibits the Monitor from asking staff questions about staffing, adequacy of facilities, physical plan surveys, surveys of the disabled, aged and infirm and have recently expanded the prohibition to certain implementation plan items.
- There is little evidence that IDOC implemented the policies they made effective February 2024.

[1] Physical facilities and equipment; staffing; sufficient physicians with appropriate credentials; implementation of policies; organizational structure; the electronic medical record implementation; and data.
[2] These are represented in the Report with citations.

- IDOC is in the beginning phase of collecting and managing data. Experienced and knowledgeable individuals are not guiding this process. IDOC collects data but does not define or standardize data elements. There is considerable facility variability in reported data.
- IDOC does not effectively use data obtained to analyze or develop corrective actions.
    - SIU mortality reviewers have identified thousands of deficiencies. IDOC has yet to document analysis of these deficiencies to develop systemic or facility specific corrective actions.
    - SIU has been collecting performance and outcome data for approximately two years and there is evidence of one initiative that has been implemented based on inadequate performance (colon cancer screening). None of the current 23 measures is at IDOC goal.
    - SIU has collected approximately 500 adverse events but there is no analysis of this data and few s.
- Clinical care is unchanged from prior reports.

The Monitor adds a mortality review of three asthma deaths as an attachment to this report. Asthma deaths are typically preventable and appear preventable in these three cases. This disease specific mortality review indicates that systemic attention to asthma is needed. IDOC should engage experts in asthma care to assist in updating clinical staff in asthma care. Because asthma care and COPD care is conflated in IDOC, separate training on COPD should be provided as well.

The Monitor added Data and Information as a new section to the Monitor's Reports because the Consent Decree requires IDOC to provide the data and information necessary to verify compliance with the Consent Decree. The Consent Decree requires that data and information used in the V.G. report is to be agreed upon by Plaintiffs' and the Monitor. This has not been accomplished. IDOC has prohibited interviews about staffing, adequate facilities, surveys for aged, infirm, and disabled and some implementation plan items. Attorneys interfere in some interviews and limit ability to conduct private interviews.

The Monitor remains committed to assisting IDOC in attaining compliance. The Monitor has:

- Offered to work together with the new vendor and IDOC to conduct staffing analyses at selected facilities;
- Offered to work together with IDOC or designee to craft a comprehensive audit;
- Continues to review all policies and suggest improvements;
- Offered to assist in development of data collection methodologies;
- Offered to meet with Parties to determine data and information necessary to establish compliance with the Consent Decree; and
- Offered to meet with the Executive Director before or after each Monitor Report to give an update.

To date the only participation IDOC has requested from the Monitor is policy review. The Monitor remains committed to the offers listed above and to assisting IDOC attain compliance.

Statewide Issues: Leadership and Organization Leadership Staffing

Addresses item II.B.2; II.B.3;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.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:

To evaluate the Consent Decree provisions listed above, the Monitor requested thirteen documents[3] and IDOC provided all but one. The one document not provided was a spreadsheet (as of May 2025) listing all physicians, their assigned facilities, and qualifications (document request #33). IDOC did not receive this document from their departing vendor.

The Monitor used three of these documents to evaluate the organizational structure.

- Updated tables of organization, including OHS, showing the organization of health care (document request #2).
- Tables of organization for Central Region facility medical programs, including HCUAs, Medical Director, state and vendor medical employees, and site leadership. This should include Danville, Decatur, Graham, Hill, Illinois River, Jacksonville, Lincoln, Logan, Taylorville, and Western, with incumbent names (document request #3).
- Any changes to OHS position descriptions (document request #5).

The organizational structure of the medical program remains essentially unchanged. We found that the table of organization for OHS and IDOC staffing files do not show the same numbers of OHS positions. This will be discussed in the staffing section below. The Agency Medical Director still has no direct line supervision to staff in the facilities. IDOC recently added a new position (Medical Services Operations Administrator) to their table of organization.[4] This proposed position had a position description with the following key responsibilities provided: [5]

[3] Document request provided to IDOC on 5/10/25. These are document request numbers 1-3, 5-6, 8-11, 16, and 33.
[4] Office of Health Services Proposed table of organization dated May 2025 provided in document request #2.
[5] This position has an associated position description from which these responsibilities are taken (document request #5).

- Supervises the Director of Nursing.
- Provides operational oversight for healthcare services across all IDOC facilities.
- Develops and implements performance monitoring and metrics.
- Does not have a direct line supervision over HCUAs, instead:
    1. "Builds effective relationships with facility administrators and healthcare staff";
    2. Strategizes on facility operations and process improvement;
    3. Works with facility leadership to address infrastructure challenges, including space utilization and environmental.

The Monitor requested facility tables of organization which IDOC provided (document request #3). Sixty-five percent of facility medical staff are vendor employees; 35% are state employees. Each warden develops their own organizational chart, including for health care. Supervision of vendor staff is not codified in policy even though vendor staff comprise approximately 65% of facility medical employees. In the past, the Monitor has been told that State supervisory personnel cannot supervise vendor employees.[6] The State and vendor position descriptions and IDOC policy needs to clearly state that supervisory authority is blind to whether the employee is State or vendor.[7]

Reporting relationships for vendor staff vary widely and inconsistently:

- At 13 facilities, the HCUAs are listed as supervising all medical staff.
- At 11 facilities, no supervisor is listed for vendor staff.
- At 4 facilities, alternative supervisory relationships are noted:
    - In one, the Director of Nursing supervises all vendor staff.
    - In two, the HCUA supervises contract professionals but not non-professional staff.
    - In one, the HCUA supervises only contract nurses, leaving other vendor staff unsupervised.[8]

OHS policy states that the HCUA is the responsible administrative authority of the facility medical program, "reports" to the Office of Health Services through regional coordinators, and that the facility Medical Director is the responsible medical authority.[9] Neither the HCUA nor the facility medical director positions are portrayed in facility organizational charts consistent with OHS policy.

HCUAs continue to function without meaningful direct line supervision by OHS staff and have facility-specific supervisory responsibility over vendor medical staff. OHS supervision of HCUAs as portrayed in various policies, position description, and tables of organization is given below.

[6] See page 54 of the Monitor's 6th rport including footnote #51.
[7] The vendor and IDOC each have different unions.
[8] Information on facility tables of organization came from IDOC document request #2 Table of Organization in a folder titled Facility Program Organizational Chart.
[9] OHS policy A.02.01 Responsible Health Authority submitted to facilities on 2/9/24.

- IDOC Administrative Directive 01.02.111 Facility Leadership and Direction (effective 6/1/22)[10] states, "It is the policy of the Department to provide the Warden of each institution the authority and responsibility to manage and direct the total operations of the facility."
- The position description of the HCUA states that the assistant warden of programs supervises the HCUA who "receive clinical supervision" from Regional Coordinators. [11] Clinical supervision is undefined. Regional Coordinators have told the Monitor that they do not supervise the HCUAs[12] and an HCUA has told the Monitor that the assistant warden of programs supervises her, and she viewed the Regional Coordinators as only providing help.[13] The assistant wardens of programs complete the HCUA performance evaluation.
- The facility tables of organization all indicate that assistant wardens of programs supervise the HCUAs.
- OHS policy states that the "HCUA…maintains communication with the facility Warden" but that the "HCUAs report to the Office of Health Services through their Regional Coordinators." [14]
- The HCUA Clinical Supervision table of organization documents a "clinical matrix" supervision of the Regional Coordinators over the HCUAs. [15]
- Central Management Service (CMS) position descriptions of the three Regional Coordinators do not include any supervisory responsibility including over HCUAs.[16]

There is no effective chain of command from OHS to medical staff at the facilities. The chain of authority breaks at the HCUA level. Supervision of HCUAs by OHS is nominal. Real supervision of HCUAs rests with the assistant warden of programs but these individuals have no expertise in the operation of a medical program and their supervision is not evident with respect to implementation of OHS policies or initiatives. HCUAs are unsupervised with respect to implementation of policy, OHS initiatives, and operations of the medical program. The Warden is the effective supervisor of the HCUA through the assistant warden of programs. IDOC has no mechanism to hold assistant wardens and wardens accountable for operations of the medical program.

Tables of organization, policy, and position descriptions need to reflect a clear line of authority from the Agency Medical Director to medical staff at the facility. All facility staff need to report to supervisory staff regardless of whether the supervisor is a vendor or State employee.

The staffing analysis filed with the Court shows budgeted and vacant positions. Documents provided for this report do not.[17] The Monitor requested one document to verify OHS staffing:

[10] As found on the IDOC policy website at: https://idoc.illinois.gov/content/dam/soi/en/web/idoc/aboutus/policies/policies/administration-organization-and-management/102111%20Facility%20Leadership%20and%20Direction.pdf
[11] Central Management Service Position Description of Health Care Unit Administrator effective 1/1/21.
[12] Interview with two regional coordinators 6/27/24 for the 8th Report.
[13] Interview with HCUA from NRC for 8th Report during NRC visit 6/3/24 to 6/5/24.
[14] OHS policy A.02.01 Responsible Health Authority
[15] 03-100 OHS Statewide Nursing Director HCUA Matrix as provided in document request #2.
[16] Central Management Service Position Description of DOC Regional Coordinator effective 5/22/22 provided in document request #5 for the 9th Monitor Report.
[17] The State Filled Positions and Vacancies Spreadsheet 7.15.25 would have satisfied this requirement but it appeared to have mental health staff included and was therefore an inaccurate number of staff.

1. A list of SIU and OHS allocated or budgeted staff by position type, with primary areas of responsibility and vacancies noted (document request #9).

The Monitor cannot determine the number of OHS staff due to discrepancies in the documents received. Areas of responsibility for OHS were not provided. Instead of providing a list of budgeted and vacant OHS positions IDOC provided OHS staffing data in the **State Filled Positions and Vacancies Spreadsheet 7.15.25 Payroll**,[18] which listed 18 OHS employees with one vacancy. By contrast:

- The Defendants' V.G. Report (12/18/24) listed 19 OHS staff.[19]
- The May 2025 OHS Table of Organization lists 29 employees in OHS with seven vacancies.
- A position posting document[20] includes a position[21] not listed on the State Filled Positions and Vacancies Spreadsheet 7.15.25 Payroll document or on the Defendants' V.G. Report, dated 12/18/24 but does appear in the March 2025 Assistant Director Table of Organization.
- The Defendants' V.G Report does not list the Infection Control Coordinator in the OHS positions but it has been filled for several years. The HIV Peer Educator listed on the Defendants' V.G. Report is not listed on the payroll spreadsheet. Five individuals are on the OHS table of organization but are not on the payroll spreadsheet.[22]
- JP, the apparent Food Service Program Manager, is documented in the System Leadership Council minutes of April, 2025 as being hired as for this position. He appears on the May 2025 OHS table of organization. He is not listed on the State payroll document which is dated 7/15/25.

The Monitor could not verify a precise number of OHS positions using these documents because of the discrepancies. IDOC needs to maintain a list of OHS budgeted, filled, and vacant OHS positions and these positions should be consistent with the table of organization and the staffing analysis budgeted positions.

To determine supervisory staff at the facility level the Monitor requested the following documents.

- A list of allocated/budgeted medical and dental positions (also noting FTEs) with vacancies for each position at each facility, to include IDOC and Wexford positions. Lists should be separated by position type and include statewide totals (document request #8).
- Facility Reconciliation of Hours worksheets since January 2025 (document request #16) which gives the hours worked of vendor staff by type of staff (agency or employee).
- A list of HCUAs with contact information. For vacant positions, the list should include the vacancy date and the acting appointee's name and contact information (document request #11).

[18] Document request #8.
[19] The positions in the V.G. Report and the State Filled Positions and Vacancies spreadsheet are somewhat different. The V.G. report does not include an Infection Control Coordinator whereas the spreadsheet does. The V.G. Report includes and Executive Secretary II and HIV Peer Educator but these are not present on the spreadsheet.
[20] Document request #17 Any document or information providing verification that all vendor and IDOC State positions are posted.
[21] HIV Program Coordinator documented as hired 9/16/24.
[22] The following individuals are on the March or May 2025 OHS table of organization but are not on the 7/15/25 OHS payroll document. J P (May 2025 Table of Organization OHS Food Services Program Manager), Y P (May 2025 Table of Organization OHS Executive Secretary), P J (March 2025 Table of Organization Assistant Director; Program Coordinator HIV), A N (March 2025 Table of Organization Assistant Director; Public Health Educator), and T R (March 2025 Table of Organization Assistant Director; Public Health Educator Associate).

The Monitor could not use the documents sent to verify leadership positions (HCUAs, facility DONs, supervisory nurses, and physicians) for the following reasons.

- The vendor hours-worked document does not differentiate between agency-filled Medical Director positions and employed Medical Directors which does not permit verification of budgeted, filled, and vacant facility Medical Director positions.[23]
- The State payroll document[24] and Court-filed staffing analysis[25] have different numbers of budgeted positions (575 and 501 respectively) so the payroll document does not appear accurate.
- For State director of nursing (DON) positions, the staffing analysis lists 13 positions, the State payroll document lists 11 individual positions, and the recent V.G. Report listed 12 DON positions. If IDOC eliminates positions from the staffing analysis, an explanation should be given; instead, the number appears to vary based on the document used.
- For State supervisory nurse positions, the staffing analysis lists 16 positions but State payroll document lists 15 positions.
- The staffing analysis lists 29 HCUAs. The payroll document lists seven vacancies but the list of HCUAs[26] has only four vacancies.[27]

These documents make it impossible to precisely determine the numbers of budgeted, vacant, and filled supervisory staff.

Also, the State hours-worked file shows that HCUAs are working less than the expected hours for a full-time position.[28] While the payroll file shows that there are 29 HCUAs[29] with seven vacancies (22 positions with vacancy rate of 24%) the State hours worked file from January–July 2025 show that HCUAs worked less than what 22 FTEs would work.[30] The hours worked varied considerably month to month. This represents a deficiency in staffing for a critical leadership role and indicates that IDOC should consider relief time in any workload analysis.

To verify compliance, the Monitor needs budgeted, vacant, and filled positions to compare with the staffing analysis number which lists staffing by budgeted, vacant, and filled positions. This shows whether the staffing plan is functioning. The Monitor also requested hours worked (with agency hours

[23] The Monitor does not consider filled positions and agency staff as equal because agency staff may work for limited periods of time and are not consistently aware of policy expectations. This makes it difficult to place these individuals in supervisory positions. The Monitor knows that agency staff fill physician positions which are essential. IDOC has not made the Monitor aware whether supervisory positions are filled with agency staff.
[24] State Filled Positions and Vacancies Spreadsheet 7.15.25 Payroll provided in response to document request #8.
[25] This staffing analysis was dated 8/15/21 and was filed with the Court.
[26] Document request #11 list of HCUAs with contact information. For vacant positions, the list should include the vacancy date and the acting appointee's name and contact information.
[27] The Monitor also noted that while the payroll document showed seven vacancies (22 HCUAs) the list of HCUAs showed four vacancies (25 HCUAs), an hours-worked document of State employees indicated that from January to June HCUAs worked a full time equivalent of 20.24 positions meaning that a full time HCUA works actually works less hours than a full time equivalent position due to compensation and time off.
[28] State Healthcare Hours files in document request number 8
[29] The State payroll file lists the Stateville position as vacant although the IDOC has informed that except for the infirmary this facility has been closed. The payroll document provided did not indicate any change in staffing.
[30] Document request # 8 Allocated and Budgeted FTEs Med Dental in subfolder State Healthcare Hours with file names State Healthcare Hours January through June 2025 -master, and State Healthcare Hours-July 2025-master.

separated out) because this metric gives an operational workload. This shows when overtime occurs and helps to determine if the budgeted staffing is realistic.

In a significant change, on 7/15/25, Dr. Bowman, Chief of Health Services, retired. IDOC appointed Dr. Conway, a Deputy Chief, Interim Chief, leaving her Deputy Chief position vacant. This was a significant loss to OHS.

The Monitor requested progress toward hiring a training coordinator to ensure staff training occurs as planned (document request #10). IDOC responded that they do not intend to hire a training coordinator because SIU has the ability to assist with training. IDOC needs training in a variety of areas: clinical updates, training on policies, training related to identified deficiencies, and patient training. The training provided by SIU via Health Matters is related to clinical updates and patient training and they do not track who was trained or when. For this a coordinator is necessary.

The Monitor requested all vendor contracts and subcontracts since January 2024, including medical care, pharmacy, laboratory, dialysis, and related services (document request #1). In December 2023, IDOC awarded Wexford Health Sources a ten-year contract but IDOC and Wexford failed to reach agreement. On June 23, 2025, IDOC announced plans to contract with Centurion Health. On 8/18/25, IDOC provided the Monitor Centurion's transitional contract. IDOC reported that a comprehensive contract was not finalized, and operations continued under a declaration of emergency. The Monitor requested the agreement between IDOC and the Illinois Department of Public Health to understand precisely what IDPH will provide; this was not provided.

On 9/9/25, the Monitor and consultants met with Centurion's senior staff for a full-day briefing on the Consent Decree, including recommended priorities. OHS staff attended. The Monitor is cautiously optimistic that Centurion will work collaboratively with IDOC and fill allocated positions.

The Monitor released a Special Report that included organizational structure as a deficiency related to Consent Decree provision II.A.[31] At the meet and confer, Defendants offered no plans. They ignore the requirement of II.A., instead they assert that the Department is in substantial compliance with provisions III.A., III.A.8., and III.A.9. because it has hired an Agency Medical Director, two Deputy Medical Directors and HCUAs and that qualifies as having an adequate organizational structure.[32] They assert they are compliant with Consent Decree requirements because beyond these three specific requirements all other issues relating to organizational structure are left to the discretion of the Department. They ignore whether the three groups of employees function effectively to operate an adequate medical program.

Organizational structure is an essential component of any medical program. This and prior Monitor Reports note problems with the current organizational structure including:

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[31] II.A. state, "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 and dental needs. Defendants shall ensure the availability of necessary services, supports and other resources to meet those needs". The Monitor views this provision as including an organizational structure of the medical and dental programs sufficient to meet the needs of those incarcerated.

[32]IDOC payroll data (document request 8) shows there are 29 HCUAs with 7 vacancies which is a significant number of vacancies.

- OHS provides only nominal supervision over HCUAs which results in ineffective and absent supervision as described in the Statewide Issues section.
- Over a year after releasing 88 new policies, there is little evidence that IDOC has implemented any policies. No one from OHS is responsible for the implementation of policy and that lack of leadership results in failure to implement policies.
- The Agency Infection Control Coordinator supervises no one and thereby cannot effectively supervise the infection control program. The assigned facility infection control nurses are unsupervised with respect to infection control. As a result, the infection control program is ineffective. See section on Infection Control in this and prior Monitor Reports.
- The Agency Quality Improvement Coordinator supervises no one and cannot effectively supervise the quality improvement program. The assigned facility quality improvement coordinators are unsupervised with respect to quality improvement. As a result, the facility quality improvement program is ineffective. See section on Quality Improvement in this and prior Monitor Reports.
- Administrative Directives conflict with some OHS policies. See section on Policies in this and prior Monitor Reports.
- Vendor and State employees will not always adhere to orders of higher-level staff from other than their own Agency.
- Communication between vendor and State is poor, incomplete, and disrupts delivery of timely care. See section on Vendor Monitoring in this report with respect to comments by HMA.[33]

IDOC asks the Monitor in its written response to the Special Report that the Monitor provide, in writing, recommendations to achieve compliance. The Monitor has already done this in this and prior reports. These recommendations include the following:

- All recommendations in Statewide Issues: Leadership and Organization Leadership Staffing;
- Recommendations 2, 11, and 17 in Staffing section;
- Recommendation 10 in Oversight Over Medical, Dental and Nursing Staff section; and
- Implementation Plan tasks 3, 4, 5, 6, 8.

IDOC is free to choose how they want to establish an organizational structure. But if they choose to have Wardens supervise HCUAs and have no direct line of real, not nominal, supervision from OHS to the facilities greater responsibility will fall on the Wardens to perform. The Monitor is merely giving IDOC their best opinion, based upon years of experience operating and managing health care programs in correctional facilities, on how to succeed in attaining compliance.

Summary

The current organizational structure and leadership staffing are major barriers to compliance.

- HCUAs should report directly to OHS; instead, they report to assistant wardens of programs and have a nominal reporting relationship with Regional Coordinators.
- OHS and facility supervisory staffing levels cannot be determined based on data provided by IDOC.

[33] See slide 7 in Monthly Task Meeting 6.25/.25 Draft in document request 73 for 9th Report

- Discrepancies exist between staffing analysis numbers and existing staffing data provided by IDOC.
- At a facility level, vendor and State employees do not consistently take direction from supervisory staff. Supervisory staffing appears to be insufficient based upon failure to implement policy. This section warrants a finding of **partial compliance**.

RECOMMENDATIONS:

1. Revise IDOC position descriptions of Deputy Chiefs, Medical Coordinator, Agency Director of Nursing, Regional Coordinators, HCUAs, and facility Directors of Nursing to clarify expectations and ensure appropriate lines of authority.
2. When revising the position description of the Regional Coordinators eliminate responsibility for supervision of nursing and focus on operational functions of administering the health care program. Make the position of Regional Coordinators report to the Medical Coordinator.
3. Increase the number of Regional Coordinators. The Monitor suggests six, but IDOC should depend on a staffing analysis to determine a more precise number.
4. Identify a DON at each facility who is accountable to the Statewide DON in a dotted line relationship for clinical nursing practice and quality. Line authority would remain with the HCUA for daily operations
5. In the staffing analysis, consider whether IDOC needs to hire Regional Directors of Nursing.
6. The Monitor recommends that the HCUA report to the Regional Coordinator and be responsible for implementation of expectations set by OHS. If this occurs, the position description of the HCUA should be revised to include the expectation of adherence to all security rules and other operational priorities of the Warden. If IDOC continues to want to have the Warden supervise the HCUA, the position description of the HCUA should specify what responsibilities the HCUA reports to the Warden for and delineate the responsibilities the HCUA has in reporting to the Regional Coordinator. OHS must provide more direction to the HCUAs not just guidance or consultation.
7. Review and revise the vendor position descriptions for Regional Manager, Regional Medical Director, Regional Director of Nursing, facility Medical Director, and facility Director of Nursing to ensure they are consistent with expectations of IDOC.
8. When reviewing and revising the facility Medical Director position description ensure that IDOC fills the position with a qualified physician position as described in II.A.2. of the Consent Decree. At all but the smallest facilities, this position should be full time and include expectations of acting as the facility clinical authority, appropriately supervising and monitoring the clinical performance of subordinate medical personnel in accordance with the Consent Decree, providing clinical leadership in implementation of policies, initiatives, directives of OHS, and participation in quality. Facility Medical Directors need be responsible for addressing results of SIU audits and mortality reviews for their facility. These responsibilities presume additional physician staffing is indicated.
9. IDOC should review its policies and position descriptions to ensure that there is order in the health unit and that all staff obey custody rules and clinical orders and take clinical supervision from an appropriate supervisor regardless who the superior's employer is. This must be worked out and described in policy so that all staff understand that they are on the same team[34].

[34] This is meant to address the situation at Dixon where IDOC registered nurses would not supervise vendor nurse assistants for their clinical duties.

10. The OHS Deputy Chiefs should each meet with the respective vendor Regional Medical Director weekly (in person or via video conference) to discuss 1) physician and mid-level provider staffing and what the vendor Regional Medical Director is doing to improve the staffing, 2) how the vendor Regional Medical Director is reviewing the performance of facility Medical Directors, including the Regional Medical Director's evaluation of their performance, 2) response of the Regional Medical Directors at the facility to the most recent SIU audits and opportunities for improvement found on mortality reviews for the facilities they manage and what they will do to correct deficiencies, 3) what they are doing to ensure facility Medical Directors are contributing in the quality improvement meetings, and 4) what the vendor Regional Medical Directors are doing to ensure successful implementation of OHS policies and procedures, directives, and initiatives.
11. On a weekly basis, the Medical Coordinator should meet with the vendor Regional Managers and the OHS Regional Coordinators to ensure the vendor is performing in accordance with OHS directives to include: 1) are they providing supplies, pharmaceuticals, and equipment necessary to conduct care and implement policies, 2) update staffing including what the Regional Manager is doing to ensure adequate staffing is in place, 3) review what the Regional Manager is doing to ensure IDOC policies, initiatives, and directives are implemented, and 4) any other items that are priorities of OHS. This can be in person or via teleconference.
12. On a weekly basis, the Medical Coordinator should meet individually with the Regional Coordinators to discuss similar items as described in item 11 above and include: 1) custody issues at their respective facilities, 2) progress towards implementation of policies, 3) issues with the vendor that need to be addressed, 4) other operational problems that are barriers to advancement towards compliance with the Consent Decree.
13. The Agency Director of Nursing should conduct regular meetings with all Directors of Nursing to discuss nurse practice issues and implementation of policies, initiatives, and directives. The Agency Director of Nursing should obtain regular feedback on progress of programs such as the implementation of nurse sick with follow up guidance from the Agency Director of Nursing.
14. The Agency Director of Nursing should meet regularly with vendor Regional Directors of Nursing to discuss: 1) what they are doing to ensure that nursing practice is standardized and appropriate; 2) to discuss vendor nurse staffing and what the Regional Nurse Directors are doing about it, 3) what they are doing to ensure annual performance evaluations are completed and to review copies of these, and 4) what they are doing to address nursing opportunities for improvement identified in mortality reviews or SIU audits. These meetings can be in person or via video conference.
15. The Agency Dental Director should meet regularly with vendor Regional Dental Director to discuss: 1) what they are doing to ensure that dental practice is standardized and appropriate; 2) vendor dental program staffing and what the vendor is doing about it, 3) what the vendor is doing to ensure annual performance evaluations are completed and to review copies of these; 3) how the vendor Regional dental Director is reviewing the performance of facility dentists and 4) what the vendor is doing to address opportunities for improvement in dental care identified in mortality reviews or SIU audits. These meetings can be in person or via video conference.
16. For all meetings listed above, a checklist format will help focus the meeting.
17. For purposes of monitoring, IDOC should not count as "filled" a facility Medical Director position unless the position is functionally filled which should be defined as a full-time position[35] that provides the required leadership as described in recommendation 8 above.
18. For the purposes of monitoring, IDOC should not count as "filled" a facility Dental Director, Nursing Director, Nursing Supervisor, and HCUA position unless the position is functionally filled

[35] Exceptions can be made but not if the individual cannot fulfill expectations of the position.

and the individual has the knowledge and skill to fulfill all the responsibilities of the position including quality, reporting and supervisory responsibilities.

19. The IDOC staffing and particularly the leadership staffing (Medical Directors, DONs, HCUAs, Dentists, supervisory nurses) is critically low. The facility Medical Director positions are dangerously low. The vendor and the State must expeditiously intensify their recruiting efforts.
20. The Monitor requests that IDOC provide quarterly up-to-date vacancy reports that include OHS and HCUA positions.

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: Partial Compliance

FINDINGS:

Staffing Analysis

To evaluate the Consent Decree provisions listed above, the Monitor requested the following document:

1. Progress on completing a staffing analysis, including any workload analysis or other measures used to determine the number of staff positions required. Provide whatever information is available for this item (document request #12).

IDOC provided no data or information in response to document request #12 stating that it was delayed because of the transition to the new vendor.[36]

IDOC submitted their staffing analysis to the Court on 8/15/21. This document did not include an analysis sufficient to determine staffing needs. The Monitor has asked IDOC to perform a workload analysis of all position categories as they hire new staff. This has not yet been accomplished. In their Implementation Plan tracker, IDOC documents that the staffing analysis is 100% complete even though the Compliance Officer documented a note saying:

[36] IDOC Response to Lippert Monitor 9th Report Document Request, item, 12.

> "This analysis is already close to five (5) years old, and I don't believe it took in to account any best practice standards related to patient to nurse ratios. Also, I know a number of our facilities have had significant population changes, as well as acuity changes, but this is the best we have to date. COMPLETED"

Another note in the Implementation Plan tracker for item 1a (to hire a consultant to perform a workload analysis) states that the workload analysis is on hold until after the electronic record is implemented.[37] The Monitor confirmed this in IDOC's recent V.G. report on 12/18/24 which stated:

> "Given the Department's current projects, including the implementation of an electronic health record and the implementation of a comprehensive policy and procedure manual that will both significantly overhaul the Department's health care processes, it would be fiscally irresponsible to conduct a workload analysis that would be meaningless in the near future".[38]

The Monitor disagrees with the statement that a workload analysis is meaningless. Currently, IDOC must implement policies and procedures and an electronic record both of which require a workload analysis to anticipate the effects of workflow changes and the staffing needs created by new tasks. Many of the new policies include requirements that have not previously been performed, which necessitates evaluation of staffing levels. To implement either new policies or the electronic record without anticipating staffing needs is not prudent or appropriate management.

The Monitor offered to assist IDOC in conducting a pilot workload analysis with IDOC and the new vendor at one or two sites. In doing this, use of a consultant might be eliminated. The Monitor suggested that this was an opportune time to analyze staffing as a new vendor was beginning operations. IDOC stated that they would consider this offer, but there has been no further response.[39] The need for the new vendor to develop a methodology to assess staffing, particularly given the requirement to implement new policies and a new electronic record, is necessary but IDOC treats it as "meaningless."

To compare IDOC's progress against the Court-filed staffing proposal, the Monitor has asked for budgeted, filled, and vacant positions in document requests. For the 7th and 9th Reports, IDOC has not provided staffing data sufficient to compare budgeted, filled, and vacant positions to the staffing analysis. Consequently, the Monitor cannot comment on IDOC's progress on compliance with its own staffing analysis proposal of 2021. As discussed in the last report, IDOC promulgated policy C.06.01 *Staffing Levels* in February 2024, which:

- Stipulates that IDOC will establish a written staffing plan based upon a comprehensive workload analysis for each position type.
- Requires that IDOC will develop a staffing plan to provide adequate staff and list all allocated positions with the number of hours on site.

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[37] On the Implementation Plan spreadsheet tracker made accessible by IDOC.
[38] Defendant's 2024 Report Under Section V.G. of the Lippert Consent Decree 12/18/24, page 51
[39] This was confirmed in notes in the Implementation Plan tracker dated 8/1/25 that states hiring a consultant for the workload analysis is on hold until after the electronic record is implemented noting that this may be resolved through Centurion and possible Monitor's assistance. See also IDOC Response to Lippert Monitor 9th Report Document Request, item, 12.

- Requires that the staffing plan allocate positions to post assignments (infection control, infirmary, etc.) with relief hours.
- Requires each HCUA to maintain a spreadsheet documenting the incumbent for each position and the date any position becomes vacant. HCUAs are to submit this information to regional coordinators monthly.

There is no evidence that IDOC has implemented this policy.

In summary:

- Findings warrant a partial compliance rating based on IDOC having submitted a staffing analysis in 2021 but this staffing analysis was inadequate.
- There has been no progress on conducting a workload analysis to determine how many and what types of staff are necessary to provide adequate care.
- IDOC's policy C.06.01 requires a workload analysis and tracking of allocated, filled, and vacant positions, but IDOC has not implemented this policy.
- IDOC does not currently have a mechanism to track allocated, filled, and vacant positions listed in the staffing analysis.

Implementation Plan

To evaluate the Consent Decree provisions listed above, the Monitor requested the following documents:

1. Provide a table with the percent completion of each task of the Implementation Plan. A separate document should be provided with data supporting the level/percentage of completion of a task. If unavailable, any document that provides verification for progress made on all implementation plan items can be provided.[40]

IDOC did not provide any documents related to this request in their document submission on 8/15/25. However, IDOC hired a consultant as Implementation Plan project manager in September of 2024. The project manager initiated an implementation plan tracking document upon hire. IDOC gave the Monitor access to this spreadsheet on 8/12/25 for a short period of time. Access to this spreadsheet has since been discontinued. The spreadsheet lists:

- The task number consistent with the filed Implementation Plan,
- The requirements of each task,
- A link to the "proof" verifying completion of the task,
- The owner of the task,
- The phase (not started, planning, initiation, execution, or completed),
- The progress or percent completed,
- The actual end date,
- The length in days to completion, and
- Notes.

[40] Document request #13.

Problems with the tracker include the following.

- The timelines in the spreadsheet are inaccurate and not consistent with timelines in the Court-filed Implementation Plan.
- The start date given in the Court-filed Implementation Plan are not present on the tracker.
- The end date given on the tracker is not the proposed end date on the Court-filed Implementation plan except for a few tasks. It is not possible to assess whether IDOC completes tasks as originally expected. IDOC should use the original timelines of the Court-filed implementation plan. The end date on the tracker is therefore undefined and unintelligible
- IDOC does not define "completion" of a task. The "days to complete" column on the tracker and the "proof" methodology are undefined and unintelligible.[41]
- There are no metrics against which to measure progress.
- It doesn't appear that "owners" use the tracker. Responsibilities of owners and the Project Manager are unclear.
- The tracker gives proof of completion for tasks that are incomplete.
- Proof of completion documents are large volumes of documents that are unintelligible.

The Monitor recommends to add the following date columns:

- The start date as listed on the Court-filed Implementation Plan.
- If no start date is listed on the Court-filed Implementation Plan, then the date the Implementation Plan was filed in the Court should be used (8/1/23)
- The proposed end date in the implementation plan should be included.
- A completion date should be included and not be filled in unless the item is complete.
- A days outstanding column should list the days from the start date to the current date the tracker is updated. This is filled in only for items that are not completed and is updated on regular intervals.
- A days-to-completion column should list the days from the start date to the date of completion.

Three metrics should be used: 1) the number and percent of tasks that are completed; 2) the number and percent of tasks that are overdue; and 3) the average time tasks are overdue.

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[41] **For example**, the 1st Court-filed Implementation Plan task is: "Complete initial Staffing Analysis". No start date is listed on the tracker but an end date of 8/29/21 is given which is close to the date of the Court-filed Staffing Analysis (8/17/21). The "days to complete" column in the tracker lists -540 days. A negative days to complete a task is unintelligible. The proof is a multitude of files including HMA audit files and staffing files. There is no definition of what is required for a staffing analysis. It is unclear why this is complete as the staffing analysis was inadequate. **A second example** is task 1a which is to hire a consultant to perform a workload analysis. This task also has no start date. The task has an end of 12/20/23 which approximates the proposed end date of December, 2023 on the Court-filed Implementation Plan. But this task is documented on the tracker as not completed. The "days to complete" column is filed in with 302 days but the task is incomplete. How can a days to complete of 302 days be listed for a task that is not complete. The proof for this is about two dozen folders and two dozen files on staffing data. The proof is whether IDOC hired a consultant to perform a workload analysis or not? The answer is no. What is the purpose of inserting a proof of completion when the task is incomplete? **A third example** is task 62.1 on the tracker which is to test the safety and sanitation inspection tool with the Monitors at various sites to ensure adequacy. On the Implementation Plan tracker the task has no start date and a proposed end date of August of 2024. The end date on the tracker is documented as 11/29/24 even though the status of this task is only 50% complete. The days to complete column documents 1986 days. 1986 days before 11/29/24 is 6/23/19 which is a date just after the Consent Decree was made effective. This is unintelligible. The proof given in the tracker is a link to a multitude of safety and sanitation inspection reports and environmental inspection reports. But the proof is simple: have the Monitors tested the safety and sanitation tool onsite with the inspectors and sent verification to IDOC? The answer is no. There are many examples of issues like this in the tracker.

Verification that a task is completed is documented in a column titled "proof". For almost all of the tasks, the proof is a large volume of documents. Links to 18 large volumes of documents verify 380 tasks. Implementation task #51 is "Fill IDOC Quality Improvement Coordinator position". The proof is the link "Quality Improvement". When this link is clicked it brings up all the documents requested for the 8th and 9th reports plus hundreds of additional documents none of which verifies that a quality improvement coordinator was hired. The proof for task #51 is simple: was a quality improvement coordinator hired, who is it and is the person qualified? The methodology to verify completion is unintelligible.

As a first step, the Monitor suggests defining for each task what completion consists of. This definition should be included in the tracker. The task is complete **only when** measurable indicators show the task is done. This can be:

- **Data**: a performance metric has been reached (a staff person has been hired or a process has been fully implemented)
- **A document** is completed: (policy is written, a list is developed, etc.)
- **An observation** verifies completion: (a process is developed to verify that remediation of adverse events occur- this is verified by visits to facilities to observe how an adverse event was successfully remediated).
- **A communication**: For a task such as "the audit team will train on audit methodology with Monitor on multiple site visits" is verified by an email from the Monitor that such training occurred with details of the training.

There currently appears to be no methodology to determine if a task is complete, nor is there a definition for completion for each task.

Almost half of the tasks on the tracker are listed as "completed" but are not complete. For multiple "completed" tasks the tracker states in the notes that information is past due or that the owner needed to confirm documentation for proof of completion.[42]

In September 2025, the Project Manager requested guidance from the Monitor on how to assess the proof that an item was completed. The Monitor recommended review of "completed" tasks by the Implementation Project Manager and the Monitor to assess completion and, if not, ways in which the task could be considered complete. IDOC agreed to have a monthly meeting with the Monitor to begin this process. However, on 11/6/2025 IDOC informed the Monitor that they were appealing the implementation plan order and on 1/8/2026 further informed the Monitor that they would not discuss progress toward completion of tasks because of their position with regard to the matter before the Court. It is apparent that the Department is not using the Implementation Plan as a tool to guide their efforts to improve the delivery of health care in IDOC.

[42] An example is Implementation Plan task #43.2 which states in part: "DOC 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." This is listed as 100% complete with a completion date of 4/5/25. Notes for this task include the following: "6/30/25- Deployment planned for 7/2025 per final approval timeline (April/May). 12/20- MB: Confirm Documentation for Proof of Completion". IDOC has no audit function nor does it have a policy, procedure, or a plan for developing one. How this can be listed as complete indicates a misunderstanding of what the audit is.

In summary,

- An Implementation Plan Project Manager has been hired, and a tracking device has been developed.
- The tracking document is not available to the Monitor any longer.
- Timelines in the tracker are inaccurate and need to be corrected.
- The format of the tracking tool spreadsheet needs improvement to be useful.
- Most tasks designated as "complete" are not complete in the opinion of the Monitor.
- The responsibility of owners and the Project Manager with respect to the Implementation Plan is unclear.
- This item is partially compliant based on having a project manager and a tracking device. However, the tracking device is not useful in its current form.
- IDOC has prohibited their Implementation Plan Project Manager from discussing multiple items in monthly meetings and these meetings have been discontinued.

RECOMMENDATIONS:

1. A workload analysis needs to be completed. This can be accomplished with assistance from the Monitor or via a hired consultant.
2. Staffing data needs to be in the format of budgeted, filled and vacant positions in the same format as the staffing analysis filed with the Court in 2021.
3. The tracking document for the Implementation Plan needs revision:
    a. Data used for proof of completion must be clear and precise to the task.
    b. Completion must be defined for each task. The definition should be on the tracker.
    c. Dates must align with the Court-filed Implementation Plan.
    d. A start date should be documented as listed in the Court-filed Implementation Plan.
    e. The proposed end date should be documented as listed in the Court-filed Implementation Plan.
    f. An accurate end date should be documented only when a task is completed.
    g. A days-to-complete-the-task entry is only for completed tasks. This should list the duration from the start date to the actual completion date.
    h. The days outstanding should be included in the tracker. This documents the days from the start date to the date the tracker is updated. This date stops being updated when the task is complete.
    i. The tracker should be updated at specified intervals (weekly, monthly etc.).
4. A written procedure should be developed on the Implementation Plan. It should include the maintenance of the tracker and the required involvement of staff including the Project Manager and the various Owners. This will be in place only until the Implementation Plan has been completed.

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

Staffing

FINDINGS:

Staffing Documentation and Analysis

To evaluate the Consent Decree provisions listed above, the Monitor requested the following documents:

1. A list of allocated/budgeted medical and dental positions (also noting FTE) with vacancies for each position at each facility to include IDOC and Wexford positions. These should be separated by position type. Aggregate positions statewide should be included (document request #8).
2. A list of SIU and OHS allocated or budgeted staff by position type, noting primary area of responsibility, with vacancies (document request #9).
3. The number of hours worked by staff employed by a staffing agency or locum tenens at each facility by job title since March 2025 to include dental hygienists and dentists (document request #14).
4. Facility Reconciliation of Hours worksheets since January 2025 (document request #16).
5. Minutes of any meetings with Human Resources, CMS, and vendor to review vacancies and identify barriers to hiring or any document describing progress on the effort to hire staff (document request #15).
6. Any document or information providing verification that all vendor and IDOC State positions are posted (document request #17).
7. For providers, the documentation of assignments for intake health assessments, infirmary rounds, urgent care clinic and chronic clinic for the month of May 2025 (document request #18).
8. Physician, NP, and PA assignments for each facility are to be provided to Monitor every six months and more frequently when new providers are hired or providers leave employment in IDOC. This is to include the provider's name, facility name, hours worked per week at that facility, and title (e.g., staff physician, Medical Director, "traveling medical director", NP, PA) at that facility. This document should note the names of providers and FTE or hours per week temporarily covering vacancies or prolonged absences/leaves (document request #19).

IDOC did not provide documents requested in numbers seven and eight above because of the recent change in vendors.

The information provided for this report is nonresponsive and insufficient and does not allow the Monitor to verify budgeted, filled, and vacant staffing numbers or to compare it to the Court-filed Staffing Analysis.

IDOC has produced five staffing documents in a format that provided full-time-equivalent (FTE) budgeted filled and vacant positions, including the Staffing Analysis filed with the Court.[43] These staffing documents use budgeted filled, and vacant State and vendor positions in comparable FTEs[44]. The Monitor uses the Staffing Analysis format to compare staffing because it is the official document filed with the Court. IDOC last produced a document in a similar format on 9/12/22. Staffing documents since then, have not been in the format IDOC used for the Staffing Analysis making it difficult to compare to the official Staffing Analysis document.

For the 7th Report, IDOC did not provide State staffing data so aggregate (State and vendor) staffing numbers could not be verified. For the same request of budgeted and filled OHS and facility staffing by facility and position type, IDOC has produced five, 22, and 10 different files respectively for the Monitor's 7th, 8th, and 9th Reports. None were in the format of the official Staffing Analysis. IDOC produced no tally, analysis, or aggregated information about staffing data provided to the Monitor. The Monitor was able to obtain the number of staff for the 8th Report only with considerable work. For this report, staffing numbers were unable to be verified due to an inaccurate list of IDOC staff[45] and the vendor files did not separate agency from regular staff hours which makes the file unusable for the purpose of providing accurate numbers of budgeted, filled, and vacant staff to compare to the official 2021 Staffing Analysis. For that reason, the Monitor cannot verify the budgeted, filled and vacant staff by facility and by position for this report.

Problems with the Current Data

- The data was nonresponsive the the document request. IDOC and vendor data was not aggregated as is the Staffing Analysis. Instead, IDOC supplied data for State and vendor positions separately and in different formats. State positions were given as allocated full-time positions with vacancies but the vendor gave budgeted FTE positions without giving vacancies. Instead, hours worked were given which included overtime and agency hours which are not equivalent to a filled full time position.
- The 2021 Staffing Analysis listed 501 State positions. By contrast, the State Filled Positions and Vacancies Spreadsheet dated 7.15.25 Payroll lists 575 State healthcare positions without explanation for the additional 74 positions. The Monitor found mental health positions were included and believes the payroll document is inaccurate with respect to medical and dental staffing.
- The payroll staffing file contains 52 State positions at Joliet Treatment Center but the 2021 Staffing Analysis contains only 2 State positions. These excess staff in the payroll file are likely mental health staff not medical and dental staff. IDOC should have corrected this prior to presentation as

[43] Staffing analyses produced by IDOC on 11/22/19; 6/18/20; 5/3/21; 8/17/21; and 9/12/22. The staffing analysis on 8/17/21 was filed in the Court as the official staffing analysis.
[44] State positions are termed allocated and mean that a FTE position works 37.5 hours. Lunch time is not counted as work. Vendor positions are termed Schedule E FTEs which are a 40-hour work week which includes the lunch time in work hours.
[45] The Staffing Analysis of 8/17/21 that was filed with the Court had 501 total State position. The file (State Filled Positions and Vacancies Spreadsheet 7.15.25 Payroll) provided by IDOC in document request # 8 had 575 positions. There were a number a social worker positions and a mental health position making it appear that this list included other than medical and dental employees. The difference of 74 was considerable leading to the conclusion that an erroneous file was provided.

data for medical and dental staffing; instead, they refused to acknowledge this as an error. The Defendants' V.G. Report (12/18/24) reported 294 State employed RNs.[46] The State employed RNs in the 2021 staffing analysis was 296 which is close to the number reported in the V.G. Report. However, data provided for this report (State Filled Positions and Vacancies Spreadsheet 7.15.25 Payroll) lists 319 RNs.[47]

- The vendor-calculated FTEs are based on hours worked and appear to include agency staff, making it impossible to determine budgeted, filled, and vacant FTE positions that are comparable to the Staffing Analysis filed with the Court.[48]
- The vendor worksheets for facilities gives aggregate hours-worked not facility-specific FTEs. Calculating facility-level FTEs would require approximately 2,250 manual calculations which has not been performed.[49]

Because of these discrepancies and without an acceptable explanation from IDOC explaining the variances, the Monitor cannot report an accurate number of staff as compared to the Staffing Analysis. We note that OHS staffing is equally unintelligible as described in the Leadership section of this report.

Facility Staffing

Even though staffing data is nonresponsive, lacking details on budgeted, filled, and vacant positions, there is evidence that staffing deficiencies affect operations. IDOC has not yet implemented policies, which significantly impairs progress toward compliance with the Consent Decree. This is supported by an HCUA who stated in quality improvement minutes,

> "There has been little to no training on the new procedures that are being rolled out. We also do not have the staff or tools that we need"[50].

The minutes of facility CQI meetings document numerous issues with lack of sufficient positions and ongoing vacancies that result in noncompliance with audits, untimely access to care, medication discontinuity.[51] When the Agency Director of Nursing told an HCUA that only registered nurses could do initial assessments the HCUA responded that the "staffing at the facility does not allow registered nurses to do sick call."[52] In February 2025 the HCUA at Logan requested increased FTE due to increased patient

[46] Page 8, Defendants' V.G. Report (12/18/24).
[47] The V.G. Report (12/18/24) lists 294 State RN staff at facilities on page 8 of its report. The State Filled Positions and Vacancies Spreadsheet 7.15.25 reported 319 RNs (11 CN1/CN2; 63 CN1; 6 CN1/2 and 239 CN2 RNs). The Monitor cannot verify staffing with this amount of unexplained variance. IDOC does not accurately account for its FTEs.
[48] The. Monitor strongly believes that the budgeted, filled and vacant positions format used in the Court-filed Staffing analysis should be used so comparisons can be made to the Department's Staffing Analysis. It is the Monitor's opinion that an additional file of hours-worked should be provided which separates agency from regular staff. This is useful to identify worked hours against the Staffing Analysis hours.
[49] The facilities list hours-worked by position type. To determine FTEs a calculation must be done to divide the hours worked by the expected work hours. This calculation is only provided for the aggregate statewide numbers. There are three spreadsheets (Jan-Feb; Mar-Apr; and June-July). There are 30 facilities each with mostly 25 position types or 25x30 calculations per spreadsheet or 3x30x25= 2,250 calculations.
[50] See document request #55 folder CQI 2025- folder March- file SHE CQI 3-12-25.pdf page 13.
[51] See Quality Improvement Committee minutes from January to June 2025. Included are statements that the average time to see a provider at Menard is 218 days and the average time to be seen in nursing sick call is 4 days at Sheridan when the standard is 24 hours, and backlogs for providers, nurses and dentists are reported by virtually every facility.
[52] CQI minutes from Lawrence CC for March 2025.

acuity but was told by the vendor's Regional Manager that was not possible.[53] Multiple adverse events were reported that also indicate insufficient staffing.[54] The Monitor believes that deficiencies in clinical outcomes, as well as poor performance documented in Monitor record reviews, SIU and Monitor mortality reviews[55], and SIU performance and outcome measure scores are related in part to inadequate staffing. On 10/31/25, the Monitor interviewed the Acting Agency Medical Director. When the Monitor asked if the Acting Medical Director thought that additional physicians were necessary, the attorneys objected and asked the Agency Medical Director not to respond.[56]

IDOC stated that meetings between Central Management Services, Human Resources, and the vendor to review progress on staffing do occur but no minutes or other documentation was provided.[57] There was no effort to summarize what was discussed at these meetings or any steps that might have been taken to improve staffing that were provided to the Monitor. It is not possible to determine what steps have been taken at IDOC to improve staffing of the health care program.

In response to document request #17 about posting all budgeted positions, the vendor provided no information. IDOC submitted an undated posting document for State positions which was not useful. Issues included:

- Postings do not match the vacancies listed on the State Filled Positions and Vacancies Spreadsheet 7.15.25 Payroll document.
- Some positions appear on the posting document that are not found on the State Filled Positions and Vacancies Spreadsheet 7.15.25 Payroll document.

It cannot be verified whether all vacancies are posted, whether positions postings are timely, or whether postings represent actual positions.

IDOC did not provide the requested budgeted FTE data; instead, it submitted an inaccurate number of State employees and the number of FTE hours worked at each facility. The hours worked at each facility reflects the volume of clinical activity performed, it does not show the number of full-time equivalent (FTE) positions allocated, filled, or vacant. This omission prevents the Monitor from determining whether facilities are staffed in accordance with contractual or Schedule E requirements and whether the vendor is meeting its staffing obligations to IDOC.

FTE counts are essential because they measure staffing *capacity*—the system's structural ability to provide care—rather than simply the hours worked. Work hours represent output, while FTE data reflect

[53] CQI minutes from Logan CC for February 2025.
[54] See document request #68 IDOC Adverse Events from May 1, 2024 to July 30 2025. This file has numerous examples of adverse event reports due to staffing.
[55] Death reviews continue to show very poor care and preventable deaths that the Monitor believes are directly attributable to inadequate physician coverage. Despite very high vacancy rates, the budgeted physician numbers have decrease as well from 46.2 in the initial staffing analysis in November of 2019 to 31.47 in the May-June Schedule E physician number. This is a 32% decrease in the face of very poor care with evidence of a lack of physicians. The was no workload analysis that determined this number and the concern is that it may result from inability to recruit sufficient physicians and cost savings.
[56] There were three lawyers, the Monitor and the Acting Agency Medical Director on this WebEx meeting. Two attorneys explained that they could not permit any discussion of issues related to the current court hearing on staffing or related to the Special Report which constitute essential items for discussion for the Monitor's report.
[57] Minutes of any meetings with Human Resources, CMS, and vendor to review vacancies and identify barriers to hiring or any document describing progress on the effort to hire staff (document request #15).

whether sufficient personnel are available to sustain that output. Without verified FTE counts, the Monitor cannot determine whether the reported hours represent permanent staff or a patchwork of part-time, locum tenens, agency or shared personnel. This lack of clarity applies equally to the physician**, dental and nursing staffing,** where fragmented or rotating coverage can undermine continuity of care, delay treatment, and limit program oversight.

The implications extend beyond operational management. Under the Consent Decree, IDOC is required to maintain a sufficiently staffed and sustainable system to ensure adequate medical, dental, and nursing care. Hours worked data may show service volume but cannot demonstrate compliance with required staffing levels (as in the Staffing Analysis) or support analysis of vacancy rates, staffing ratios, productivity per FTE, and workforce stability. Without accurate FTE data across clinical disciplines, the Monitor cannot confirm whether IDOC possesses the structural capacity to provide timely, consistent, and adequate care.

In short, while hours worked provide a snapshot of activity, FTE data reveal the Department's ability to sustain that activity over time. Absent verified FTE information for both state and contractual positions, the Monitor cannot assess compliance with the Staffing Analysis, staffing adequacy, contractual compliance between IDOC and its vendor, or the overall stability of health care delivery within the Department. The absence of FTE data across physician, nursing, and dental services limits the ability to evaluate access to care, continuity of treatment, and progress toward achieving compliance with the Consent Decree.

Staffing through Academic Centers

University of Illinois at Chicago (UIC)
To evaluate staffing provided by UIC, the Monitor requested the following documents

- Provide all vendor contracts and subcontracts since January 2024 including medical/dental care contracts, pharmacy, laboratory, dialysis, etc. (document request #1).
- Any documents representing any new arrangements with academic centers, or other organizations including for physician coverage and specialty care (document request #29).

Since 2009, UIC has provided telemedicine services for HIV and hepatitis C treatment. Transgender care has been provided since 2021. IDOC recently expanded the relationship with UIC to include:

- An expansion of the telemedicine diabetic treatment program to all individuals with uncontrolled diabetes, requiring insulin, SGLT2 inhibitors, GLP1 analogues or those patients with diabetes and coronary artery disease, nephropathy, or pregnancy.
- IDOC is starting a program of in-person and telemedicine multispecialty care conducted at the JITC facility. According to IDOC, this program does not increase overall specialty care visits but shifts some visits from the UIC Medical Center to an IDOC facility.

Southern Illinois University (SIU)
The Monitor requested 12 documents related to the work of SIU as follows:

- Provide all vendor contracts and subcontracts since January 2024 including medical/dental care contracts, pharmacy, laboratory, dialysis, etc. (document request #1).
- Hours of SIU consultant time provided since July 2024 by consultant type. Please be sure to include the project managers or other experts (document request #6).

- A list of SIU and OHS allocated or budgeted staff by position type noting primary area of responsibility, with vacancies (document request #9).
- The position description for the Health Matters Program Director at SIU (document request #20).
- The CV of the person filling the position of Health Matters Program Director at SIU (document request #21).
- The CVs of the physicians filling the 1.0 FTE Primary Care Physician at SIU (document request #22).
- The position description for the project manager from SIU for Policies and Procedures (document request #23)
- The CV of the project manager from SIU for Policies and Procedures (document request #24).
- The position description for the Deputy Director Quality Integration from SIU (document request #25).
- The position description of the regional PharmDs from SIU (document request #26).
- The position description of the Medical Director of Women's Correctional Health from SIU (document request #27).
- Any documents representing any new arrangements with academic centers, or other organizations including for physician coverage and specialty care (document request #29).

IDOC provided a 2019 contract with SIU which was to provide physician staffing at four IDOC facilities, but this contract was never accomplished. Since then, the work performed by SIU has changed but has not been memorialized in a revised contract. IDOC did not provide the position description of the Medical Director of Women's Correctional Health. The Monitor presumes this position does not exist any longer.

Instead of providing SIU budgeted positions with vacancies[58], IDOC provided proposed draft budgets for:

- FY 2025: 55.85 FTEs
- FY 2026: 64.85 FTEs[59]

IDOC reported that SIU provided 48,104 consultant hours across eight consultant types (equivalent to approximately 24 FTEs) from July 2024 to June 2025.[60] It is unclear whether these consultant hours are part of the budgeted positions listed above.

The responsibilities of SIU have varied widely since the initial contract was signed in 2019. The Monitor is unable to determine SIU's staffing or deliverables and recommends that IDOC provide a consolidated document for each report documenting SIU's current scope of work and staffing. Two recommendations were added to update the scope of SIU's responsibilities in a written document annually.
The Monitor has received the following data and information from IDOC about SIU's work product:

- **Mortality Reviews:** The Monitor receives SIU mortality reviews on a secure site.

[58] Monitor's document request # 9.
[59] OCM FY25 Draft Proposed Budget and OCM FY 26 Draft Proposed Budget in document request #9.
[60] Document request number 6 is, "Hours of SIU consultant time provided since July 2024 by consultant type. Please be sure to include the project managers or other experts".

- **Performance and Outcome Measures:** These are produced quarterly but only shared in response to report requests, not when created.
- **Adverse Event Reports:** SIU enters adverse event reports into its REDCap database and identifies and conducts morbidity reviews on events they consider serious. IDOC provided a spreadsheet of adverse events taken from the database for this report (document request 068), but these are not shared when created.
- **Medication Management Analysis:** This began in 2021.[61] SIU hired a pharmacist as Director of Pharmacy Standards and Operations.[62] Defendants' V.G. Report (12/18/24), stated that SIU was in process of performing a statewide pharmaceutical administrative review, had surveyed eight facility sites, and produced reports. [63] Despite repeated requests by the Monitor no survey results or reports have been provided and little is known about this project despite having been started in 2021.
- **Dental Oversight:** Defendants' V.G Report (12/18/24) stated that SIU hired a Dental Director to provide oversight over the dental quality programs.[64] The Monitor has not yet met this individual.
- **Policy Management:** SIU reportedly hired a project manager for policies, but this position does not appear in the SIU FY 2026 proposed budget.[65] The Monitor requested a position description for this position. IDOC sent a position description of a Senior Quality Specialist which has no specific assignments as project manager for policies. This person was not in attendance at a meeting on October 30, 2025, to update the Monitor on the policy review process, even though specifically requested to attend. It does not appear that SIU has a designated Project Manager for policies.
- **Health Matters Training Program:** SIU has developed a "Health Matters" training program for inmates and staff, producing five clinician-specific grand round videos, five patient-specific videos, and three patient/clinican videos.

The Monitor is unaware of any other SIU work product.

IDOC has not pursued obtaining primary care physician services with a university program since its initiative with SIU failed several years ago. IDOC provided no plans for a university-based primary care initiative.

Summary

- Given the data and information provided, the Monitor cannot determine the number of budgeted, filled, and vacant positions for OHS, SIU, or the facilities and cannot make a comparison with the expectations in the Court-filed Staffing Analysis.
- Vendor-reported hours worked data do not distinguish regular staff from agency staff.[66]
- Data provided for State positions[67] is inaccurate making it unusable for to determine medical and dental staffing.
- The scope of services provided by SIU remains undefined.

[61] This was mentioned in the 5th and 6th Monitor Reports in the Pharmacy and Medication sections
[62] This was discussed in the Monitor's 7th Report in the Pharmacy and Medication section on page 187.
[63] Defendants' V.G. Report (12/18/24) page 15
[64] Defendants' V.G. Report (12/18/25) page 43
[65] Health Care Monitor 8th Report, Lippert v. Jeffreys, November 13, 2024, page 90, 92.
[66] Three files in the Wexford folder provided in document request #8.
[67] State Filled Positions and Vacancies Spreadsheet 7.15.25 Payroll provided in document request 8.

- IDOC has not shared all SIU work product with the Monitor.
- The Defendants' V.G. Report 12/18/24 lacks sufficient data on budgeted, filled, and vacant medical and dental positions and on agency staff.

Staffing as Discussed in the Monitor's Special Report
In response to the continued lack of staffing, the Monitor released a Special Report that included staffing and the staffing Analysis as deficiencies related to Consent Decree provisions II.B.2., II.B.3., IV.A., and I.V.B. of the Consent Decree.[68]

Defendants offered no plans to address these areas at the meet and confer.[69] No IDOC administrative or clinical staff were present at the meet and confer.

Defendants and the Monitor disagree that the staffing analysis filed with the Court in 2021 was an adequate analysis. For nursing positions, IDOC listed patient encounters for 11 nursing activities. The "analysis" consisted of surveying HCUAs to estimate the number of staff needed to perform the nursing service. No other positions were included in any analysis. All positions were estimates without consideration of the impact of new policies or the electronic record.

In their written response to the Special Report[70], Defendants question the accuracy of the Monitor's data when reporting budgeted positions. The Monitor has used staffing data provided by IDOC for all prior reports. For this report, the State staffing numbers appear inaccurate, and vendor hours are only hours worked and not budgeted vs. filled staff.[71] Staffing data provided by IDOC to the Monitor for this report was not useable for comparison to the Staffing Analysis from 2021.

In their written response to the Special Report, Defendants state the Monitor made comments about IDOC supervisors without disclosing which supervisors made the assertions. It is true that on multiple occasions supervisors have stated that there is insufficient staffing. It is inaccurate that Defendants are not informed of who made the statement. All of these assertions are in the Monitor's reports as was the one they referred to.[72]

In their written response to the Special Report, Defendants state that the Monitor has a preferred method of analyzing staffing.[73] There are multiple ways to conduct a staffing analysis. The Monitor has offered

[68] The Consent Decree requires in provision II.B.2. that IDOC have "adequate qualified staff" and provision II.B.3. requires that IDOC "provide enough trained clinical staff… and oversight by qualified professionals, as well as sufficient administrative staff". Provision IV. A. requires IDOC to conduct an analysis of staffing sufficient to meet obligations and objective of the Consent Decree; IV.B. requires implementation of the plan and hiring of the staff.
[69] Meeting held October 8, 2025.
[70] Defendants' Response to the Special Report, dated November 14, 2025, page 6.
[71] The Monitor assesses two sets of staffing data. One is the number of budgeted positions that are filled in order to compare it to the Court filed staffing analysis to evaluate progress in filling positions. The second set of data is to ascertain how much coverage there is. This assessment would include budgeted staff and overtime and agency staff. The first set of data is to ascertain how well IDOC is performing compared to their staffing analysis, and the second to determine the effective number of staff working as compared to the staffing analysis.
[72] The supervisors in question in the Defendant's written response was related to **interviews of two Regional Coordinators. The interviews were attended by IDOC legal counsel so IDOC should be aware of their comments.** This interview is discussed on page 91 of the Monitor's 8th Report. Both Regional Coordinators stated that the primary barrier to implementation of the policies and procedures was staffing.
[73] Defendants' Response to the Special Report, dated November 14, 2025, page 7.

to go to facilities with the vendor and IDOC senior staff to conduct an analysis of staffing. The Monitor does not have a preferred method but is of the opinion that that the analysis conducted by IDOC was not adequate for the reasons stated three paragraphs earlier.

In their written response to the Special Report, Defendants conclude by stating that:

> "…the Department's position is that it is in substantial compliance with the Decree's requirements with respect to staffing and a staffing analysis, " and " The Department will continue its ongoing work to assess its staffing needs …"[74]

The Monitor notes that the last statement above is consistent with a statement in the Court-filed Staffing Analysis that states,

> It must be noted that this analysis should be considered a starting point with the understanding that the needs of IDOC's healthcare system are dynamic and modifications of this analysis will be required to accommodate those changes.[75]

In their written response, Defendants state that the decrease in population warrants a decrease in staffing and added that "The Department noted that the specific staffing targets set forth in the 2021 staffing analysis report were not fixed but instead would evolve over time". [76] The Monitor agrees and recommends that IDOC act on its intention to reassess staffing with changing conditions. The population has dropped, policies have been written and a new electronic record will be implemented in the future. It is time for a reassessment of staffing need; a new workload analysis is indicated. During these changes that have occurred, IDOC has never re-evaluated their staffing even though they state it may be necessary to do so.

Defendants state that the Monitor does not provide documentation in accordance with V.H. and V.E. to provide sufficient information to evaluate his conclusions of noncompliance. [77] The following is offered including:

- This and prior Monitor Reports should be reviewed, with special attention to the Staffing Analysis and Staffing sections
- Defendants' own data provided for staffing over the past Monitor Reports should be examined to show the information provided to the Monitor on a report-to-report basis.
- Comparison of the 2021 Staffing Analysis filed with the Court and current budgeted and filled positions.
- Comparison of the 2021 Staffing Analysis filed with the Court and current hours worked by position.
- Comments by IDOC supervisory staff that there are insufficient staff.[78]

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[74] Defendants' Response to the Special Report, dated November 14, 2025, page 7.
[75] Page 4 in the 8/17/21 Staffing Analysis filed with the Court.
[76] Defendants' Response to the Special Report, dated November 14, 2025, page 7.
[77] Ibid, page 11.
[78] Page 14 and page 91 in the Monitor's 8th Report Regional Coordinators stating was the key issue with failure to implement policies.

- Staffing deficiencies resulting in clinical deficiencies.[79]
- The Monitor notes that Defendants' own vendor, HMA, recently initiated work and noted the following observations about staffing:[80]

1. Position vacancies or absences, including those with time sensitive responsibilities (scheduling, grievance response, provider, medical director), are not adequately covered creating disruptions in service delivery and surveillance of patient and system risk.
    - Pay for critical postings is reported as less than market, including benefits.
    - Use of locum and agency for positions. No clear standardized onboarding process.
    - Critical long-term vacancy filled but person sent out of state for training by Wexford.
2. Staffing is based on contract numbers rather than patient outcomes, including numbers that are not adjusted to patient acuity/changing patient needs/patient volume (e.g. ADP doubled without increase in staffing numbers).
3. Tracking of staffing does not answer critical care delivery questions as they stand. Was service provided by appropriate clinician? Was it timely? Was there access?

Not only does IDOC's own vendor acknowledge staffing deficiencies but items 2 and 3, above, in their observations support a staffing analysis to determine current needs.

Defendants ask the Monitor to provide, in writing, recommendations to achieve compliance.[81] This has already been done in this and prior reports. These recommendations include the following:

- Recommendations 1 and 2 in the Monitor's current Report in Staffing Analysis and Implementation Plan section's recommendations.
- All recommendations in the Staffing section recommendations at the end of this section of the Report.
- Implementation Plan task numbers 1.a., 1.b., 2, 2.b.-d., 3, 4, 8.a., 37, 47, 51a,

Conclusion: Due to insufficient, inaccurate, and inconsistent data, this provision remains noncompliant.

RECOMMENDATIONS:

1. Develop a recruitment plan with the explicit mission to reduce the rate of vacancies. Responsible parties include OHS, the vendor, 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 Medical Director, DON, and Nurse Supervisor positions to increase accountability for performance improvement.
3. IDOC needs to provide budgeted and vacant State, vendor, and OHS positions, separated by type of position quarterly. This needs to be provided by facility and with cumulative regional and systemwide aggregate numbers that combine vendor and State staff. The data needs to be provided in the format of the Staffing Analysis for comparison. Separately, hours worked should be provided to include contribution of agency, overtime and compensation time hours to evaluated

[79] See page144-145 in the Monitor's 8th Report on nursing staff deficiencies affecting nursing sick call performance.
[80] Monthly Task Meeting PowerPoint, slide number 7 as provided in document request 73 for the Monitor's 9th Report.
[81] Defendants' Response to the Special Report, dated November 14, 2025, page 11.

whether each FTE is working the hours expected.

4. 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.
5. 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.
6. 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.
7. The IDOC audit, related to provision II.B.9., should include an evaluation of staffing.
8. Implement policy C.06.01 Staffing Levels.
9. IDOC needs to provide accurate budgeted, filled, and vacant SIU positions with primary areas of responsibility.
10. The scope of services for SIU should be presented annually in a document unless these are specified in the contract.

Oversight over Medical, Dental, and Nursing Staff

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.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: Noncompliance

FINDINGS:

Credentialing of Physicians and Dentists

To evaluate the Consent Decree provisions listed above for physicians, the Monitor requested four documents[82]. IDOC provided no documents.[83]. They began transitioning to a new vendor in June of 2025 but as of December of 2025, IDOC has not sent any credential packets for any physicians. The Monitor has no information about the number of physicians the new vendor has hired.

IDOC notified the Monitor on 6/23/25 that they were entering into a transitional contract with a new vendor. The Monitor met with the new vendor on 9/9/25 and requested that, prior to hiring a physician, the credential packet be presented to the Monitor. In a briefing document, the Monitor provided the vendor with the following requirements:

- Consent Decree III.A.2 requires all physicians to have board certification in Internal Medicine, Family Practice or Emergency Medicine or to have completed residency training in one of these fields.
- IDOC has consistently failed to obtain credential documents for physicians from the vendor in a timely manner.
- The Monitor requires credential packets to include primary source verification of the following:
    - Completion of medical school,
    - Completion of residency training,
    - Board certification if completed,
    - National Practitioner Data Bank report,
    - Curriculum Vitae,
    - Copy of current state license,
    - Copy of current state substance control license,
    - Copy of current DEA license, and
    - Signed privileging sheet.
- IDOC policy C.01.01, requires physician credential files to be maintained onsite at each facility where the physician works. The Monitor has recommended maintaining a central OHS credential file instead, to prevent duplicate credential files for physicians working in multiple sites, reduce the burden on facilities, and provide greater privacy for credential information.
- As of the last Monitor report, one full-time physician was working without credentials but with Monitor approval . In addition, five physicians without proper credentials were working part-time in IDOC facilities, including one Regional Medical Director. Another physician, though credentialed, signed a privileging sheet declining participation in direct patient care. Physicians unwilling to provide patient care should not be employed. Physicians without credentials may only do so with the Monitor's explicit approval.

The numbers of physicians recruited was not discussed.

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[82] Document requests #30, 32, 33, and 35.

[83] In response to document requests #30, 32, 33, and 35, IDOC responded as follows: "The Department requested responsive records from Wexford. On August 15, 2025, at 10:19 am, IDOC received a document production from Wexford purporting to be responsive to IDOC's requests for information. However, given the timing of the production, IDOC needs additional time to review the documentation and determine its responsiveness for accuracy. IDOC will supplement its responses as appropriate.

The Monitor is hopeful that IDOC will not continue the prior vendor's practice of failing to provide credentialing information in a timely or complete manner. Transfer of credentialing information is the responsibility of IDOC, which must ensure timely delivery.

IDOC submitted policy C.01.01 Licensure and Credential Verification to facilities in February of 2024. The policy was due for annual review in April of 2025. During this time, the selection of the new Monitor had not been finalized, and the Monitor's review of the policy was not completed until 8/22/25.

Monitor's Recommended Policy Additions

- Credentialing procedures for all professional groups, not just physicians;
- Assurance that staff assigned to prenatal care are appropriately credentialed for that role.
- Biennial recredentialing for physicians, physician assistants, nurse practitioners, and dentists;
- A defined sequence of review prior to hiring;
- Inclusion of a privileging sheet in every credential packet prior to beginning work;
- Inclusion of a collaborative agreement with a supervising physician for physician assistants or nurse practitioners;
- A prohibition on professionals working until their credential packet is approved;
- Documentation in RN credential files of training required by AD 04.03.121 Treatment Protocols procedure G.3.b. if they practice under treatment protocols; and
- Verification that Infection Control Nurses and Quality Improvement Coordinators have appropriate experience and training.

The Monitor accepts the IDOC policy requiring credential files to be maintained at the facility level but continues to believe this approach is unnecessarily burdensome and creates additional security risks with respect to personal information. There is no evidence that this policy has been implemented.

Having sufficient credentialed physicians was included in the Monitor's recent Special Report submitted to the Parties and to the Court. This is based on the lack of an adequate staffing analysis of physician need and failure to hire sufficient qualified physicians.

The initial staffing analysis of 11/23/19, included 47.2 budgeted physicians.[84] The final staffing analysis filed with the Court 8/17/21 included 33.465 budgeted physicians. This decrease in physicians was unexplained and without documented analysis. The last staffing information provided by IDOC was on 8/6/24 for the Monitor's 8th Report that showed there were 33.7 budgeted physicians but only 16.49 physicians working[85] for 30 facilities.[86] As the Monitor stated in the 8th Report[87], "Physician staffing is dangerously low. Pending a workload analysis, the Monitor advises IDOC to increase budgeted physician staffing". IDOC is unable to recruit and retain qualified (credentialed) physicians. Ten or more facilities do not have a physician. The shortage of physicians is dire and dangerous and for that reason, the Monitor included it in the Special Report.

At the Special Report meet and confer, Defendants did not offer any plan to correct the problem.

[84] Excluding one obstetrician.
[85] Facility Reconciliation Worksheets – Q3'24 Lippert provided 8/6/24 for document request 10 Monitor's 8th Report
[86] Stateville has since closed.
[87] Page 24 Monitor's 8th Report

Defendants letter to Plaintiffs inaccurately argues that the Special Report estimates that 94.6% of physician hours provided were from physicians with appropriate credentials. This statement was not in the Special Report and the Monitor can not locate it in recent reports so it is unclear where this statement came from. Defendants also argue in support of their assertion of compliance in their written response that the Special Report estimates that 29 of 33 physicians working in IDOC have appropriate credentials. There is no such statement in the Special Report. The Monitor believes the statement comes from the Monitor's 8th Report and is a misrepresentation. The Monitor's 8th Report has a table (on page 30 of the 8th Report) that lists all credentialed physicians and 29 of 33 had credentials. However, the Monitor points out that there were only 16.49 FTE physicians who worked. Many of the physician were locum tenems and worked part-time or worked only for a short period of time. The issue is the physician shortage. IDOC cannot recruit and retain qualified physicians.

IDOC has 16.49 of 33.7 (49%) of physician positions filled and do not have enough budgeted physicians. Instead, of having a plan to correct this serious deficiency, they state:

> It is the Department's position that the Department is in substantial compliance with the Decree's requirement for the credentialing of physicians and denies that any additional steps are necessary to bring credentialing of physicians into compliance.

Defendants state in their written response to Plaintiffs that the Monitor does not provide documentation in accordance with V.H. and V.E. to provide sufficient information to evaluate his conclusions of noncompliance. The following is offered including:

- IDOC has 16.49 of 33.7 (49%) of physician positions filled. There are 29 facilities.
- HMA, an IDOC vendor stated the following.
    - Position vacancies or absences, including those with time sensitive responsibilities (scheduling, grievance response, provider, ***medical director*** [Monitor's emphasis]), are not adequately covered creating disruptions in service delivery and surveillance of patient and system risk
        - Pay for critical postings is reported as less than market, including benefits
        - Use of locum and agency for positions. No clear standardized onboarding process.

Defendants asks the Monitor in its written response that the Monitor provide, in writing, recommendations to achieve compliance. This has already been done in this and prior reports. These recommendations include the following:

- Recommendation number 7 in Credentialing section of this Report.
- Recommendation number 8 in Staffing section of this Report.
- Recommendation number 1 and 2 in the Staffing Analysis and Implementation Plan section of this report.
- Implementation tasks 1.a., 1.b., 3, and 4.a.
- Raise salaries of physicians steadily and incrementally until physicians are willing to work.
- Do exit interviews with regular and locum tenens physicians to determine what are the benefits and disadvantages of the physician position in IDOC and attempt to eliminate the disadvantages.

In summary:

- IDOC has changed vendors in June, 2025 but as of December of 2025, IDOC has not sent to the

Monitor credential packets for any physicians.

- At the time of the change to a new vendor, physician staffing was dangerously low and there were insufficient credentialed physicians. IDOC has not informed the Monitor of any new physician hires by the new vendor.
- The Monitor met with the new vendor in September of 2025 and requested that credential packets be submitted to the Monitor prior to hiring. None have been received.
- Given that IDOC has provided no credentialing information regarding physician hires, this provision is found noncompliant.

Credentialing of Dentists

The Monitor requested the following data:

- The vendor policy and procedure for verifying credentials of physicians, dentists, and mid-level providers as described in IDOC policy C.01.01 Licensure and Credential Verification policy item V.[88]
- Curriculum vitae of all current Wexford physicians and dentists.[89]
- Latest complete credential files of all current physicians, mid-level providers and dentists as maintained by IDOC as described in policy C.01.01 Licensure and Credential Verification policy item VII.[90]

While the Vendor's late response may explain the absence of its submissions, it does not fully account for the Department's inability to produce any of the requested documentation. Policies governing licensure and credential verification presume shared responsibility and redundancy, particularly for documents critical to patient safety and regulatory compliance. At a minimum, the Department should maintain copies of credentialing policies, curriculum vitae, and credential files that have been reviewed and approved by the Chief of Oral Health Services, with copies retained at Central Office. Reliance on a single external source for essential credentialing records creates an avoidable vulnerability. Redundant documentation is not duplicative; it is a fundamental safeguard to ensure continuity, oversight, and accountability within the Oral Health Services Program.

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. 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.

[88] Document Request #30.
[89] Document Request #31.
[90] Document Request #32.

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.[91]
7. IDOC should vigorously explore opportunities to expand affiliations with academic medical centers in Illinois to include the recruitment and hiring of physicians.
8. Establish redundant credentialing record retention at Central Office. IDOC should maintain complete and current copies of all medical and dental credentialing documentation, including licensure verification, curriculum vitae, and credentialing approval records, for each clinical provider. These records should be retained at Central Office following review and approval by IDOC OHS leadership.

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

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;*

[91] 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.

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.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.*

OVERALL COMPLIANCE RATING: Noncompliance

FINDINGS:

Oversight over Medical Staff

In June of 2025, IDOC changed medical vendors. IDOC has not yet officially informed the Monitor of any Centurion providers and has not provided credential information .

IDOC does not have a policy on annual performance evaluations and should develop one.

The Monitor requested a list of videos, brochures and any other training materials developed by SIU for use by IDOC with staff or patients (document request #36). Six clinician instructional videos were listed but the videos could not be accessed. The videos include how to write a SOAP note, suture removal, risk stratification for chest pain, testicular cancer awareness, and how to perform a diabetic foot examination. The attendance at these videos is not captured so it isn't clear if anyone attended.

The Monitor also requested the dates, topics, and presenters at OCM Grand Rounds. If attendance is tracked please provide the names and credentials of those attending. List how many are intended to receive training and how many received training (document request #38). Ten grand rounds were listed. There were 10 grand rounds listed with an average of five individuals attending statewide for the 28 facilities per session. Many of the attendees were OHS staff.

The Monitor requested all providers referred for peer reviews performed as a result of mortality reviews, adverse event report, or for other reasons since July of 2024. Include the actual peer review. Include any log that tracks peer review - Who was referred, date referred, reason for referral, current status, outcomes of any, etc. IDOC stated that they do not track this information and asked the Monitor to review the Mortality Reviews for referral to peer review. That IDOC does not track this information supports a finding that IDOC does not perform any oversight.

The Monitor requested annual clinical performance reviews of physicians, nurse practitioners, physician assistants, dentists, dental hygienists, and dental assistants since July 2024 (document request #40). No information was provided except for dentists. IDOC explained that they received documents from their prior vendor but needed additional time to determine responsiveness and accuracy. No further response occurred.

The Monitor requested documents that provide verification for Consent Decree provision II.B.6.r. which states 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. The Monitor asked for data and information on how IDOC implements this provision and give all instances when IDOC has implemented this provision. Provide pertinent policy or procedure (document request #42). The Monitor also requested and any disciplinary action taken against physicians, nurse practitioners, and physician assistants, since July 1, 2024 (including both vendor and state employed personnel (document request #43). IDOC did not respond to these requests and stated that they received documents from the prior vendor but needed to assess them for accuracy and responsiveness but made no further response.

The failure to provide any data or information related to oversight over physicians and mid-level providers makes II.B.2., II.B.3., II.B.6.q., II.B.6.r., and III.A.4. noncompliant.

Oversight over Dental Staff

Dentist Performance Evaluations

All submitted performance evaluations were completed using Wexford's Peer Review form (PR-001C). The Monitor received 26 dentist performance evaluations conducted between February 11, 2025, and June 30, 2025. Performance evaluations for two dentists employed by the mobile vendor, Jet Dental, during this period were not submitted. In addition, no performance evaluation was submitted for the Vendor's lead dentist, who provides clinical care within the IDOC system.[92]

The ratings ranged from "Poor" to "Excellent," with the majority assessed as "Fair." Specifically, the evaluations included one "Poor," twenty-two "Fair," three "Good," and one "Excellent" rating. In prior reporting periods, network dentists evaluated one another without formal training or standardized criteria, limiting the reliability of those reviews. In the current submission, the Vendor's lead dentist completed all evaluations, which standardized the process and improved consistency and objectivity.

Given the Department's engagement of a new vendor, the Monitor encourages performance evaluations to place greater emphasis on the quality and performance of clinical care. The Wexford Peer Review form (PR-001C) primarily focused on administrative and process-related elements, and while it references the appropriateness of care, it does not adequately assess clinical quality or provider performance.

Accordingly, the Monitor recommends the development or adoption of an evaluation instrument that more fully assesses clinical care standards and provider competency. Such evaluations should be conducted on-site, rather than solely through remote record review, and should involve the Vendor's designated lead

[92] The Chief of Oral Health Services or the Vendor's Dental Director should review the lead dentist.

dentist and/or the Chief of Oral Health Services to ensure meaningful, direct assessment of clinical performance.

Performance Evaluations of Dental Hygienists and Dental Assistants.

The Monitor requested annual performance evaluations for dental hygienists and dental assistants. Evaluation data submitted by Wexford were compiled during March and April 2025.[93] The number of evaluations received is summarized below:

Clinician	IDOC	Wexford
Dental Hygienist	0	22
Dental Assistant	0	36

The vendor's performance evaluations assess multiple domains, including Attitude, Job Knowledge, Quality, Productivity, and Attendance. Each domain is rated on a numeric scale from 1 to 10, with the individual scores combined to produce an overall performance rating.

Review of the evaluations revealed that assessments of **Job Knowledge** and **Quality** were not completed by a licensed dentist. Instead, the evaluations were predominantly conducted by non-dental personnel, raising concerns about the clinical validity of ratings in these domains. Additionally, narrative feedback was frequently absent. Specifically, **26 dental assistant evaluations and 18 dental hygienist evaluations contained no narrative comments**. This absence of supporting documentation is notable, as ratings at the lower end of the scale (6 and below) should include explanatory feedback, and ratings at the higher end of the scale (9 and above) should be supported by descriptive narratives to substantiate performance strengths.

Because dental hygienists provide direct clinical care, their performance evaluations should include a comprehensive assessment of clinical competency. Similar to dentist evaluations, hygienist evaluations should address core clinical domains, including periodontal assessment, quality of care, radiographic competency, infection control and OSHA compliance, oral health education, and clinical documentation. These areas require evaluation by a licensed dentist, as non-dental personnel are not qualified to assess clinical judgment or the quality of dental care.

Accordingly, the Monitor recommends that the Chief of Oral Health Services collaborate with the new vendor to ensure that clinical competency for dental hygienists is evaluated by appropriately qualified dental professionals. In addition, dentists responsible for supervising clinical care at IDOC facilities should provide direct input into the performance evaluations of both dental hygienists and dental assistants.

Oversight over Nursing Staff

The Monitor requested the following documents to review oversight of nursing practice:

[93] It is unclear whether the Department withheld the evaluations or whether they were simply not completed or made available until the end of the year.

- Tables of organization for Northern Region facilities medical programs including HCUAs, Medical Director, state and vendor medical employees and site leadership.
- A list of allocated/budgeted medical and dental positions (also noting FTE) vacancies for each position at each facility to include IDOC and Wexford positions. These should be separated by position type. Aggregate positions statewide should be included.
- List of corrective actions or process analyses initiated due to mortality reviews, performance and outcome measures, adverse event reports, or any other reason.
- Annual nursing clinical performance reviews over the past year.
- Nursing disciplinary actions over the past year (including both vendor and state employed personnel).
- List training completed in the last 12 months for any nurses employed by either the state or the vendor at NRC, Graham, Menard, Logan, Stateville, Illinois River, and Pontiac.
- List the dates, topics, and presenters at OCM Grand Rounds. If attendance is tracked, please provide the names and credentials of those attending.

Capacity to supervise nursing practice

Compliance with the provisions of the Consent Decree requires change in the delivery of nursing care and the customs and practices of nursing staff in the IDOC.[94] These changes will not occur spontaneously. Directors of nursing and nursing supervisors with clear lines of authority are essential if these changes are to be achieved and patient outcomes improved.

The organizational charts of eight facilities in the Northern region were reviewed.[95] At Dixon the director of nursing reports to the HCUA. The facility has four nursing supervisor positions, and all were vacant in the last staffing report received.[96] The facility has allocations of 50 registered nurse positions. The vendor is allocated 12 LPN and 14 nursing assistant positions. This is a total of 76 nursing positions who are supervised by the director of nursing.

Statewide there are 29 nursing supervisor positions allocated, however only a third of these positions are filled.[97] The nursing supervisors should be doing the bulk of daily supervision of nursing staff, but IDOC only has a third of the capacity it has determined it needs. The problem of supervision is exacerbated when there are also high vacancy rates among nursing staff because the nurse supervisor and director of nursing have their time diverted from supervision to scheduling, onboarding new or temporary staff, and providing direct patient care. The HCUA certainly assists with supervision but even then, this is insufficient oversight to implement changes that must be made in the delivery nursing care safely.

Five of the facilities organizational charts that were reviewed show an appropriate line of accountability for leadership and supervision of all nursing positions, including those allocated to the vendor. Pontiac's organizational chart was problematic in that the facility director of nursing reports to the vendor's medical director, not the HCUA. Two of three nursing supervisor positions are vacant, so the 43 nursing positions employed by the state are supervised by one nurse supervisor and the director of nursing. The vendor's

[94] Notably these changes affect the delivery of medication, the assessment of patients' health conditions, the ways that care is ordered and provided, and documentation. The term nursing staff is inclusive of registered nurses, licensed practical nurses, and nursing assistants.
[95] East Moline was the only facility in the Northern Region that did not respond to the Monitor's documentation request #5.
[96] Information received from IDOC in response to the Monitor's documentation request #8.
[97] There are a total of 29 nursing supervisors allocated of which 9.67 FTE are filled (33%).

allocation of 17 LPNs and nursing assistants are not recognized as reporting through any nursing chain of command. Accountability for nursing practice is not sufficient at Pontiac. At Sheridan state employed nursing staff report to the director of nursing who reports to the HCUA. The Assistant Warden for Programs supervises the vendor's staff.[98] There is no line of accountability for the supervision and practice of the six nursing assistants to the director of nursing, which leads to discontinuity of patient care. The absence of nursing direction and supervision of tasks delegated to nursing assistants may also violate State regulations regarding nursing assistants. Stateville's organization chart does not include a line of accountability for the practice of the 51 nursing positions allocated to the vendor.

Training Provided

None of the position descriptions reviewed thus far require any sort of annual demonstration of competency as required by II.B.6.q.[99] Training documents provided by the requested facilities in response to the Monitor's documentation request #76 vary greatly. Pontiac, NRC, Menard, and IRCC provided what appears to be a file that keeps track of employees' completion of required training. Only CPR certification and crisis training have any particular emphasis on health care delivery otherwise the training is solely about factors important to institutional operations. Pontiac provided a more extensive list of required trainings to include several topics relevant to nursing practice and could be considered the fundamental criteria for maintaining a training record.[100]

Among these records were various checklists, "read and sign" memos, and in-service credits for attendance at various meetings such as the restrictive housing committee, and health care unit staff meetings. There were records of only two trainings that related to any change or improvement in service delivery. One was a memo instructing nursing staff to read and sign the policy E.06.01 regarding sick call. The memo included no instruction to implement the new policy. The second was an attestation that staff had viewed a recorded training on medically assisted treatment, a program to treat addiction. Neither of these required any test of knowledge or competency demonstration.

The medical vendor sent 851 pages of various training documents. These included a new employee orientation checklist, an attestation that the clinical skills binder had been reviewed, the checklist for the one-day orientation of agency nurses, a read and sign memo concerning the eight rights of medication administration, and documentation of completion of IDOC Cycle Training and New Employee Orientation. Among these were a few instances of testing staff knowledge after training but no evidence of competency demonstration. Finally, there was documentation that nursing staff request privileges annually which are granted by a supervisor, but again, there is no test of knowledge or demonstration of competency that are documented as part of this process.

Nurses are to receive training from the facility medical director upon hiring and annually thereafter. There is no standardized curriculum or expectations established for this training. Several facilities were found noncompliant with the AD for treatment protocols because this training did not take place annually.[101] See more discussion about this in the section on Sick Call.

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[98] In this instance, if the organizational chart is accurate, OHS has no effective supervision of the health care vendor.
[99] Health Care Monitor 7th Report, December 27, 2023, page 66.
[100] The record sent by Pontiac tracked completion of training in HIV, life support, negative air pressure checks, OSHA and BBP, treatment protocols, and confidentiality.
[101] These were Centralia, East Moline, and Lawrence.

The Implementation Plan includes several items that address the training and competency of nursing staff.[102] It does not appear that any of these have been initiated. Furthermore, there is no *prioritization* or a *plan* for the training of the nearly 1,000 nursing positions in the IDOC. IDOC should consider adding Unit-based Nurse Educators at the large facilities. These positions add capacity because they take the training burden off of the Director of Nursing and Nurse Supervisors. Unit-based Nurse Educators excel at teaching and coaching acquisition of new skills and develop nurses' critical thinking by working alongside staff. These positions can be key to identifying process improvements that eliminate barriers to desired practices. The Unit-based Nurse Educator would also have primary responsibility for the annual evaluation of nursing competencies.

The Executive Director of the Office of Correctional Medicine stated that a position was recently filled which is responsible for development and coordination of clinical training.[103] She also stated that they have initiated Grands Rounds, which is available to IDOC staff. While the Monitor supports this effort, it does not appear to have penetrated nursing services, since no evidence of training participation or completion was provided. A more organized and structured training program needs to be developed to achieve compliance with II.B.6.q.

Performance evaluation

The Monitor received 177 performance evaluations of state employed RNs and LPNs from 12 facilities.[104] Performance appraisals from Jacksonville, Graham, and East Moline had no employee self-evaluations and no signatures or dates so it is not possible to know if the appraisal was reviewed with the employee. Pontiac and Menard stood out due to the number of untimely performance appraisals.[105] It is unclear why the majority of performance appraisals were completed late. A registered nurse, either the HCUA, Director of Nursing, or Nursing Supervisor completed the performance evaluations of nursing staff in all the appraisals reviewed.

The appraisal consists of an evaluation whether the employee met their objectives since the last appraisal, then a ranking of the employee's performance against eight generic criteria, general remarks by the supervisor, and objectives for the next reporting period. The objectives tend to be very task and rule oriented and focus on attendance and compatibility with other employees. The content of the performance evaluation differ from one facility to another but all the evaluations of employees at a single facility differ very little from one to another. There was no evidence of coaching to improve performance. There were a few objectives for the development of individuals, such as participation in crisis training. The performance appraisals of RNs and LPNs make no mention of supervision of nursing assistants performing delegated tasks or RN supervision of LPNs when an independent clinical judgement is necessary. The performance appraisals are silent with regard to any program goals, projects, or initiatives, such as vaccination programs, colorectal cancer screening, and infection control or refer to any of the changes called for in the Consent Decree. There is no evidence that actual proficiency in nursing practice is evaluated.

[102] See Implementation Plan items 7 (3), 28 (4), 40 (9), 53 (6 & 8), and 94 (1 & 2).
[103] Interview of Executive Director, Office of Correctional Medicine, SIU on 6/27/2024. The title of this position is Health Matters Program Director.
[104] Decatur and Sheridan each have state employed nurses but did not respond to the Monitor's documentation request #70.
[105] Pontiac: five of seven performances were done late; Menard had 12/19 that were late.

Vienna did not send performance appraisals of nursing employees. Instead, an annual request for privileges, a skills inventory, and skills checklist for vaccine administration was sent. Of these documents, only the checklist for vaccine administration has been instituted as a result of a program improvement effort to increase vaccination as a preventive health measure. All of the other tasks appear unchanged to reflect any new expectations with regard to the work done by nursing staff. There were a few tasks that an employee indicated on self-assessment they were unprepared to do, and the supervisor reviewed it with the employee until they were competent. No employee was denied privileges to perform nursing tasks based upon an evaluation of their clinical performance. There are no expectations for nurses to supervise nursing assistants to whom tasks are delegated nor RN responsibility to supervise LPNs using treatment protocols that require a judgement based upon a patient assessment.

The vendor is also responsible for supervising the performance of nurses they employ. They provided the instructions for evaluating their employees' performance. The purpose of the assessment is to determine if an employee merits an increase in pay. Performance Indicators are extremely generic and consists of the vendor's core values, key traits, and clinical competence. There are no instructions or criteria listed to evaluate clinical competence. If the person responsible for completing the evaluation is not considered the clinical resource at the site, someone at the regional level is to be contacted to evaluate clinical competence. An individual's performance in meeting the indicators is then identified as a single x on a scale from high to low with no description of how the employee's performance was ranked on any of the indicators. This is absolutely meaningless. The list of performance reviews for RNs and LPNs is dated 2022, which is two years ago. This was the same document that was provided to the Monitor for the 7th Report.[106] This information indicates that the vendor does not evaluate the performance of employees on a regular basis and that the evaluation itself is meaningless as a measure of performance and clinical competency.

Discipline

The Monitor requested disciplinary actions of nursing staff over the past year (including both vendor and state employed personnel) to evaluate compliance with II.B.6.r. *that Defendants and the vendor shall timely seek discipline and, if necessary, seek to terminate their respective health care staff that put patients at risk.* The vendor sent 26 records of discipline involving nursing staff. Of these 20 were discipline for poor attendance, one was for leaving keys out, one for inappropriate comments about staff and patients, one was for hostile behavior in the workplace, and one was for refusal to work a mandatory overtime shift. Only two disciplinary actions concerned clinical practice; these both involved a single employee. There are numerous adverse events reported, mortality review findings, pharmacy inspections, treatment protocol review findings, and read and sign training memos that identify problems with nursing practice and yet only twice, with one nurse was disciplinary action taken? The Monitor is not aware of any nurse referred for peer review as a result of mortality review.[107]

Many times, poor performance can be attributed to system deficiencies. For example, if nurses are rushed to complete medication administration because of unrealistic time constraints it may be that documentation on the MAR is missed. The organization has an obligation to address workplace factors that cause employees to take risks and make unintentional errors. However, employee discipline may be

[106] See the material provided in response to item #47 of the Monitor's request for documentation for the 7th report. This was disingenuous on the part of the vendor.

[107] 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.

warranted when an employee's actions are reckless[108], there is evidence of impairment, or the action is malicious. Sufficient evidence was not provided to the Monitor that indicates timely discipline is sought when nursing practice is impaired, reckless, grossly negligent, malicious and puts patients at risk.

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.

Summary of Medical, Dental, and Nursing Oversight

- IDOC submitted no performance evaluations for providers.
- A lead dentist submitted dentists' evaluations which is an improvement but did not have an evaluation done for him.
- The lead dentist does no on-sight review of work which is not appropriate.
- Performance of dental assistants and dental hygienists does not include review of their clinical care.
- Accountability for nursing practice is insufficient because reporting relationships do not recognize a single nursing authority.
- Chain of command of nursing services varies by facility and is not conducive to an effective and functional organization.
- Nurse training is not prioritized or planned.
- Nurse clinical training is not followed by competency evaluation.
- Nurse training does not include supervision of LPNs and nurse assistants.
- Nurses are seldom disciplined for clinical reasons though there are numerous adverse events, and mortality review findings that warrant discipline. The Monitor is unaware that any occurs.
- Credentialing information was not sent, peer reviews for providers were not sent, dentist oversight is not standardized, clinical care of hygienists and dental assistants in unrelated to clinical care, and nursing training and oversight is inadequate. This warrants a noncompliance rating.

Recommendations for medical, dental, and nursing oversight were combined below.

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.
4. Adopt a standardized evaluation framework that emphasizes clinical quality for dental performance evaluations. The vendor, in coordination with the chief of oral health services,

[108] Applicable examples are not using the MAR when administering medication or not accounting for keys or controlled substances. For more discussion of how to determine when disciplinary action should be considered in patient safety please see: Just Culture: A Foundation for Balanced Accountability and Patient Safety - PMC (nih.gov)

should develop or adopt a standardized evaluation instrument that places greater emphasis on clinical quality, provider competency, and adherence to standards of care, rather than focusing primarily on administrative or process-related measures.

5. Incorporate on-site clinical observation into dentist evaluations**.** Dentist performance evaluations should include **on-site clinical observation,** rather than relying solely on remote chart review. Direct observation allows for meaningful assessment of diagnostic skills, treatment delivery, infection control practices, and patient interaction, and provides a more accurate measure of clinical performance.
6. Ensure supervising dentists provide input into hygienist and assistant evaluations. Dentists responsible for supervising clinical care at IDOC facilities should give direct input into the performance evaluations of dental hygienists and dental assistants, particularly with respect to clinical competence, quality of care, and documentation practices.
7. Annual peer reviews, not Salary Compensation Calibration, of the onsite Medical Director, staff physicians, nurse practitioners, physician assistants, Directors of Nursing, Nurse Supervisors, and Nurses (RN and LPN) should be provided to the Monitor.
8. Implement policy C.02.01 Licensure and Credential Verification.
9. The facility DON or nursing supervisor 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.
10. 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.
11. Address the training and competency evaluation items that are included in the Implementation Plan; these are items 7 (3), 28 (4), 40 (9), 53 (6 & 8), and 94 (1 & 2).
12. Develop a policy and performance evaluations.
13. Shift the dental peer review process to engage independent third-party contractors for reviews onsite. This approach will allow for a more thorough assessment of clinical records, including the evaluation of physical radiographs, and help mitigate the issues associated with remote reviews.
14. For dental providers with repeat deficiencies or poor evaluations, implement corrective action plans and performance improvement discussions. The Chief of Oral Health Services should oversee these plans to ensure that issues such as illegible notes, incomplete health history reviews, and improper use of SOAP notes are addressed and corrected.
15. Ensure that the Monitor receives detailed, individual evaluations for dental hygienists and dental assistants from the vendor. These evaluations should include specific appraisal objectives related to clinical care.

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:

Statewide Quality Improvement Program

Documents Guiding the IDOC Quality Program

IDOC revised policy A.06.01 Quality Management Program based upon comments submitted by the Monitor[109]. The revised policy was effective 7/1/25. Many of the Monitor's suggested changes were accepted. There are still a few changes that the Monitor believes are necessary and these will be provided to IDOC for their next revision. For the first time, the policy statement reflects a focus on deficiencies of a comprehensive audit (II.B.9). However there are no procedural statements about the audit process. This audit is still being designed;the procedure should be developed afterward. Another omission in the revised policy is a description of the patient safety program (II.B.6.o).

The CQI manual was updated and made effective on 7/1/25. The document does not provide sufficient instruction to staff in IDOC facilities on how to conduct quality activities. There is a one and a half page explanation on how to conduct chart reviews which the Monitor advises against using for a variety of reasons.[110] There is a page of instruction on how to perform a corrective action plan that is not thorough or instructive.[111] A page is dedicated to how the SLQC and facilities should develop improvement iniatiatives which is descriptive and not useful as instruction.[112] The current manual also does not discuss how the the comprehensive audit, grievances, and the patient safety program are to be utilized in the quality program.

The Monitor recommends that the manual should include instruction on:

[109] The Monitor submitted comments on February 4, 2025, to IDOC.
[110] The chart selection process is, in the Monitor's opinion defective because it is random. Charts should be selected from complex patients with serious disease. Directions presume that existing staff will conduct the record reviews. Record reviews for purposes of quality for this organization should currently be done by independent reviewers in order to reduce bias. Also, at this point facility CQI work should focus on conducting corrective action and evaluation of data and metric results.
[111] For example, it states as step 3: identify the root cause of the problem. The totality of instruction on this matter is, "This is the third step in finding the underlying issue using root cause techniques to ensure that the underlying issue has been identified". This gives the facility staff no instructional information on how to conduct a root cause analysis. The same type of instruction is given for all 6 steps of this section.
[112] The facility process to identify priority improvement projects states in its entirety, "Consistent with the statewide strategic priorities, facilities may also identify facility-specific improvement priorities, create performance objectives, and customize facility improvement plans". How they are to do this is not stated.

1. Data to be reported in facility monthly CQI reports and how to obtain that data;
2. Expectations of facilities in using existing deficiencies identified through quality activities (performance and outcome measures, deficiencies identified in mortality reviews, adverse event lists, grievances, and facility audits related to II.B.9) to analyze their performance and decide whether they need to perform corrective actions;
3. Expectations for reporting the work of the facility CQI program to central office;
4. How to write an annual facility CQI plan;
5. How to develop and conduct a corrective action;
6. Who is to perform root cause analysis and description and training on techniques that can be utilized in a root cause analysis;
7. How to determine if a deficiency is systemic vs. non-systemic; and
8. Direction regarding who is to conduct process analysis and techniques expected to be used in analyzing processes.[113]

A Quality Improvement Plan was also submitted 7/1/25 but only contains a retrospective look at the prior two year's quality projects (fiscal years 2024 and 2025). A plan should include specific tasks, timetables, goals, programs, projects, strategies, and protocols for the *upcoming* year. This lack of forward planning was discussed previously in the Monitor's 6th Report for the fiscal year 2023 plan.[114]

Quality Improvement Leadership

IDOC has no organizational line of accountability for the medical and dental quality program. Policy A.06.01 states that facility Quality Improvement Coordinators will be a dedicated position.[115] This has not been accomplished. The document provided in response request #54 shows that there has been no change to facility quality improvement leadership. The following job categories were assigned as quality improvement coordinators:

- HCUAs – 16 facilities
- Directors of Nursing – 8 facilities
- Medical Records Supervisors – 4 facilities
- Assistant Warden of Programs – 1 facility

Because Facility Quality Improvement Coordinators are all assigned this responsibility and do not have dedicated positions, they have no position descriptions. Therefore they have no official assignments and their role as Facility Quality Improvement Coordinators is only as described in policy. Information requested on the percent of time assigned to the duty of quality improvement coordinator, the quality improvement training of the individual, and the licensure of the individuals were not provided. Because each of the Facility Quality Improvement Coordinators has other full time responsibilities, they have little time to conduct quality work.

[113] The Institute for Healthcare Improvement (IHI) has a free download of a toolkit addressing various techniques in conducting process analysis. This can be found at https://www.ihi.org/library/tools/quality-improvement-essentials-toolkit#downloads.
[114] On pages 17-18 of the Monitor's 6th Report (3/13/23), the Monitor discusses the FY23 CQI Plan. The plan was described a description of what had already been done and was therefore not a plan. It was described as more suited to a policy manual.
[115] A.06.01 Quality Management Program made effective 06.12.2025.

Furthermore the persons assigned to be facility Quality Improvement Coordinators have no reportability to the Agency Quality Improvement Coordinator.[116] There is no organizational accountability for the quality program. The lack of CQI leadership at the facility and accountability to OHS contributes to the failure to implement CQI policy and initiatives.

The statewide Systems Leadership Quality Council (SLQC) met five times from January 2024 until April 2025. Beginning with the 6/28/23 meeting, administrative issues are included in the agenda (administrative reports, special litigation report, Lippert consultant report, policy and procedure report, dental issues, dietary issues, infection control issues, transgender care, forms and tracking tools, and OHS staffing).[117] IDOC is sufficiently behind in implementation of the quality program that the SLQC should focus only on quality and should be meeting monthly.[118] This Council as it currently functions is providing insufficient leadership for the quality program.

Analysis and Tracking of Deficiencies; Corrective Actions; Process Analysis; and Development of Root Cause Analysis

Analysis, collecting, tracking, and correcting deficiencies is an essential element of quality improvement and is specifically called out in the Consent Decree in multiple areas.[119] The new policy A.06.01 Quality Management Program states the following:

1. The Agency QI Coordinator will maintain tables that track all deficiencies and corrective actions.[120]
2. The Agency Medical Director will designate staff to analyze, categorize and prioritize all deficiencies from all sources and based on these will discuss and recommend systemic corrective actions.[121]
3. The SLQC will recommend systemic corrective actions based on deficiencies.[122]
4. The facility will receive all identified deficiencies from all sources, discuss the deficiencies and decide which deficiencies can be immediately addressed and to decide whether a corrective action needs to be developed.[123]

[116] CMS position description Quality Improvement Healthcare Training Program Coordinator effective 03/01/22 as provided by IDOC.
[117] Minutes of the SLQC were provided in response to the Monitors documentation requests for the 6th report (item 35), the 7th report (item 21), the 8th Report (item 24), and the 9th report (item 48).
[118] The recently submitted policy A.06.01 calls for bi-monthly meetings but, in the Monitor's opinion, these are insufficient to address the issues pending before this committee.
[119] II.B.2 states IDOC shall require… monitoring of health care by collecting and analyzing data to determine how well the system is providing care. II.B.6.i states IDOC shall implement changes in morbidity and mortality review with action plans and follow-through. II.B.6.m. and n. states IDOC shall implement changes in preventable adverse event reporting and action taken on reported errors (including near misses). III.M.2. states, defendants shall ensure that 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.
[120] Procedure II.B.1-3 of policy A.06.01 Quality Management Program effective 7/1/25.
[121] Procedure II.D. of policy A.06.01 Quality Management Program effective 7/1/25.
[122] Procedure II.E of policy A.06.01 Quality Management Program effective 7/1/25.
[123] Procedure I.B.2 a-e and II.B.3 of policy A.06.01 Quality Management Program effective 7/1/25.

IDOC documents corrective actions plans using a paper form. Each step of a corrective action is documented on a new form. Multiple forms are used to document different steps for the same corrective action. The Monitor recommends documenting all corrective action plans in an electronic tracking file which is required by the OHS policy.[124] This will eliminate the burden of managing a multitude of paper forms, allows for periodic updating, reduces duplicate work, can be updated as needed, and serves as a tracking document. The Monitor has provided IDOC with a list of fields which should be present on the tracking form.[125]

The current paper form combines the issue of noncompliance that resulted in the corrective action and the root cause analysis in a single text box. These should be in separate sections. If a root cause analysis is done the entire analysis should be provided. Existing corrective action forms did not provide any analysis of root cause or any corrective action.[126]

The Monitor requested any documentation of follow up by the System Leadership Quality Council on any corrective actions issued from any source.[127] The majority of documents received were corrective action plans but there is no indication of review by SLQC. There also is no evidence of discussion of follow up of corrective actions in SLQC meeting minutes.[128]

Many deficiencies identified in adverse events, mortality reviews, and performance and outcome measures have process related causes. For this report, the Monitor requested:

- Any corrective actions or process analyses that have been initiated due to findings of performance and outcome measures (document request #67)
- Any corrective actions or process analyses that have been initiated due to adverse event reports (document request #69)
- Any corrective actions or process analyses due to mortality review findings (document request #77).

The Department responded that it does not maintain a consolidated list of all corrective actions or process analyses initiated since April 2024 and referred the Monitor to the individual Corrective Action Plans. It went further to state that neither the facilities nor the SLQC have had an opportunity to create new initiatives, corrective actions, or process analyses since the recent rollout of the new Quality Management Program in July 2025.[129] Despite these quality programs having identified thousands of deficiencies since the request date of April of 2024 there are no records of corrective actions initiated to address process related causes.[130]

The Implementation Plan calls for process analysis of four key areas of service, these are specialty care, sick call, chronic care, and medication management. The Monitor requested IDOC to identify the process analyst responsible for each of these.[131]

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[124] Procedure I.B. of policy A.06.01 Quality Management Program effective 7/1/25, page 8.
[125] Sent to the Agency CQI Coordinator via email on 9/10/25.
[126] Documents provided by IDOC in response to the Monitor's document request 9th report dated 5/10/2025, item 53.
[127] Monitor's documentation request 9th report, dated 5/10/2025, item 51.
[128] Meeting minutes provided in response to the Monitor's documentation request, dated 5/10/2025, item 48.
[129] IDOC Response to Lippert Monitor documentation request for the 9th report, 5/10/25.
[130] This is discussed in the mortality review section. The Monitor estimates IDOC has identified approximately 6300 deficienties in mortality review, adverse events and other sources.
[131] Monitor's documentation request 9th report, dated 5/10/2025, items 112, 115, and 131.

IDOC responded that a process analyst had not yet been designated. Further the Implementation Plan tracker lists no process analyst as responsible for any of these four task areas. There is also no evidence that a process analysis has been completed for any of the four areas.

Document request #50 asks for the list and details of all process analysis projects initiated by the System Leadership Council, SIU, or OHS with the latest report of their work. The list should include the status of the project and percent completed. IDOC responded with a copy of the Quality Improvement Plan, three charters from SIU, Office of Correctional Medicine, and a revised charter about phrmaceutical practices. None of these documents included a process analysis, information on the status of the project, or the percent completed. [132]

Document request #53 asks for a corrective action tracking log of all root causes identified in evaluation of deficiencies as described in item 3 (Identify the Root Cause of the Problem) on page 17 of the IDOC Quality Manual.

IIDOC did not provide the requested log. They indicated training is being developed to support root cause identification and is expected to be offered later in 2025. The Monitor is heartened to hear of these plans and suggests that OHS make use of the information available from the Institute for Health Care Improvement related to root cause analysis.[133]

Several findings related to root cause and process analysis are:

- IDOC has no staff who are trained or experienced in root cause analysis or process analysis.[134]
- IDOC has not created an alternative to process analysis to evaluate system processes.[135] Dysfunctional processes are not thoroughly evaluated and none have been corrected.
- IDOC considered the implementation of policy for sick call a process analysis which is not correct.[136]
- Corrective action plans typically assign individuals or groups of individuals as responsible for deficiencies and do not identify systemic issues which are clearly dysfunctional. The practice of holding individuals accountable for systemic issues is harmful.
- IDOC has not completed root cause analysis for any corrective action.

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[132] The revised charter for the pharmacy initiative includes dates facilities were visited by the team, but this is not equivalent to a status report or percent completion of the initiative.

[133] Typing in the URL of "RCA2" will lead to a google search result: RCA2: Improving Root Cause Analysis and Actions to Prevent Harm. When selected, this is an IHI website that has a brief video and a group of downloads that are free if a person gives their name, organization, and email. One of the downloads is a 51 page document on using root cause analysis which can be a useful instructional guide to conducting an effective root cause analysis. The other document gives brief instructions on prioritization of corrective actions. The Monitor strongly suggests incorporating this free document as part of their CQI training.

[134] Since the 2nd Report, the Monitor has recommended hiring experts in process analysis to assist IDOC in analyzing their dysfunctional processes of care.

[135] SIU is conducting the pharmaceutical administration and operations initiative which may be an analysis of systemic issues but IDOC has not provided the Monitor any work product and the Monitor has not been informed about this project except anecdotally.

[136] This statement is based on the Implementation Plan tracker. Task 53 contains 8 sub-tasks on conducting a process analysis of sick call. No analysis has been provided to the Monitor but IDOC considers this task completed. IDOC has told the Monitor that it has implemented the new sick call policy. The notes of these Implementation Plan tasks ask for confirmation of proof of completion. The Monitor is unaware of any process analysis.

- Deficiencies are not grouped into similar types that may lead to identification of systemic deficiencies.

Training

The Monitor requested training procedures, plans, and training accomplishments of the statewide CQI program with respect to facility CQI programs and OHS since April of 2024.[137]

One of the documents was a memo to health care managers announcing that on-line training was available through the Institute for Healthcare Improvement in quality improvement and safety.[138] However no record of the course material was provided, and neither were any records of completed training. All of the other documents provided by IDOC were updates on CQI projects, performance and outcome scores, mortality reviews and adverse event reports. There were no documents related to training on CQI techniques.

OHS needs to establish clear expectations for initial and ongoing training in CQI methodology and technique. In addition to training content, the Department must identify who is to be trained, timeframes for completion, and expectations for demonstrated proficiency. Finally, the Department must be able to document training received and demonstrate that sufficient numbers and types of staff are proficient in CQI techniques and methodology.

Patient Safety

The 2024-2025 Quality Improvement Plan lists five patient safety goals which the Monitor asked to review.[139] IDOC responded that this information is not yet been compiled due to implementation of the quality plan.[140]

Facility CQI

The Monitor assessed QI meeting minutes from January to June of 2025.[141] Of the 180 meeting minutes that should have been provided, only 58 (32%) were made available. Only one facility provided quality improvement minutes for all six months requested. Twelve facilities provided no meeting minutes. Items required in IDOC policy (discussion of mortalities, deficiencies, and development of corrective actions from deficiencies) are not effectively discussed or addressed in these meeting minutes.

[137] Monitor's documentation request dated 5/10/2025, item 49. Details to be provided were to include who was intended to receive training and who received training. Was there an intended due date for receiving training and how many received training by that due date. Provide action plan for how training will be provided for those who still need training?
[138] Memo from the Agency Quality Improvement Coordinator, dated 6/23/2025.
[139] Monitor's document request, 9th report, dated 5/10/2025 item 52.
[140] IDOC Response to Lippert Monitor documentation request, dated 8/15/2025.
[141] Minutes of these meetings since April 2024 was provided by IDOC in response to the Monitor's documentation request # 55.

For this request, IDOC provided five policies,[142] four forms,[143] the IDOC Quality Improvement Program Manual of 7/1/25 and the IDOC Quality Improvement Plan of 7/1/25 in response to the Monitor's request for a standardized data glossary.[144] An explanatory page is included which states that the data glossary is on pages 5-10 of the Quality Management Program Manual. The remainder of the material provided was irrelevant to a data dictionary.

A data glossary or a data dictionary is a document that defines each data element used in regular monitoring and reporting of quality improvement including how the data is collected, calculated, and interpreted. The definitions in the five pages in the Quality Management Program Manual are not data elements but are terms that are not even used in facility CQI meetings. Examples of definitions in the Quality Management Manual included:

- American Correctional Association
- Benchmark
- Patient Safety
- Quality Management Program Manual
- Supplier
- System Leadership Quality Council (SLQC)

Examples of data elements in CQI that might be used in a glossery or dictionary include for example:

- *Timely Provider Follow Up/ Specialty Visits:* The number and percent of visits post specialty care visits that occurred within five days of the specialty visit.
- *Consultant Report Present*: The number of full reports that were obtained within two days of the specialty care visit.
- *Sick Call Face-to-Face*: The number and percent of sick call requests that were seen within 24 hours of placement of the request.
- *Medication Error Rate*: The number of medication errors per 1000 doses administered.
- For intake facilities: *Intake Evaluations Completion Rate*: The number of intake evaluations completed within seven days.
- *Days Without a Physician:* The number of days in the past month without physician coverage.
- *Number of Sick Call LPN Visits:* The number of visits for sick call conducted by an LPN.
- *Hepatitis C Treatment:* The number and percent of untreated hepatitis C patients.

The data dictionary or glossary needs to include:

- Terms related to quality items that need to be monitored on a monthly basis.
- A description of the data to be used and how that data is collected, calculated, and interpreted.
- How the data is reported and followed in facility CQI meetings.

[142] Administrative Directive 403125 Quality Management Program; policy A.06.01 Quality Management Program; policy A.06.02 Mortality and Morbidity Review; policy A.06.03 QM Adverse Event Reporting; and policy A.06.04 Clinical Peer Review.
[143] A form titled Administrative Meeting Agenda; a form titled Quality Improvement Study Report; the Corrective Action Plan form; and the Adverse Clinical Event-Near Miss -Sentinel Event Reporting Template.
[144] Monitor's documentation request 9th report dated 5/10/2025, item 55.

IDOC has not yet defined the data necessary to have a functioning CQI program nor has it established ways to obtain that data. The template for facility CQI meetings is not appriopriate for a CQI meeting as it is largely made up of administrative topics. IDOC needs a template for a CQI meeting that addresses CQI topics.

The Monitor requested copies of each facility's Quality Improvement Plan as described in the IDOC Quality Manual section VIII.B.4. and policy A.06.01 procedure I.C. [145] IDOC responded that facilities have not yet had an opportunity to develop their QI plan yet.[146]

The Monitor has recommended that the Agency CQI Coordinator and Regional Coordinators provide each facility its list of deficiencies from performance and outcome measures, mortality reviews, adverse events, grievances, and ultimately II.B.9. audit reports and use these to determine whether corrective actions are needed. The corrective actions planned to address deficiencies could be incorporated into the facility CQI plan. Plans do not need to be complex narratives and can even be as simple as bullet points. When facilities identify systemic issues (policy, staffing, space, capital equipment, organizational structure, etc.) it should be referred back to the SLQC.

Facilities do not currently have the support necessary to conduct a robust quality program as they lack:

- Dedicated CQI coordinators.
- Access to a data system to capture and report data.
- Procedures for how to create corrective action.
- Training sufficient to conduct process improvement or root cause analysis.
- Staffing consistent with ability to perform the required changes.
- Collaboration between State and vendor staff.
- A supervisory relationship with OHS.

The Monitor also requested any facility specific CQI studies completed since July 2024 including the results of study, analysis, and corrective action.[147] The IDOC did not provide any such studies.

Grievances

In document requests #60 and #61, the Monitor asks for the list of grievances and the policy and procedure for addressing medical and dental grievances.
Two policies were provided in response to the Monitor's request[148]:

- An Illinois administrative code[149] was submitted which requires that all inmates have a right to file a grievance and that a grievance procedure be in place.
- An administrative directive[150] was submitted that establishes the procedures for placement and evaluation of grievances.

[145] Monitor's documentation request, 9th report, dated 5/10/2025 item 56.
[146] IDOC Response to Lippert Monitor Documentation Request dated 8/15/2025.
[147] Monitor's documentation request, 9th report, dated 5/10/2025 item 58.
[148] Monitor's documentation request 9th report dated 5/10/2023, item 60.
[149] Illinois Administrative Code 504, tab B, subchapter e, subpart f, section 504.800.
[150] Administrative Directive 04.01.114 Local Individual in Custody Grievance Procedures, effective 8/1/23

A specific procedure for how medical and dental grievances are evaluated is not included in the administrative directive. The administrative directive states that medical grievances are all forwarded to the HCUA (or health personnel assigned by the assistant warden of programs) if the grievance officer (a person assigned by the warden) believes a response from a health employee is necessary. The HCUA or designee evaluates the grievance. It is not clear whether all medical and dental grievances are forwarded to the HCUA for evaluation.

IDOC has a policy and procedure on grievances issued 2/1/24, but this policy was not provided by IDOC.[151] The procedure concurs that if the Counselor or Grievance Officer requests a response from healthcare employees, the grievance is forwarded to the HCUA (or designee of the assistant warden of programs if there is no HCUA). The Quality Improvement Coordinator is designated by policy to present and review grievances during facility CQI meetings. Recurrent or substantiated health care grievance are to result in the facility quality committee reviewing the process of care related to the grievance and to report to the system leadership council the recurrent findings considered for corrective action. [152]

CQI meetings are infrequently conducted and the only discussion of grievances is to list the number of grievances. No meaningful quality initiatives are conducted based upon the grievances and there is no evidence of any process analysis of a recurrent problem.[153] It is evident from this review that Policy A.09.01 Grievance Mechanism has not been impemented by facilities.

IDOC produced a list of grievances since 7/1/24 in response to the Monitor's document request #60,. The transition centers are included as was Stateville which has been closed. There were small numbers of grievances at the transition facilities. At other facilities, there were 22,356 grievances for a year time period. This is a large number of grievances. The categories of grievances are the major service areas which are reasonable categories.[154] Excluding mental health (9% of grievances) the top five categories of grievance include:

1. Medical treatment (41%)
2. Medication (19%)
3. Sick Call (6%)
4. Dental (5%)
5. Medical Furlough and Permits (4%)

These top five grievance categories are essential areas of service that are not yet in compliance with the Consent Decree. IDOC has not conducted process analysis or root cause analysis on any grievance categories even though IDOC policy requires a review of the process of care for recurrent grievances. [155]

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[151] Policy A.09.01 Grievance Mechanism effective 2/1/24.
[152] Ibid, Procedure, VII.
[153] The Monitor reviewed facility quality meeting minutes submitted between January and June 2025. This material was provided by IDOC in response to item 55.
[154] These include medical treatment, medication, mental health, sick call, dental, medical furlough, medical supplies, optical, HIPAA, permits, medical records and other.
[155] Chronic care, medication management, sick call, and specialty care were four areas the Monitor determined were not functioning well and recommended process analyses. There is no evidence of any process analyses being done for any of these. A sick call initiative is in process but the Monitor has no evidence that any analysis was accomplished nor was a process analysis report provided. SIU is conducting a survey of pharmaceutical operations but this has been ongoing for a few years and the Monitor has no work product yet so does not know whether a process analysis has been accomplished.

IDOC does not use grievance as an opportunity to identify its deficiencies or opportunities for improvement.

Dental CQI

Dental Quality Improvement (CQI) activities have been largely limited to SIU's data collection efforts. These efforts focus on two performance and outcome measurements:

1. The percentage of patients who were offered, received, refused, or excluded from dental cleanings within the past two years.
2. The percentage of patients who were offered, received, refused, or excluded from dental examinations in accordance with the Biennial Examination requirement.

Review of facility-level CQI minutes revealed little evidence that dental services and care are being routinely incorporated into quality improvement activities. Only one facility, JTC, initiated a dental-specific CQI project during the review period (March 2025). Overall, there does not appear to be a coordinated or systematic effort to use CQI processes to evaluate and improve dental care delivery. As outlined throughout the dental sections of this report, numerous opportunities exist for the Department, in collaboration with the vendor, to conduct targeted CQI initiatives, particularly in areas where performance falls short of Consent Decree requirements or where deficiencies have been identified through performance evaluations.

A clear example of an area appropriate for a statewide Dental CQI initiative is the longstanding absence of documented periodontal assessments at intake and comprehensive examinations. Despite policy requirements and community standards of care, records reviewed consistently failed to demonstrate the use of a periodontal probe or the documentation of periodontal findings. This deficiency has been identified across facilities and over multiple reporting periods, making it well suited for a coordinated, statewide CQI project rather than isolated, facility-level corrective actions. An example for a quality project is provided below.

Periodontal Screening and Recording

Problem Identified:
No consistent documentation of periodontal screening using a probe at intake or comprehensive examinations. Implementation of this statewide CQI initiative would allow the Department to systematically address a persistent deficiency, improve the completeness and quality of dental examinations, and demonstrate measurable progress toward compliance with established standards of care and Consent Decree requirements.

Aim Statement:
Ensure periodontal screening is performed and documented for ≥95% of eligible patients at intake and comprehensive examinations.

Measures:

- % of exams with periodontal probing documented
- % with periodontal classification recorded
- % of denture patients appropriately excluded

Data Source:
EHR templates; chart review

Frequency:
Monthly monitoring; quarterly CQI reporting

Summary of the Quality Program

1. The policy A.06.01 on CQI does not include the comprehensive audit (II.B.9) or the patient safety program (II.B.6.o).
2. The Quality Management Program Manual needs significant changes to provide direction to facilities on how to conduct quality work.
3. The IDOC system-wide Quality Improvement Plan is a retrospective look at the prior year's activity but instead it needs to be a plan for the upcoming year.
4. System Leadership Quality Council meetings should be separate from administrative meetings and should take place monthly.
5. Deficiencies are not analyzed, categorized, prioritized, or tracked.
6. Corrective actions are not tracked.
7. There is no evidence that SLQC follows up on all corrective actions or even is aware of the numbers of outstanding corrective actions.
8. There is no evidence of process analyses or root cause analyses being completed. These are areas where training is needed or expertise must be obtained.
9. Training consists mostly of updating staff on the CQI program but does not include training on CQI techniques necessary to evaluate deficiencies and create corrective actions.
10. There is no policy or procedure for a patient safety program and there is no evidence produced that one exists.
11. Facilities do not have dedicated CQI coordinators which is a major barrier to an effective CQI program.
12. Only 32% of monthly CQI meetings (evidenced by minutes) were completed from January, 2025 to June 2025. Effective quality improvement at the facilities is not operational.
13. A data dictionary to be used for facility quality improvement monitoring and for reporting in facility CQI meetings is not completed. IDOC should seek assistance in development of a data dictionary for facility CQI reporting.
14. Facility Quality Improvement Plans are required but no facilities have produced one.
15. IDOC reported no facility quality improvement studies since July of 2024.
16. Grievances are a significant but unused source of potential deficiencies and opportunities for improvement that should be evaluated by the quality program. There is no evidence that OHS policy A.09.01 Grievance Mechanism has been implemented which requires that recurrent grievances are to result in a review of the involved process of care.

Based on these findings, the quality improvement program warrants a partial compliance with a significant amount of work remaining to be accomplished. One recommendation to amend the policy was removed. Multiple recommendations were added.

RECOMMENDATIONS:

1. The quality program implementation plan needs 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; and
    e. Discussion of how to use process analysis.
2. IDOC needs to develop a dental quality improvement program with input from the Monitor.
3. If IDOC wants a quality improvement manual, the current version needs considerable revision.
4. The annual quality improvement plan needs to be a forward plan for the fiscal year ahead not a retrospective summary of CQI activities over the past year.
5. IDOC needs to develop a patient safety program and integrate it into their CQI program.
6. The data dictionary for facility CQI needs to be re-written.
7. Deficiencies and corrective actions need to be tracked in an acceptable format.
8. Training for advanced CQI techniques (root cause analysis and process analysis) is not being provided. The Monitor has recommended hiring persons with this expertise. If IDOC chooses not to do that, considerable training needs to be accomplished on these techniques.
9. Facilities need to have dedicated and trained CQI coordinators.
10. Every facility should have a quality improvement plan.
11. A coordinated, systemwide Dental Clinical Quality Improvement (CQI) program needs to be established that extends beyond data collection and incorporates regular, facility-level review of dental services and care.

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:

Policy

Policy A.06.01 Quality Management Program,[156] acknowledges that deficiencies, scores, and reports from a comprehensive audit are included in the quality improvement program. However, there are no specifics given about this audit and there is no procedure for how it is to be accomplished or use of the data collected. A separate policy and procedure needs to be developed that describes the comprehensive audit more specifically.

Evidence of a Comprehensive Audit

The Monitor requested any reports or audits related to Consent Decree item II.B.9 (Design of Audit Function) and IDOC responded that anything related to II.B.9 could be found in the GANTT chart

[156] The version made effective 6/12/25.

provided by the Implementation Plan project manager. However, no reports or audits were included. The Monitor's access to this GANTT chart has since been discontinued. Also requested were any draft audit instruments. IDOC provided six documents that were originally provided by the Monitor in May, 2023[157] to IDOC as examples that might be used as audit components. Another five documents were provided by IDOC in response to this request. These were modified versions of the examples provided by the Monitor. The content of these documents was created in 2023.

The Monitor discussed the audit with IDOC during a monthly call.[158] At this meeting the current IDOC legal counsel was unaware of the audit discussion in July of 2023. The Monitor sent counsel the example audit tools originally discussed in July 2023 and offered to work with OHS and its partners to help develop an audit.[159] To assist IDOC's forward movement the Monitor suggests a discussion of the following:

- The procedures of an audit;
- The frequency of audits;
- The methodologies used;
- Who will conduct the audits;
- The scope of the audit; and
- A process for developing an audit instrument and test environment.

Summary

- There is no policy or procedure that spells out the process for the comprehensive audit.
- There has been no discussion with IDOC or its partners about what constitutes an audit.
- IDOC has provided edited versions of five examples of audit components provided by the Monitor. These were completed in 2023 so do not represent recent work product.
- There is insufficient evidence of progress to warrant more than a noncompliance rating.
- The Monitor offers to further develop an audit process with OHS and its partners and has suggested topics to begin discussing.

RECOMMENDATIONS:

1. Expedite meeting with the Monitor to discuss development of the audit.
2. Develop a comprehensive medical and dental audit as described in the Consent Decree and outlines in the Implementation Plan.

Performance and Outcome Measures

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.*

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[157] Email from Dr. Raba to Dr. Bowman, Ms.Lawshea, Ms. Jennings, Dr. Puisis, Catherine Knox on 5/19/23 with six attached files: one each for mortality review, chronic care, infection control, specialty care, discharge planning, and nursing sick call. These were sent as examples of more comprehensive audit tools. Dr. Raba asked for a follow up meeting which occurred 7/20/23 in Springfield, Illinois. Another follow up meeting was suggested to discuss further however this has not taken place.

[158] Meeting with OHS 9/18/2025.

[159] Email from Catherine Knox to Robert Fanning and LaMenta Conway 9/23/25.

OVERALL COMPLIANCE RATING: Partial Compliance

FINDINGS:

Policy
The Monitor's 8th Report recommended establishing a policy for performance and outcome measures. There is currently no policy that describes the use of performance and outcome measures by the IDOC.

Actual Practice Monitoring Performance and Outcomes in Health Care
The Monitor has long recommended IDOC develop and use a dashboard that displays the performance and outcome results.[160] IDOC has not developed such a dashboard but instead produces documents quarterly in PDF format to depict the results of their performance and outcome measures. The PDF documents that were provided in response to the Monitor's request included duplicate results so only three quarters of data were made available. [161] Much later the Monitor discovered that a full year of data had been provided by IDOC in response to another request for information related to dental CQI.[162]

At this time IDOC collects data for 23 measures up from 11 measures discussed in the last report. The Monitor requested any new or revised performance and outcome measures *with details and methodology*.[163] IDOC provided no data or information in response to this request even though multiple changes have been made in these measures.[164] For any new or revised measures the failure to define the details and methodology make the data not able to be interpreted. For some measures it is unclear how charts are selected; where data is permitted to be found; what parts of the chart are searched; all definitions (e.g., excluded) are not provided.

Because IDOC has now been monitoring 11 measures for two years and 12 new measures for about a year it is useful to look at trends and assess what the data means. The following is a table of quarterly performance and outcome measures as provided to the Monitor in the 7th, 8th, and 9th Reports.

[160] Health Care Monitor 2nd Report, Lippert v. Jeffreys, 7/6/2020 pages 37, 39, 41-42. See also the 3rd through 8th reports for the same recommendation regarding a dashboard for performance and outcome measures. See also Implementation Plan item 39a.
[161] Documents provided in response to the Monitor's documentation request 9th report, dated 5/10/2025, item 66. The 1st quarter FY 2025 was duplicated; the 2nd quarter was missing.
[162] This was in response to the Monitor's documentation request 9th report, dated 5/10/2025 item 59. This is also a good example of the errors that were made in assembling and collating the IDOC response to the Monitor's documentation request.
[163] Monitor's documentation request 9th report, dated 5/10/2025, item 64.
[164] The sick call responsiveness performance measure has been on pause since October of 2024. The dental visit measure was divided into two measures, at the urging of the Monitor, to be consistent with Consent Decree performance requirements. Dental cleaning and dental examinations were the two new dental measures. A measure to benchmark blood glucose control was changed from an A1c of 8 to and A1c of 7 which is the benchmark used in the community to determine good diabetic control. While this is a reasonable change, with the advent of the electronic record, IDOC should consider benchmarking four ranges of control: less than 7; 7-8; 8-10; and above 10. This should be relatively easy to do given IDOC will have access to all electronic laboratory data.

Statewide Performance & Outcome Quarterly Data April 2023 to June 2025								
	April-June 2023 4th QRT 2023	July-Sept 2023 1st QRT 2024	Oct-Dec 2023 2nd QRT 2024	July-Sept 2024 QRT 1 2025	Oct-Dec 2024 2nd QRT 2025	Jan- Mar 2025 Qrt 3 2025	Apr-June 2025 4th Qrt 2025	IDOC Goal
Annual Flu vaccine	60%	61%	71%	59%	56%	75%	70%	90%
Breast Cancer Screening	85%	78%	88%	70%	67%	64%	86%	90%
Cervical Cancer screening		77%	95%	80%	90%	85%	75%	90%
Colon Cancer screening	11%	n/a	n/a	28%	47%	60%	63%	90%
Controlling High BP	60%	55%	52%	58%	57%	55%	57%	90%
Covid vaccine	62%							90%
Dental Cleaning				58%	58%	58%	67%	90%
Dental Examination				54%	57%	64%	58%	90%
Dental Visit	41%	42%	48%					90%
DM annual eye exam	70%	69%	61%	60%	68%	63%	68%	90%
DM annual foot exam				9%	13%	7%	14%	90%
DM BP < 140/90	57%	62%	64%	68%	69%	59%	66%	90%
DM Hgb A1c < 7				45%	56%	56%	54%	90%
DM Hgb A1c <8	66%	67%	72%					90%
DM Nephropathy check	84%	89%	86%	87%	87%	86%	82%	90%
Emergency Care Follow up Nurse				69%	70%	67%	67%	90%
Emergency Care Follow up Provider				35%	39%	38%	37%	90%
Hyperlipidemia Screening		23%	22%	24%	25%	24%	21%	90%
Offsite Clinical Care Follow up Nurse				60%	61%	58%	56%	90%
Offsite Clinical Care Follow up Provider				34%	41%	47%	39%	90%
Osteoporosis				0%	0%	0%	6%	90%
Pneumococcal vaccine	43%	49%	47%	41%	33%	37%	35%	90%
Pregnancy - BMI				0%	7%	0%	0%	100%
Pregnancy - Ultrasound				63%	25%	20%	63%	100%
Shingrix Vaccination				20%	21%	16%	21%	90%
Sick call responsiveness	34%	49%	41%	34%	**Paused**			
Weight Monitoring		n/a	n/a	55%	56%	58%	57%	

IDOC has not produced any analysis of this data. There is only one measure that has shown significant improvement (colorectal cancer screening). Colorectal cancer screening was subject of intense staffing intervention. The remaining 22 measures show random variation around a mean, that signify system inertia. These measures are unlikely to show much improvement or deterioration because the systems appear stable. Unless the system is changed, the variation will continue up and down around a mean.

Change, if it is to occur must be a result of redesigned workflows or change in processes which may include staffing changes.

IDOC now provides the number of charts sampled for each quarterly submission with the number of those records where the measure was completed and the number of documented refusals. The remaining charts are in a category titled "excluded". This category can be as high as 86% of records reviewed.[165] The "excluded" group must be defined and the methodology for conducting the record reviews needs to be provided so that it can be determined whether this group of records includes an offer for the intervention. If an offer of service is not verified, then the record should be categorized as not offered instead of excluded. This has implications for scoring provisions of the Consent Decree.[166]

Individual Measures

The following are discussions of individual measures. The Monitor notes that the scores include those who accept the intervention plus those who refused the intervention. The score only indicates that the intervention was offered (except for those excluded). The Monitor has previously asked that refusals be noted as well, because high refusal rates (as with influenza vaccination and colon cancer screening) need to be addressed by the quality program with corrective actions.

Annual Influenza Vaccination:

Four facilities consistently met or exceeded the 90% goal across all four quarters: East Moline, Murphysboro Re-Entry, Kewanee Life Skills, and Lincoln. However, performance varied significantly among other facilities. For example, Hill achieved 100% in the first and third quarters but dropped to 0% in the second quarter. Vandalia also scored 100% in the first three quarters but fell to 80% in the fourth quarter. Some facilities showed notable improvement by year-end. For instance, Danville improved from 10% in the first quarter to 70% in the fourth quarter, and Lawrence finished the fourth quarter at 100% after scoring 0% in the second quarter. Unfortunately, many facilities remained well below the 90% goal throughout the year, with particularly low scores reported by Big Muddy River and Pontiac. There were high rates of refusal for this measure (52%)[167] indicating an ineffective vaccination process in need of attention.

Pneumococcal Vaccination:

Performance varied significantly across the system. Murphysboro Re-Entry consistently achieved 100% vaccination rates in the last three quarters of the year. Logan met the benchmark in the first three quarters but failed to maintain it in the fourth quarter. Other facilities, such as Kewanee Life Skills, Decatur, and Pinckneyville, reached the vaccination goal in isolated quarters. However, many facilities, including NRC, Southwestern, and Vandalia, reported vaccination rates close to zero for much of the year.

Shingrix Vaccination:

This measure performed very poorly overall and showed no meaningful improvement. Decatur and Kewanee Life Skills met the goal in the last quarter. Pinckneyville had some of the higher results compared

[165] As in the DM- Annual Foot Exam measure for the 4th quarter of 2025.

[166] For example, the provision for influenza vaccination requires that the vaccine be offered for all individuals. If the excluded category includes those for whom an offer of vaccination was not made, then it will affect the scoring. This terminology " offered, received, refused, and/or excluded is present in definitions 1-4 and 6-22. In each one of these the definition of excluded should be provided.

[167] This is for the 4th quarter of 2025.

to other facilities but remained unsustainable. Most facilities reported extremely low scores. Overall performance on this measure remains poor.

Weight Monitoring:
Performance on this measure was inconsistent across facilities. Decatur met or exceeded the 90% goal in multiple quarters. Many facilities remained below the target, with numerous sites scoring under 80% and several below 50%, indicating overall unreliable performance across the system.

Sick Call Responsiveness:
Reporting was limited to the first quarter, preventing any assessment of performance trends. Based on first-quarter data, five facilities met the 90% goal: Decatur, Hill, Jacksonville, Kewanee Life Skills, and Murphysboro Re-Entry. Most other facilities scored very low. This measure is paused as will be discussed below.

Breast Cancer Screening:
Decatur's screening rates remained between 70 and 80% for the first three quarters, then increased to 100% in the fourth quarter. Logan remained below the goal all year, with rates consistently between 60 and 70 percent. Pontiac reported 0% in the 3rd quarter, and Centralia reported 100% in the 4th quarter. This measure includes monitoring transgender individuals which likely accounts for the reports at Pontiac and Centralia.

Cervical Cancer Screening:
Decatur achieved or exceeded the 90% goal in the first half of the year, scoring 90% in Q1 and 100% in Q2. However, performance declined in the second half of the year, resulting in scores of 80% in both Q3 and Q4, which did not meet the target. Logan met the 90% goal in Q3 with a score of 90%. However, the goal was not met in the other three quarters.

Colon Cancer Screening:
Twenty-three facilities improved scores an average of 24 percentage points. Five facilities had an average decreased score of 13.8 percentage points. This is an improvement and not an apparent random variation. This appears directly related to the colorectal cancer screening intervention. Considerable patient education was initiated. It is unclear if staffing was modified but considerable management staff were involved in managing the intervention. This was the only measure to show this degree of change and demonstrates the need for systemic change in the other performance measure processes. Further analysis and corrective action may be needed to attain goal-scores. Refusals for this measure were 34%[168] which is high and in need of further assessment and corrective action.

With respect to colorectal cancer screening at individual facilities, Kewanee Life Skills met the 90% goal in three consecutive quarters, achieving 100% in Q2, Q3, and Q4. Murphysboro Re-Entry also met the goal in multiple quarters, but not consecutively. Several facilities demonstrated late-year improvement, including Decatur, which met the goal in Q3 and Q4, and East Moline, which achieved 100% in Q2 and Q3 and 90% in Q4. Danville, Vienna, Vandalia, and Taylorville reached the 90% benchmark in Q4. Many facilities did not meet the 90% goal in any quarter, with Big Muddy River, Lawrence, and Menard consistently reporting low scores.

[168] 4th quarter statewide measures data.

Controlling High BP:
Controlling high blood pressure varied considerably across facilities, with most remaining below the goal for much of the year. A few facilities, including Logan, Murphysboro Re-Entry, and Decatur, met the goal in the last quarter. Facilities such as Robinson and Western reported persistently low rates across all four quarters. The Big Muddy River steadily declined from 80 percent to 30 percent over the year. Overall, the data reflects inconsistent performance.

DM – Annual Eye Exam:
Performance on the DM Annual Eye Exam measure was mixed across facilities, with only a small number consistently meeting the goal. Some facilities, such as Centralia, Dixon, Jacksonville, and Lawrence, met the goal in multiple quarters, while others showed intermittent success without sustained results. Many facilities, including East Moline, Hill, Robinson, and Murphysboro Re-Entry, remained well below the goal throughout the year.

DM – Annual Foot Exam:
Performance on the DM Annual Foot Exam measure fell well below the 90% goal in most facilities. Jacksonville demonstrated sustained improvement in the last three quarters, while Kewanee Life Skills and Robinson met the benchmark only once during the year, and they could not maintain that performance in the 3rd and 4th quarters. Most facilities, including Big Muddy River, Decatur, Dixon, Menard, and Pontiac, consistently reported poor results.

DM – BP <140/90 mmHg:
Performance on the DM-BP <140/90 measure varied widely across facilities. Murphysboro Re-entry consistently met the benchmark in all four quarters. Several facilities, including Graham, Lawrence, Sheridan, Logan, and Menard, achieved the goal in the fourth quarter. Many facilities showed fluctuating results without sustained improvement, and several remained well below target throughout the year. Goal blood pressure for those with diabetes and on medication is 130/80.[169] The National Committee for Quality Assurance (NCQA) uses140/90 as a metric benchmark but qualifies this measure by stating "the on-treatment blood pressure goal is < 130/80 if it can be safely obtained. This qualifies this metric to one that identifies persons who should be on medication or should have their medication increased, if already on medication, to bring blood pressure to a goal of 130/80.

DM – Hgb A1C <7%:
Performance on the DM Hgb A1C<7 measure was generally below the 90% goal across the system. A small number of facilities, including East Moline, Murphysboro Re-Entry, and NRC, met the benchmark in isolated quarters, but none maintained compliance throughout the year.

DM – Nephropathy Check:
Performance on the DM Nephropathy Check measure was generally strong, with many facilities consistently meeting or exceeding the goal. Jacksonville, Lincoln, East Moline, and Kewanee Life Skills met the goal in all four quarters and frequently reported 100%. Joliet and Lawrence remained below the goal throughout the year, and facilities such as Murphysboro Re-Entry and Dixon showed declines in the fourth quarter. This goal is not a difficult measure to attain as it requires a blood test be drawn on an

[169] UpToDate Hypertension in adults: Goal blood pressure; and American Diabetes Association Standards of Care. Chapter 10 Cardiovascular Disease and Risk Management: Standards of Care in Diabetes – 2026 as found at https://diabetesjournals.org/care/article/49/Supplement_1/S216/163933/10-Cardiovascular-Disease-and-Risk-Management

annual basis for those with diabetes.

Emergency Care Follow-Up – Nurse:
Facilities such as Vandalia and Jacksonville met or exceeded the goal in multiple quarters, while NRC and Decatur also showed better performance overall. Robinson, Sheridan, and Illinois River showed inconsistent improvements between quarters. Several facilities, including Menard, Joliet, and Pinckneyville, remained below the goal throughout the year. This measure is only that the patient was seen. The main problem with post-hospital visits is quality of the nurse evaluation and is not addressed in this measure.

Emergency Care Follow-Up – Provider:
This measure was consistently below the goal across the system, with no facility maintaining compliance for more than one quarter. Isolated instances of 100% performance occurred at Jacksonville, Kewanee Life Skills, Murphysboro Re-Entry, and Northern Reception and Classification, but were not sustained. Most facilities, including Big Muddy River, Centralia, Danville, Logan, and Shawnee, reported performance rates significantly below the goal throughout the year, often dropping below 50%. These data are unsurprising given physician staffing is around 50%. This measure is only that the patient was seen. The main problem with post-hospital visits is quality of the provider evaluation post hospital visit, which is not addressed in this measure. Also, it does not address whether the visit included informed care with respect to the patient.

Offsite Clinical Care Follow-Up – Nurse:
Performance varied greatly across the system. Several facilities, including Kewanee Life Skills, Taylorville, and Vandalia, achieved 100% across all four quarters. East Moline consistently met the 90% benchmark throughout the year. Many facilities, including Menard, Pinckneyville, Joliet, and Western, fell well below the goal, often reporting very low compliance rates. The performance of facilities such as Robinson and Dixon was inconsistent, with significant fluctuations across quarters. This measure is only that the patient was seen. The main problem with post-furlough visits is the quality of the nurse evaluation, which is not addressed in this measure.

Offsite Clinical Care Follow-Up – Provider:
Performance on the Offsite Clinical Care Follow-Up – Provider measure remained inconsistent. In the fourth quarter, three facilities met the benchmark, including Vandalia, Murphysboro Re-Entry, and Pinckneyville, with Murphysboro Re-Entry achieving 100% compliance in both the third and fourth quarters. Most other facilities continued to struggle, with the majority reporting rates below 50% in the final quarter. This measure is only that the patient was seen. The main problem with post-hospital visits is quality of the provider evaluation post furlough visit, which is not addressed in this measure. Also, it does not address whether the visit included informed care with respect to the patient.

Osteoporosis:
The results were reported for only two facilities, Decatur and Logan, both of which fell significantly short of the goal throughout the year. Decatur reported 0% compliance across all four quarters. Logan also reported 0% in the first three quarters, but showed a slight improvement to 10% in the fourth quarter.

Pregnancy – Ultrasound:
Neither of the two female facilities met their goals. Decatur met the benchmark in the first quarter but

declined to 50% in both the second and third quarters. Logan remained below the goal for the entire year, starting at 25% and fluctuating between 0% in the 2nd quarter and 67% at year-end.

Pregnancy – BMI:
Two facilities reported their data, and neither achieved its goals. Decatur and Logan both performed significantly below the goal. Logan reported 0% compliance across all four quarters. Similarly, Decatur reported 0% for most of the year, with only a slight improvement to 17% in the second quarter, which was not sustained.

With respect to the four new measures on whether patient are seen after emergency visits and after furloughs by nurses and providers, a key aspect missing in the measure is whether the report of the hospital or specialist is present during these evaluations. A notable finding in record reviews is that an ER or hospital discharge summary and the consultants full report are not made available to staff to review when seeing the patient for follow up after offsite care.

Interventions Related to Performance and Outcome Measures

IDOC has 23 performance and outcome measures none of which are at the IDOC goal. Only three corrective actions have been initiated to attempt to improve scores to goal.

Colorectal cancer screening is specifically called out in the Consent Decree (III.M.1.c) which states that all prisoners will be offered annual colorectal cancer screening. Though IDOC established recommendations for cancer screening in 2019[170], by 2020 the Monitor found no evidence of implementation of colorectal cancer screening on site visits.[171] By 2021, IDOC had introduced FIT testing for colorectal cancer screening and the Monitor recommended using a tracking log screening which was not done.[172] At a site visit to Shawnee in 2021, the Monitor found none of 12 eligible candidates for colorectal cancer were screened.[173] By 2022, the Monitor found that record reviews from a sample of seven facilities showed only 22% of eligible patients were appropriately screened for colorectal cancer and multiple individuals were still being screened with digital rectal exams for colorectal cancer screening which not a recommended intervention.[174]

Four years after the Consent Decree began, IDOC submitted the first group of 12 performance and outcome measures one of which included offers to screen for colorectal cancer in eligible individuals. The first data the Monitor has for colorectal cancer screening is the 4th quarter of 2023 (April to June, 2023). Colorectal cancer screening was offered to 11% of eligible patients. By this time there had been several colorectal cancer deaths due to lack of appropriate screening and early identification of the disease. IDOC determined this was a serious problem and paused screening in the following two quarters to develop an initiative to improve colorectal cancer screening rates.[175] Colorectal cancer screening in the July-September, 2024 quarter with 28% of eligible patients offered colorectal cancer screening. The results of the initiative continue to improve. Over the past year, offers of screening improved to 63% of eligible

[170] See Monitor's 3rd Report p117
[171] See Monitor's 2nd Report p117.
[172] See Monitor's 3rd Report p 53-54.
[173] See Monitor's 4th Report p 154.
[174] See Monitor's 5th Report p 11.
[175] The SLQC meeting minutes from April, 2024 document that the colorectal cancer screening initiative was started on 4/2/24.

candidates. Changes initiated to effect these results are not described or discussed in SLQC meetings. This improvement is meaningful even though IDOC has not reached its goal (90%). If the scores remain in variation around the 63%, additional systemic improvements will be needed to reach the expected goal. The initiative did not include a workflow or staffing analysis. To reach the goal it is likely both will need to be done. Best practices learned in the initiative need to be incorporated into B.01.01 Preventive Service and Periodic Health Assessment and implemented at *all* facilities. Persistent monitoring and follow up on corrective action will be necessary to demonstrate that the improved results can be maintained. The 4th quarter, 2025 results show only 29% of eligible patients were actually screened for colon cancer. The refusal rate was 34% and so requires attention.

The other two initiatives were pneumococcal vaccines and sick call. The Monitor has not been provided any updates on the pneumococcal vaccine initiative[176] and the April 2025 SLQC minutes indicate that no update was available.

IDOC began an initiative on sick call in 2023.[177] The sick call measure, as initially created, measured the timeliness evaluating health requests and provider follow up when referred as described in AD 04.03.103 Offender Health Care Services. The new IDOC Policy E.06.01 on sick call made effective in February 2024 had contradictions with the existing administrative directive. The System Leadership Quality Council meeting minutes[178] dated November 8, 2024, document that the Nurse Sick Call performance measure was paused due to noncompliance with policy and inconsistent tracking across facilities, resulting in data that was not valid or reliable. Subsequent meeting minutes dated April 9, 2025, indicated that the Nurse Sick Call measure remained paused due to conflicting directives given in Administrative Directives and policies, which led to facilities not consistently following either written process. The measure remains paused at this time. The IDOC Implementation Plan includes a process improvement project for sick call that the Implementation Plan tracker indicates has been completed.[179] IDOC has provided no evidence that the process improvement project has been carried out.[180] The Monitor also recommends that staffing needed for sick call be evaluated as part of any initiative to improve sick call.[181] IDOC has not provided a date when a performance measure for sick call measure will resume.

The SLQC meeting minutes do not reflect a detailed review of the results of individual measures or a discussion of overall and facility-level performance trends, and there is no clear analysis to identify the underlying reasons for poor scores. The causes of underperformance are not identified and studied and corrective action plans are not developed or reported on during meetings. These gaps reflect inadequate oversight and governance, limiting leadership's ability to monitor performance effectively, ensure accountability, and drive meaningful improvement.

IDOC continues to manually derive all data from record reviews. This limits the number of measures, significantly limits the sample size, and requires significant manpower to complete this assignment. IDOC has not informed the Monitor of any plans to utilize the electronic record to obtain this data.

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[176] IDOC response to Lippert Monitor 9th report documentation request item 67.
[177] See Monitor's 7th Report p 29.
[178] Documents provided in response to the Monitor's documentation request for the 9th report dated 5/10/2024, item 048.
[179] Implementation Plan item 53, Lippert v. Jeffreys Gantt- Reqs-External dated 6/5/25.
[180] IDOC Response to the Lippert Monitor's 9th report documentation request dated 8/15/2025 item 112.
[181] This has been a consistent recommendation since the Monitor's 2nd Report. See recommendation 5 of the Monitor's 2nd Report on p. 89.

Summary

- IDOC has doubled the number of performance measures to 23 measures. Areas that are problematic and have no metrics include:
  - Medication administration[182],
  - Staffing[183],
  - Access to specialty care[184].
- All performance measures except colorectal cancer screening show normal variation around a mean that indicates stable systems. These systems are stable but ***are not performing adequately*** or at goal and IDOC needs to assess workflows, staffing, and other root causes of the inadequate performance to identify corrective actions necessary to improve scores.
- Over six years, IDOC has implemented one corrective action based on performance and outcome measures (colorectal cancer screening) that has shown some effectiveness. Continued monitoring is necessary to determine if the corrective action results in more acceptable scores. Workflow and staffing analysis will likely be necessary to achieve expected the goal (90% of eligible patients offered colorectal cancer screening).
- The SLQC does not conduct sufficient analysis of performance and outcome data or determine the systemic causes of underperformance and changes necessary to improve performance.
- Findings still warrant a partial compliance rating.

RECOMMENDATIONS:

1. Develop a policy for performance and outcome measures to include how to address stable scores with variation that are not at goal.
2. Integrate performance and outcome measure results and findings into the overall quality improvement program.
3. Continue to expand clinical performance measures.
4. Add non-clinical performance measures relevant to the Consent Decree, including staffing and vacancy rates.
5. Add clinical performance measures including ones on access to specialty care consultations and medication administration.
6. Implement an electronic dashboard to track performance measures.
7. Configure the dashboard to automatically obtain data from the electronic medical record, laboratory systems, and other reliable data sources.
8. Define clear governance and accountability for the dashboard, including ownership and maintenance responsibilities.
9. Standardize metric definitions, including numerator, denominator, calculation methodology, data source, reporting frequency, and performance goals.
10. Ensure performance data is accessible and usable by staff and leadership.
11. The SLQC and facility CQI Committees need to regularly review performance results and facility-level trends for all measures.
12. Analyze to identify reasons for improvement or decline in performance.
13. Develop and document corrective action plans for underperforming measures.

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[182] IDOC can consider as measures the percent of medications that patients receive within 24 hours of being ordered or the average percent of total medications patients receive that are ordered.
[183] IDOC can consider vacancy rates of budgeted positions.
[184] IDOC has follow up after ER visits and furlough visits, but an important metric is the average length of time to complete a furlough visit.

14. Incorporate best practices from consistently high-performing facilities into improvement efforts.
15. Enhance leadership reporting to ensure that performance measure results are presented in a detailed and comprehensive manner, including facility-level trends, substantive analysis of the reasons for poor performance or changes in performance, and clearly defined corrective action plans, with ongoing tracking of those action plans and accountability by leadership.

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: Partial Compliance

FINDINGS:

Policy
The Monitor's 8th Report recommended in the 8th report that adverse event reporting be a stand-alone policy and not included with the policy on Mortality and Morbidity Review.[185] IDOC has since developed A.06.03 QM: Adverse Event and Incident Reporting, made effective 7/1/25. The Monitor has not yet had an opportunity to review this new policy but will do so and submit comments and suggested revisions for IDOC to consider.

The new policy continues to use the exact HHS definition of adverse events[186] which pertains to adverse events *during hospitalization*. The Monitor recommends using a definition of adverse events which is more in line with *outpatient medical services,* such as the one used by the Agency for Healthcare Research and Quality.[187] A suggested definition of adverse events is any event that causes harm or risk of harm to patients.[188]

Although Policy A.06.03 states that adverse events may be reported anonymously, the procedures as written do not support true anonymity for written submissions. The policy asks for reporter information, and the policy directs staff to submit the form by email to Office of Correctional Medicine (OCM) , which automatically discloses the sender's email address. The policy also provides a phone-reporting option, but does not state anything about caller ID to ensure anonymity. To meet the intent of the policy, the reporting process should be revised so that reporter information is optional and submitted through a method that does not reveal the sender's identity, such as a web-based form or a physical drop box.

[185] Monitor's 8th report, dated 11/13/2024, page 62.
[186] Adverse Events; U.S. Department of Health and Human Services; Office of Inspector General updated 9/17/25 as found at: https://oig.hhs.gov/reports/featured/adverse-events/ . The definition provided in this communication defines an adverse event as: "An event in which care resulted in an undesirable clinical outcome-an outcome not caused by underlying disease-that prolonged the patient stay, caused permanent patient harm, required life-saving intervention, or contributed to death." This is quoted exactly in the definition of adverse event in policy A.06.03 QM Adverse Event Reporting.
[187] This reference was from Ambulatory Care Safety as found at https://psnet.ahrq.gov/primer/ambulatory-care-safety.
[188] This was discussed at length in the Monitor's 8th report, dated 11/13/2024, pages 63-64.

Policy A.06.03 directs the OCM to identify those adverse events that warrant a morbidity review. The policy states that six months of records and any other relevant information is to be gathered but does not define how quickly facilities must provide the required documents. There are no criteria for when a case should move to a morbidity review nor guidelines for what the morbidity review is to consist of.

The completed morbidity review is sent to the Agency Quality Improvement Coordinator who reviews it and develops corrective actions within 30-days. However, the steps involved in reviewing and developing corrective actions are not described in the policy.

According to the policy, morbidity review is conducted only on serious adverse events. The remainder, which are the majority of the adverse events, are disseminated to the respective HCUAs and facility Quality Improvement Coordinators for review and discussion at the next scheduled Facility Quality Improvement meeting. The policy should be revised to require the Agency Quality Improvement Coordinator or designee[189] to analyze, investigate, and categorize *all* adverse events. To ensure thorough analysis, the policy needs to identify every step in the process, from the moment an event is reported through the point at which corrective actions are assigned. Each step should specify who is responsible and include a due date, so the work can be monitored and delays addressed. Every event should follow a defined investigative pathway, and the depth of the review should be determined by clear criteria rather than individual judgment.

The level of intervention should be based on a clear assessment of the risk, the severity of harm, and the scope of the problems identified in the investigation. A more detailed, system-wide intervention is needed when the review shows that the issues are not isolated but reflect broader system failures, including problems with policies, staffing, processes, or practices. In those situations, a full and thorough root cause analysis, along with a deeper look at the system, is necessary to understand what went wrong and how to prevent it from happening again.

After their analysis, the Agency Quality Improvement Coordinator or designee should determine whether a more limited, focused intervention may be appropriate when the review confirms that the cause is local and isolated. In all situations, the follow-up actions should match the seriousness of the problem and the level of risk it presents so the response is proportional to what was found in the review. These events that are local or isolated or deserving of facility attention should be referred to respective facility CQI program for attention.

As part of this process, the Agency Quality Improvement Coordinator should consider whether the event is a one-time issue or has occurred before, how often it occurs, the level of risk it presents, and whether the issue is isolated to one facility or has broader relevance across the system. These considerations help determine the appropriate level of response including whether a systemic corrective action is necessary. The policy also needs criteria for when a case should include a root cause analysis.

Policy A.06.03 should be revised to include:

- Criteria for when a case should move to a morbidity review;
- The steps to investigate an adverse event consist of the following:
    - Categorizing each adverse event,

[189] The Monitor has recommended that a patient safety coordinator be the one to analyze adverse events at an agency level as the Agency Quality Improvement Coordinator would have insufficient time to do so.

- Checking relevant policies to assess whether policy was followed,
- Assessing whether staffing was appropriate,
- Assessing space, equipment, supplies, and other support services were available to the employee,
- Walking through the steps that should have been taken,
- Talking with staff to understand the challenges they faced during the adverse event.
- Assessing risk and severity of harm,
- Assessing the frequency of events and raising the level of concern for high risk, essential areas of service, or frequently occurring events, and
- Conducting a root cause analysis when criteria exist to do so.[190]

The policy should include definitions of what needs to be tracked and describe how data is to be entered. The adverse event dataset[191] provided by IDOC contains the following fields for each reported incident:

- Record ID,
- Facility,
- Date Incident Was Reported,
- Last Name,
- First Name,
- IDOC #,
- Encounter Timing,
- Date of Single Encounter,
- Date Range, (Low),
- Date Range, (High),
- Date Ongoing,
- Type of Encounter, and
- Incident Summary.

Only a few of these categories are self-explanatory and all need to be defined in policy and the data set. In order to assist in developing more specific corrective action the "Type Of Encounter" should be expanded to include:

- Staffing,
- Policy infraction,
- Dietary,
- Nursing sick call,
- Chronic care,
- Urgent or emergent care,
- Infirmary care,
- Intersystem transfers,
- Specialty care including post-furlough visits,
- Hospital return,
- Preventive care,

[190] A root cause analysis should be conducted for significant sentinel events, for frequent events, high risk events, or for events in essential service areas.
[191] IDOC AEs and Incidents Reported May 1 2024 to July 30 2025 provided in response to the Monitor's documentation request 9th report, dated 5/10/2025 item 68.

- Dental care,
- Delayed or missed appointments,
- Lockdowns,
- Durable medical equipment Issues,
- Laboratory or Other Diagnostic Testing Issues,
- Medication Administration,
    - Transcription issues,
    - Wrong patient administrations,
    - High-risk medication issues,
    - Insulin-related event,
    - Narcotic-related event,
    - Packaging issues,
    - Missed or delayed access to medication,
- Pharmacy Issues,
- Falls,
    - Post-fall documentation,
- Workplace injuries,
- Equipment issues,
- Limitations in clinical or administrative workplace,
- Timekeeping,
- Withdrawal management process,
- Quality Improvement issues,
- Medical refusal documentation,
- Interpreter issues, and
- Security staffing.

The tracking document should also include data fields to indicate whether a corrective action was initiated, whether immediate corrective action was arranged, and whether the corrective action was systemic or facility specific.

Lastly A.06.01[192] Quality Management Program Procedure II.F.2.9. requires the Agency QI Coordinator to track facility corrective actions through to completion. This policy also needs revision to clearly state that plans must contain clear deliverables, specific steps, due dates, responsible parties, and the resources needed to complete the work. Monitor has recommended that IDOC add these additional fields to the corrective action plan. The leadership team (HCUA and CQI Coordinator or Agency Quality Improvement Coordinator) should monitor the progress of all action plans, ensure accountability, and provide support and guidance as needed. Regular updates should be provided to the SLQC so they can monitor progress to completion and provide support and guidance.

Document Reviews

The Monitor requested the following documents related to this provision[193].

[192] Effective 7/1/2025. The numbering of this procedure needs to be corrected. The requirement to track facility corrective actions through to completion is at the top of page eight.
[193] Monitor's Document Request for 9th Report for medical monitoring in Lippert

- All providers referred for peer reviews performed as a result of mortality reviews, adverse event report, or for other reasons since July of 2024. Include the actual peer review. Include any log that tracks peer review - Who was referred, date referred, reason for referral, current status, outcomes of any, etc. (document request 39)
- Training procedures, plans, and training accomplishments of the statewide CQI program with respect to facility CQI programs and OHS since April of 2024. Who was intended to receive training and who received training. Was there an intended due date for receiving training and how many received training by that due date. Provide action plan for how training will be provided for those who still need training (document request 49).
- List and details of all process analysis projects initiated by Systems Leadership Council, SIU or by OHS with the latest report of their work. List should include the status of the project and percent completed (document request 50).
- Any documentation of follow up by the System Leadership Quality Council on any corrective actions issued from any source (document request 51).
- Provide all root causes identified in evaluation of deficiencies as described in item 3 (Identify the Root Cause of the Problem) as found on page 17 of the IDOC Quality Manual. Provide a corrective action tracking log for these (document request 53).
- List, by facility, all adverse events and incidents reported since May 2024 to include name, # and facility and details of adverse event or incident (document request 68).
- List of corrective actions or process analyses since April 2024 initiated due to adverse event reports. Include who developed the corrective action. For each corrective action, list the corrective action(s) needed, why were these corrective actions chosen, what is the expected outcome from this action, who is responsible for implementing the corrective action, what is the target date for completion, and what is the current status. Include any progress report, including the frequency of review, on each action and any oversight or status review by leadership (document request 69).

With regard to document request 39, IDOC stated they do not maintain a centralized log of peer review but are following up on peer reviews. The Monitor strongly recommends that IDOC track peer reviews as it will be necessary to verify II.B.2. which requires monitoring to include effective peer review.

With respect to document request 53, no root cause analyses were provided by IDOC. IDOC stated that SIU was developing a "five whys" training to support root cause identification. The Monitor suggests it may be more effective to centralize root cause analysis in OHS by hiring someone with expertise to do this. If all facilities are to do root cause analysis a significant amount of training will be necessary.

There were 461 adverse events that have been reported from May 1, 2024 to July 30, 2025. The following are the type and frequency of events reported:

- Nearly 200 were related to medications.
- 81 adverse events were related to inadequate space.
- 20 were related to missed specialty clinic orders.
- 18 were related to delay in provider visits.
- 12 were related to inadequate infirmary care and post discharge care.
- 6 events were related to intrasystem transfers.[194]

[194] This is discussed in the intrasystem transfer section of the report.

This listing represents a wide range of health care processes that warrants root cause analyses. The adverse event and mortality review process is not using identified deficiencies to initiate corrective action.

With respect to document request 69, IDOC provided no documents stating that they do not maintain a consolidated list of corrective actions or process analyses and that corrective action plans are within individual corrective action forms. This request is asking for what is required by policy A.06.01 Quality Management Program which requires the facility quality improvement coordinator track all corrective actions (procedure I.B.3.d.ii.) and the Agency QI Coordinator to track all facility corrective actions to completion (procedure II.F.9.) and all system-wide deficiencies and corrective actions (procedure II.B.). IDOC is not following its own policy and procedure.

A multitude of documents were provided regarding training (document request 49) but there was no specific training on adverse events. There was a PowerPoint overview presented at the IDOC quarterly meeting on quality improvement that briefly discussed adverse events but there was no record of training provided to facilities on how to address adverse events.

IDOC provided five documents in response to the Monitor's request for any process analyses done in response to adverse events (document request 50) but none were process analyses. One document is a revised charter for a review of pharmaceutical operations however no data or information about this effort has been provided. This type of review could address the multitude of adverse events reported for medication errors. We look forward to receiving a report of the findings and opportunity to review the deliverables .

Although there were 461 adverse event reports[195] only 38 corrective actions files were provided[196]; only 14 of these were complete corrective actions and only one of these was clearly documented as related to *adverse events*.[197] The evidence provided shows that the IDOC is beginning to develop corrective actions related to adverse events, but this process is immature and not yet effective. The Monitor acknowledges that not all adverse events require a corrective action but for only one corrective action resulting from 461 adverse events means that the adverse event process is still not functioning effectively.

The adverse event list and mortality opportunity for improvement (OFI) lists need reference numbers that can be used on corrective action forms so that the event can be identified from the adverse event list or mortality OFI lists. The adverse event and mortality OFI lists also need a disposition field that tells what action was taken related to the deficiency. Currently there is no way to identify what action was taken on any of the 461 adverse events and hundreds of opportunities for improvement documented in the mortality reviews. Adopting the IHI hierarchy[198] for action plans would strengthen the development of stronger, more effective corrective actions.

[195] Documents provided in response to the Monitor's documentation request dated 5/10/2025 item 68.
[196] Documents provided in response to the Monitor's documentation request dated 5/10/2025 item 51. A total of 65 files were provided but only 38 were corrective action forms.
[197] The one related to an adverse event was related to lack of sufficient dental space at Jacksonville. A request was placed for an additional dental chair, but the request was denied.
[198] IHI action hierarchy is found at: https://www.ihi.org/sites/default/files/SafetyToolkit_ActionHierarchy.pdf.

The data indicate that some types of events are reported more frequently in certain facilities; however, this doesn't necessarily mean that other facilities don't have these issues. It may simply suggest that those events are not being reported. It is crucial to assess whether staff members understand that issues must be reported immediately. Staff might become desensitized to recurring problems and stop reporting them. To encourage reporting, the facility should implement strategies to support staff, appreciate them for reporting, and demonstrate that these reports lead to meaningful change.

Summary:

- The adverse event policy is now a standalone policy which was made effective 7/1/25. The Monitor comments on the policy were discussed in this report and will be made during the annual policy review in 2026.
- All adverse events should be analyzed, tracked, and have a disposition. There is no evidence that there is analysis of adverse events.
- The policy does not explain when to conduct a root cause analysis.
- The process for identifying contributing factors and system issues remains unclear. Staffing-related issues should be identified during reviews and addressed when they contribute to an event.
- Reporting is still uneven across facilities. Some event types appear only in certain facilities, suggesting reporting gaps.
- Tracking of completed training on the new policies and procedures will need to be accomplished when an acceptable policy is completed.
- Events need to be placed into clear categories and groups so that system-level analysis can be completed.
- There are no clear expectations to ensure a consistent and thorough review when events are investigated.
- There are 461 adverse events reported and only one verified corrective action for adverse events and no disposition on almost all adverse events. This needs investigation and correction.
- There is no way to track the status of adverse events or corrective action plans and their deliverables even though the IDOC policy requires tracking corrective actions.
- Leadership support is needed to ensure corrective actions are completed and to guide the work.
- The previous recommendation for a dedicated person to manage adverse events remains crucial, given the complexity and the workload. The tracking and management of Adverse Events also requires a more robust structure and support from someone with data expertise.

RECOMMENDATIONS:

1. Create a process that allows staff to submit truly anonymous adverse event reports and reassure staff that reporting errors will not lead to discipline.
2. Add detailed instructions to the adverse event policy that explain how events should be investigated and analyzed.
3. The Agency Quality Improvement Coordinator or designee needs to analyze all adverse events.[199]
4. Define what type of review should be used and when a root cause analysis is required for each adverse event.

[199] The Monitor has recommended that OHS hire a dedicated person to manage adverse events. See task number 34 in the Implementation Plan.

5. Establish a clear process for identifying contributing factors and system issues.
6. Ensure staffing-related issues are identified and addressed during reviews.
7. Improve adverse event reporting across all facilities.
8. Track training on the new adverse event reporting policy to show who has completed it and who is overdue.
9. Place events into specific categories and groups so that system-level analysis can be done.
10. Provide clear expectations and guidelines for the investigators to ensure every event receives a consistent, thorough review.
11. Utilize the IHI Action Hierarchy to implement actions that address the root cause of the problem, minimize vulnerability, and prevent recurrence of the issue.
12. Develop a system to track all corrective action plans, including deliverables and due dates, to monitor progress.
13. Leadership should regularly review the status of action plans and provide active support and guidance to ensure that corrective actions are completed on time.
14. Check to ensure the action plan has fully addressed the issue and that the problem does not recur.
15. Assign a dedicated person to manage adverse events-related activities, as the work is complex, and ensure robust data support for tracking, managing, and analyzing the data.

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: Partial Compliance

FINDINGS:

IDOC chose to contract with Health Management Associates (HMA) as a third-party administrator to ensure that the performance standards set out in the contract with the health care vendor are met. Since then, IDOC terminated its relationship with the vendor in June of 2025. A new vendor was obtained and initiated work under an emergency contract. Until a final contract with the new vendor is established, with specific terms related to performance, HMA has no basis to function as a contract monitor.

To evaluate the Consent Decree provision listed above, the Monitor requested five documents.

- Any procedure (and instrument) used to monitor performance of vendor. IDOC provided insufficient information for this request. [200]

- Any statewide and facility specific vendor monitoring reports. The material provided by IDOC predated the contract with HMA for vendor monitoring and consisted entirely of notifications sent

[200] Materials provided by IDOC in response to the Monitor's documentation request dated 5/10/2025 item 70 included a "procedure to monitor the vendor" which dealt only with vendor complaints and contract reconciliation. This is insufficient as a procedure to monitor performance. Also provided were 19 worksheets used to track compliance with select medical and mental health administrative directives as well as the staffing requirements outlined in Schedule E of the vendor contract. No information was provided to indicate whether this document is to be used by the current third party administrator.

to the previous vendor of noncompliance with the terms of the contract or ADs. None of these documents included any specific action plans to correct performance and do not demonstrate effective contract oversight.[201]

- Attachment 1 and 2 to the contract with HMA for third party administrator services.

Attachment 1 describes expected responsibilities of a third-party administrator to oversee the delivery of comprehensive medical service that includes onsite and offsite services. Attachment 2 is the 146-page technical proposal of HMA.[202]

Findings Regarding the Prior Vendor's Performance Reported by HMA

The Monitor requested any reports provided by HMA to IDOC regarding the medical providers' contract performance and reporting of key performance indicators. The Monitor noted that in the materials sent by IDOC that HMA has sent a quarterly status report to the Agency's Compliance Chief.[203] This report was not provided to the Monitor by IDOC and would have been responsive to the request. The Monitor has since requested it from IDOC.[204]

While the materials provided by IDOC were not responsive to the request for any reports, they did include findings from HMA's early monitoring of health care delivery by the prior vendor.[205]

5/27/25 Task Meeting between HMA and IDOC document findings including:

- IDOC does not have performance metrics for alignment to best practices. HMA described these as under development by the quality program.
- HMA is engaged in learning about existing external vendor monitoring and vendor self-monitoring activities.
- The process of monitoring has not yet started.
- HMA will pilot audits of certain services (intake, chronic care, scheduled and unscheduled furloughs) in the absence of vendor audits of their services.

6/25/25 Task Meeting

- HMA found poor communication between IDOC and the prior vendor.
- "Position vacancies or absences, including those with time sensitive responsibilities (scheduling, grievance response, provider, medical director), are not adequately covered creating disruptions in service delivery and surveillance of patient and system risk.
    - Pay for critical postings is reported as less than market, including benefits.
    - Use of locum and agency for positions. No clear standardized onboarding process.
    - Critical long-term vacancy filled but person sent out of state for training by Wexford."

[201] Materials provided by IDOC in response to the Monitor's documentation request dated 5/10/2025 item 71
[202] Materials provided by IDOC in response to the Monitor's documentation request dated 5/10/2025 item 72.
[203] Slide 6 of the 5/27/25 PowerPoint slide set.
[204] Email from the Monitor to Robert Fanning, et. al. dated 10/28/25.
[205] Materials provided by IDOC in response to the Monitor's documentation request dated 5/10/2025 item 73. Material provided were five draft audit forms proposed by HMA to audit vendor performance and two PowerPoint slide sets for meetings HMA held with IDOC in May and June 2025.

- "Staffing is based on contract numbers rather than patient outcomes, including numbers that are not adjusted to patient acuity/changing patient needs/patient volume (e.g., ADP doubled without increase in staffing numbers)".[206]
- "Tracking of staffing does not answer critical care delivery questions as they stand. Was service provided by appropriate clinician? Was it timely? Was there access?"
- "Peer review process is not visible to IDOC."[207]
- The prior vendor did not participate in quality improvement activity.

HMA conducted audits of chronic care, intake and furloughs as measured against administrative directives.[208] The HMA audits should use OHS policy, not the Administrative Directives.

The *chronic care* audit was a chart review audit of 47 charts: 19 at Lawrence and 28 at Dixon.

- 13% did not align with clinical guidelines;
- 3 charts showed delays in specialty care referrals;
- 3 charts showed poor control without change of plan;
- 3 charts had abnormal findings that were not addressed;
- 3 charts had a chronic disease that was not addressed;
- Problem lists were completed by nurses or not completed;
- Patients don't have an individualized plan of care aligned with treatment; and
- Level of control is not routinely documented.

HMA conducted a chart review audit of 52 records of patients from NRC and Graham undergoing the *intake process*. Findings included:

- Backlogs of intake health assessments are the norm at NRC.
- An audit of backlogs of intake evaluation showed that RN screening did not impact timeliness for intake physicals.[209] There is no prioritization of backlogged appointments.
- Physicals are occurring without laboratory results at NRC.

HMA conducted record reviews of seven patients at Lawrence and 12 patients at Dixon who were transferred offsite for unscheduled *furloughs*. The process of scheduled and unscheduled *furloughs* was also examined at Centralia. Findings included:

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[206] The Monitor's opinion is that this is consistent with the argument for a workload analysis. Staffing must be consistent with servicing patient needs.

[207] While HMA uses the term "peer review" here, it is likely that they are speaking about performance evaluation. The prior vendor has not recently performed performance evaluations but are required to do so. Peer review, specifically of physicians who perform in an egregious manner, is conducted by SIU OCM. The results of the peer review are to be sent to the Agency Medical Director to determine a disposition. The vendor is not involved in peer review and IDOC should be knowledgeable of the circumstances resulting in any referral to peer review and is responsible for the disposition of peer review. To date, IDOC has not completed a dispositions any peer review completed.

[208] The chronic disease, intake, and furlough audits of HMA as described in PowerPoint slides 12, 20, and 26 in the Monthly Task Meeting 6.25.25 describe that the audit was based on requirements of Administrative Directives. The findings presented here were taken from those slides.

[209] Persons classified as medically low risk and medically high risk whose intake evaluations were evaluated greater than seven days were delayed to the same extent. High risk medical patients were not seen sooner as a result of their disease. HMA recommended risk-based monitoring of queues for the initial health assessment as a quality project.

- Almost half of unscheduled furloughs (emergency room visits) were for exacerbation of chronic disease that were apparently not well managed at the facility.
- A third of unscheduled furloughs were not appropriate.
- When backlogs occur for scheduled furloughs there is no clinical prioritization to ensure high-risk patients are sent on a priority. The scheduling and rescheduling is conducted and controlled by non-clinical staff.
- Medical Director functions are not fulfilled contributing to problems with furloughs.
- No adjustments in clinical practice account for delays in offsite care.
- Lack of a clinically appropriate utilization review inhibits timeliness.
- The current rate of referrals greatly exceeds furlough capacity.

IDOC responded to the Monitor's request for a list of any actions taken by IDOC on the *findings* or *recommendations* provided by HMA that there were "no findings or recommendations provided by HMA in reports to date." This statement is not true. HMA has presented multiple findings to IDOC at the Monthly Task Meetings as just described in the six paragraphs before this. IDOC also stated that a new contractor is in place.[210] The Monitor has previously recommended process analysis for all three areas of concern brought forth by HMA.[211] Regardless of who the vendor is or their longevity, IDOC should be monitoring these essential service areas and acting on the findings. There is no evidence that IDOC uses vendor monitoring to improve services systemically.

Systemic Problems Identified with Specialty Care

HMA acknowledges that the current rate of referrals for specialty or diagnostic care exceeds capacity and gives three recommendations:

- Decrease unscheduled furloughs;
- Decrease scheduled furloughs; and
- Manage backlog actively through utilization and escalation processes prioritizing higher risk individuals.

HMA recommended an analysis of furloughs at Centralia, Menard, and Logan. Instead, the Monitor ***strongly recommends*** that any analysis of furlough issues include Dixon and be performed as a formal process analysis that includes all aspects of specialty care including determining:

- The effect of provider staffing on access to specialty care,
- Compliance with standards of care with respect to referrals,
- The effectiveness of scheduling and tracking of appointments,
- The effectiveness of obtaining reports from specialists and their review by providers,
- Whether patients have access to a sufficient panel of specialists,
- Whether there are sufficient officers and vehicles to transport patients to their appointments,
- Whether a utilization process is necessary if full physician staff were in place and how an ***appropriate and safe*** utilization procedure could be initiated.

[210] Documentation provided by IDOC in response to the Monitor's documentation request dated 5/10/2025 item 74.
[211] Specialty care and chronic care process analyses have been recommended by the Monitor for years and included in the Implementation Plan (tasks 52 and 54). The Monitor has also included recommendations since the Monitor's 3rd Report in the Reception section that a process mapping or redesign of the intake process needs to be accomplished.

There have been continuous problems with furloughs since the beginning of this decree many of which resulted in preventable morbidity and mortality. These include:

- In December of 2019, the Monitor sent to the Agency Medical Director a suggested implementation plan that included performing a process analysis of the specialty care process.[212] This was included in the final version of the Implementation Plan but has not yet been accomplished.[213] The Implementation Plan tracker documents that an Agency Deputy Chief and the Southern Regional Coordinator are conducting an analysis however the Monitor has not been provided any information about what the analysis consists of.[214]
- Tracking of furloughs is inadequate .
    - Not all referrals are entered into the tracking log and often appear only when the referral is accomplished. The tracking of referrals is dysfunctional and inaccurate.
    - There are insufficient clerks to assist in scheduling.
- Between the 3rd and 4th Monitor Reports (February of 2021 and September of 2021), the utilization process was discontinued at the request of the Monitor for reasons of patient safety and efficiency.[215]
- There are insufficient officers to transport patients. Furloughs at some, and possibly at all, facilities are limited to the number of available officers and transport vehicles irrespective of the patients' need.[216]
- Several patients had care denied by utilization review that caused harm including possibly contributing to death.[217] Moreover, there was inadequate oversight over denials of care and delayed utilization review of care that created a patient safety risk.
- Multiple patients are not referred for specialty care when it is indicated or have had delays in receipt of specialty care. Providers continue to fail to acknowledge and act on follow up specialty care recommendations resulting in risk, harm and often contributing to death. This is evident in the Monitor's mortality reviews and in SIU mortality reviews.

At a recent meeting between the Monitor and new vendor reinstituting utilization review was discussed.[218] The Monitor's understanding was that IDOC agreed to discontinue utilization review in 2021 and as a result provision III.H.5. was no longer monitored. Were IDOC to revert to a utilization process, monitoring provision III.H.5. would need to be reinstituted.

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[212] Email to Dr. Bowman and Kelley Presley dated 12.11.19 from Dr. Puisis.
[213] Lippert Implementation Plan Dkt 1688 filed 8/1/2023, items 51 – 52.
[214] Lippert v Jeffreys Gantt-Reqs-External 6/5/2025.
[215] The Consent Decree requires that all denials of care by utilization review, as well as those that are delayed greater than five days are to be reviewed by Agency Deputy Chiefs. This was never accomplished. Only a fraction of denials were reviewed and there was no evidence that delayed approvals were reviewed. The utilization process was a barrier to access, delayed consultations, procedures, and testing, and placed inmates at risk. It also consumed considerable time. The Monitor therefore recommended its discontinuation. See the Monitor's 2nd Report pp 110-114 for this discussion.
[216] One example is Dixon. The Warden told the Monitor that 200 of 536 custody positions were fill not including those on leave-of-absence. Dixon had two ADA vehicles, one of which was broken. The scheduling clerk for specialty care visits said that about 300 specialty care visits were approved per month, but custody could only transport 12 inmates a day due to lack of vehicles and officer staff. So there was a continuous backlog. The response to this is not decreasing the backlog but getting more officers and vehicles. See the Monitor's 6th report, Lippert v Jeffreys, dated 3/13/23, page 115.
[217] See specialty care patients #1 through to #14 Monitor's 2nd Report (pages 111-113); patients #1 and #4 Monitor's 3rd Report; mortality review patient #1 Monitor's 5th Report. Denied care stopped sometime in 2021 when the utilization process was discontinued.
[218] The meeting of the Monitor, new vendor and IDOC took place on September 9, 2025.

Currently, it is not safe to re-initiate utilization review for the following reasons.

- IDOC has only 50% of budgeted physician positions filled. Patients with uncertain clinical status are referred to hospitals due to lack of coverage at the facility. These unscheduled visits are a safety valve when there is no available physician.
- The process of specialty care is dysfunctional. A utilization process should not be re-instituted until a safe and effective specialty care process is in place. For that reason, the Monitor recommends a process analysis of specialty care as soon as possible.

The Monitor continues to recommend monitoring the vendor with a comprehensive audit process (II.B.9.) to satisfy II.B.2. of the Consent Decree. IDOC has declined until recently to initiate a comprehensive audit process and is now only in the conceptual phase. How a comprehensive audit will ultimately be accomplished by IDOC and how the third party administrator may contribute to it is unclear.

Summary

- IDOC has hired a third-party administrator to monitor their contract with the health care vendor. The third-party administrator is not able to carry out this work until a contract with the new vendor is completed.
- It is unclear how dental care will be monitored.
- HMA has begun to perform audits which are useful and instructive. Their findings should lead to quality improvement initiatives when indicated.
- Audits used by HMA are based on administrative directives but should be based on OHS medical policy.
- The Monitor strongly recommends that the furlough findings of HMA result in a formal process analysis of the specialty care as previously recommended in the Implementation Plan.
- Because a qualified third-party administrator has been hired, this provision moves from non-compliance to partial compliance. Procedures for monitoring, effective monitoring and actions on findings are still necessary for compliance.

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 comprehensive audit process that would include mortality review, performance and outcome measurements, adverse event reporting and staffing. Monitoring should be standardized across facilities so comparisons can be made. The Monitor's recommendation is to provide this service through the audit team.

<u>Mortality Review</u>

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: Partial Compliance

FINDINGS:

Policy

In the 8th report the Monitor recommended that A.06.02 QM: Adverse Clinical Event Reporting, Morbidity and Mortality Review effective February 2024 be revised and a policy for adverse events be established. This was accomplished and the new Policy A.06.02 is now limited to Mortality and Morbidity Review effective 7/1/2025. IDOC has accepted nearly all of the Monitor's suggested changes for the mortality review policy.

Data About Deaths of Individuals in Custody

The Monitor requested a current mortality list in document request #75.[219] The mortality list should include the name, IDOC #, date of death, date of birth, age, date of incarceration, facility at time of death, category of death (natural, accidental, homicide, suicide), cause of death (presumptive if autopsy not done), death expected or unexpected, autopsy done Y/N, date of autopsy, and whether a mortality review completed. The list provided by IDOC[220] includes the following deficiencies:

- The cause of death is missing. This is an essential data element in identifying trends in issues affecting the population, assists in guiding strategies to reduce deaths, and helps assess whether quality efforts to reduce deaths are effective.
- The date of incarceration should be provided. Length of incarceration is important in evaluating preventive health programs and to determine effectiveness of existing services.
- Data for certain items are not consistently entered (category of death, death expected or unexpected, and autopsy performed).
- The date of the autopsy is filled in with a five digit number which is not intelligible and is not always filled in.
- The Monitor has asked that this information be provided quarterly, but this does not occur. The Monitor has received mortality lists with the document requests for reports. The Monitor continues to request this information as deaths, death rates, and causes of death are important metrics to follow. This information should be provided at regular intervals (quarterly) as the document is produced.

This list also tracked whether the mortality review had been completed. This is a good addition. However, the list only reports 80 mortality reviews as completed. Upon further request, IDOC reported to the Monitor that 295 mortality reviews have been completed.[221] The list of all deaths, cause of death, and mortality review are not filled in which give an incomplete representation of mortality and mortality review. Policy A.06.02 requires that every death be reviewed, therefore the number of completed mortality

[219] Dated 5/10/2025.
[220] A list of deaths since January of 2022 was provided by IDOC in repose to the Monitor's documentation request, dated 5/10/2025, item 75.
[221] On review of the mortality list, the Monitor sent an email to SIU and Katelin Buell asking for the total number of mortality reviews that have been completed to date because 80 seemed inaccurate. IDOC replied but only with the number completed in 2025 (85). The Monitor asked again for the total number and IDOC responded that 295 mortality reviews were done since 2022.

reviews compared to deaths needs to be tracked.[222] All deaths since the inception of the Consent Decree should be reported.

The absolute number of deaths and the death rate are increasing in IDOC as shown in the following table. The increase in death rate should be discussed by the M&M committee and this trend should be monitored.

IDOC Key Mortality Data*						
Year	Deaths	Autopsies	Cause of Death Listed	Mortality review complete	Population at year end ****	Death Rate/ 100,000
2022	73	34	0	0	29,506	247
2023	82	50	0	4	29,696	276
2024	97	57	0	58	28,842	336
2025**	72	32	0	18	29,289	423
Totals	324***	173	0	80		
*From Mortality Data Report provided in document request #75						
** 2025 included dates from 1/1/25 to 7/31/25 or 211 days. Prorated, this would mean that the 72 deaths are projected to be 124 deaths in 2025 which is high for IDOC. The mortality rate is prorated and an estimate.						
*** There were 325 deaths but for one death the date of death was not included and for this annual calculation, the date was important.						
****Population at the end of year was used. This was a convenience population number available on the IDOC website. It should not appreciably affect the result. Because the trend is of importance, the Monitor believes it is useful to present.						

The table below shows categories of death. Nine percent of all deaths are caused by suicide. Policy A.06.02 Mortality and Morbidity review requires that a mortality review and administrative review be completed by IDOC as specified in administrative directive 04.04.102 and a psychological autopsy be sent to the HCUA. These documents should be reviewed in the mortality review but there is no evidence this occurs consistently. The REDCap report should indicate whether a psychological autopsy was done and if it was reviewed as part of the mortality review. The number of "undetermined" categories of death should be better defined and resolved. If all undetermined were added to "natural", the rate of natural would approximate the national average.

[222] Policy A.06.02, I.

Category of Death							
Year	Natural	Undetermined	Suicide	Homicide	Accidental	Pending	Total
2022	50	13	9	1	0	0	73
2023	54	21	6	0	0	1	82
2024	58	24	11	2	1	1	97
2025	21	46	4	1	1	0	73
Totals	183 (56%)	104 (88%)	30 (9%)	4 (1.2%)	2 (0.6%)	2 (0.6%)	325
National* Statistics	87%		6%**	2%			
* Ann Carson, from Bureau of Justice Statistics Mortality in State and Federal Prisons, 2001-2018 Statistical Tables							
** The comparison is 2022-2025 data to data between 2001-2018. However, even if the suicide rate is consistent with current national averages, it still describes an increase in suicides which should be concerning.							

There is no evidence from the minutes of SLQC meetings that trends in cause of death and frequency of categories of death are presented and discussed. This is an important risk management and patient safety activity that should be a regular function of the Systems Leadership Quality Council.

Mortality and Morbidity Committee

The Departments' response to the Monitor's request for minutes of the Mortality and Morbidity review committee since April of 2024 was that there are none. IDOC instead ask the Monitor to review each individual mortality review and approximately 97 folders of death records were provided.[223] This is not what was requested.

There is no evidence therefore that the mortality review committee meets. Meetings and minutes of these meetings are required by Policy A.06.02. Also required by policy are distribution of minutes of the committee meeting.[224] It is important to know who attends meetings and if there was any discussion about deaths. IDOC is apparently unaware that it is not following its own procedure.

A.06.02 requires that The Agency Quality Improvement Coordinator present the findings of mortality and morbidity reviews at the next scheduled SLQC.[225] The Monitor was also provided with a PowerPoint presentation by the Agency Quality Improvement Coordinator at an IDOC quarterly meeting on 4/2/2025 with the following data from mortality reviews[226] completed from 1/1/25 to 3/30/25. This appears to be a summation of OFIs as documented in REDCap:

- 69.7% of mortality reviews included "red flag"[227] deficiencies.
- 67.1% included failure to follow clinical guidelines or standards of care.
- 61.8% had a delay in access to an appropriate level of care.

[223] Email from the IDOC Chief Privacy Officer to Dr. Puisis dated 11/4/2025.
[224] A.06.02 Policy IV, V.D. , Procedure VI.B.
[225] Procedure V. A-B.
[226] OCM-SIU produced an IDOC Mortality Review OFI Report for July of 2024. This report included all deficiencies identified in mortality reviews for the month of July, 2024 by individual death review. Deficiencies, therefore, can be collated by REDCap which is also demonstrated in this PowerPoint. These data should be used as the basis for tracking deficiencies.
[227] Red flags are clinical signs or symptoms that indicate a potentially serious underlying condition requiring prompt medical attention. These significant warning signs need to be urgently evaluated to prevent harm or complications.

- 55.3% identified failure of appropriate communication between providers where transfer of care occurred.
- 32.9% failed to react appropriately to an abnormal test result.
- 32.9% included a medication delivery error.
- Problem lists were accurate 7.2% of the time.
- 11.3% of deaths were suicides.

Initiatives Resulting from Mortality Review

IDOC provided no data or information in response to the Monitor's request for any actions initiated as a result of mortality review findings.[228] The Monitor is aware that IDOC has taken some actions related to mortality reviews, performance and outcome measures, or adverse events including: their colorectal cancer screening, sick call, pneumococcal vaccine, pharmacy initiative, and a variety of video educational videos. But these initiatives do not appear to be linked to any organized effort to change behavior. Videos are provided but the staff who watch the video is not tracked. Initiatives for colorectal cancer, sick call, and pneumococcal vaccine have been started but there is no monitoring to assess whether the initiative has been effective. IDOC has not for example, provided any analysis or investigation into the root causes of why the deficiencies related to colorectal cancer screening occur and have not demonstrated that a colorectal cancer screening initiative has been designed to correct these causes. Target goals have not been established for any of the initiatives and results are not monitored.

IDOC has not produced any analysis of deaths including death rate or cause of death analysis, The Monitor reviewed a July 2024 report of opportunities for improvement (OFI) that contained a sample of six records. These records had an average of 21 OFIs per mortality review.[229] Using the average of 20 OFI per mortality review from the sample, multiplied by the 295 mortality reviews conducted since 2022, there are an estimated 5,900 OFIs that have accumulated over the past three years. Yet there are no documented corrective actions for mortality review.[230] IDOC needs to address why there is no aggregate analysis of OFIs from mortality reviews nor corresponding corrective actions.

Undertaking corrective action based on identified deficiencies is an essential component of quality but is not being done by IDOC in an organized and structured manner.[231] This must be addressed by the quality program.

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[228] Monitor's 9th report documentation request dated 5/10/2025 item 77. The list is to include who developed the initiative, corrective action, or process analysis. For each corrective action, list the corrective action(s) needed, why were these corrective actions chosen, what is the expected outcome from this action, who is responsible for implementing the corrective action, what is the target date for completion, and what is the current status. Include any progress report, including the frequency of review, on each action and any oversight or status review by leadership.

[229] In document request 76, IDOC provided a document titled July 2024 OFI Report which is a listing of opportunities for improvement (OFI) for death records reviewed in July 2024. There were six records reviewed with an average of 21.4 OFI per review. This is a crude estimate but gives a rough estimate of the number of OFI in total.

[230] In document request 67, 69, and 77 the Monitor asks for any corrective actions developed due to performance and outcome measures, adverse events, and morbidity and mortality review respectively. IDOC provided no documents for these requests.

[231] IDOC has initiated an analysis of pharmacy operations, but it has been ongoing for two years without any evidence of work product. It has also conducted initiatives on colorectal cancer screening, sick call and pneumococcal vaccination but there has been no follow through to assess effectiveness. It has also instituted training (health matters) on identified clinical weaknesses identified presumably on mortality reviews, but whether anyone attends the courses is not monitored and the effectiveness of the training has not been measured.

Recommended Revisions to REDCap in the Mortality Review Process

- The following data elements should be metrics on a dashboard and tracked by facility:
  - S4 Medical History question A1 "Was problem list accurate and complete".
  - Question S4 H.1.2 "Did the health status transfer summary (HSTS) have sufficient/relevant clinical information".
  - Question G1.2.D Who saw patient for sick call (RN or LPN)?
  - Add a data element in section S3 that confirms Y/N Was the code response adequate?
- Item C.1 of the REDCap form includes chronic care visit schedules which are based on the administrative directive which should not be used. The OHS policy F.02.01 Chronic Care should be used instead. Chronic clinics should include evaluations of ***all chronic illnesses***. Patients should be seen not at set intervals but based on the degree of control of the least controlled problem. A data element should be added, "Was the patient seen for all of his chronic illnesses at chronic care visits" and "Was the interval of the visit appropriate for the degree of control for the least controlled conditions"? These should also be metrics on a dashboard.
- Add a question in the Miscellaneous section on whether the patient had evidence or suggestion of a cognitive disorder and track.
- Identify the indication for each medication as patients often are on medications for unclear reasons or are not being monitored for existing conditions.

The Monitor appreciates the consistency of the mortality review process used by SIU and the large volumes of useful data that are produced. The Monitor makes several suggestions for the mortality review process[232] including:

- The adequacy of intervals for chronic care (section S4 item C1) is determined on administrative directives, not the current policy of OHS. In all cases, intervals for chronic care visits should be based on the least well controlled disease. Mortality review findings are that chronic care intervals are adequate when patients are not seen for all of their diseases or have uncontrolled disease and are not seen as frequently as necessary. It should be made clear to members of mortality review that OHS MPPM are the standard to be used for evaluation of performance.
- Section S4, item K, determines whether the patients' activities of daily living (ADLs) were impaired by disease or disability. For example, all the asthma patients reviewed by the Monitor for this report had intermittent exacerbations of asthma that impaired their ability to function but were found by mortality review as no having impairment of ADLs. Some additional discussion and better definition may help in determining findings for S4, section K.
- Section S4, item P, is a determination of whether the patient was in the proper setting at the correctional facility for the level of care needed. The Monitor is unaware of the definitions currently used for this question. This question may be intended to evaluate whether the patient should be sent to a hospital, but in correctional centers, inmates have no choice where they must be housed and housing can contribute to death. Responses to this question during mortality review have not recognized that the patient was in an inappropriate setting. This may be the due to a lack of familiarity with the housing options in IDOC correctional facilities. For example, one patient's autopsy confirmed that heat

[232] See also the Monitor's Mortality Review, an attachment which is included with this report.

stress contributed to his death. His mortality review stated that he was in the proper setting at the correctional facility for the level of care needed. This patient should not have been housed where he was because the heat level in his cell contributed to his death. Persons with asthma that is out of control should be monitored more closely and failure to use an infirmary is a problem that should be acknowledged. Certain patients (serious cognitive disorders or dementia, developing amyotrophic lateral sclerosis, etc.) should not be housed in general population.

- The involvement of pharmacists in the mortality review is very valuable. Additional areas that the Monitor suggests the pharmacist consider as part of mortality review are as follows.
  - Patients seldom receive all of their ordered medication but the percentage of medication they receive is not evaluated. With the advent of the electronic medical record this should be a standard part of the evaluation.
  - The accuracy and appropriateness of nursing hand-written medication administration records should be commented on. The Monitor finds consistent errors in the handwritten MARs.
  - Whether the patient was appropriately informed regarding medications should be evaluated. Elderly patients on multiple medications seldom have these evaluated or simplified. Patients with asthma do not receive instruction on inhaler use nor is use of asthma medications monitored.

Monitor's Mortality Review Findings

The Monitor also reviewed 15 death records; of which five were preventable deaths. There is no improvement in quality of care. Facilities without regularly assigned physicians provided substandard care. The Monitor provides a review of three of these deaths in Mortality Review which is attached to this report.[233] The Monitor highlights these because they were documented as asthma deaths and most asthma deaths are considered preventable.[234] In one of the deaths the patient also had chronic obstructive lung disease (COPD).[235] In all three deaths there were significant medication administration and monitoring deficiencies that are repeatedly continued without correction. Also, providers do not adhere to standard of care with respect to step management of asthma.[236] Overuse of rescue medication as opposed to increasing controller medication was a major issue. No one of the three received spirometry which is a baseline standard for both asthma and COPD. Intervals of care were not based on the severity of the patient's condition. Asthma triggers were not considered when managing asthma. Excessive heat was not considered as a risk which contributed to the death of one of the patients. IDOC should provide instruction to clinical staff on appropriate asthma and COPD care and monitor the effectiveness of the training. Root cause analysis of these asthma deaths needs to be done because asthma deaths are almost all preventable.

There were additional preventable deaths. One patient[237] had asthma, diabetes, peripheral vascular disease, hypertension, hyperlipidemia, diabetic neuropathy, chronic kidney disease, and a long-standing

[233] Mortality review patients #3, 4, and 5.
[234] Global Initiative for Asthma 2025 update. See page 14 in introduction where it states, "Most of these deaths occur in low and middle-income countries, and most of them are preventable".
[235] Mortality review patient #5.
[236] Medications for asthma are stepped up or down depending on the frequency of symptoms and severity of obstructive disease. In IDOC, these three patients were not stepped up for increasing severity of disease.
[237] Mortality review patient #1.

diabetic foot ulcer. He arrived in IDOC in May of 2024 and transferred to Robinson which did not have a full time physician at the time. His diabetes and hypertension remained uncontrolled throughout his entire incarceration. In July 2024 the patient's blood glucose was very high (A1c 13.1). A doctor evaluated the patient briefly in July and wrote "plan for chronic care (DM, HTN) later in summer when able". The lack of physician time resulted in episodic care. This patient's blood pressure was elevated throughout his entire nearly eight months of incarceration. The only change in his blood pressure medication was a small increase in diuretic; he remained on the same dose of amlodipine (5mg) for the entire incarceration. His first and only chronic clinic visit was almost seven months after incarceration at which visit the blood pressure was 154/94. Patients with chronic kidney disease have a lower goal blood pressure of 130/80. Though the blood pressure had been continuously elevated during past visits, the doctor elected not to increase medication because the patient had not yet taken his medication that day. The glucose remained high throughout the entire incarceration (last A1c 10). The patient died of a stroke on 1/9/25. Elevated blood pressure is a major risk for stroke, and this was a likely preventable death.

Another patient[238] was incarcerated in May of 2024 and transferred to Taylorville. There did not appear to be a full-time physician. During 2023 and 2024 there was only one chronic clinic visit (8/25/23) and his medical conditions were not carefully monitored. Initial diagnoses included peripheral vascular disease, type 2 diabetes, hypertension, hyperlipidemia asthma, diabetic neuropathy and a leg ulcer. A chest CT scan in June of 2024 suggested cirrhosis and though signed as reviewed was not added to the problem list or monitored. The patient's osteoporosis with lumbar fractures were not monitored in chronic clinic but he was on acetaminophen and naproxen for pain. In August of 2024, the patient was hospitalized for septic shock, aspiration pneumonia, and GI bleeding. Esophageal varices were identified with cirrhosis. The hospital made a clear recommendation to stop the naproxen[239] and start omeprazole[240]. This was not done. The provider failed to start omeprazole and elected not to discontinue the naproxen despite the hospital's recommendation to do so. This was particularly problematic because the FDA gives its highest warning that naproxen can cause fatal GI bleeding and the patient was just hospitalized for a GI bleed. The patient continued to take the naproxen and sustained a fatal gastrointestinal bleed two weeks after hospitalization. This was a preventable death.

Summary

- IDOC has acceptably revised its mortality policy.
- IDOC does not track cause of death, deficiencies related to mortality review[241], or corrective actions related to the deficiencies.
- The mortality list is incomplete. All deaths since the inception of the Consent Decree should be provided on the mortality list so that deaths can be tracked.
- IDOC does no apparent analysis of deficiencies to determine what systemic or individual corrective actions are needed to prevent future deaths.
- IDOC has not demonstrated that it can effectively correct deficiencies identified in mortality reviews.
- Deficiencies identified in mortality review show serious widespread systemic issues that IDOC needs to develop corrective actions for.
- IDOC provided no mortality review committee minutes for this report.

[238] Mortality review patient #7.
[239] The naproxen has an FDA black box warning that it can cause GI bleeding that can be fatal.
[240] Omeprazole is used to treat gastric ulcer and GI bleeding in this case.
[241] SIU maintains the data in REDCap but it is not used in a tracking document. This is easily corrected.

- Death data shows a rise in suicides that should be monitored closely.
- The asthma deaths warrant an initiative to engage in re-training staff on standard of care for asthma and COPD.
- Psychological autopsies are not included in mortality review.
- The death rate is rising and should be monitored.
- The Monitor suggests revisions to several areas in REDCap and also suggests using REDCap data for metrics on a dashboard.
- The Monitor also suggested tailoring mortality review to consider some of the unique risks in the correctional setting in determinations about appropriateness of housing and ability to carry out ADLs and to expand evaluation of medication management.

These findings warrant continuation of the rating of partial compliance. The inability to track and utilize deficiencies to conduct corrective actions is a serious barrier to forward progress.

RECOMMENDATIONS:

1. IDOC needs to make REDCap accessible to the Monitor and his team.
2. REDCap provides an enormous source of data that is currently unused. IDOC needs to track and categorize deficiencies from mortality reviews so that they are actionable.
3. The mortality review committee meetings should be open to the Monitor and his team.
4. IDOC should implement its policy to track all deficiencies and corrective actions from all sources in a spreadsheet or table.
5. IDOC should implement its policy to include the psychological autopsy and other documents required to be completed in accordance with administrative directive 04.04.102 Suicide Prevention and Intervention and Emergency Services in material reviewed by the OCM mortality reviewers.
6. Minutes of the Mortality and Morbidity Committee need to be taken and distributed consistent with A.06.02.
7. Implement the following metrics on an electronic dashboard:
    a. REDCap S4 Medical History question A1 “Was problem list accurate and complete”.
    b. REDCap question S4 H.1.2 “Did the health status transfer summary (HSTS) have sufficient/relevant clinical information”.
    c. REDCap question G1.2.D Who saw patient for sick call (RN or LPN)?
    d. REDCap section S3 that confirms Y/N “Was the code response adequate”?
8. Consider the following revisions to the REDCap mortality form:.
    a. Item C.1 should be revised to be consistent with F.02.01 Chronic Care policy.
    b. Add the following data element, “Was the patient seen for all of his chronic illnesses at chronic care visits”? This should be added to the dashboard recommended above.
    c. Add a question in the Miscellaneous section on whether the patient had evidence or suggestion of a cognitive disorder and track.
9. IDOC should confer with the Monitor about a strategy to initiate corrective actions and track deficiencies and corrective actions.
10. IDOC must analyze mortality review findings and develop systemic and facility specific corrective actions to reduce preventable deaths and improve care.

Data and Information

Addresses item V.G

> **V.G.** *Every six (6) months for the first two (2) years and yearly thereafter, Defendants shall provide the Monitor and Plaintiffs with a detailed report containing data and information sufficient to evaluate Defendants' compliance with the Decree and Defendants' progress towards achieving compliance, with the Parties and Monitor agreeing in advance of the first report on the data and information that must be included in such report. Defendants will, upon reasonable notice, permit private interviews of Defendants' staff or consultants, in the presence of their attorneys and union representatives at staffs request. It is Defendants' obligation to ensure that the attorneys and union representatives are present on site during any tour days so that staff who request their presence may be interviewed by the Monitor. Defendants will use best efforts to ensure that any vendor complies with all provisions of this paragraph in the same fashion as Defendants. In furtherance of this effort, Defendants represent that any vendor contract will require vendors to comply with all court orders, policies and procedures of IDOC. The Monitor will have reasonable access to all Class Members and their records and files, as well as to those service providers, facilities, buildings and premises that serve, or are otherwise pertinent to, Class Members, where such access is reasonably related to the Monitor's review and evaluation of Defendants' compliance with this Decree. The Monitor's access to information or data for the purpose of fulfilling his or her duties under this Decree shall be subject to an Agreed Protective Order.*

OVERALL COMPLIANCE RATING: Partial Compliance

FINDINGS:

Provision V.G. of the Consent Decree describes the process for the Monitor to obtain data and information to determine compliance with the Consent Decree. The Monitor introduces this section to report on the sufficiency of data and information the Monitor receives in the V.G. Reports and upon request for the Monitor's Reports to evaluate compliance.

IDOC was to have produced a report every six months for two years and annually thereafter with data and information necessary to demonstrate compliance. Over the six years of the Decree, IDOC has produced five reports.[242] The first three reports contained multiple assertions of compliance and imminent compliance, narratives, and anecdotes about a variety of plans. However, IDOC provided no data or information that could be used to verify compliance. The requirement for the Parties and Monitor to agree in advance on the data and information that is required to be in the report have never been accomplished and IDOC now maintains that this V.G. requirement is unnecessary. [243]

In the June, 2022 V.G. Report, IDOC began to insert documents to verify compliance but there was no agreement between Parties and the Monitor that the documents were appropriate as is required by the Consent Decree. IDOC asserted compliance with 30 provisions. IDOC provided documents related to only

[242] May of 2020, November 2020, May 2021, June 2022, and December 2024.

[243] See page one in the Defendants' 2024 Report Under Section V.G. of the *Lippert* Consent Decree in which Defendants state that the "Decree does not require that any subsequent Section V.G. report [more than the first report] include any data or information not agreed to prior to the first Section V.G. report".

11 provisions. The documents provided did not by themselves verify compliance with any provision.[244]

There was no V.G. Report for 2023.

The 2024 V.G. Report mostly references one and occasionally two or more documents to support conclusions about IDOC's progress toward compliance for each separate provisions without explanation about how the documents verified compliance. Most provisions referenced only a policy as verifying compliance with no evidence that the policy had been implemented.[245] The documents submitted that were not policies also did not confirm compliance. Data integrity was not assessed. For example, IDOC submitted the offsite specialty tracking log document as verification of compliance for three provisions related to specialty care. However, the Monitor found that these logs are often inaccurate and contain incomplete information.[246] Most facilities have developed their own unique practices for data entry, definitions of data elements, and maintaining the log. IDOC did not perform any analysis or evaluation of its data prior to submitting it and did not opine on its integrity or to what extent it verifies compliance. The report discusses performance and outcome measures used by IDOC but does not consider whether clinical care represented by the data is appropriate or what actions will be taken to improve performance and outcomes. Few documents include data that indicates quality of clinical care. Documentation of corrective actions is minimal and not consistent with the volume of deficiencies identified.

V.G. Reports do not submit data and information sufficient to verify compliance and Parties and the Monitor have not agreed on the data and information that is necessary to do so.

In the first years of the Consent Decree, the Monitor met with Defendants to discuss data and information that needed to be included in the V.G. Report. At that time, IDOC was unable, technically, and operationally, to obtain data or information sufficient to demonstrate compliance with the items in the Consent Decree. Paper systems used to obtain data were not standardized, completion was optional, and every facility tracked data differently. The medical program was not in the practice of using standardized data to internally monitor their staffing,[247] clinical work, or operational aspects of the medical program. The electronic record is not implemented and there are still no staff to coordinate data management. Since the beginning of the Consent Decree, the Monitor has recommended hiring data staff to obtain, analyze and produce the necessary data for the Consent Decree in an understandable format. IDOC has resisted this recommendation and still lacks capacity to obtain and manage data. The Monitor and IDOC were unable to come to agreement on the data and information required to verify compliance and the Monitor was confined to requesting documents that IDOC could provide.

The Monitor team met with OHS staff and legal counsel on 9/10/25 to discuss data that would be essential

[244] In some cases documents (policies, forms, logs) were used to verify that a process existed (e.g. mortality review) when its implementation or quality was not verified. IDOC submitted IDOC population data to verify that its staffing was adequate using the rationale that because the population had decreased their staffing must be adequate. IDOC also provided as exhibits position descriptions, CVs of recent hires, and proposed staffing plans without indicating what these documents were meant to verify.

[245] IDOC has not verified implementation of any of its policies.

[246] The Monitor has described the inaccuracies in these logs in nearly every report submitted. Current and past mortality reviews by SIU and the Monitor describe the clinically inappropriate specialty care.

[247] IDOC does monitor hours worked by the vendor in order to pay them. However, IDOC does not monitor how many combined State and vendor staff are working in comparison to Staffing Analysis numbers on a regular basis. They did this prior to 2022 when the Staffing Analysis was produced. It is clear that IDOC has staffing data but does not effectively use it to demonstrate compliance with the Staffing Analysis .

to track for purposes of the Consent Decree.[248] The meeting was instructive, collaborative, and useful. It is apparent to the Monitor that IDOC but has begun to investigate how to obtain and track data in an effort to verify compliance with the Consent Decree but has still not committed to meet Plaintiffs and the Monitor to determine the data and information necessary to do so. The electronic record project manager, who joined this meeting by phone indicated that there was a data plan in development to capture data from the electronic record, but it is not yet finalized or implemented.[249]

Since the last report IDOC has developed a Monitor database[250] to begin to provide necessary data and information. However only 19 facilities appear to be using it at present. Not all of the Monitoring team has been able evaluate it because it is not accessible consistently. For some files, a mandatory sign-in code is required but entering the code typically results in an error message stating "we're having trouble signing you in". This freezes the program requiring a force quit. The Monitor will be able to evaluate the data being collected when IDOC fixes access to this program.

Document requests, interviews, and facility visits are the means and methods used by the Monitor to evaluate compliance with the Consent Decree. The Monitor did not conduct facility visits for this report due to timing related to the change in Monitor and a consultant. On 5/10/25 the Monitor requested information on 172 items. To ensure a timely report, the Monitor requested delivery of documents as soon as possible. Instead, IDOC returned information for 140 (81%) requests all on the deadline date of 8/15/25. IDOC did not respond to 32 requests for information but gave an explanation why they could not respond. Documents in response to the requests for information were of variable integrity, quality, accuracy and responsiveness to the Monitor's requests. Overall data and information received was inadequate to verify compliance as represented in this report.

Another source of data and information are video interviews with IDOC management staff. The Monitor requested monthly calls with the Chief Oral Health, Agency Quality Improvement Coordinator, Implementation Project Manager, and Chief Health Services. These are ongoing. In addition to regularly scheduled meetings, the Monitor has requested multiple individual interviews. The communication contributes to the Monitor's understanding of IDOC's process of care and are intended to be informative to staff. The Monitor is hopeful that IDOC staff finds these sessions instructive and useful as well.

The Monitor must schedule all meetings through IDOC legal counsel. Lately it has been difficult to schedule timely meetings. For one of these meetings, the subject resigned two months after request but the meeting had not yet been scheduled.[251] Three other meetings were never scheduled.[252] Three other meetings were not

[248] This discussion did not include all quality-of-care data or data from the comprehensive audit since the comprehensive audit is not yet developed.
[249] This was by phone during a meeting with IDOC, including IDOC legal counsel, on 9/10/25 in downtown Chicago.
[250] IDOC provided a file titled "Monitor Databases" as their future method of providing data. The name "Med Database" has also been used for this file. This file was not provided timely to review for this report. It contained errors as noted in the Sick Call and Comprehensive Dental Care sections of this report. The Monitor's opinion is that IDOC should engage persons with data expertise to obtain information from the electronic record.
[251] Meeting with the Agency Medical Director requested 5/12/25 but never scheduled. The Agency Medical Director resigned on 7/15/25.
[252] On 7/16/25, the Monitor asked for a meeting with Executive Director Hughes but that meeting has yet to be scheduled. On 8/17/25, the Monitor asked to meet with the person responsible for organizing IDOC building projects wanting to know about what medical and dental projects are included in IDOC's building plans; the meeting has yet to be scheduled. On 9/15/25, the Monitor requested a meeting with the person responsible for putting together the State employee staffing data provided in document request #8. IDOC did not honor the request, instead on 10/30/25, four state attorneys and one IDOC

scheduled for four to five months.[253] Beginning on 9/17/25, after the Special Report, IDOC refused to allow any staff interviews to include topics involving adequate facilities, physician or dental staffing, physical plant surveys and surveys of disabled, infirm, and aged populations.[254] Attorneys subsequently expanded this to include general staffing and certain implementation plan topics; the extent of the prohibition is not clear and IDOC would not provide written guidance. These topics are essential elements of the Consent Decree and the Monitor needs to be informed about them to effectively monitor the Consent Decree.[255] These restrictions have occurred simultaneously with an increasing number of attorneys attending the Monitor interviews with staff.[256] The attorneys now occasionally actively participate, sometimes to the extent of reducing participation and conversation with the intended interviewee.[257] The effect of these actions is twofold. By reducing participation of staff in interviews, the Monitor knows less about the working knowledge and plans of the assigned staff and progress on changes called for by the Consent Decree. Secondly, when lawyers answer questions or interpret how IDOC operates, their opinion is at least one step removed from the actual operations of the medical program and therefore does not accurately reflect how the program is working.[258]

The Monitor recently submitted a Special Report that included data systems as an issue of noncompliance. Six years into the Consent Decree, Parties and the Monitor have not agreed upon the data and information necessary to measure compliance. IDOC has no data personnel and uses clinical staff or office staff to obtain and manage data. IDOC needs a functional data infrastructure and personnel who can design and implement effective data collection methods. For these reasons the Monitor introduced this topic in the Special Report.

At the Special Report meet and confer, Defendants provided no plans to correct the problem of insufficient data.

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legal counsel conducted the meeting and attempted but could not explain the accuracy of the data in their State staffing document.

[253] On 6/5/25, the Monitor asked for a meeting with the person associated with oversight of policies. After repeat requests the meeting occurred on 10/30/25 almost five months later. On 6/20/25, the Monitor asked for a meeting with the Infection Control Coordinator. This meeting was not scheduled until 11/13/25 almost five months later. On 7/10/25, the Monitor asked for a call with the SIU person responsible for entering adverse events into REDCap. This meeting didn't occur until 10/31/25 almost four months later.

[254] Email from Robert Fanning that said in part, "I want to clarify the scope of discussion considering your Special Report filed September 11, 2025, which expressly directs the Department to participate in a meet and confer within 30 days on identified areas of non-compliance. Several of the topics proposed for tomorrow — including adequate facilities, physician and dental staffing, overall staffing, physical plant surveys, and surveys of disabled, infirm, and aged populations — are directly identified or related to areas of alleged non-compliance in the Special Report. The Department believes it would be inappropriate and prejudicial to engage in substantive discussions on these matters outside of the formal meet and confer process required by Section V.J. of the Decree as requested by the monitoring team. "

[255] The Monitor read the section of the Consent Decree at one of these meetings that states: "Defendants will, upon reasonable notice, permit private interviews of Defendants' staff or consultants, in the presence of their attorneys and union representatives at staffs request." Attorneys ignored this and gave an explanation related to litigation concerns between Plaintiffs and Defendants. This makes it difficult for the Monitor to obtain information necessary to evaluate the medical program.

[256] There were five attorneys on a 10/23/25 call with the Dental Chief. On 10/30/25, IDOC did not provide a staff person responsible for providing the data for a staffing document; instead, five attorneys attempted ineffectively to explain it. On 10/31/25 three attorneys attended a "private" meeting between the Monitor and Agency Medical Director. At an 11/6/25 meeting with the Monitor's team and the Implementation Plan Project Manager, there were five attorneys present.

[257] As example, this was evident in the 11/6/25 interview with the Implementation Plan Project Manager during which very little was said by the Project Manager and most of the conversation was conducted by attorneys.

[258] In an interview with the Implementation Plan Project Manager, a discussion of the data used to verify completion of an Implementation task resulted in a disagreement between one of the attorneys and the Project Manager which resulted in the Project Manager being silenced and described as misunderstanding.

In the Defendants written response to the Special Report[259], they state,

> Section V.G of the Decree requires the Department to "provide the Monitor and Plaintiffs with a detailed report containing data and information sufficient to evaluate Defendants' compliance with the Decree and Defendants' progress towards achieving compliance, with the Parties and Monitor agreeing in advance of the first report on the data and information that must be included in such report."
>
> The Department maintains it is in compliance with this requirement.

The Monitor disagrees. Defendants also state that the new medical vendor will be able to provide this data in the future which they did not present in the meeting or in their letter, as a plan. Also in the written response, Defendants said it has office specialists to obtain all data that has been requested by the Monitor and built document production requirements into terms of the contract with its new vendor. This was not presented at the meet and confer as a plan.

In their written response to the meet and confer, Defendants ending statement is that …it is the Department's position that it is in substantial compliance with the Decree's requirements with respect to section V.G. of the Decree and denies that any additional steps are necessary to bring its work under section V.G. into compliance with the Decree.

Summary

- The V.G. Reports do not provide sufficient data and information to verify compliance.
- There needs to be an agreement between Parties and the Monitor on the data and information to be included in the V.G. Report. IDOC no longer believes this requirement is necessary.
- It is apparent to the Monitor that IDOC is unable to produce data and information sufficient to verify compliance due to lack of a standardized process for collecting data statewide and resource capacity to produce reports that are effective in demonstrating compliance.
- There are insufficient data staff to manage and produce data documents.
- The introduction of increasing attorney presence and involvement in interviews and restrictions on topics of discussion has decreased access to the data and information needed to evaluate progress towards compliance with the Consent Decree.

RECOMMENDATIONS:

1. Agree on the data and information necessary to verify compliance.
2. Standardize all data and define data elements in a data dictionary.
3. Develop the data elements necessary to monitor compliance with each element of the Consent Decree.
4. Hire data staff to manage production of data necessary to show progress towards compliance. These staff should be familiar with methods to query large databases.
5. Be respectful of the Monitor and Consultants need to interview staff in an atmosphere that facilitates candid communication.

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*

[259] Defendants' Response to Lippert – Sept 2025 Special Report V(J) Document dated 11/14/2025.

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: Partial Compliance

FINDINGS:

The Monitor requested the following five documents related to this provision.

- Policy and procedure for electronic medical record, including: 1) replacement or need for devices or equipment and 2) use of the electronic medical record. (document request #78)
- Any surveys or reports that attempt to predict the number of electronic medical records (EMR) devices and related point-of-care devices/equipment needed for current and future health care personnel.(document request #79)
- The documentation workflows developed by the EMR vendor for intake screening and health assessment, transfer screening, discharge planning, infirmary care, sick call, chronic care, emergency care, specialty care, dental care, preventive care, provider orders, diagnostic reports, medication administration and medication adherence monitoring and counseling (document request #80).
- Provide copies of the monthly Project Status Reports since work began on the EHR under the contract with Fusion. (document request #81)
- Identify the members of the State Training Team as described in the Fusion contract (document request #82)

Policy

IDOC's response to the Monitor's request for policies and procedures for the electronic medical record were that policies have not been finalized.[260] IDOC stated that these policies would be developed in coordination with the EMR system build and that they were anticipated prior to go-live. The response goes further to state that these documents would be provided to the Monitor for review in advance of go-live. Though a pilot go-live has been conducted at Logan, Decatur, and JITC, IDOC has not provided the any policies for the EMR.

The prior report recommended IDOC revise its health record policies to address specific gaps, including initiation of the health record on the day of arrival, clear requirements to maintain progress notes, preventive screening data, advanced directives, and restrictions on the usage of the DOC 0090 form. A review of the current policies[261] indicates that IDOC has addressed the recommendation regarding

[260] Monitor's 9th report documentation request dated 5/10/2025, item 78, IDOC Response to Lippert Monitor 9th Report Documentation Request, dated 8/15/2025.
[261] H.05.01 Retention or Destruction of Health Records Final 2.9.2024, H.04.01 Transfer of Health Records Final 2.9.2024, H.01.01 Organization, Maintenance and Governance of Health Records Final 2.9.2024

documentation timing; policy H.01.01 now explicitly mandates that clinical entries be contemporaneous and made during the shift the writer is working. However, the other identified gaps remain unaddressed. By not revising the policy before implementation leaves IDOC at risk for emergencies that could have been expected (e.g. downtime procedures when the EMR stops working due to connectivity or electrical problems).

Implementation of the Electronic Health Record

IDOC provided a document titled "All Facilities EHR Users Equp Requests" as the list of devices necessary to implement the EMR as requested by the Monitor.[262] This document appears to show that a device count was developed based on surveying staff and obtaining their individual requests for devices they thought were needed. This did not include the operational needs of the system and is not an effective device count. While individual needs must be considered, device counts should be based on user workflows (how and where work is performed), the type of setting (infirmary nursing stations, workstations, clinic rooms, etc.), identifying where staff work, and the expected number of staff.

Staff from only ten facilities responded to this survey. The device needs of only 314 staff were recorded. However, there are many more current and expected health care workers providing services in IDOC whose needs were not represented in this data. There was considerable variability in requests from facility to facility when the work performed in these facilities should be similar. Some employees listed no devices or needs, yet almost every person will need to access the EHR at some point during the workday. In a meeting with IDOC on data on 9/10/25, the EMR project manager joined by phone and indicated a device count is not yet done and future needs still have to be determined.[263] It is apparent that operational needs have not been adequately addressed.[264]

Project status reports indicate that IDOC and the Department of Innovation and Technology (DoIT) are managing procurement of end-user devices, including computers, monitors, and scanners.[265] However, the June 2025 status report, documented infrastructure and hardware at facilities as a high-priority risk as several facilities lacked adequate internet and Wi-Fi connectivity. A comprehensive assessment remained necessary to confirm that sufficient equipment and network access were available to support implementation. To address connectivity limitations in areas such as housing units, the medication orders and medication administration workflows included an offline capability, allowing nursing staff to document medication administration without an active internet connection and synchronize the data once connectivity was restored.

IDOC provided 21 workflows that included eight of the 15 workflows requested by the Monitor.[266] IDOC also included a PowerPoint slide set describing the status of workflows as of 8/4/25. That slide set documented that work remained on 11 workflows. There were 17 workflows moved to user acceptance testing which indicates that at the time this information was submitted to the Monitor workflows were not

[262] Documentation provided by IDOC in response to the Monitor's 9th report documentation request dated 5/10/2025, item 79.
[263] The Monitor team met in person with IDOC in Chicago on 9/10/25 and Robert Burkett the EHR project manager joined by telephone.
[264] By operational needs, the Monitor means for example, the needs for EMR devices on the infirmary to document care; the number of devices needed in dental clinics, the number of devices needed to scan documents and where these devices will be located, the manner of medication administration and the devices needed to document administration, etc. These needs which are significant, are not described in the document provided, and will have to be addressed after IDOC in retrospect.
[265] Documentation provided by IDOC in response to the Monitor's 9th report documentation request dated 5/10/2025, item 81.
[266] Documentation provided by IDOC in response to the Monitor's 9th report documentation request dated 5/10/2025, item 80.

yet complete. For that reason, the Monitor will not comment on specific workflows in this report.

IDOC made 88 policies effective on 2/9/24 but has yet to demonstrate their implementation. No workflow could be identified for a completely implemented policy. For this reason, workflows are likely to need redesign in the future. Modifications of workflows will remain as a long-term need and the Monitor recommends that IDOC retain personnel capable of redesigning workflows in the EMR.

IDOC provided monthly status reports from January to June of 2025 in response to the Monitor's request.[267] The June 2025 report documents delays in implementation due to Content Process Review sessions moving more slowly than anticipated. Specific challenges included submitting incorrect workflows that required rework, discovering additional forms required during sessions that were not initially listed, delays in receiving feedback on some workflows, deciding to remove radiology from the EHR project, and removing paper scanning data migration from the project. While these are the types of challenges typical of an electronic record implementation, they apparently were not anticipated by IDOC and the implementation is delayed as a result. The Monitor's last report[268] documented a date for complete implementation by 2/28/25. The three-facility pilot was not until the first week of December 2025 and a full implementation date has not been determined.

Additional issues with implementation include the following.

- The EMR vendor required the correct patient data migration file. Due to the lack of appropriate data and incomplete analysis, it was recommended that data migration be excluded from the pilot phase.
- Monthly status reports document multiple high-priority items initially included in the project scope have been removed. This is cause for concern. The Monitor was not provided with sufficient information regarding the implications of these changes, including their potential impact on system functionality, operational readiness, or overall outcomes. A formal impact analysis is needed to understand how these scope adjustments may affect project success.
- The Monitor is concerned that the current implementation approach is focused on transferring existing paper-based processes into the electronic medical record rather than fully leveraging the electronic system to improve clinical workflows, assessments, treatment planning, documentation quality, and continuity of care. Many current paper-based processes are inefficient, unreliable, and inadequate to support safe and effective care. Without deliberate workflow redesign and optimization, the electronic medical record risks perpetuating these deficiencies in digital form rather than delivering meaningful improvements in efficiency, reliability, and patient safety.
- To ensure continuity of care and the development of a comprehensive treatment plan, it is essential to promptly obtain records from off-site providers, hospitals, and other facilities. This includes clinical reports, test results, follow-up plans, and treatment plans. These documents should be reviewed by the on-site clinical team and integrated into the patient's treatment plan. Currently, IDOC lacks a reliable, standardized process to track which off-site records have been requested, whether they have been received, and whether they have been reviewed and incorporated into the patient's treatment plan. This workflow should be implemented in the new EMR for better tracking of each step in the process.

The contract with Fusion describes establishment of a State Training Team so the Monitor requested

[267] Documentation provided by IDOC in response to the Monitor's 9th report documentation request dated 5/10/2025, item 81.
[268] Health Care Monitor 8th Report, Lippert v. Jeffreys, November 8, 2024, page 87.

identification of the members.[269] IDOC responded that this team has not been finalized.[270]

The Monitor submitted a Special Report on non-compliance which included the electronic medical record requirements. The Consent Decree requires that IDOC have a contract for an electronic record within 120 days from the effective date of the Consent Decree and complete implementation of the electronic record within 36 months after the contract is signed (this would have been 9/6/22). IDOC offered no plans at the meet and confer to address implementation of the electronic record.

> In their letter of response to the Special Report[271] Defendants' state they have until April of 2027 to implement the record because a contract wasn't signed until 4/10/24. This response ignores the requirement that IDOC have a contract within 120 days of the effective date of the Consent Decree. Defendants further state that the Department denies that it is not in substantial compliance with the Decree's requirements with respect to the deployment of an electronic health record infrastructure and denies that any additional steps are necessary to bring policies and policy implementation into compliance.

Summary:

- A policy that includes the electronic medical record is not yet completed.
- Device counts are incomplete.
- Significant infrastructure and connectivity issues remain.
- Workflows are incomplete.
- IDOC's policies are not implemented and workflows do not include all policy requirements. This will require further EMR workflow development and maintenance.
- IDOC denies that it has not timely implemented the EMR.

RECOMMENDATIONS:

1. Provide the training plan to the Monitor when it is developed.
2. Base the roll out and device needs on expected numbers of employees and expected workflows and not on current employee numbers or existing workflows.
3. 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.
4. Ensure that point-of-care[272] devices are integrated into the electronic medical record.
5. 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.
6. 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.

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[269] Monitor's 9th report documentation request dated 5/10/2025, item 82.
[270] IDOC Response to Lippert Monitor 9th Report Documentation Request, dated 8/15/2025.
[271] Defendants' Response to Lippert – Sept 2025 Special Report V(J) Document dated 11/14/2025.
[272] 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.

7. Current workflows are incomplete and policies are not implemented. IDOC should obtain and retain, trained staff on managing and modifying workflows in the EMR.

Policies and Procedures

Medical & Dental Policy Development

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.*

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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.[273]

1. Provide a list of training completed on IDOC Medical Policies and Procedures. The list should include the topics covered, date, instructor, name and credential of persons in attendance.
2. Provide evidence of the annual review and revision of the IDOC Medical Policies and Procedures as outlined in A.05.01 Policies and Procedures. Provide copies of any changes made to IDOC Medical Policies and Procedures, a list of policies reviewed and the date the review was completed.
3. Provide a list of variances to Administrative Directives (ADS) which have been initiated since the Medical Policy and Procedure Manual was completed and the status of each variance requested.
4. Provide any new Administrative Directives or revised ADs from 2022 related to health or dental services.

In addition to these specific requests, the Monitor reviewed the minutes of the System Leadership Quality Council from January 2024 through April 2025, the minutes of facility Quality Improvement Committee meetings from January through June 2025 and the Statewide Summary of Clinical Quality Performance Reviews for Fiscal Year 25.[274]

IDOC reported in the last VG report that it had distributed its comprehensive Medical Policies and Procedures Manual and that preexisting Compliance Unit Audits and CQI initiatives would be the mechanisms to evaluate compliance. It also reported that it had a plan for training staff in the Medical Policy and Procedure Manual (MPPM) and that SIU would assume responsibility for both training and the updating the MPPM.[275]

<u>Implementation of the Medical Policy and Procedures</u>

[273] Monitor's documentation request dated 5/10/2025, items 83-86.
[274] Monitor's documentation request dated 5/10/2025, items 48 & 55.
[275] Defendants' 2024 V.G. Report dated 12/18/2024 pgs. 24-25.

While there is increased awareness among health care staff that there is a MPPM there is little evidence yet that these have been implemented. For example, implementation of A.06.01 Quality Management Program was paused last year because of conflicts with AD 04.03.125 Medical Quality Management Program.[276] The initiative to improve and standardize the sick call process implemented July 1, 2024, also had to be paused. This was because health care staff were not following either AD 04.03.103 Individual in Custody Health Care Services or E.06.01 Non-emergency Health Care Requests and Services.[277] Change initiatives to improve vaccination and preventive care as described in B.01.01 Preventive Service and Periodic Health Assessment and G.09.01 Immunizations show little progress toward improvement.[278] The same can be concluded from efforts to improve the care of patients with chronic conditions such as diabetes or hypertension as described in F.02.01 Chronic Care.[279]

OHS indicated an intent to obtain variances to the Administrative Directives where there was conflict with the new policies and procedures.[280] The Monitor requested a list of variances that had been initiated since February 2024 when the 1st edition of the MPPM was made effective.[281] IDOC responded to this request with nine documents, of which only one was a variance requested after February 2024. This was a request to delay requiring use of form DOC 0422 relating to dental records so that 30,000 copies of a previous form (DC 7126) could be used up. Other documents IDOC provided were seven revised ADs.[282] IDOC has provided no evidence that variances were obtained to facilitate implementation of the MPPM.

The consequences of being found noncompliant with the ADs while trying to follow the MPPM was brought up during the facility QI meetings that were reviewed for this report.[283] The November 2024 System Leadership Council minutes reflect a request from the Compliance Unit Chief to OHS to assist with updating the ADs to resolve the conflicts with the MPPM. Until the ADs were updated the facilities would be found noncompliant if practices did not match the ADs.

The Monitor also requested any new or revised ADs since 2022.[284] IDOC sent six revised ADs which have been issued in the 19 months since the MPPM was made effective.[285] These are listed in the table below:

[276] Minutes of the System Leadership Council 11/8/2024 & 4/9/2025.
[277] Minutes of the System Leadership Council 11/8/2024 and 4/9/2025.
[278] Clinical Performance Review 4th Quarter FY 25 results were for example that only 63% of eligible persons were offered colon cancer screening, only 21% of eligible patients were offered screening for hyperlipidemia, only 35% of eligible patients were offered pneumococcal vaccine and only 21 of those eligible were offered vaccine for shingles.
[279] Clinical Performance Review 4th Quarter FY 25 results were that only 68% of eligible patients with diabetes were offered an annual eye exam and only 14% were offered an annual foot exam.
[280] Changes in personnel responsible for IDOC Administrative Directives contributed to delays in obtaining the necessary variances. OHS-Monitor Monthly Meeting August 22, 2024 and September 19, 2024.
[281] Monitor's Documentation Request dated 5/10/2025, item 85.
[282] Also provided in response to request # 85 was a variance requested in 2022 and a revised AD on Response to Medical Emergencies effective 3/1/2023. Both these were issued well before the MPPM was distributed and were therefore not considered.
[283] Sheridan CQI minutes for April 2025 and Kewanee CQI minutes for March 2025.
[284] Monitor's documentation request dated 5/10/2025, item 86.
[285] The MPPM was effective 2/2024; this section of the report considers revisions of ADs that were provided through 8/2025 or a period of 19 months.

AD Number and Title	Effective Date
04.03.123 Contact Lenses	01/01/2025
04.03.100 Individuals in Custody Medical Records	03/01/2025
04.03.102 Dental Care for Individuals in Custody	06/01/2025
03.03.125 Medical Quality Management Program	07/01/2025
04.03.140 Training and Counseling on Communicable Diseases	07/01/2025
04.03.116 Bloodborne Pathogens	08/01/2025

At the current pace of revision it will take another 18 months before the conflicts with the remaining ADs are eliminated.[286] Given that the MPPM are not static they will continue to need updating and revision. If an AD must be changed whenever a new edition of the MPPM is issued, the inability to implement change, as witnessed this last year, will be a continual problem. OHS can anticipate that over the next several years major updates to the MPPM will be needed, given the electronic record and other improvements called out in the Consent Decree. A more timely and expedient method to update the Medical and Health Care ADs is needed. The Monitor has suggested to OHS that reducing the number of ADs and creating an over-riding AD that directs compliance with the most recent issue of the MPPM would resolve the bottleneck created by the current set of ADs.[287] There may be other solutions as well to streamline revisions of the ADs, but the current process is unnecessarily time consuming. Patient care is impacted adversely when staff receive consequences for providing care consistent with contemporary practice because of delays in revising outdated ADs .

Training Provided on the New Medical Policies and Procedures

The Monitor understood that the Agency Medical Coordinator was providing training monthly on the 1st edition of the MPPM for facility HCUAs.[288] The Monitor requested a list of training completed on IDOC Medical Policies and Procedures. The list was to include the topics covered, date, instructor, name, and credential of persons in attendance.[289]

IDOC provided emails with an invitation to Webex meetings to review the MPPM on 2/22/2024, 3/27/2024 and 4/24/2024. PowerPoint slides for the meetings on 2/22/2024 and 4/24/2024 were also provided. The meeting in February 2024 included an overview of the reason for developing the manual, how it was organized, and briefly reviewed the correlation between some of the items in the Consent Decree and the new OHS policy and procedure. The meeting in March 2024 reviewed the three policies and procedures on Quality Management A.06.01- A.06.03. The meeting in April 2024 reviewed policies and procedures A.01.01 – A.05.01, A.07.01, and A.08.01. The material provided to the Monitor did not include information about the participants. No other documentation of training in the MPPM was provided.[290] Based on the documentation received from IDOC in preparation of this report, the training provided to facilities did not cover 76 of the 88 policies and procedures in the 1st edition of the MPPM.

[286] It doesn't appear that there is an unwillingness by the Compliance Unit to accept revisions to update the ADs however the current process is unnecessarily cumbersome and time consuming.
[287] The Monitor understands from a meeting with IDOC that took place 10/30/2025 that the Chief Compliance Officer is considering a similar solution which will eliminate these conflicts and delays in implementation.
[288] Health Care Monitor 8th Report, Lippert v. Jeffreys, November 8, 2024, page 90.
[289] Monitor's documentation request dated 5/10/2025, item 83.
[290] The Monitor is aware that the Agency DON distributed written material for facilities to review about implementation of the E.06.01 Non-Emergency Health Care Requests & Services in June and July 2024 for which staff received training credit.

Item #40 step 9 of the Implementation Plan is to "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. (Completion date: November 2023)". It appears some training took place but there is no record that could be provided of training completion or demonstration of subject knowledge. The Monitor was able to meet with IDOC on 10/30/2025 to discuss the status of efforts to implement the MPPM and during the meeting was informed that IDOC has plans to use resources available through the Department's Training Academy to provide training in the 2026 edition of the MPPM. The Monitor understands that the system is capable of delivering online training, documentation of completion, and can check for comprehension. It also can be used by personnel employed by either the state or vendor with the end result being a singular database to account for the training that has been provided in the MPPM and the ability to document each individual's knowledge of the MPPM. The Monitor looks forward to reviewing the results of this effort in the future.[291]

Annual Review of Medical Policies and Procedures

A.05.01 Policies and Procedures: VI. states that the annual review of policies and procedures takes place according to a schedule. The Monitor received the schedule for reviewing policies and procedures in December 2024 that was attached to the Department's V.G. Report.[292] There were twenty or so policies and procedures in the 1st edition that were published before OHS considered the Monitor's input on the draft.[293] IDOC indicated that comments on policies and procedures provided by the Monitor in late January and February 2024 would be considered when the policy and procedure is revised in 2025.[294]

Since January 2025 the Monitor has reviewed 83 of the policies and procedures in the first edition of the MPPM. Until recently the Monitor had received no feedback on suggested revisions to various policies and procedures under review.[295] On September 4, 2025, the Monitor received copies of three revised and one new policy and procedure, all concerning quality, from the Agency Quality Improvement Coordinator.[296] The Monitor was told these included consideration of our feedback.[297]

The Monitor requested evidence of the annual review and revision of the IDOC Medical Policies and Procedures as outlined in A.05.01 Policies and Procedures. Also requested were copies of any changes

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This training consisted of signing a document as having reviewed E.06.01 and the sick call log and did not include a test of knowledge or competency evaluation. Health Care Monitor 8th Report, Lippert v. Jeffreys, November 8, 2024, page 142.

[291] The Monitor understands that the goal for implementation of online training begins 1/1/2026. Whether this will be sufficient to evaluate the training and competency of staff in the medical policies and procedures remains to be seen.

[292] Attachment II.B.8

[293] These are D.02.01, E.04.01, E.05.01, E.06.01, G.10.01 – G.18.11, H.01.01, I.0101, and I.05.01. This was because the Monitor's comments were received after OHS had finalized the 1st Edition.

[294] OHS Monitor Monthly meeting 2/29/2024.

[295] The majority of these reviews were completed primarily in the months of June through September 2025.

[296] These were A.06.01 Quality Improvement Program, A.06.02 QM: Mortality and Morbidity, and A.06.04 QM: Peer Review (Previously A.06.03). A new P & P was also provided which is now A.06.03 QM: Adverse Event Reporting. These revised policies and procedures were not provided in response to the Monitor's documentation request #84 but only because the Quality Improvement Coordinator reported that these had been completed during a monthly meeting on 9/3/2025.

[297] Meeting with the Agency Quality Improvement Coordinator. The Monitor had not reviewed these revisions at the time this report was written.

made to IDOC Medical Policies and Procedures, a list of policies reviewed and the date the review was completed. [298]

The documents IDOC sent in response to this request were not sufficient. Two documents were labeled 1st Review Draft IDOC Medical Policy and Procedure Manual. One is dated as effective 1/1/2025, the other as effective 1/1/2026. Neither contain policies and procedures which have been revised. Some policies do have text highlighted in red and yellow.[299] These appear to be working versions of someone's review but are unauthored. Two other documents were policies with revisions and comments made by the Agency Director of Nursing. The fifth document was an email informing an attorney in IDOC that the Chief Inspector had no objections to A.09.01 Grievance Mechanism.[300] No evidence was provided that policies and procedures are being reviewed in an organized manner consistent with policy A.05.01.[301] IDOC did not provide a list of the policies that have been reviewed and the date the review was completed. The Monitor has not received copies of any policies and procedures that have been revised as a result of the annual review, except those provided by the Agency Quality Improvement Coordinator.

As stated in the 8th report the Monitor was given to understand that SIU had made available one of the staff from the Office of Correctional Medicine to serve as the project manager for the MPPM. The Monitor noted that the SIU policy project manager should be expected to manage the schedule and review/updates.[302] It has been nearly a year since the 8th report was released, and the Monitor still has seen no evidence of any work being performed by the project manager for policies and procedures.

In June 2025 the Monitor requested a meeting to discuss how the annual review of policies and procedures was proceeding, what the plan or approach would be to disseminate revisions (and expected implementation timeframes) and how best to facilitate the Monitor's review and input to the policies and procedures and as necessary, the ADs.[303] Five months later, on 10/30/2025 the requested meeting took place.[304] The Monitor was informed that sometime in September 2025 IDOC engaged SIU to assist with a full overhaul of the MPPM and that IDOC plans to issue a revised set of policies and procedures in January 2026. The revised MPPM will include consideration of feedback provided by the Monitor and address the 2026 NCCHC Prison Health Standards. The Monitor will not have an opportunity to review these revisions in advance of their publication. The Monitor also understands that the process for periodic review and revision of the MPPM will be revisited by IDOC. Clearly the process for review and revision of the MPPM is still being developed. A.05.01 Policies and Procedures should be revised to reflect the process IDOC determines that it will use to complete the periodic review and revision of medical policies and procedures.

<u>The Medical Policies and Procedures are not Comprehensive</u>

[298] Monitor's documentation request dated 5/10/2025, item 84.
[299] Preventive Health Care, Emergency Drills and Plans, Health Care Discharge Planning, Intake Screening, and Chronic Care had some of the text highlighted.
[300] Dated August 14, 2025.
[301] OHS has established a committee to do this review work. A.05.01 Policies and Procedures, Policy, V., Procedure II-III. No evidence was provided that this committee has been formed or that staff have been instructed to complete reviews.
[302] Health Care Monitor 8th Report, Lippert v. Jeffreys, November 8, 2024, page 89.
[303] Email from Catherine Knox to Robert Fanning dated 6/5/2025. Also requested was discussion about the revisions to the ADs and variances obtained, and progress with implementation by the facilities.
[304] By this time the section on Policies and Procedures for the Monitor's 9th Report had been written. It was later revised to reflect the information gained from the discussion with IDOC.

In the 8th Report the Monitor stated that the 1st edition of the MPPM was not considered *comprehensive* and did not address all the provisions of the Consent Decree.[305] IDOC does not cite the relevant provisions from the Consent Decree nor has the MPPM been reconciled with it. These same concerns were raised in the Monitor's 7th report.[306] The 8th Report went further and listed some topics that were not adequately addressed in the 1st edition of the MPPM. These include radiology procedures, laboratory procedures, cleaning and supply of linen in the infirmary, inventory, and control of pharmaceuticals, etc. During the 2025 review of the MPPM the Monitor kept an ongoing list of topics which should be addressed in the MPPM. At OHS' request this list was recently provided by the Monitor.[307] At the meeting with IDOC on 10/30/2025 the Monitor offered to provide a brief outline of material to be covered by each of the additional policies that were recommended and this offer was accepted.[308] The Monitor has suggested that the comprehensiveness of the MPPM be measured by a comparison to the provisions of the Consent Decree and the accreditation standards of the National Commission on Correctional Health Care (NCCHC).

While some guidance is included in AD 04.03.102 Dental Care for Individuals in Custody, the information provided is limited in scope and detail.[309] Twelve dental policies were submitted by IDOC for review by the Monitor; 11 of which addressed infection control in dental care and one addressed oral health services. All policies were returned by the Monitor with recommendations for revision.[310] The Monitor understands that IDOC plans to establish a separate dental services manual, which is commendable since there are additional subjects that need to be addressed by policy.[311] For example, E.04.01 Oral Health Services does not address several areas of dental care and treatment such as extractions, preventive care, and dental hygiene. Each of these areas are specifically identified within the Consent Decree (III.K.7, III.K.8, III.K.10).[312] Either E.04.01 should be broadened, or separate policies developed. In addition, G.18.10 Dental Radiology does not address required safety measures, such as radiological hazard signage as required by II.K.5 in the Consent Decree. As discussed in the preceding paragraph there are no procedures for radiology in the medical areas. The Monitor recommends that G.18.10 Dental Radiology be expanded to address all the medical and dental X-ray units within facilities and the title revised.[313]

Subject matter experts from SIU are helping OHS to draft infection control and pharmacy policy and procedure manuals and this is applauded.[314] However these efforts have been underway for more than

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[305] Health Care Monitor 8th Report, Lippert v. Jeffreys, November 8, 2024, page 88-89.
[306] Health Care Monitor 7th Report Lippert v. Jeffreys, December 27, 2023, pages 50-51.
[307] Email to the OHS Medical Coordinator from Catherine Knox dated 9/10/2025.
[308] The Monitor agreed to provide this after the 9th Report was completed with a projected goal of completion the end of January or February 2026.
[309] This AD was distributed to the field as effective 6/1/2025 without any input or review by the Monitor in advance.
[310] The Monitor returned comments on the dental policies and procedures initially on 9/14/2023. Comments from the Monitor's annual review were submitted to IDOC on E.04.01 Oral Health Services on 7/11/2025 and on G.17.01, G.18.01-G.18.11 on 9/23/2025.
[311] Meeting with IDOC 10/30/2025.
[312] See also Implementation Plan item #83 which stipulates that a comprehensive set of dental policies and procedures will be developed with input from the Monitor.
[313] If IDOC believes that dental radiology needs to remain a separate policy within the dental manual then additional policy needs to be developed for the operation of radiology units in the medical clinic. For a P & P resource see 3.1.13 Medical Imaging Services - Health Care Department Operations Manual (HCDOM) from the California prison health care system.
[314] System Leadership Quality Council minutes May 2024, November 2024 and April 2025. Use of subject matter experts is consistent with the process called for in the Implementation Plan, Item 40, step 4.

one year and there is as yet no draft that has been made available to the Monitor for review. The length of time necessary to draft written policy is unnecessarily long. The reason for these delays should be explored and remedied.

Compliance With the Consent Decree

Compliance with II.B.8, III.K.4, and II.K.5 was not achieved with the dissemination of the 1st edition of the MPPM. Compliance requires that there is evidence that staff know how to execute the policies and procedures and data that demonstrates that work is performed consistent with their written guidance. There was virtually no plan for implementation of the MPPM. There have been notable changes in the stakeholders which may have contributed to the lack of progress since the last report. These include the retirement of the Agency Medical Director, changes in the Chief of Compliance and Medical Compliance Administrator, retirement of one of the Regional Medical Coordinators, and the change in medical vendor. The barriers created by conflicts between the AD and the Medical Policies and Procedures appears to have brought progress forward nearly to a standstill. Having policies and procedures that staff have been trained in, evidence that they have been implemented, and which are monitored and managed is foundational to making progress towards compliance with the Consent Decree.

The Monitor's Special Report discussed the fact that IDOC had yet to establish a comprehensive set of health care policies as required by provision II.B.8 of the Consent Decree.[315] Defendants take the position that they have complied with II.B.8 since at least February 2024.[316] This coincides with the date that the policies were made effective. Defendants response ignores two aspects of the provision that the policies must be implemented and that they must be comprehensive, neither of which have been achieved.

The Court emphasized the importance of demonstrating that the new policies and procedures were actually executed in practice " …the job is not done until they have been implemented, and there is much to do on that front."[317] The Agency Medical Director told the Monitor at a meeting that took place 2/9/2024 that implementation would be a long process.[318] Defendants have provided no data that shows effective implementation of its policies. In fact, information provided by the Department in response to the Monitor's request for documentation for the 9th Report provides ample evidence to the contrary.[319]

The Monitor's opinion is that barriers to implementation include failure to ascertain that staffing is sufficient to carry out the changes defined in the Medical Policy and Procedure Manual, continuation of Administrative Directives which contradict the MPPM, and an organizational structure that is indifferent and ineffective in implementing changes required by the new policies. IDOC indicated to the Monitor at a meeting to discuss implementation of the MPPM on October 30, 2025, a willingness to consider an avenue to eliminate conflicts with the MPPM going forward. If so, this would eliminate one of the factors that has caused implementation to stall in the last year.

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[314] Use of subject matter experts is consistent with the process called for in the Implementation Plan, Item 40, step 4.
[315] Health Care Monitor, Special Report on Structural Provisions, Lippert v. Jeffreys, September 11, 2025, pages 3-4.
[316] Defendants' Response to Lippert – Sept 2025 Special Report V(J) Document, November 14, 2025, pages 8-10.
[317] Court order to extend the Consent Decree Case: 1:10-cv-04603 Document #: 1790 Filed 5/9/2024, page 2.
[318] OHS-Monitor Monthly call 2/29/2024.
[319] Minutes from the System Leadership Quality Council (SLQC) dated 11/8/2024 and 4/9/2025, Clinical Performance Review 4th Quarter 2025, Facility Quality Improvement Committee Minutes, Monitor Database, Information provided in response to the Monitor's documentation request for the 9th report, 5/10/2025 for example items 122, 124, 145 etc.

The Defendants' state in their response to the Special Report that they will continue to revise and implement its policies on an ongoing basis. This response does not directly address the Monitor's finding in the Special Report that the existing edition of the MPPM is not comprehensive. Defendants' maintain that no additional steps are necessary to bring policies into compliance. This statement ignores the Consent Decree language in II.B.8 that the policies must be *comprehensive* and *cover all aspects of a health care program*.

Defendants state that the Monitor does not provide documentation in accordance with V.H. and V.E. to provide sufficient information to evaluate his conclusions of noncompliance. Ample documentation of the basis for the Monitor's conclusion are found in this and prior Health Care Monitor reports. Defendants also ask the Monitor in its written response to provide, in writing, recommendations to achieve compliance. Recommendations to achieve compliance are in this and every one of the Monitor's reports (see the section on Policies and Procedures). They are also found in the Implementation Plan tasks 2.a., 2.d., 3, 5, 6, 7.1., 8.a., and 40.

Summary

Defendants have produced the first edition of a set of medical policies and procedures for this are considered in partial compliance with the Consent Decree. However, these policies are not yet comprehensive and cover all aspects of a health care program. Further Defendants have not implemented those policies that are considered in effect. Except for the conflict with Administrative Directives, Defendant's do not acknowledge the barriers to implementation of policies that have been experienced to date. These are staffing and ineffective authority to manage change in the organization.

In addition to demonstrating that the MPPM is comprehensive, Defendants need to address implementation barriers that remain in place and develop the capacity to provide meaningful data and analysis that demonstrates substantial progress toward compliance with the MPPM.

RECOMMENDATIONS:

1. Expedite resolution of conflicts between ADs and MPPM. Establish a process to prevent ADs from obstructing policy implementation.
2. Establish methods to manage the MPPM to include assigning responsibilities for:
   - Maintaining the review schedule.
   - Tracking review and revision of each policy.
   - Documenting training and implementation progress.
   - Addressing barriers to implementation.[320]
3. Incorporate the Monitor's comments and suggested revisions to the MPPM during the annual review cycle.
4. Reconcile the MPPM to the Consent Decree to ensure that all its provisions are addressed.
5. Expedite completion of the infection control, pharmacy and dental draft policies that have been identified as necessary and provide these for review by the Monitor.

[320] Previously this was to be the responsibility of a project manager provided by SIU. Since it is obvious that there is no project manager assigned, these responsibilities need to be reallocated. This reallocation needs to be defined in a position description, charter, or policy and procedure.

6. Develop a schedule and assign subject matter experts to draft additional policies necessary to complete a comprehensive set of policies and procedures.[321]
7. Implement standardized, facility-level training with centralized reporting, ensuring all staff are trained and knowledgeable of the policies relevant to their roles.[322]
8. Confirm the process for periodic review and revision of the MPPM by IDOC. Also establish the mechanism to obtain the Monitor's review and input on revisions and any new policies. Revise A.05.01 Policies and Procedures to reflect the process IDOC determines that it will use to complete the periodic review and revision of medical policies and procedures.

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:

The Monitor requested the following from IDOC to evaluate compliance with the provisions from the Consent Decree listed above.

- Identify any expert brought on to evaluate the needs of the aged and infirm, and any professionals engaged to evaluate facilities' physical plant in relation to remodeling or building space for caring for the medical and dental needs of that population. Reports should be included.
- Provide any new consultant's plans since the [CGL] (May 2023) and Introba (January 2024) reports addressing the physical space and equipment related to medical and dental needs.

[321] See footnote 32.
[322] See the Implementation Plan narrative pages 1, 3-4, and items 7, 8a., 40 subpart 9.

- A list of construction, remodeling, or physical plant improvements for any of the health care units.

The Monitor also reviewed the updated Implementation Plan tracker, news reports, and the State of Illinois Budget in the evaluation of compliance.

IDOC produced 10 documents; none of which were responsive to the Monitor's request to identify experts to evaluate the needs of the aged and infirm, and to evaluate facilities' physical plant in relation to remodeling or building space for caring for the medical and dental needs of that population.[323] IDOC has not engaged a qualified professional to evaluate the medical and dental facilities to determine the adequacy of clinical space. In addition, IDOC informed the Monitor that they have not engaged any new consultants regarding the physical space and equipment related to medical and dental needs.[324] IDOC also provided a list of maintenance projects that appeared to be repairs or replacements of existing equipment or space mostly unrelated to medical space or equipment in response to the Monitor's request.[325]

IDOC also provided anecdotal information to the Monitor that the Stateville facility would be closed and that Stateville and Logan facilities would be rebuilt. No further information was provided to indicate any planning or design work related to the rebuild of either facility.

On 8/9/24, Federal Judge Andrea Woods issued an unprecedented Court order to depopulate Stateville Correctional Center by the end of September 2024 citing health and safety concerns.[326] This order was related to a long-standing case *Dobbey et al., v. Weilding et al* which was a class action case regarding structural conditions at the Stateville facility initially filed in 2013.

Stateville is not the only facility in disrepair. IDOC commissioned the CGL Master Plan which was completed in May of 2023 and included a conditions assessment of each IDOC facility. That assessment documented:

- Twenty percent of IDOC bed capacity was in facilities opened prior to 1926.
- Many facilities are experiencing significant physical plant issues.
- The 65% of facilities built during the 1970s to 2000 period now lack space necessary to accommodate today's staffing, programming, and treatment needs.
- IDOC buildings are not well maintained. There is $2.5 billions in deferred maintenance costs.
- Only three of 27 facilities reviewed were judged as "fully operational"; three were considered "approaching on "inoperable"" and the remainder had "impaired operational" designations

[323] Documentation provided by IDOC in response to the Monitor's documentation request, dated 5/10/2025, item 7. Three of the documents IDOC provided related to a project to provide officer training in managing patients with dementia. Another six documents provided were the 2023 Introba reports which are old drafts of plans to replace medical units at six IDOC facilities. These drafts were never used as the project was not budgeted according to a note in the Implementation Plan tracker for task 95. The final document produced was the CGL Master Plan from May of 2023 which did not include an individual specifically designated to evaluate medical and dental facilities to determine their adequacy.
[324] IDOC Response to Lippert Monitor 9th Report Documentation Request, dated 8/15/2025.
[325] Documentation provided by IDOC in response to the Monitor's documentation request, dated 5/10/2025, item 87. Included were a generator in the healthcare unit, concrete walkway leading to the healthcare unit, a roof, air conditioning units, a fire alarm, a roof, a dental chair, shower repairs, etc.
[326] Judge orders prison officials to relocate Stateville population by Sept 30; Illinois Times, 8/15/24 as found at https://www.illinoistimes.com/news-opinion/judge-orders-prison-officials-to-relocate-stateville-population-by-sept-30-18930446/

- Almost all the facilities were described as having insufficient space for the medical program and increased medical spaces was identified as a primary physical plan need. [327]

The CGL Master Plan did not include a specific evaluation of medical and dental space, capital medical and dental equipment needs, or living spaces for those with medical conditions who require specialized medical housing (infirmary space or living space for those with disabilities, dementia, or other medical conditions). The CGL Master Plan was produced in May of 2023 when the population of IDOC was approximately 30,000 individuals, the low end of population over the past decade.[328] Even given a lower population over the past decade, CGL concluded that almost all facilities did not have enough medical space and this was identified as a major need. The report did identify that a geriatric housing unit was needed due to health, mobility, and hearing loss of this population without defining the prevalence of those with cognitive disorder or disabilities to determine if their plan for a geriatric unit would ensure sufficient space.

The reason the Monitor recommends a separate evaluation of medical and dental equipment and space is that the CGL report did not specifically evaluate these aside from general space concerns. The Monitor understands that evaluation of physical space requires expert systematic evaluation of all facilities which is not something that can be done solely by the Monitor. For many issues, technical expertise is required that the Monitor does not have.[329] It is for this reason that the Monitor has recommended since the 2nd Report for an expert to conduct an evaluation of physical space for the medical and dental programs.

The Monitor has twice asked IDOC for a strategic plan[330] because the CGL report mentions an IDOC Strategic Plan and 14 key strategic goals, none of which include improvement of medical or dental services. The strategic plan has not been provided to the Monitor by IDOC. The strategic intentions of IDOC with respect to medical and dental facilities remains unknown. Based on review of the CGL document there is no goal or plan to improve the medical and dental units in IDOC facilities. According to IDOC, the OHS medical program has not participated in any strategic planning.[331] IDOC has not informed the Monitor whether OHS will participate in strategic planning in any new facility construction. The Monitor strongly recommends a medical strategic plan be developed to inform the process of planning new facility construction and rehabilitation of existing facilities.

Taking into consideration that there are four years left before termination of the Consent Decree, the Monitor issued a Special Report on outstanding structural components one of which was adequate physical facilities. Adequacy of facilities was included because remedying physical plant requires a survey of what deficiencies exists, developing a plan to remedy existing deficiencies, funding necessary projects, and

[327] Taken from the CGL Facility Master Plan, Illinois Department of Corrections, Final Report- May 2023 as provided by IDOC in response to the Monitor's document request item7.
[328] Using the June-2023 -Prison population data set as found on the IDOC website at https://idoc.illinois.gov/reportsandstatistics/prison-population-data-sets.html
[329] The Monitor does not have the expertise to completely or thoroughly evaluate building codes, life-safety issues, fire codes, ADA accessibility requirements, infection control and ventilation standards and specialized requirements for room sizes, workflow needs, medical gas needs, IT wiring, specialized plumbing, lighting features, radiology shielding, patient and staff privacy, safe egress and emergency response, separation of clean and dirty workflows, structural limits of existing facilities, renovation feasibility, cost implications, and whether the space can be adapted to meet existing healthcare needs.
[330] Email exchange between Melissa Jennings and Dr. Puisis in April and May of 2024 and an email exchange between Robert Fanning and Dr. Puisis in August of 2025.
[331] In 2024, Ms. Jennings indicated that OHS did not have a section in the 2023 Strategic Plan.

then carrying out plans to remedy deficiencies. These steps take time and may require legislative approval. Given the four-year deadline for termination of the Consent Decree, the Monitor decided that these steps should begin now if IDOC is to show evidence of compliance with the requirement of adequate facilities.

Prior to issuing the Special Report, the Monitor and Consultants met with the new vendor and IDOC staff in an introductory meeting. During a break, the Monitor asked IDOC legal counsel how IDOC defines adequate facilities. Counsel did not respond specifically but did say that if he knew how the Monitor would define "adequate", he would not have recommended signing the Consent Decree.

The Special Report was submitted 9/11/25. At the meet and confer, IDOC would not define how they interpret the term "adequate facilities" even though they and Plaintiffs together authored the Consent Decree .[332] They offered no specific plans to attain adequate facilities.

On 9/17/25, IDOC prohibited the Monitor or his Consultants from speaking with IDOC staff about adequate facilities, physician and dental staffing, overall staffing, physical plant surveys, and surveys of disabled, infirm, and aged populations.[333] This prohibition has not been rescinded and is a barrier to evaluating compliance.

On 11/14/25, IDOC counsel sent the Monitor a letter in response to the meet and confer which contained no plans.[334] In their letter, IDOC did not deny the realities portrayed in the CGL Master Plan, but took the position that because of budgetary concerns, needed facility remediation would not occur and is "not explicitly required under the Decree terms". They would not define what their understanding of what "adequate" means in the meet and confer or in their letter to Plaintiffs in response to the meet and confer. The Department's position is that it is in substantial compliance with the Decree's requirements relating to facilities and equipment and denies that any additional steps are necessary to bring its facilities and equipment into compliance.

IDOC also asserts that the Monitor has not provided sufficient information required by V.H and V.E of the Consent Decree to support the conclusions in the Special Report. The Monitor's response is that the Monitor has reported at length since the 2nd Report about the inadequacy of existing facilities and equipment. These innumerable references to facility, equipment, and space deficiencies should have already be known to Defendants. A Federal Judge also recently ordered closure of one of IDOC's facilities based on health and safety concerns. The CGL Master Plan, provided by IDOC, contains specific mention of lack of space in medical units at almost every facility. The CGL Master Plan reports on many of the physical plant structural deficiencies that affect IDOC buildings including medical and dental spaces.[335]

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[332] The meet and confer took place on October 8, 2025. For purposes of monitoring the Consent Decree the Monitor defines adequate facilities as: Safe, suitable, and sufficient environment (physical environment, equipment and infrastructure) to ensure safe, effective and efficient care is provided for the services needed and specialized housing and equipment required for people with conditions involving disability, age, and infirmity.

[333] The email from Robert Fanning stated, "Several of the topics proposed for tomorrow — including adequate facilities, physician and dental staffing, overall staffing, physical plant surveys, and surveys of disabled, infirm, and aged populations — are directly identified or related to areas of alleged non-compliance in the Special Report. The Department believes it would be inappropriate and prejudicial to engage in substantive discussions on these matters outside of the formal meet and confer process required by Section V.J. of the Decree as requested by the monitoring team."

[334] Defendants' Response to Lippert - Sept 2025 Special Report V(J), dated November 14, 2025.

[335] Because the CGL Master Plan does not include specific evaluation of medical and dental spaces or spaces for the disabled, infirm, or aged, the Monitor reconfirms the Monitor's recommendation to do so.

Defendants also asked in its written response that the Monitor provide, in writing, recommendations to achieve compliance. This has already been done in this and prior reports. See also the Implementation Plan which was developed specifically to include the specific tasks to ensure Defendants fulfill the requirements of the Decree. These are tasks # 64-70[336] and #95-99a[337].

Summary

- Contrary to IDOC's assertion of compliance with the Consent Decree's requirements relating to adequate facilities, CGL (IDOC's consultant) identified significant physical plant issues including lack of physical medical space at almost all facilities.
- A qualified consultant has not specifically evaluated the adequacy of medical and dental spaces.
- IDOC offered no plans to remedy the lack of adequate facilities at the meet and confer. They refused to define what they believe constitutes adequate facilities.
- In their written response to the meet and confer, IDOC asserts that they are compliant with requirements of the Consent Decree related to facilities and equipment without providing any evidence other than the statement that "The Department remains committed to pursuing its projected $1 billion in capital investments and ongoing maintenance and believes these steps are reasonable and appropriate". The Monitor confirmed that the current State budget appropriated $900,000,000 for undefined capital improvements[338]. Defendants deny that any additional steps are necessary to bring facilities and equipment into compliance. The Monitor disagrees. Additional steps should include capital that is appropriately allocated to ensure medical and dental spaces are made adequate.
- IDOC had prior intentions to obtain a consultant to evaluate clinical space and equipment and a consultant to evaluate the needs of the aged, disabled, and infirm.[339] IDOC's written response to the meet and confer to take no additional steps implies that no further analysis of medical and dental space is planned nor that the prevalence of the aged, infirm, and disabled is identified nor that their needs will be addressed.
- IDOC has provided the Monitor insufficient information to evaluate their plans to provide adequate facilities with respect to the medical and dental programs. Currently, IDOC does not have adequate facilities. $900,000,000 has been appropriated to IDOC in the State of Illinois annual budget but how it will be spent is uncertain . This provision remains partially compliant on the basis of the State's appropriation.

RECOMMENDATIONS:

1. Develop structural space and fixed equipment requirements for all clinical activities necessary to provide adequate medical and dental care.
2. Hire a qualified architectural/engineering consultant to do a comprehensive review to determine

[336] Tasks 64-70 are for a consultant to survey the needs of disabled, infirmed, and aged and to determine specialized medical housing necessary for this group of individuals and assess whether adequate services exist currently.
[337] Tasks 95-99a are for a consultant to survey all clinical spaces to determine whether space and equipment necessary to provide adequate medical and dental care is available. This evaluation should include all health care and dental units and all spaces used to care for or provide specialized housing (infirmaries or housing for disabled, aged, and infirm). The tasks include that a plan be developed to correct any deficiencies to include funding and a timetable for execution.
[338] Capital Projects List(xls) found at https://budget.illinois.gov/State budget document.
[339] See the initial Defendants' Implementation Plan dated 12/30/2021 page 5 and tasks 5, 64-73, 76-78, 103-110.

whether adequate physical clinical space and equipment relative to useful life determination is available at **all** IDOC facilities. The consultant is to develop a plan to address existing and future physical plant and equipment deficiencies identified. Facility specific documents should focus on the types of patients expected to be housed, the requirements specified in an IDOC health care-specific strategic plan, requirements of IDOC policy and the Consent Decree.

3. Hire a subject-expert consultant or agency to evaluate the health care, special housing, and programmatic needs of the persons who are aged, infirm, disabled, demented and have memory deficit, quantify those numbers for this patient population, and provide recommendations on the clinical care needs and related housing required for this population. This analysis should precede completion of the physical plant analysis.
4. Perform hemodialysis onsite in the IDOC facilities where the renal failure patients are housed.[340]
5. Perform primary and select specialty care onsite facilitated by telemedicine and e-consults.
6. 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 needs based on medical classification acuity needs.

Equipment and Supplies
Addresses items II.B.6.p. and III.B.2.
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.***

OVERALL COMPLIANCE RATING: Partial Compliance

FINDINGS:

The Monitor requested the following from IDOC to evaluate compliance with the provisions from the Consent Decree listed above.

- A list of all durable medical equipment. This was not provided by IDOC.[341]
- A list of all medical equipment that requires calibration at each facility.[342] The list needs to include the equipment description, location, date of last calibration and servicing with the entity that performed calibration or servicing. See also item 163 which requests the calibration, inspection, and servicing information for dental equipment. The document IDOC provided in response to this request was a list of purchased medical equipment and was not responsive to calibration and serving information.
- Copies of current dated IEMA Radiology Safety inspections for all facilities with radiology units

[340] Given the limited number of females with chronic renal failure, it would currently be reasonable for residents of female facilities to receive hemodialysis services at an offsite dialysis center.
[341] IDOC Response to Lippert Monitor 9th Report Documentation Request, dated 8/15/2025 item 89. The Department stated that they received this information from the vendor the day it was due to the Monitor and would supplement its response after reviewing the material. No further information has been received from the Department since then.
[342] Monitor's documentation request 9th report, dated 5/10/2025, item 90.

or log noting the facility and the date of the most recent IEMA inspection noting re-certification or deficiencies. IDOC did not provide these.[343]

The Monitor notes that Patient Safety Goal #2 of Quality Improvement Plan is to "improve the management of medical equipment". The objective was to "increase the number of automatic electronic defibrillators (AED) inspections."[344] The opportunities for improvement were to educate staff on the use of equipment, establish the frequency for inspection, documentation of maintenance and testing, ensure the AED is appropriately placed and stored, and ensure used or expired pads are replaced timely. There is no evidence of this occurring.

Summary

- IDOC provided no data or information responsive to the Monitor's documentation request.
- In past reports durable medical equipment was not standardized with every facility reporting differently.
- IDOC has shown no evidence of improvement in providing adequate equipment that is regularly maintained and replaced as necessary since the Monitor's 4th Report.
- This warrants a finding of non-compliance but because the vendor change may have been responsible for failure to provide documents, the Monitor continues with the partial compliance rating.

RECOMMENDATIONS:

1. See recommendations that jointly refer to space and equipment in the above Clinical Space section.[345]
2. Establish a systemwide standardized list with uniform nomenclature of equipment (including high-grade electric hospital beds and electric exam tables) 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. Monitor 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.
4. 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. Ensure that all IDOC facilities have at least two functional AEDs.
6. Investigate the need for Hoyer lifts in IDOC's infirmaries.
7. Post biannual IEMA radiation safety inspection letters (dated) and certificate (not dated) in all radiology suites and maintain copies in the health care unit administrator's office.

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.*

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[343] IDOC Response to Lippert Monitor 9th Report Documentation Request, dated 8/15/2025 item 91. The Department stated that they received this information from the vendor after the deadline and would supplement its response after reviewing the material. No further information has been received from the Department since then.

[344] Quality Improvement Plan effective 7/1/2025, page 16.

[345] These recommendations reflect the intent of Implementation Plan narrative page 5 and items 95, 96, 97, 98, and 99.

OVERALL COMPLIANCE RATING: Partial Compliance

FINDINGS:
The Monitor requested the following from IDOC to evaluate compliance with the provisions from the Consent Decree listed above.

- Safety and Sanitation reports since September 2024 from Danville, Decatur, Graham, Hill, Illinois River, Jacksonville, Lincoln, Logan, Taylorville, and Western.[346] The schedule for cleaning and sanitation of the health care areas at Vienna and Pontiac. This information should include who performs the cleaning, each room that is cleaned, and what the cleaning consists of.
- Provide any reports completed by the Environmental Services Coordinator since September 2024.[347]

IDOC's most recent V.G. Report (12/ 2024) provided no data or information verifying their progress on the provision above (III.J.3).

Policy
IDOC has two OHS policies[348] and Administrative Directive 05.02.140 Safety and Sanitation Inspections (effective 1/1/25) governing safety and sanitation practice. The administrative directive directs the Warden of each facility to develop a written procedure that includes:

- Daily housekeeping and cleaning schedules;
- A Medical Inspector appointed by the Warden to evaluate safety and sanitation in the health care unit. This person is required to be a licensed health care professional from the facility health care unit.
- A comprehensive safety and sanitation check list unique to each zone.
- General standards to be followed for housekeeping, maintenance, solid waste disposal, water and sewage disposal, pest control, and heating and ventilation. The health care unit is to have an additional specific standard which the administrative directive does not provide. OHS policy is silent on this standard. A specific health care standard is needed.
- The Medical Inspector is to conduct a monthly inspection of the health care unit and any satellite care areas.[349] A monthly safety and sanitation report is to be submitted to the Warden using a checklist to document that each item was inspected.

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[346] Monitor's 9th Report documentation request dated 5/10/2025, item 92. This report is a periodic inspection of the physical space used for purposes of conducting health care (including delivery of dental care) or for specialized medical housing. This includes inspection of all physical structures, fixtures, equipment, infirmary beds, negative pressure units, wheelchairs, and supplies. The inspection also identifies deficiencies and documents corrective action, repair, or replacement, unnecessary items and operability of equipment, fixtures, and supplies. Sanitation reports assess high-risk physical spaces in the housing units and infirmaries that impact on the health and safety of the population, including showers, bathrooms, the presence or absence of safety grab bars in toilets/showers, stairs, floors, walls, ventilation, mold formation, etc. and other physical plant features that impact on access to care including condition of sidewalks, stairs, and ramps.

[347] Monitor's 9th report documentation request dated 5/10/2025, items 93 and 94.
[348] G.22.01 Healthcare Unit and Sanitation and G.03.01 Facility Infection Control.
[349] The administrative directive defines satellite areas as any non-HCU location where health care services, including medication administration, are provided but it needs to include any area where specialized medical housing occurs. For example, the 3rd floor of Dixon that houses a multitude of disabled individuals should have the showers, toilets and living units inspected to ensure the unit is safe for these individuals.

- Violations of minor safety and sanitation standards are to result in work orders and major violations are to result in a written report to the Safety and Sanitation Coordinator. Major violations are separated into serious and other-than-serious. Serious violations have a *substantial probability* that death or serious physical harm could result from the deficiency. " Other-than-serious" violations are those that serious injury or illness would *likely* result from the deficiency.
- The monthly safety and sanitation reports are to include:
    - Standards that are not met;
    - Recommended corrective actions; and
    - Progress statement of action taken to correct previously reported deficiencies.

This administrative directive is a good first step in developing effective safety and sanitation procedures. However there are several shortcomings in the guideline. First, having each Warden write separate procedures creates a variety of practices that do not ensure standardized practices, which at least for healthcare is essential. Checklists are useful but those used for the healthcare unit must be more tailored and specific than those used for general population areas. It is the Monitor's opinion that a licensed health care professional is not required to conduct safety and sanitation evaluation and is probably not best suited for this responsibility.[350] Also, safety and sanitation inspections must not be confined to the health and dental units. The safety and sanitation of facilities includes a multitude of factors that can result in health deterioration. Evaluation for rodents, insects, excess heat[351] or cold, water contamination[352], contamination with toxic substances, etc. must all be subject to the environmental safety and sanitation inspections. At a minimum, satellite health units including showers, toilets, and housing units for those with severe medical conditions, the aged, disabled, and infirm need to be evaluated.

OHS policy G.22.01 Healthcare Unit and Sanitation (Environmental Inspections) is consistent with the administrative directive and states that the HCUA is to assign a staff to:

- Conduct a monthly inspection;
- Write a report to the Warden;
- Identify deficiencies with corrective action plans to include work orders; and
- Provide a written report to the Warden.

Policy G.03.01 Facility Infection Control procedure I.Q. requires the assigned Infection Control nurse to participate in safety and sanitation rounds and to track:

- Availability of handwashing supplies;
- Availability of personal protective equipment;
- Appropriate handling and sanitation of contaminated laundry;
- Appropriate cleaning and disinfection of equipment, furnishings including showers/tubs and bathrooms;

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[350] It is important that the person assigned this role understand how each area is to be sanitized, what constitutes a functioning piece of equipment, and the standards of sanitation, furnishings, equipment, infrastructure components (walls, ceilings, vents, electric outlets, faucets, showers, etc.), and medical processes. Given the shortages of licensed health care professionals, IDOC should consider utilizing other staff to perform these duties.

[351] An inmate died from asthma and excessive heat in his cell contributing to his death (mortality review patient #3).

[352] Hannah Meisel, Judge Orders Stateville Prisoners Moved; Kendall Chronicle, August 21 2024 as found at https://chronicleillinois.com/news/kendall-county-news/judge-orders-stateville-prisoners-moved/. See also Elizabeth Weill-Greenberg, Illinois Prison Water Contamination Keeps Getting Worse; The Appeal July 28, 2022 as found at https://theappeal.org/illinois-prisons-legionnaries-disease/?utm

- Monitoring negative pressure rooms and spore counts for sterilization equipment; appropriate management of sharps;
- Unsafe or unsanitary beds, examination tables, dental chairs, or equipment;
- Functionality of washing machines and dryers; and
- Initiate mitigation efforts of infection control risk identified during these rounds.

Health care staff are to adhere to the administrative directive and the medical policies and procedures. However, even when taken together these documents provide insufficient guidance on how safety and sanitation inspections for the health care unit are to be completed, documented, and followed up on.

Safety and Sanitation Inspection Reports

Safety and Sanitation reports from ten of the facilities were requested.[353] Reports from each facility from May of 2025 were reviewed. The administrative directive and OHS policies G.03.01 and G.22.01 were effective at that time. Every facility used a different format and reported findings differently. Five of the facilities used a checklist.[354] The checklists varied from a five item checklist[355] to 32 pages[356]. The checklists focused on housekeeping (cleanliness, neat, etc.) and varied in which rooms were evaluated and in areas of inspection. There was a lack of health care specific items on the list (equipment, storage of medical supplies, presence or absence of required equipment or supplies, etc.). Checklist terminology is such that deficiencies can be missed. For example, a checklist item "missing tiles" assume all floors are tile and there may be deficiencies of the floor other than missing tiles, such as water buildup, debris, mold etc. Checklist items should be simple terms (beds, walls, floors, outlets, medication carts, medical supplies, oto-ophthalmoscopes, etc.) with the inspector to add commentary about the wide variety of deficiencies that can occur. One checklist included only two of the eight items required in OHS policy G.03.01[357]; otherwise, no other facilities appeared to have implemented this policy. How rooms where medical care takes place are to be evaluated are not described[358]. The requirement of the administrative directive, to prioritize deficiencies with the designations of minor, major-other than serious and major-serious was not used.

Six of the 10 facility reports identified no new deficiencies for the month evaluated. The most new deficiencies identified were three however it was difficult to determine how many of these were identified by the facility and how many resulted from the Environmental Inspection. [359]

The Compliance Unit also conducts environmental inspections as an external audit.[360] These inspections currently evaluate the dietary and the health care unit on an intermittent basis but apparently annually. These audits: 1) identify deficiencies; 2) sometimes cite a standard violated but typically describe why the deficiency is problematic; 3) give a corrective action; 4) assign a priority level to the corrective action;

[353] Monitor's 9th report documentation request dated 5/10/2025, item 92.
[354] Lincoln, Illinois River, Logan, Taylorville, and Graham.
[355] Taylorville.
[356] Lincoln.
[357] Taylorville asked whether handwashing supplies were available and whether negative pressure rooms were checked.
[358] Graham and Lincoln listed the areas inspected on their checklist. Logan listed only the infirmary, employee restroom, and the laundry room but it appeared that the checklist provided was incomplete.
[359] Jacksonville listed a number of deficiencies that were cited in the Compliance Unit's environmental inspection. It was difficult to determine which were new deficiencies the facility identified and those identified by the environmental inspector.
[360] Documentation provided by IDOC in response to the Monitor's documentation request, dated 5/10/2025, item 94.

and 5) track the corrective action to completion consistent with the administrative directive. The Compliance Unit investigation does not evaluate topics designated in policy G.03.01 but neither does the facility medical inspection. The safety and sanitation report is not as thorough or complete as the environmental inspection and fails to identify deficiencies that are obvious.

The Compliance Unit inspections do not evaluate all of the medical spaces, equipment, supplies, and processes that should be inspected. However, the Compliance Unit inspection sets an example on how to conduct inspections. Deficiencies identified result in recommendations for corrective action which are tracked in a meaningful manner. Corrective action trackers were provided for six of the ten facilities for whom safety and sanitation reports were requested.[361] These trackers are well organized. There are columns for due dates to complete the corrective action and the date completed but these are not filled in. We encourage the Compliance Unit to update the due dates and completed dates. These reports included photos of various fixed furnishings and cabinetry, floors, ceilings, vents, walls, plumbing, sinks, and electrical items in the health care units for every facility. This survey is consistent with the CGL report that stated most of the IDOC facilities have considerable structural degradation. These results of these inspections support the Monitor's recommendation to have a qualified consultant conduct a survey of the medical and dental facilities and equipment including medical housing for the aged, disabled, and infirm to produce a report with recommendations for remediation.

One facility is used as an example of how the safety and sanitation report compares to the Compliance Unit inspection. Danville provided all monthly safety and sanitation reports. It does not have a separate safety and sanitation report for the health care unit but does mention health care unit findings in their facility safety and sanitation report. The same three findings were present for the health care unit from January 2024 to June of 2025: 1) chipped Formica on the counters; 2) window cranks were hard to turn; and 3) no temperature control in the pharmacy vault. The latter finding is a serious matter as temperature control is essential to the stability of medication necessary to prevent degradation of medication. This deficiency was not identified as serious. In June of 2025, at least a year and a half after the complaint first appeared, the maintenance department began fixing the chipped Formica. The problem of temperature control in the pharmacy vault was also addressed a year and a half later. The correction of this deficiency was to fabricate a new cabinet for the medications. However, that correction does not solve the temperature control problem if the pharmacy vault continued to be used. The hard to crank window crank was not resolved for over 18 months because permission from Springfield was necessary to fabricate a new part. Peeling paint and a cracked window were other deficiencies identified and apparently were resolved within a month of reporting.

In contrast to the minimal findings in the Danville safety and sanitation reports, the Environmental Services Coordinator from Compliance audited the health care unit at Danville in February of 2025 and found numerous problems. This inspection found the following deficiencies.[362] The statement in bold is the action taken as described in the corrective action tracker.

[361] Corrective action trackers were provided for Danville, Decatur, Graham, Hill, Illinois River, Jacksonville, and Logan but not for Lincoln, Taylorville, and Western. Note that these documents were not requested by the Monitor but are appreciated.
[362]Danville CC FY25 Environmental Health Inspection Suite Memorandum dated 2/28/2025 provided by IDOC in response to the Monitor's documentation request, dated 5/10/2025, item 94.

1. Most work surfaces and carts exhibited missing lamination. This had been present since a 12/2/22 inspection report and had not been corrected. Tape or a liquid barrier were being used as a repair method but were documented as inappropriate. **A purchase request was submitted 4/2/25**.

2. Both sinks adjacent to the isolation rooms were missing laminate surfacing, and had extensive rusting. One sink was unsanitary with tape holding a remaining piece of laminate in place. The conditions of the surfaces inhibited cleaning and were unsanitary. These same findings were presented in the 10/19/21 inspection report and had not been corrected. **Purchase request submitted 4/2/25.**

3. In the health unit and optometry room medical supplies were stored under a sink basin. There was extensive rust underneath numerous sink basins which raises concerns regarding unsanitary storage. **Not yet addressed.**

4. Multiple rooms had metal sinks with water damage and rusting. Missing laminate was observed on surfaces. Condition of support showed exposed wood which inhibits effective cleaning. **Purchase request submitted 4/2/25.**

5. Openings were present under entryways that could permit insect and rodent movement inside. **In progress.**

6. Several ceiling vents had varying degrees of debris and rust buildup. **In progress. Staff are removing and replacing supply and return vents and porters are cleaning.**

7. Multiple water fountains and fixtures had mineral deposits on faucet fixtures. **Area porters are directed to clean the water fountains.**

8. There was continuous observation of a variety of chair cushions that were cracked or otherwise damaged which permitted entry of body fluid with internal padding that inhibited effective cleaning. **No action taken yet.**

9. There were several uncovered electrical thermostats. **Thermostats are pneumatic not electric. No electrical hazard present.**
10. Negative pressure in isolation rooms was indicated with mechanical instead of accurate electronic monitors. One room did not activate upon loss of room pressure. No alarm system was present or activated based on IDOC requirements to alarm when the exhaust system malfunctions. **Replacement scope submitted for approval to R & M FY25.**
11. Continuous observation of biohazard receptacles or trash can lids were damaged, missing, or had to be manually manipulated. **No action documented.**

12. Several biohazard bags filled with soiled linens were not stored properly within containment bins as required. **No action documented.**

13. In a dental room, tape and absorbent padding was being used as a makeshift bumper guard on a wall. **No action documented.**
14. The infirmary shower and optometry faucet remained dripping when shutoff or was otherwise damaged. **In progress.**
15. In the pharmacy room and small pharmacy loose medications were observed scattered on the floor. **No action documented.**


16. The pharmacy vault room had apparent ceiling or skylight water intrusion with debris buildup and potential mold growth observed on the ceiling surface. There were various holes leading to the attic and a pungent odor of potential mold and mildew was present in the room. Proper ventilation could not be located within the vault room.[363] **This room should not be used as the pharmacy vault.**



17. The mini refrigerator behind the nursing station was in disrepair and damaged and components were being held together with unsanitary material. **No action documented.**

[363] This was the same issue identified in the facility inspections that had been ongoing for the entire year and a half of requested reports. Medication needs to be stored under conditions of proper temperature and humidity. A storage problem of this magnitude needs to be resolved by movement of medication product to an alternate storage area until the problem could be remedied which was not done.

18. In the dental unit, a mini refrigerator holding staff food and drink was located underneath a lab work cabinet. **No action documented**.
19. In the dental X-ray room there was a non-functional panoramic X-ray instrument. **No action documented.**
20. In the dental area patient chair #1 was not functional due to suction line issues. **No action documented.**
21. In the blood draw room, the biohazard container had an exposed syringe that was not properly secured as required. **No action documented**

22. The laundry room sink had missing or detached caulk. **In progress.**
23. The health care unit approach and/or sidewalk had limited damage with uneven terrain, open gaps, and loose aggregate which could interfere with movement of wheelchairs, gurneys, or wheeled carts. This is a potential health and safety issue. **In progress submitted to R & M FY25.**

Lack of maintenance and repair as described at Danville are evident in the Safety and Sanitation Reports from multiple facilities. Western reported the same deficiencies from July of 2024 to February of 2025 including:

- The ventilation in the infirmary shower was not working.
- The ventilation in the infirmary tub room was not working.
- The vents in the pharmacy needed cleaning.
- The medical records closet needs shelving built.
- Replace all fluorescent bulbs with LED above dental chairs.

Logan reported the same deficiencies from February, 2024 through April of 2025 including:

- Both toilets very slow to flush,
- Ceiling tiles missing in medical records, and
- Light above infirmary leaking water.

Jacksonville did not produce all monthly inspections however the following are noted from those reports received:

- A persistent statement was "space is limited in HCU which hinders care and is in Violation of Lippert Consent Decree."
- Physical plant problems that require rehabilitation or replacement including comments such as: "No light in shower. Without redesigning the whole shower, there is nothing that can be done at this time".
- Infirmary Bathroom—HCUA previously discussed her concerns with the shower stall in the Infirmary bathroom. The area is unlighted, there is a lip that makes it difficult to use a shower chair for individuals who need it, and there appears to be water damage to the tile outside the shower area. It was discussed that a ramp can be installed to fix this issue. BA [redacted] will request that additional language be added to the [redacted] contract so that they could create a ramp for this.

Currently their contract only pertains to mechanical issues. **TA [redacted]Chief Engineer [redacted] feels there is not enough space for a ramp. DON [redacted] will contact Lincoln to see how they were able to make their Infirmary bathroom ADA-compliant.**

- The negative pressure rooms didn't produce negative pressure from June of 2024 through March of 2025 due to a part malfunction.

Hill's safety and sanitation reports are extremely brief finding few problems. Hill reports did identify a rusted malfunctioning shower door with mold growth in the shower. This was present for over a year and was frequently the only finding. Few findings were present until March, 2025 when 25 new deficiencies were identified in the health care unit, the biohazard container in dental was damaged, and radiology equipment was identified as not functional. This was clearly related to the Environmental Services Report dated 3/28/25 which identified all of these findings. Comparison of the Hill safety and sanitation reports in February and March, 2025 to the Environmental Service Report in March, 2025 demonstrate the failures of facility safety and sanitation inspections.

The Decatur safety and sanitation reports sometimes are a single page combining the entire facility. Other reports are multiple pages with each living and work unit. When the health care unit is separately discussed, there are few findings. The Environmental Services report, on the other hand, documents that the pressure gauges for the respiratory isolation rooms were not calibrated to rest at zero when the doors were open and the alarm did not activate appropriately. The report noted that this had been present since 9/14/22 so it hadn't been corrected for several years and was never mentioned in the facility safety and sanitation reports. As with other facilities the Decatur safety and sanitation report failed to identify the multiple deficiencies found on the Environmental Services report in the health care unit.

Not all facilities completed reports every month.[364]

Cleaning

IDOC provided the cleaning schedule for Pontiac in response to the Monitor's documentation request but did not provide one for Vienna.[365] The Pontiac schedule is a single sheet for each day that lists 14 items:

Bathroom
Sweep
MOP
Shower
Desks
Walls
Trash
Door handles
Light switches
Ice machine
Phone

[364] Several document files from the Western facility would not open and gave an error message that they were corrupted. This has been an ongoing problem with Western for some time. The Monitor believes that the prior IDOC legal counsel corrected the problem for newer files but the older files remain corrupted. IDOC might check the files they send the Monitor to ensure they can be opened.

[365] Documentation received from IDOC in response to request 93 also included a misplaced folder for document request #85.

Tables/chairs
Window/ledges
TV/Kiosk

The task is signed off by "staff" with a correctional officer signature and lieutenant countersignature at the bottom. The person actually completing the task is not documented. The shift hours are listed not the time that the task was actually. Accountability for cleaning is not sufficiently documented on the Pontiac CC Unit Cleaning Log. The Monitor recommends a standardized procedure be developed for sanitation that is modified according to the room arrangements in each facility. The cleaning schedule should provide how the task is to be accomplished, specifically what is to be done, and the actual time the task was completed and by whom. Cleaning of healthcare spaces should follow CDC guidelines.[366]

Summary

- An administrative directive and OHS policy for the safety and sanitation process are in place but these policies offer inadequate guidance and need revision.
- Safety and sanitation inspections in medical and dental units fail to identify obvious deficiencies so the process is currently ineffective.
- The scope of what should be evaluated and the standard against which the inspection is conducted in the medical unit is not yet established. As a result, every facility has differing approaches to these inspections. Inspections fail to uniformly evaluate clinical equipment, furnishings, storage and refrigeration units, cabinetry, sinks, showers, toilets, emergency response bags, negative pressure units, infirmary beds, and other items necessary to be in the health care unit and living spaces of the aged, infirm, and disabled.
- Safety and sanitation reports do not include potential infectious vectors (mold, vermin, infestations of birds and other feral animals, and contaminated water).
- Environmental inspection reports of health care units show poorly maintained and degraded furnishings, fixtures, showers, sinks, floors, walls, electrical outlets, etc. These findings support the need for a consultant evaluation of medical and dental physical plant and equipment.
- Deficiencies identified do not result in timely corrective actions.
- Facilities do not use a corrective action tracker and monitoring corrective actions is not possible with the information provided on current facility safety and sanitation reports.
- The environmental inspection process is of excellent quality but does not include a complete scope for the health care inspection . IDOC should consider how the guidance provided by the Environmental Inspections could be leveraged as a methodology to conduct safety and sanitation rounds in medical units.

For all these reasons, the current status shows some improvement but significant work remains to be done. A partial compliance is now warranted.

RECOMMENDATIONS:

1. Revise and expand the current health care unit safety and sanitation policy[367] to include specific aspects of the clinical space and equipment that are to be inspected during monthly safety and sanitation rounds (see recommendation #2).

[366] Environmental Cleaning in Global Healthcare Settings as found at https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/index.html
[367] IDOC Policy Manual, G.22.01 Healthcare Unit Safety and Sanitation (Environmental Inspections).

2. Finalize, with input from the Environmental Services Coordinator and the Monitor, the health care area safety and sanitation inspection tool to include a more detailed evaluation of the HCU and all other clinical treatment areas and satellite clinics. The tool needs to address the functioning and calibration of medical, dental, and radiology equipment, the condition of gurneys, examination tables, chairs, furniture, and infirmary beds, the contents and security of emergency response bags, the readiness of AEDS, the logs of instrument sterilization testing (spore test), functionality of the negative pressure rooms, the sanitation and orderliness of all clinical spaces, appropriate storage and placement of medical and dental equipment, supplies and medications, and the health care physical plant including the lighting, infirmary showers, toilets floors, ventilation, etc.
3. Collaborate with the Environmental Services Coordinator to develop a separate non-medical-area safety and sanitation inspection tool to ensure that potential health and safety related deficiencies are inspected during monthly safety and sanitation rounds and reported to the monthly facility CQI committee for review and analysis.[368]
4. Track the progress of corrective actions to address deficiencies noted in safety and sanitation reports prioritizing those work orders that have an impact on preventing disease and injury to inmates and staff. Optimally the monthly facility safety and sanitation inspection rounds would also inspect any corrective actions generated by the Environmental Services Program Coordinator.
5. Analyze results of safety and sanitation inspections done by the facility and Environmental Services Program Coordinator to identify systemic issues concerning patient safety or that impede the delivery of timely, adequate health care.

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:
Policy

IDOC Policy D.06.01 On-Site Diagnostic Services was made effective 2/1/24. The Monitor provided comments for the annual revision on 8/25/25 but has not yet received feedback on the comments or any revisions proposed by IDOC to review. Changes suggested by the Monitor were to maintain a log that monitors whether an order for diagnostic testing was completed; whether it was timely; if it was a critical result; and when was it reviewed. This has been a consistent problem including in mortality reviews completed for the 9th report.[369] IDOC has no current mechanism to ensure laboratory or radiology timeliness and effective follow up. Another revision was to ensure that pending test results were transmitted to the receiving facility after their receipt and reviewed by a provider at the receiving facility.

[368] The Environmental Services Program Coordinator only has the capacity to do safety and environmental inspection on an annual (at best) basis. Facility safety and sanitation inspections are performed on a monthly basis and should including follow-up of corrective actions generated by the Coordinator inspections.
[369] Mortality review patients # 1, 2, 3, 7, 9, 10, and 12.

There is no auditing of follow up on diagnostic tests to ensure timely evaluation. As part of the evaluation of the MPPM in this report the Monitor has commented that laboratory and other diagnostic procedures should encompass more than just one policy and procedure. These could be in a standalone manual like the plan for dental services and infection control.

The Monitor requested the following from IDOC to evaluate compliance with the provisions from the Consent Decree listed above.

- Any log maintained of timeliness of provider review of laboratory results. The Department responded that no such log was maintained, and the information could only be found in individual patient records.[370]

Any log maintained of timeliness of order of X-ray, return of radiologist's report, and provider review of X-ray report.[371] IDOC returned 10 documents related to X-ray reporting which were nonresponsive. None of the documents included a date of provider review. Only two showed the order date and completion date.[372]

The Monitor requested all contracts but, as with the last report, the laboratory contract with UIC has not been provided.[373] The UIC lab requisition form, Alphabetical Test List, states that "labs not listed on the requisition form need pre-approval by the corporate/regional medical director. A signed non-formulary form is Mandatory. It must include the test, date, and be attached to the requisition. If one is not attached the testing will not be performed". It was communicated that the most frequently ordered tests that require pre-approval are prostate-specific antigen (PSA), vitamin D level, and hepatitis C RNA quantitative (unless requested by the UIC telehealth hepatitis C clinic). This pre-approval is required even if the non-formulary test was recommended after specialty consultation. This restrictive non-formulary test list creates a potential barrier to care and seems to be a remnant of the previous medical vendor's collegial review process that has been discontinued. IDOC clinical leadership should address this requirement as this process has the potential to being a barrier to care.

Limited point-of-care testing including FIT testing, fingerstick capillary blood glucose, urine pregnancy tests, rapid COVID and flu testing, and tuberculosis skin tests are performed onsite by facility staff. CLIA certificates or certificates of waiver were not evaluated but must be present.

The Monitor continues to strongly recommend that tuberculosis skin testing (TST) be eliminated and replaced by interferon gamma release assay (IGRA) testing in all IDOC facilities. IGRA is currently only

[370] IDOC Response to Lippert Monitor 9th Report Documentation Request, dated 8/15/2025 item 95.
[371] Monitors 9th report documentation request, dated 5/10/2025, item 96.
[372] Danville provided a list of referrals to providers from nurse sick call. East Moline provided a list of 137 X-rays completed since 1/1/25 to 7/17/25 which took 3.6 days on average to complete. Eleven X-rays took a week or longer to complete. Lawrence sent 16 files containing 576 X-ray orders with scheduled dates on a separate sheets. This was nonresponsive as it was not a log and would have required considerable work to construct a log. Mixed in was a progress note form and an email describing the document request. Menard sent 31 pages of X-ray movement forms that listed all X-rays to be done on particular days. There were no order days and no way to determine an order and completion date. This was nonresponsive. NRC sent two X-ray schedule sheets that did not have the date of order. NRC also sent a log of referrals from nurse sick call for provider follow up. The NRC documents were also nonresponsive. Shawnee sent a 23-page document that was list of X-rays done at Shawnee, but it did not have dates of the order or completion. Southwestern sent a single page with 14 orders for X-rays. The average time to take the X-ray was 5.7 days. One X-ray was not completed. The date the X-ray was reviewed is not included. These documents were nonresponsive.
[373] Documentation received from IDOC in response to the Monitor's 9th report documentation request 93.

available in the four reception and classification centers. Systemwide use of IGRA to screen for tuberculosis would minimize human error, diminish the risk of accidental finger sticks, and free up nursing staff for other clinical responsibilities. IDOC recently responded that they will not expand the IGRA testing program.[374]

Summary

- Policy on laboratory testing should include time frames for critical laboratory testing and follow up, as well as *how* laboratory tests are to be followed up.
- IDOC provided no data or information to verify that diagnostic services (laboratory and X-ray) are timely.
- IDOC will not expand IGRA testing. IDOC does not now verify timely tuberculin skin testing but will need to do so.
- IDOC provided no data or information to evaluate timely access to diagnostic services.

Because of the recent change of vendor the Monitor will continue the current rating of partial compliance for this report. However without data on timely access to diagnostic services for the next report, the Monitor will consider finding this provision noncompliant.

RECOMMENDATIONS:

1. Convert all of the 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. Continue to evaluate the need for radiation exposure monitoring badges in all 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 standardized paper and ultimately electronic 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 (see section in this report on Cancer Screening).
5. Review and investigate the tests on the existing non-formulary laboratory test list and evaluate the need for facility providers to obtain pre-approval from the medical vendor for non-formulary tests.
6. Revise D.06.01 Diagnostic Services to require a log be maintained that monitors whether an order for diagnostic testing was completed; whether it was timely; and if it was a critical result when was it reviewed. Also, to include in the revision expectations that pending test results are transmitted to the receiving facility after their receipt and reviewed by a provider at the receiving facility.
7. Establish the method and means to track timeliness of access to diagnostic services and follow up.

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;*

[374] Email from Katelin Buell to Catherine Knox 11/21/25.

OVERALL COMPLIANCE RATING: Partial Compliance

FINDINGS:
Seven documents were requested to evaluate the provisions above. All seven were provided and discussed in this section.

IDOC provided the CV of the current IDOC dietician[375] who is a registered dietician with a Master of Science in Nutrition and is well qualified for the position.

The Therapeutic Diet policy[376] was finalized in February 2024, including nutrition counseling referral forms authorized by the Medical Director. In May 2025, IDOC issued the Therapeutic Diet Manual[377] for FY2025, signed by the Agency Dietitian and the Agency Medical Director.
The manual includes:

- Ordering guidelines
- Diet order request form
- Diets for pregnancy and lactation
- End-of-life diet guidance
- Texture-modified diets
- Liquid diets
- Therapeutic diets (including heart healthy diet, sodium-restricted diet, consistent carbohydrate diet, chronic kidney disease diet, high calorie/high protein diet, and gluten-free diet)
- Religious diets (including kosher, halal, and vegetarian diets)
- Educational materials for each diet to support patient understanding and adherence

The content in the IDOC Therapeutic Diet Manual seems to be taken directly from Nutrition Care Manual[378] and is not customized for IDOC. The therapeutic diet manual states that the exact amount and type of carbohydrate served must be individualized by a Registered Dietitian Nutritionist, and that the diet requires both initial and ongoing collaborative planning with the patient. This process is intended to incorporate individualized goals, food preferences, and relevant comorbidities. Based on the medical records[379] review, individuals who need diet consultation are not being referred to the Registered Dietitian.

A letter from the Registered Dietitian and Licensed Dietitian Nutritionist confirms that a comprehensive analysis was completed for the FY2026 5-week master menu[380]. The FY2026 menu meets and exceeds the nutritional needs of the general population and provides an acceptable macronutrient distribution. The menu meets and exceeds recommended caloric intake. Sodium levels exceed recommended intake, and there is a need to focus on low or no added salt options.

For the FY2025 master menu, the average daily nutritional values are:

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[375] Provided by IDOC in response to the Monitor's documentation request item 97.
[376] D.05.01 Therapeutic Diets Final 2.9.2024.
[377] Therapeutic Diet Manual 2025 provided by IDOC in response to the Monitor's documentation request item 101.
[378] A manual maintained by the Academy of Nutrition and Dietetics that is created by an expert panel of Registered Dieticians and updated regularly.
[379] Monitor's Document Request for 9th Report for medical monitoring in Lippert
[380] Letter dated 9/27/2024 provided by IDOC in response to the Monitor's documentation request item 98.

- Calories: 2161.46
- Carbohydrates: 297.36 grams
- Lipids: 73.69 grams
- Protein: 83.23 grams
- Sodium: 3913.91 milligrams

For the FY2026 master menu, the average daily nutritional values are:

- Calories: 2524
- Carbohydrates: 351 grams
- Lipids: 82 grams
- Protein: 108 grams
- Sodium: 3772 milligrams

The average daily nutritional values are not available for therapeutic diets.[381]

The staff should receive updates and training on the policy and the Therapeutic diet manual. Based on the documents provided,[382] the OHS policy updates and training sessions provided in February 2024 and April 2024 did not include the therapeutic diet or nutrition policy content. No additional training slides or materials were provided that contain this policy.

The SIU/OCM dietitian estimated providing 11 hours of support[383] during FY2025 (July 1, 2024 through June 30, 2025) and an additional hour on 7/31/2025 in FY 2026 to the OHS dietician. This support included written and verbal communications and research. Based on this information and the medical record review, the current level of dietitian availability does not appear sufficient to meet the clinical needs for nutritional care. Some medical staff have contacted the dietitian for guidance; however, this process requires formalization and tracking to ensure consistent and timely nutritional support. Establishing a standard process will also allow identification of the actual demand for dietitian services.

The Monitor requested a list of individuals with provider-ordered therapeutic diets at Dixon, Menard, Logan, Pinckneyville, and Graham, including the date of order, diet type, and the current diet in place. Based on the information provided[384], there are 11 individuals on therapeutic diets at Dixon, 22 at Pinckneyville, 13 at Menard, and 2 at Graham. The *list* for Logan was not provided, instead 19 pages of individual orders were provided. Without complete lists and corresponding order details for all facilities, it is not possible to verify whether the therapeutic diet orders align with the diets currently being provided.

The Monitor requested the number of individual and group dietary consultations and patient education sessions, including the names, identification numbers, and the facility where each consultation occurred. The information provided[385] included only 2 individuals from Sheridan. No other diet consultations occurred. Dietary consultation does not appear to be an established process. No information regarding group sessions or consultations was received from any other facilities in response to the Monitor's documentation request.

[381] Documents provided by IDOC in response to the Monitor's documentation request item 98.
[382] Documents provided by IDOC in response to the Monitor's documentation request item 83.
[383] Document provided by IDOC in response to the Monitor's documentation request item 100.
[384] Documents provided by IDOC in response to the Monitor's documentation request item 102.
[385] Documents provided by IDOC in response to the Monitor's documentation request item 103.

IDOC responded to the Monitor's request for the times of day for meals at 10 facilities in the Central Region with a document titled "Times for Med Admin, Meals, Insulin, Sick Call Provider Clinic (SC) and Provider Clinic (CC),".[386] The schedule outlines the designated time frames for meals, and insulin administration.

FACILITY	Breakfast	Lunch	Dinner	Snack	AM Insulin	Noon Insulin	PM insulin
Danville	4:00 AM	9:00 AM	4:00 PM		4:00 AM	10:30 AM	4:00 PM
Decatur	4:00 AM	11:00 AM	4:00 PM		4:00 AM	11:00 AM	4:00 PM
Graham	5:00 AM	10:00 AM	4:00 PM		4:00 AM	9:00 AM	4:00 PM
Hill	5:00 AM	11:00 AM	5:00 PM		4:30 AM	12:00 PM	4:30 PM
IRCC	4:00 AM	10:00 AM	4:30 PM		4:00 AM		4:00 PM
Jacksonville	4:30 AM	9:30 AM	4:00 PM		4:00 AM	9:30 AM	4:00 PM
Lincoln	4:00 AM	10:00 AM	4:00 PM		3:30 AM		4:00 PM
Logan	4:00 AM	10:30 AM	4:00 PM		4:00 AM	10:00 AM	4:00 PM
Taylorville	4:15 AM	9:40 AM	3:45 PM		4:00 AM		4:00 PM
Western	4:00 AM	11:00 AM	5:00 PM		5:00 AM	12:00 PM	4:00 PM

There continue to be inconsistencies in mealtimes and insulin administration times across facilities. Consistency is important because the timing of insulin in relation to meals directly affects blood glucose control. When insulin is given too early or too late compared to food intake, patients may experience hypoglycemia or hyperglycemia. Danville, Graham, Hill, and Western need to adjust timing for meals and insulin. Standardized and coordinated timing helps ensure safe and effective diabetes management and supports stable blood glucose levels.

Based on the medical records[387] reviewed, several patients with significant medical and nutritional needs, including those with amyotrophic lateral sclerosis (ALS), diabetes, hypertension, and documented swallowing difficulties, were placed on regular or non-individualized diets without referral to a registered dietitian. In some cases, substantial weight loss and previously recommended nectar-thickened liquids or modified feeding plans were not followed, and hospital feeding recommendations were not acknowledged. Patients with diabetes were not placed on a consistent carbohydrate diet and no dietary consultation occurred despite clinical indications.

Summary:

- IDOC has a qualified registered dietician on staff.
- Dietician consultations are not requested when indicated and it appears that patients with chronic disease do not have access to dietician consultation.
- Dietician consultations are not tracked.
- Systemwide, meals for persons with persons with diabetes are not coordinated with insulin administration.
- Meal composition information is not made available to inmates with diabetes or other chronic diseases so that they can manage their condition.
- A finding of partial compliance is warranted.

[386] Documents provided by IDOC in response to the Monitor's documentation request item 4.
[387] Dietary patients 1-9.

RECOMMENDATIONS:

1. The percentage of fat, protein, carbohydrates, and sodium in diets should be calculated and documented for all master menus.
2. Individuals in custody should have access to information on food components, (e.g., carbohydrates and fats) in their meals so that they can make informed dietary choices based on their medical conditions.
3. Diet managers at facilities should receive supervision and have access to consultation with a registered nutritionist/dietician.
4. Formalize and track the process for medical staff to request Registered Dietitian Nutritionist (RDN) consultation to ensure consistent and timely support.
5. Ensure dietitian availability is sufficient to meet clinical demand, and monitor utilization to determine required service hours.
6. The therapeutic diet manual should be rewritten to include all therapeutic diets.
7. Mealtimes should be adjusted reasonably so as not to be a barrier to participation in meals. 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.
8. IDOC should track meal participation by meal.
9. The commissary food and snack panels must be evaluated and adjusted to include healthy choices appropriate for all patients including those with diabetes.
10. Policy, procedure, and practice should be established to ensure persons with diabetes and other chronic health conditions receive nutritional evaluation and have access to a registered nutritionist/dietician when clinically indicated.
11. The Therapeutic Diet Manual should be customized to IDOC. Similar to the master menu, the average daily nutritional values should be evaluated for therapeutic diets, and the therapeutic menu should be reviewed and approved by the Registered Dietitian.
12. Ensure ongoing training for clinical staff on the Therapeutic Diet Policy and the Manual, therapeutic diet ordering procedures and use of patient education materials.
13. Implement consistent meal and insulin administration timing across facilities to support safe and appropriate glycemic control.

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:

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

- The medical records of up to 20 incoming transfers that arrived at Centralia, Dixon, Joliet, Pinckneyville, Southwestern, and Western during the 2nd and 3rd week of May 2025.[388]
- Any intrasystem transfer audits completed by receiving facilities or SIU.[389]
- List of persons placed on transfer hold since March 2024 with the date the medical hold was placed and the reason.[390]

Other material reviewed included adverse events, mortality reviews, and facility Quality Improvement minutes submitted from January through June 2025.

The Department's most recent report of their progress accomplishing changes related to III.D.1 is that there is a means and method to place a medical hold in the automated offender management system known as the 0360. They also intend to further automate the process for placing holds when the electronic health record is in place. They also contend that III.D.2 transfers from one infirmary to another involve a physician-to-physician handoff and that all persons received on transfer are evaluated immediately by a nurse upon arrival.[391] They cite two Medical Policies and Procedures which have been developed as evidence of compliance.[392] No data or analysis accompanied the V.G. report to demonstrate that IDOC monitors performance against the provisions in the Consent Decree regarding intrasystem transfers.

Performance of Transfer Screening

In response to the Monitor's request for any intrasystem transfer audits IDOC provided a list of findings from the M&M committee about the completeness of Health Status Transfer Summary (HSTS). Criteria used by the M&M committee include whether the documentation indicated the purpose of the transfer, where the person was transferred to, and whether a full health history, code status, and medications were documented. This list shows that among 65 patients whose death was reviewed by the M&M Committee from May 2024 to March 2025 there were 209[393] transfer summaries and only five (2%) had sufficient information about the reason for transfer and the patient's medical history.[394]

The majority of the transfers reviewed by the M & M committee were for off-site specialty care which is included in the Department's policy E.03.01 Intrasystem Receiving, Transfer and Continuity of Care. The findings from the M&M list support previous objections raised by the Monitor to the use of the Health Status Transfer Summary (HSTS) (DOC form 0900) for off-site care and discharges from the infirmary

[388] Monitor's document request dated 5/10/2025, item # 104. Documentation to include the intersystem transfer form, nurse reception note, documentation of what documents were received by the facility (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 as well.
[389] Monitor's documentation request dated 5/10/2025, item 105.
[390] Monitor's document request dated 5/10/2025, item # 106.
[391] Defendants' V.G. Report, December 18, 2024, page 32.
[392] Policy E.10.01 Medical Holds and E.03.01 Intra-System Receiving, Transfer and Continuity of Care.
[393] There were 13 undated transfer summaries that were not included. Of these, one summary was considered sufficient.
[394] List provided in response to the Monitor's document request dated 5/10/2025, item # 106. Of note: two of the summaries marked as sufficient (H1.2) however the note in H1.3 indicates the transfer summary was not sufficient. These entries should be considered errors.

back to general population.[395] The purpose and content of communication in these circumstances is completely different and better guidance needs to be provided for health care staff than is present in E.03.01.

The Monitor suggested previously that the transfer report provided by SIU does not lead to any conclusions about possible process improvements.[396] Perhaps the data collected in REDCap could be revised slightly to include identification of the sending and receiving facility, some indication of what was insufficient or not relevant in the transfer summary and finally whether there was any interruption in care. It would also be important to review any transfer from facility to facility and not just specialty care. With these additions the REDCap data could be used to report on compliance with III.D.2.

Record Review

The Monitor reviewed the health records of 15 patients who died and had been reviewed by the M&M committee during this report period. There was documentation of intrasystem transfers in seven of these records. Six of these transfers took place after the IDOC policies on transfer and medical holds were made effective.

One of these was a patient who arrived at NRC after discharge from a hospital and diagnosis of metastatic small cell cancer to the brain, with left side weakness, superior vena cava thrombosis, centrilobular emphysema, anemia, and thrombocytopenia.[397] He was placed in the infirmary for six days to evaluate his condition and establish a plan of care. Once evaluated by physical therapy and his pain and anxiety were addressed he was discharged and transferred to Stateville the same day. There was no HSTS and the discharge summary from the infirmary includes no information about the recommendations for ongoing treatment of his cancer. There is no documentation of communication from one Medical Director to another to hand off responsibility for the patient's care as called for in the transfer procedure.[398] This individual was unsteady ambulating and a fall risk – neither were noted on transfer.

Another patient was transferred from NRC to Pinckneyville. At intake he gave a history of seven psychiatric hospitalizations; the most recent was a year earlier. He also had attempted suicide twice by cutting his wrists. The HSTS does not note his psychiatric history or the suicide attempts. He had a positive IGRA test for tuberculosis, followed by a negative chest X-ray. This was also not documented on the HSTS. It was only after a psychiatrist noted the TB findings and specifically brought the omission to the attention of a provider that prophylaxis was initiated for the patient to prevent tubercular disease; this was six weeks after the transfer took place.[399]

Another patient arrived at NRC in April 2024 after discharge from a 24-day hospitalization in the Chicago area for treatment of acute chest syndrome secondary to sickle cell disease.[400] He also had cardiomyopathy related to congestive heart failure and a history of pulmonary embolism. His treatment plan for the sickle

[395] Health Care Monitor 8th Report, Lippert v. Jeffreys, November 13,2024, page 118. The Monitor previously recommended that transfer summary directions for offsite care be removed from E.03.01 and addressed in the policies for specialty care and hospitalization, feedback sent to IDOC on E.03.01 dated 4/19/2023.
[396] Health Care Monitor 8th Report, Lippert v. Jeffreys, November 13,2024, page 119.
[397] Mortality patient 15.
[398] E.03.01 Intra-System Receiving, Transfer and Continuity of Care, Procedure I. C.
[399] Mortality patient 8. He was received at Pinckneyville on 3/1/2024. The first dose of Rifampin was 4/19/2024.
[400] Mortality patient 11.

cell disease consisted of extended-release morphine twice a day and immediate-release morphine as needed every four hours. On 5/23/24 he was transferred to Lincoln which did not have any morphine on hand. The patient went without four regularly scheduled doses of extended-release morphine and had no access to immediate-release morphine to control sickle cell pain for two days after transfer. Arrangements should have been made by the sending facility to ensure that the transfer did not take place until the ordered medication was on hand.

Process issues were identified in two other records reviewed. One was a patient who gave a history of asthma at intake.[401] He was seen by a provider urgently for shortness of breath the day after arrival and prescribed an inhaler, nebulizer treatment, and a short course of prednisone. The provider did not take an admission history or complete a physical exam. This patient was transferred to Vienna twenty days later without completion of the admission history and physical. The receiving facility failed to note and schedule this for the patient. This patient was seen twice urgently before he was seen in chronic clinic for asthma. Both times was because he was short of breath. This was a medically fragile patient who should have had a thorough history and physical exam at the first provider encounter and should have been seen for the asthmatic chronic condition within a week of arrival to IDOC. Neither of these were done.

Another patient with asthma was received at NRC in July 2024.[402] His previous IDOC health record documents ongoing treatment and exacerbations of asthma on previous admission. It is not clear when he transferred to IRCC, but the patient's chart was received at IRCC the next month (8/26/2024). There was no HSTS documented. His chart was not reviewed by a nurse for 16 days after arrival at IRCC. The nurse noted that he has no acute or chronic conditions. This patient died from acute asthma exaggeration 22 days after the chart was transferred to IRCC, his asthma went unrecognized at the receiving facility, and the only medication he received was a rescue inhaler issued at the intake facility. The failure of the sending facility to complete a transfer summary and for the receiving facility to thoroughly meet with the patient and review the record timely contributed significantly to this patient's death.

Continuous Quality Improvement

Nine CQI studies about the completeness of information and records received when patients are transferred from one facility to another were reported by six facilities between January and June 2025.[403] Five of the studies identified no issues with transfer information and records while four studies reported deficiencies. These included incorrect HSTS, records that were incomplete or that were not sent at all. The Monitor has recommended since the 2nd report that the transfer audit tool used by facilities be expanded to evaluate *continuity of care* as called out in III.D.2.[404] We have suggested the tool evaluate the timeliness of sending and receiving screening, accuracy of the clinical information (diagnoses and medications) entered on the HSTS DOC form 0090, whether the MAR was transferred concurrently, and that care was continued without interruption (medications, pending appointments and completion of referrals).

[401] Mortality patient 5.
[402] Mortality patient 4.
[403] QI minutes from Decatur January 2025, East Moline February – May 2025, Jacksonville March 2025, and Murphysboro March 2025.
[404] Health Care Monitor 2nd Report, Lippert v. Jeffreys, August 6, 2020, pages 78-79, Health Care Monitor 3rd Report, Lippert v. Jeffreys, February 15, 2021, page 57, Health Care Monitor 4th Report, Lippert v. Jeffreys, September 16, 2021, page 92, Health Care Monitor 5th Report, Lippert v. Jeffreys, June 22,2022, page 73, Health Care Monitor 6th Report Lippert v. Jeffreys, March 13, 2023, page 69, Health Care Monitor 7th Report Lippert v. Jeffreys, December 27, 2023, pages 88 & 91, Health Care Monitor 8th Report, Lippert v. Jeffreys, November 13,2024, page 119.

Also reported in these QI minutes were issues with transfers that had not been part of a QI study. These were receiving patients from intake facilities who were transferred before the physical exam had been completed and documentation that had not been filed in the patient record.[405]

Discontinuity of care on transfer and clinically inappropriate transfers were the subject of ten adverse events that have been logged from May 1, 2024, through July 30, 2025. It does not appear that these have been the subject of any further review or problem analysis.[406] Failure to document the evaluation and workup of patient conditions[407] or not sending critical information or medications when the patient transferred were problems identified in six of these events.[408] Root cause analysis of these six events should be undertaken to identify how these errors could be avoided.[409]

Another four were patients who should have had a medical hold in place.[410] Each of these patients experienced a significant delay in care, one of which had an urgent GI referral. Errors appear to be a failure to check to see if the patient had outstanding referrals or existing appointments and lack of knowledge on the part of the sending facility about the resources available at the receiving facility for transport or specialty services available in the local community. The implementation of the electronic health record may help eliminate transfers when there is an existing referral or specialty appointment. Inappropriate transfers could also be addressed by establishing a medical classification system that more adequately describes and monitors the capacity of receiving facilities to provide specialty care.[411]

The Department's policy E.10.01 Medical Holds was reviewed this year by the Monitor and only minor revisions were suggested.[412] The Department does not monitor whether medical holds are placed properly, that they are effective in preventing transfers, or that the hold is removed when no longer necessary. No facility QI studies were reported on medical holds based upon the review of QI minutes submitted since January 2025. A list of over 4,000 medical holds was provided to the Monitor dated as effective 3/1/2024 through 1/27/2026. Of these over 900 have an end date. There was no analysis of this data by IDOC. All facilities, except Decatur, have at least one medical hold in the system. IDOC does not require that facilities complete CQI studies on medical holds and IDOC does not otherwise audit medical holds.

The policy and procedure on medical holds is satisfactory but there is no monitoring completed by IDOC that shows facility compliance with their policy.[413] It appears that all facilities are capable of entering

[405] QI minutes from East Moline April 2025, Robinson January 225, and NRC March and April 2025.
[406] Log of adverse events sent in response to the Monitor's documentation request dated 5/10/2025, item 68. The Monitor suggested in the 8th report, page 118, that transfer errors be a category trended on the adverse event log and analyzed periodically.
[407] Two patients arrived at the receiving facility without documentation about the purpose of a skin graph or an accurate plan of care and the other had no documentation identifying arrangements for ongoing care of cancer.
[408] Allergy information for one patient was lost at transfer and ultimately resulted in an allergic reaction requiring hospitalization. Two patients were not provided needed medication and had seizures that required hospitalization and another went into withdrawal because methadone was not available at the receiving facility.
[409] Implementation of the electronic record may help. However the electronic record will not be a solution if patients are not being assessed thoroughly in the first place.
[410] Each of these events took place after IDOC distributed policy E.10.01 in February 2024.
[411] See the Health Care Monitor 8th Report, Lippert v. Jeffreys, November 13, 2024, page 103 regarding this recommendation.
[412] Monitors review of E.10.01 submitted to IDOC 7/15/2025.
[413] D.10.01 Medical Holds.

medical holds into the offender management system. It also appears that IDOC has the capacity to produce a list of medical holds but there is no evidence that it is used to evaluate or monitor medical holds. IDOC needs data to show that patients do not experience delays in access to secondary care because of transfer to another facility. There has been no evaluation of adverse events or corrective action taken to prevent transfers that risk patient harm because of delays in ordered care. It was suggested in the last report that M&M review should evaluate whether a medical hold should have been in place for any patient referred for specialty care and to place this information in REDCap.[414]

Summary

IDOC is partially compliant with III.D.1 and 2. The Department has yet to *demonstrate* compliance with either the policy on transfers (E.03.01) or the policy on medical holds (E.10.01). From the review of mortality records and adverse events the Monitor concludes that transfers delay access to secondary level services and that there are serious interruptions in ordered primary care. Intrasystem transfers is a high-volume, high-risk activity for patient harm. While IDOC does have some collection of data on transfers and medical holds the data is not evaluated or analyzed to identify and reduce risks to patients resulting from intrasystem transfer. The Monitor's analysis of records and information provided by IDOC identified the following problems which should be considered for corrective action:

- Failure to complete the HSTS, missing records, incomplete charts and failure to transfer the record with the patient.
- Lack of information on the HSTS that increases risk of harm to the patient or causes a delay in care.
- No provider-to-provider handoff on complicated patients.
- Failure to ensure the receiving facility can provide *uninterrupted* care.
- Failure to complete baseline intake evaluations and plans of care.
- Delay assessing patients' health needs by the receiving facility.
- Failure to place medical holds and override or removal of medically necessary holds.
- Transfers to facilities without sufficient resources to provide timely specialty care.

Recommendations to bring IDOC practices into compliance with the Consent Decree are listed below.

RECOMMENDATIONS:

1. Evaluate as part of Mortality Review whether a medical hold was or should have been in place for any patient referred for specialty care and to place this information in REDCap.
2. Revise E.03.01 and put the guidance about transfers for offsite care and discharge from the infirmary elsewhere. Also add guidance about how medication (both KOP and nurse administered) is to be managed when patients transfer with expectations for timeliness of the first dose at the receiving facility.
3. Do not assign LPNs to complete the assessment or determine the disposition of receiving screening as this is outside scope of practice.
4. Monitor implementation of E.03.01 to ensure timely completion of receiving screening and in a setting that is private.

[414] Health Care Monitor 8th Report, Lippert v. Jeffreys, November 13, 2024, page 118.

5. Patients should have a medical hold placed whenever there is an acute change in their condition (worsening symptoms or new symptoms) or undergoing diagnostic work up (abnormal labs, radiography, or other testing) until the patient's condition has been diagnosed and stabilized and a plan of care has been developed.
6. Complete revision of the receiving screening form 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. Standardize any other documentation of receiving screening.
7. Revise the data collected during mortality review to include identification of the sending and receiving facility each time the patient transfers, an indication of what was insufficient or not relevant in the transfer summary and finally whether there was any interruption in care after arrival at the receiving facility.
8. Transfer errors should be one of the categories trended in the review of adverse events, near misses, and sentinel events.

Medical Reception

Nurse Intake Screening and Health Assessment[415]

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*
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.2. *IDOC shall provide 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.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.

[415] Dental intake screening is addressed in the dental section of the report.

1. Identify the providers responsible at each facility for intake health assessments, … for the month of May 2025.[416]
2. The documentation workflows developed by the EHR vendor for intake screening and health assessment…
3. Copies of health records for 20 new admissions to NRC and 10 new admissions for each of Menard, Logan, and Graham for the month of April 2025. Records to be sent include the problem list, data base, intake screening forms (including vaccine history and any RHM screenings), medical history, physical examination, dental exam and instruction on oral hygiene, health assessments, and corresponding progress notes, orders, results of diagnostic testing, and any patient refusals for the first 45 days following the reception date.
4. Any advice or consultation that was requested from IDPH about diagnostic tests recommended at intake to IDOC facilities.[417]

The Monitor did not site visit any of the four reception and classification centers for this report. The Monitor has previously visited reception and classification centers at NRC, Logan and Graham Correctional Centers.

The only performance measure IDOC monitors specific to medical reception is that individuals aged 35 and older would be offered and receive a screening test for hyperlipemia *at intake or within 30 days of incarceration.* A threshold of 90% was set by IDOC. Actual performance for the third and fourth quarters reported for fiscal year 2025 was 24% and 21%.[418] This is essentially unchanged from performance reported for the first two quarters in fiscal year 2024 (23% and 22%). No interventions or corrective action have been implemented to improve performance on this measure.

Another measure that mentions intake is that screening for breast cancer is offered received, refused, and/or the patient was excluded *at intake*, within 60 days of transfer, or within the last two (2) years. This measure does not exclusively evaluate performance at intake. However, performance on this measure improved from 64% the third quarter of FY 2025 and increased to 86% in the fourth quarter.

The Monitor's evaluation of compliance with II.B.6.a, III.C.1-4 is based upon the material described here as well as review of mortality records and institution monthly reports. The Monitor also reviewed an audit of the intake process completed by HMA in May 2025.[419] The records reviewed for this report represents actual practices 16 months after IDOC distributed E.05.01 Intersystem Receiving Screening.

Policy

IDOC policy on medical reception, E.05.01 Intersystem Receiving Screening, was made effective in February 2024. Key points of the policy and procedure include:

[416] Apparently these records were received by IDOC on 8/15/2025. IDOC informed the Monitor that they needed additional time to review the documentation provided by the vendor and would provide supplemental material as appropriate. No other communication was received from IDOC after this initial response. IDOC Response to the Monitor's documentation request dated 5/10/2025, item 18.
[417] Monitor's documentation request dated 5/10/2025, items 18, 80, 107, and 153.
[418] Health Care Monitor 8th Report, Lippert v Jeffreys, November 13, 2024, page 127 " Actual performance for the first two quarters reported for fiscal year 2024 was 23% and 22%."
[419] HMA Monthly Task Meeting PowerPoint dated 6/25/2025 provided in response to the Monitor's documentation request, dated 5/10/2025, item 73.

- Identification of patients with special health care and housing needs, those who appear frail or otherwise vulnerable, and anyone who will need orders for medical services or nursing care before the full health evaluation is completed.
- Screening is to include a full set of vital signs, vision and hearing screening, actual height and weight (rather than self-report), and additional screening or diagnostic tests based upon the medical history.
- Findings from intake screening are reviewed by a provider in person or by phone within 12 hours of the patient's arrival and orders obtained, as necessary, for additional diagnostic studies, medications, diet, housing restrictions, nursing and medical care.
- Each patient is to receive a full physical assessment as early as possible but in all cases not later than the 7th day after arrival.
- This assessment includes, in addition to a physical exam, a complete history of all the problems identified at intake screening, and any other conditions which have been identified as a problem since screening. The assessment also includes review of the available lab and radiology results and offering of preventive health care measures.
- The assessment culminates with orders for care and a problem list reflecting all problems requiring follow up or which have historical significance.

The Monitor's comments on this policy were not received in time to be considered before IDOC made it effective.[420] Some of the modifications to the policy suggested by the Monitor include:

- Add procedural direction for requesting previous patient records and criteria for determining urgency of referral to a provider and add time frames for preliminary provider evaluations for those individuals with acute, out-of-control, or complex serious conditions.
- Provide privacy for intake screening, the history and physical exam and accommodations for individuals with disabilities (speech and hearing) as well those whose primary language is not English.
- Have diagnostic results available at the time of the full physical assessment.
- Use nursing protocols to initiate diagnostic tests, vaccinations, and the A & B preventive health care screening recommended by the United States Preventive Health Services Task Force (USPSTF).
- Complete the full physical assessment before classification so that any ADA, durable medical equipment, or other special needs are known when facility, programming, and housing assignments are made.
- Evaluate all acute and chronic medical conditions at the health assessment (not just those identified in nurse screening) with a baseline therapeutic plan for all problems including immunization and preventive health care.[421]
- Obtain recommendations from IDPH for screening communicable diseases based upon disease prevalence in the community.
- Screen persons 50 years of age and older for cognitive impairment using a standardized tool, such as the Montreal Cognitive Assessment (MoCA) test.

[420] A draft of policy, E.05.01 Intersystem Receiving Screening, was provided to the Monitor for review on 8/23/23. The Monitor provided OHS with an extensive revision to the draft on 1/25/24. However, OHS distributed the policy in February 2024 without considering the Monitor's comments. The Monitor was assured that our comments will be considered during OHS's upcoming annual review of the policy. These comments were resubmitted to OHS by the Monitor on 7/11/2025.
[421] These are the A and B recommendations of the United States Preventive Health Services Task Force.

- Evaluate the need for physician orders for life-sustaining treatment (POLST) when indicated.
- Establish time frames for continuation of care after intake.
- Define what is to be on the problem list and who is responsible for maintaining it.[422]

Another IDOC policy made effective February 2024 was F.02.01 Chronic Care. Requirements at intake include:

- Nurses obtain orders for medications and disability accommodation for any person reporting a chronic illness before completing intake screening unless a provider sees the patient before clearing the intake screening area.
- The intake health assessment completed by providers for those persons with chronic illness or other active problems is to include a history and physical examinations for all diagnosed illnesses. The intake note is to document an assessment of all chronic, temporary, and potential illnesses needing work-up with the status of each problem and a plan of care for each problem. The provider is to enter all chronic diseases, latent diseases, and significant familial cancer history on the problem list.

The Defendants' Section V.G. Report simply states that initial intake screening and health assessment take place and briefly describes what is included in each. Documentation provided by the Department are three policies and procedures A.07.01 Privacy of Care, E.04.01 Oral Health Services and E.05.01 Intersystem Receiving screening.[423] The Department provided no evidence that actual practices in IDOC facilities are consistent with these policies and procedures.

Record Review

The review of patient intake records does not reflect any change in performance from previous reports.[424] Forty-nine records were reviewed of intakes received in April of 2025. There were 20 patient records from NRC, nine from Graham and ten each from Logan and Menard.[425] Four patients were 50 years of age or older or 8% of the sample.[426]

Age Distribution of Sample	NRC	Graham	Menard	Logan	Total	Percent
≤35 years of age	12	3	5	6	26	53%
35 to 49 years of age	6	5	5	3	19	39%
50 to 70 years of age	2	1	0	1	4	8%
Grand Total	**20**	**9**	**10**	**10**	**49**	**100%**

[422] Health Care Monitor 8th Report, Lippert v. Jeffreys, November 13,2024, pages 128-129.
[423] Defendants Section V.G. Report, December 18, 2024, pages 13, 18, 30, 31, 42.
[424] Health Care Monitor 8th Report 11/13/24 pages 126 - 140, Health Care Monitor 7th Report, 12/27/23, pages 91 – 100, Health Care Monitor 6th Report, 3/12/23, pages 73-83.
[425] Graham only sent nine records in response to the Monitor's document request for the 9th Report, dated 5/10/2025, item 107.
[426] Persons 50 years of age and older represent 24% of the population incarcerated in the IDOC as of June 2025. June 30, 2025, population data set found at https://idoc.illinois.gov/reportsandstatistics/prison-population-data-sets.html

An essential component of the reception process is to identify conditions that require follow up for a short period of time (fractures, prophylactic tuberculosis treatment, syphilis, abnormal PAP smears, etc.) as well as conditions that require long-term follow up. All these temporary and long-term conditions should have an order for scheduled follow up. By policy, IDOC elects to schedule a patient to be seen for all chronic care problems and temporary problems together to reduce the number of appointments.[427] However there is no evidence, based upon the records reviewed for this report, that the policy has been implemented. A table of the acute or chronic care problems identified in the 49 records reviewed follows this paragraph. Fourteen (29%) patients did not have any acute or chronic medical problem. The remaining 35 (71%) patients reviewed had a total of 87 acute or chronic problems which needed scheduled follow up. Only 16 of the 87 problems had follow up ordered. This means that 80% of problems that were present at intake screening were not scheduled for any follow up.

[427] F.02.01 Chronic Care, Policy IV.

Acute and Chronic Conditions Identified at Intake					
Condition	NRC	Graham	Menard	Logan	Total
Obesity[428]	2	4	5	3	14
Asthma	6	2	2	2	12
Epilepsy	1	3	1	3	8
Hypertension	5	1		1	7
Hep C	1	1	1	3	6
CVA	1			2	3
GERD	1	1		1	3
Diabetes	1			1	2
Eczema		1		1	2
Heart Failure		1		1	2
Neuropathy	1		1		2
Opioid addiction on suboxone				2	2
Psoriasis			1	1	2
Sleep apnea	1			1	2
Abnormal uterine bleeding				1	1
Anemia				1	1
Carpal tunnel syndrome				1	1
Chronic kidney disease			1		1
Connective Tissue Disease				1	1
Coronary Artery Disease		1			1
Galactorrhea				1	1
Herpes				1	1
HIV			1		1
Hyperlipidemia	1				1
Irregular menses				1	1
Open wound with drainage				1	1
Post-partum thyroiditis				1	1
Pulmonary embolism				1	1
Recent motor vehicle accident with hip injury	1				1
Rosacea			1		1
Sciatica	1				1
Elevated liver enzymes	1				1
Positive QuantiFERON	1				1
Thrombocytopenia				1	1
Total	25	15	14	33	87

[428] The Monitor considers obesity a chronic medical condition which is consistent with current standards of care.[428] IDOC does not currently treat obesity as a chronic medical condition.

Initial Intake Screening

The following table lists the criteria and results of the review of initial intake screening records. These results do not indicate compliance with II.B.6.a, III.C.1, or III.C.3. Each result is discussed in more detail in the following paragraphs.

Initial Intake Screening	2025 Results	2024 Results
1. A complete set of vital signs was taken at medical reception	82%	43%
2. A complete smoking history was taken	16%	0%
3. Additional labs were ordered	0%	38%
4. Urgent medications were ordered	39%	59%
5. Point of care testing was done	10%	42%
6. Urgent referrals were seen by a provider no later than the next day	88%	50%

There is considerable variation in performance among the reception and classification centers. Menard was the only facility to consistently document a full set of vital signs, vision screening, and complete smoking history.[429] Logan did not document a full set of vital signs in half of the ten of the records reviewed and vision screening was documented as completed only twice. Logan did not document a complete smoking history in any record reviewed. At NRC documentation of vital signs and vision screening was not documented or incomplete in three of the 20 records reviewed.[430] Graham was missing vital signs and vision screening in only one of the nine records provided for review, an improvement since the last report when half the records had incomplete documentation of vital signs.[431]

There were 15 patients who would have benefited from additional lab or diagnostic testing. However no additional diagnostic work was ordered (0%). Only one of ten patients had a nurse complete point of care testing or additional monitoring scheduled when such testing was indicated (10%). These additional screening measures were the PEFR for persons giving a history of asthma and blood pressure monitoring for those patients with elevated blood pressure readings at receiving screening. Nurses should, as a function of protocols or a brief preliminary provider evaluation[432] obtain labs and complete other diagnostic testing in advance of the health assessment by the provider.

Initiation of medication therapy is a critical function during medical reception. Critical medications need to be initiated immediately (i.e. insulin, anticoagulants, antibiotics, etc.) to minimize dose disruption. Other medications for chronic conditions need to be started within 24 hours (i.e. hypertensives, inhalers, anticonvulsants, etc.). The records provided for the Monitor's review often did not include provider orders

[429] Temperature, heart rate, respirations, blood pressure, height, weight and visual acuity. Smoking history needs to include the number of pack-years smoked, and if the patient has quit smoking, the year that smoking stopped. Without this information on tobacco use, it is impossible to determine which individuals should be screened for lung cancer.
[430] This is an improvement since the Monitor's last report when only eight of 20 records reviewed from NRC had complete vital signs documented, page 131.
[431] Health care Monitor 8th Report, Lippert v. Jeffreys, November 13, 2024, page 131-132.
[432] See the Monitor's input on E.05.01 Intersystem Receiving Screening, Medical Policy and Procedure Manual provided to OHS on 1/25/24 and during the annual review by the Monitor on 7/11/2024.

or sufficient documentation to evaluate whether orders were obtained and the patients' receipt of the first dose of medication was timely.

There were at least 15 patients who should have had orders for medication written the day of receiving screening but there was no documentation among the records received that this was done.[433] As an example, one these records documented that the patient was taking two HIV medications, however neither medications is listed in the initial reception screening or in the provider's health assessment.[434] Another patient reported being on two inhalers, an anticonvulsant, and four medications for treatment of mental health disorder.[435] The first order for any of these medications was two weeks after the initial receiving screening was completed. This was an unfortunate lapse in prescribed treatment for the patient. Three persons reported taking suboxone at the initial health screening however there were no orders or other documentation to continue treatment for opioid use disorder or for withdrawal management.[436] There needs to be better documentation of the reconciliation of medication history at the time of reception, medication orders obtained, and the date and time the first dose of ordered medications are received by the patient.

In the Monitor's 8th report the point was made that nurses did not understand the importance of their role in documenting the patient's baseline condition at the time of arrival at prison.[437] This is a continuing deficit based upon records reviewed for this report. Only 50% of patient conditions were identified by nurses during the initial receiving screening. Further only two of six patients with conditions that indicated need for some type of accommodation (i.e. cane, lower bunk etc.) were identified during initial receiving screening (30%).[438] For example when a patient reported at intake screening that he had hepatitis C the nurse should have inquired to find out who was providing his care and whether he had been treated for the disease; this did not happen.[439] There are numerous examples of incomplete follow up by nurses when patients provided information about their medical condition and history.[440] The Monitor urges IDOC to seriously consider the training and competency that nurses need to *demonstrate* in order to complete a thorough initial health screening.

There were nine patients referred urgently to a provider by the nurse at reception screening. All but one of these was seen no later than the next day.[441] However there were 13 patients who should have been referred urgently to a provider and were not.[442] Only 65% of the nursing decisions about urgency in scheduling the provider's health assessment agreed with the Monitor's assessment. Three patients had no urgency for provider health assessment indicated.

Initial Health Assessment

[433] Medical reception patients # 2, 4, 6, 9 -11, 13-14, 16, 18, 20, 27, 36, 40, 48.
[434] Medical reception patient # 48.
[435] Medical reception patient # 10.
[436] Medical reception patients # 11, 16, 19.
[437] Health Care Monitor 8th Report, Lippert v. Jeffreys, November 13, 2024, page 133. The stated purpose of E.05.01 is to "Establish the baseline health condition at the time of arrival.", MPPM page 108.
[438] Medical reception patients # 2, 10, 11, 22, 30, 31.
[439] Medical reception patient # 4.
[440] See medical reception patients # 1, 2, 4–7, 10-11, 13, 16, 20, 24, 28-29, 32-33, 40-42, 44, 46, 48–49.
[441] The medical reception patient referred urgently and not seen by a provider timely was # 2. He was a parole violator who gave a history of epilepsy and history. He also reported using a cane because of a fractured leg. He was not seen by a provider for 34 days.
[442] Medical reception patients # 4, 8, 9, 10-14, 16, 18, 28, 46, 48.

Practices related to health assessments are not based on current policy and appear to be developed differently at each facility. The intake health assessment is to be completed within seven days.[443] Of the 49 charts of new intakes provided for this review only 21 had the medical evaluation completed within seven (7) days of admission (43%). Graham was particularly poor with none of the assessments completed within seven days. At Graham it took an average of 35 days to complete the health assessment for the nine records reviewed (the range was 33-37 days). The same was found for Logan with none of the health assessments completed within seven days. The average time to complete the health assessment at Logan was 13 days (the range was eight - 19 days). At NRC only 12 of 20 (60%) of individuals were evaluated within seven days. The average time at NRC to complete the assessment was 7.4 days (the range was 1 - 36 days). At Menard 8 of 10 (80%) intakes received an assessment within seven days. The average time at Menard to complete the health assessment was five days (the range was four - 12 days). IDOC performance is not compliant with III.C.1.

All of the records reviewed for this report were dated more than a year after policies F.02.01 and E.05.01 were made effective and therefore documentation should reflect practices consistent with these. Based on the findings of these record reviews these policies have not been implemented.

Percent of Record Documentation Consistent with Policy for Reception Health Assessment	
1. Provider reviews nurse reception screening within 12 hours (with help of on-site healthcare employee) by phone or in person with orders for labs, medication, or other studies needed.	0%
2. The labs based on known medical problems include: QuantiFERON, HIV, HCV ab with reflex to PCR, syphilis, Hep BsAb, Hep BsAg, Lipids, pregnancy test (women age 55 or under), HbA1c for age 35-70 with BMI 25 or greater.	0%
3. The provider is to review any lab or radiologic results.	43%
4. A history is taken of all problems found in screening and for all chronic illnesses and any other issues that present.	0%
5. Examination for all diagnosed illnesses.	76%
6. All provider assessments include vital signs including height and weight.	18%
7. All persons with chronic illness or other active problems have an assessment and plan comprised of all chronic, temporary, and potential illnesses needing work up to include the current status of each problem.	0%
8. Enrollment in chronic clinic for each condition that may result in a negative outcome if continuity of care is lost.	20%
9. History of vaccination and health maintenance status which is legibly documented.	0%
10. Vaccination history from ICARE is requested.	0%
11. Information received from ICARE is assessed to determine preventive and vaccine needs and offered by provider.	0%

Most intake records reviewed treat chronic disease as a triaging intervention.[444] Chronic conditions are not always identified and when identified, they are not evaluated comprehensively. Preventive health care

[443] E.05.01 Intersystem Receiving Screening, Policy IX.
[444] This finding that intake is viewed as medical triage rather than a comprehensive assessment was noted in the Monitor's 8th Report, see page 134-135.

and immunizations are not addressed at all. Comprehensive evaluation of each chronic condition, initiation of preventive health care and immunizations are all required by the receiving screening and chronic care policies. IDOC needs to make a more concerted effort to ensure implementation of these policies and extinguish these long-engrained practices at the reception and classification centers.[445]

There is no evidence in the records reviewed that providers review the nursing intake screening documentation within 12 hours as required by policy. The Monitor suggests a signature line for the provider on the nurse screening form which is dated and timed. Alternatively, nurses can document the date and time on the screening form that a provider was called to discuss the nurse screening form. Documentation should include the signature and the orders directed by providers as specified in policy.

The Monitor recommended that IDOC confer with IDPH about which lab tests for communicable disease screening are recommended for the incarcerated population.[446] Based upon the Department's response to the Monitor's documentation request for this report it is apparent that IDOC has not pursued this advice.[447] The Monitor believes all United States Preventive Services Task Force A & B laboratory recommendations for screening should be included in intake screening.

Policy E.05.01 Intersystem Receiving Screening item VII, identifies the labs that are to be obtained at intake. These are listed in item 2. of the preceding table. None of the reception centers adhere entirely to this list of labs.[448] NRC and Graham appear to order QuantiFERON, HIV, Hep C, complete metabolic panel, and syphilis tests. Logan adds, in addition, thyroid tests, a blood count, and lipids. Menard did not provide laboratory testing results. None of the facilities did hepatitis B testing, which is required by Policy E.05.01. Actual practices are not consistent with the Department's current policy; they represent legacy practices that originated at each facility. Laboratory screening of persons received at intake is inadequate.

By policy, all laboratory test results are to be reviewed by the provider during the health assessment. This occurred only 43% of the time. This lapse occurs most frequently at NRC (20 of 22 labs not reviewed out of the entire sample of 49 charts from four reception centers). NRC does not ensure that laboratory tests are available at the provider health assessment. There also is no follow up by providers at NRC to discuss laboratory results with the patient. This results in uninformed care and mistakes. Among our findings on record review was one patient[449] who had a hemoglobin A1c of 12.3 that went unattended during the period of record provided to the Monitor. Elevated liver function tests were present in two patients;[450] creatinine was elevated (1.51) in another patient[451] and BUN (29) were elevated in another patient[452]. Patients should be informed of the results of any diagnostic testing, but this did not appear to occur in over

[445] Defendant's Implementation Plan, dated 8/1/2023, task 88 (6) "Develop a standardized protocol for patient treatment at the reception center to ensure 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." See also task 54 (16) "Intake assessment to conclude with an initial assessment and therapeutic plan for all chronic illnesses."
[446] Health Care Monitor 8th Report, Lippert v. Jeffreys, November 13,2024 pages 137-138, 141.
[447] Documentation received in response to the Monitor's documentation request for the 9th report, dated 5/10/2025, item 153.
[448] The Monitor has some disagreements with this list and has made recommendations for laboratory testing in the annual policy review sent to IDOC on 7/11/2025.
[449] Medical Reception patient #20.
[450] Medical Reception patients #23 and #25.
[451] Medical Reception patient #37.
[452] Medical Reception patient #38.

50% of cases.

Laboratory collection must be timely so that the provider can review the results during the health assessment and they inform the plan of care. In the Monitor's 8th Report delayed laboratory collection at NRC and Graham contributed to problems with review of results.[453] The Monitor recommended then and reiterates the recommendation now that these issues should be addressed by mapping the desired intake process and comparing it to current practices to identify changes necessary to achieve better sequencing and flow of the medical reception process.

Providers do not take any history of patient's stated medical conditions. The history should include the approximate time the problem started, the most recent caregiver, prior care history, current symptoms experienced and medications currently being taken. When a history is documented, IDOC providers merely list the diagnosis or condition reported by the patient without any historical details. Without a history of symptoms or medication use, the status of a patient's asthma cannot be determined. None of the 12 patients with asthma, in the sample of records sent by IDOC, had a history taken or an appropriate assessment completed.[454] Nurses identified eight patients with a history of seizure, some of whom were on no medication. However, when seen by the provider for the health assessment, no further history was obtained.[455] The provider should have documented the type of seizure, when the last seizure occurred, the medications used in the past, when the last time medication was used, who provided care, etc. None of this information was obtained and in some cases these patients were not evaluated for medication treatment or enrolled in the chronic clinic for further follow up.

IDOC policy requires vital signs, weight, and height to be obtained as part of the assessment. Of the records reviewed vital signs were only obtained in 18% of the assessments. Vital signs completed during health assessments done at Menard but did not always include the patients' height. The purpose of the height is presumably to calculate the body mass index (BMI) which is used to determine obesity and to determine certain preventive screening. Physical examinations were done but did not always include all of the expected components such as peak expiratory flow rates for persons with asthma.

IDOC Policy E.05.01 does not define how providers are to document the subjective history, objective findings of the examination or the assessment and plan of care that comprise an initial health assessment. The assessment is not merely a restatement of the problem or symptom (e.g., asthma or ankle pain) but is the synthesis of a diagnosis, if known, and the professionals' clinical judgement of the status of the patients' condition. For asthma, as an example, an assessment might be moderate persistent asthma in good control. For diabetes, it might be type 2 diabetes in poor control. For some conditions, a diagnosis is not known but presumed to be chronic or in need of follow up. For example, a left sided weakness that is not diagnosed may be assessed as left sided weakness, unknown etiology, work up in progress.

As a result of this lack of guidance, provider practices at IDOC reception centers are inadequate and incomplete. For example, at NRC the assessment most often was "see problems list" or nothing was documented for the assessment. Assessments done at Logan were more complete but did not always address every condition or describe the status of the condition. Often the assessment merely restated a diagnosis: asthma, seizure, or diabetes. Sometimes a variety of phrases that are not assessments were used

[453] Health Care Monitor 8th Report, Lippert v. Jeffreys, November 13, 2024, page 137.
[454] Medical Reception patients # 2, 6, 10, 14, 21, 26, 27, 29, 30, 32, 40, 47.
[455] Medical Reception patients #2, 4, 8, 12, 14, 18, 29, 49

such as "see problem list"; "routine health care"; "lab results reviewed"; etc. Allergies are often placed in the assessment but should be documented elsewhere such as the problem list.

DOC policy E.05.01 requires providers to enroll patients into chronic clinic for any problem that may result in a negative outcome if continuity of care is lost. This can include asthma and other chronic diseases, but also chronic arthritis, long-term disabilities (neuropathies), or conditions requiring term-limited treatment (TB prophylaxis, active tuberculosis, etc.). See the table titled **Acute and Chronic Conditions Identified at Intake** in the first part of this section for the 87 conditions identified. Only 20% of these were referred from the initial health assessment for chronic clinic follow up.

IDOC decided, in policy E.05.01, to require providers to address vaccination and preventive interventions (colorectal cancer screening, lung cancer screening, etc.) during the health assessment. None of the male or female reception centers conduct the immunization practices required by the IDOC policy. None legibly documented vaccination history and none documented an ICARE vaccination history. None used ICARE to order needed vaccinations. The Monitor has recommended that nurses complete the vaccination and preventive health assessment by protocol rather than on the basis of individual provider orders.[456]

IDOC does not currently have a way to track preventive cancer screening. Logan incorporated questions into their electronic record to ask about cervical and breast cancer screening but did not use the electronic record to ask about lung, colon or hepatocellular cancer screening. The Logan electronic record does not track cervical or breast cancer screening so that aggregate data can be provided. On intake screenings 16 individuals were candidates for cancer screening and 10 (62%) were offered screening as part of the provider health assessment. Notably, Menard initiated fecal immunochemical test (FIT) during intake and six people were offered the test. This test is meant for persons 45 years of age and older. Only one of the six people who were offered the test was over 45 years and that person refused. None of the other five people who were offered the test were 45 years of age or older. The one person in this group who accepted the test was 27 years old. Persons under 45 years of age do not need FIT testing. This misinterpretation of the recommendations for the FIT test needs to be corrected. The availability of preventive cancer screening needs to be improved.

The last report highlighted the lack of policy direction about how the health status of parole violators is to be evaluated upon return to prison.[457] In the records reviewed for this report was a parole violator and the documentation of his initial screening and subsequent health assessment and plan of care emphasizes that this problem has not yet been addressed. This individual was re-incarcerated at Shawnee where intake screening was completed.[458] Epilepsy and asthma were identified by the nurse as problems. The nurse took no further history and did not complete a PEFR for asthma. He reported to the nurse a history of bleeding hemorrhoids and that he used a cane due to a past fracture of his leg. A TB skin test was applied but never read. Six days after arrival at Shawnee, he was sent to Graham where another intake screening was performed. TB screening was repeated with QuantiFERON. The nurse screening did not identify epilepsy but did identify asthma; PEFR was completed. The patient was never provided a cane or his need for a cane evaluated. The provider assessment was completed 5/27/25 with no assessment of asthma, epilepsy, or his mobility disorder. The initial receiving screening and health assessment of parole violators

[456] Health Care Monitor 8th Report, Lippert v. Jeffreys, November 13, 2024, page 138. See also the Monitor's feedback on E.05.01 sent 1/24/2024 and again for the annual review of this policy on 7/11/2025.
[457] Health Care Monitor 8th Report, Lippert v. Jeffreys, November 13, 2024, page 135-136.
[458] Medical Reception patient #2.

who are reincarcerated needs to be fully addressed in policy as recommended since January 2024.

Administrative Directive 04.03.101 still requires, for those individuals over age 40, a digital rectal exam and guaiac testing.[459] The Monitor was told that this is no longer a requirement, and that OHS distributed a directive to the facilities regarding this.[460] However there are still examples of patients who are offered this during the initial physical exam so this legacy practice continues. AD 04.03.101 should be eliminated since the MPPM now addresses required physical examinations.

Health Management Associates (HMA) which was engaged to monitor vendor performance completed an audit of the medical reception process at NRC in May 2025. The findings from this audit similarly establish that health assessments are incomplete and not completed timely. The audit also found that patients who had health conditions needing medical attention were not seen by providers timely.[461] To help alleviate the backlog of intake health assessments SIU proposed an initiative charter to complete physical exams for a period of two months using an exam form of their own design.[462] The Monitor was provided no further information about the proposal or its acceptance by IDOC. SIU resources would be better deployed to undertake the process improvement project to design a better process for the workflow of medical reception (task 88 of the Implementation Plan).

Compliance with III.C.4 for follow up on all pertinent findings and provision of appropriate care and treatment has not been achieved.

Summary

The Monitor has repeatedly recommended that IDOC engage each of the reception and classification centers in a process by which the desired outcome of receiving screening is discussed and the sequence of steps necessary to achieve that outcome are mapped out.[463] OHS needs to be clear with reception and classification centers what changes are necessary to ensure that patients' needs are addressed when they arrive at IDOC consistent with E.05.01 Intersystem Receiving Screening and F.02.01 Chronic Care.

No changes have been made to initial intake screening or the initial health care assessment yet. Staffing of reception centers is insufficient as measured by the lack of timeliness and inadequacy of the initial intake screening and health care assessment as well as initiation of plans for subsequent health care. A policy and procedure for receiving screening has been developed but it is clear that it has yet to be implemented by the Reception & Classification Centers.

RECOMMENDATIONS:

1. Redesign the medical reception process so that it ensures:
   a. All findings and treatments from nurse intake health screening are evaluated by providers.

[459] II. G. 2. a. (3) (f) v. If under 40 years of age, a visual examination of the anus. If 40 years of age or older, a digital rectal exam with guaiac testing. Effective 5/1/2021.
[460] Health Care Monitor 8th Report, Lippert v. Jeffreys, November 13, 2024, page 139.
[461] Monthly Task Meeting Power Point Presentation dated 6/25/2025 provided in response to the Monitor's documentation request dated 5/10/2025 item 73.
[462] OCM Intake Physical Charter dated 5/7/2025 provided in response to the Monitor's documentation request dated 5/10/2025 item 29.
[463] Implementation Plan Task # 88.

b. Prior records are requested and available to providers as needed during the initial health care assessment.
c. An immunization history is obtained as part of the information gathered by nurses. By protocol, immunizations are 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 receive recommendations for preventive measures updated based on the A & B recommendations of the USPSTF.
f. All medical problems are identified and entered onto the problem list by providers.
g. For every medical problem there is an adequate history, focused physical examination, assessment, and therapeutic plan. The assessment of chronic conditions includes documentation of complications, including hospitalizations, with chronic disease markers, documentation of the most recent civilian therapeutic plan, and medication history.
h. Train providers on what an assessment is and what constitutes acceptable documentation of an assessment. If needed a policy can be developed for this.
i. Train providers on what constitutes a medical problem, sufficient for entry onto a problem list and what constitutes acceptable documentation of a problem. If needed a policy can be developed for this.
j. All intake laboratory and other diagnostic tests are evaluated at the full physical assessment by providers as part of the intake process, and
k. Patients are enrolled in chronic clinic for all of their active acute and chronic medical conditions.

2. Revise E.05.01 Intersystem Receiving Screening in accordance with the Monitor's comments provided 1/25/2024 and implement it and the portions of the policy F.02.01 Chronic Care that pertain to intake.
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 and recommends that IDOC adopts IGRA testing for tuberculosis screening of all incarcerated individuals.
5. Confer with IDPH about which lab tests for communicable disease screening are recommended for the incarcerated population. Initiate universal screening for hepatitis B and eliminate obtaining a routine metabolic panel.
6. 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 is impossible to determine which individuals require screening for lung cancer. This information is also useful as a cardiac risk assessment.
7. IDOC should add universal hepatitis B screening (HBsAg, antibody to HBsAg, and total antibody to hepatitis B core antigen) to the routine laboratory testing performed at intake screening in conjunction with a hepatitis B vaccination program.
8. 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.
9. Expand metrics on the timeliness and thoroughness of medical reception and report performance

results to CQI on a regular basis.

10. To implement these redesigned recommendations, the Monitor recommends that IDOC map a process of how they expect intake to occur in IDOC facilities integrating all these recommendations. This mapping should consider staffing, equipment, and organizational needs (laboratory support, pharmacy support, custody support with respect to classification, and information technology support with respect to the medical record and interfaces with IDPH ICARE and other Illinois jails with information systems).

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:

- Provide times at each facility in the Central region designated for sick call.
- The name and credential (RN, LPN, NA) of every individual assigned to perform sick call for the first full week in May 2025 (5/4-5/10) at Centralia, Logan, Lawrence, Illinois River, Pinckneyville, Pontiac, Southwestern, and Western. The list must include nursing staff employed by the State and the vendor.
- The log of all sick requests received since January 1, 2025 (including dental) from Dixon, Logan, Danville, Decatur, Graham, Hill, Illinois River, Jacksonville, Lincoln, Logan, Taylorville, and Western.
- A copy of the nursing protocols or standing orders currently in effect. Copies of any protocols or standing orders that are being considered for adoption by IDOC. Any written guidelines other than AD 04.03.121and IDOC Medical Policy and Procedure E.06.01 on the use of nursing protocols or standing orders.

- Identify the process analyst responsible for the process improvement project on sick call, and provide any revised forms or templates being developed to document sick call encounters, and logs proposed or being used to manage sick call. Logs need to include the reason for each no shows and refusals.
- Provide a copy of Appendix A to Policy and Procedure E.06.01 Non-Emergency Health Care Requests and Services.[464]

In addition to the material received from the list above, CQI and SLQC minutes were reviewed as well as rosters of nursing personnel and training records. Training videos and grand rounds notices provided by SIU were reviewed as well as the Monitor Databases that were provided by IDOC. Records of patients who died and had mortality and morbidity review completed during this report period were also reviewed.

Access to an Appropriate Level of Primary Care

The primary means to access the health care program for a non-emergent concern is to submit a request for sick call. These requests are to be received by the health care program each day and reviewed to determine if a face-to face encounter is needed and to direct requests to the appropriate health care personnel to address. A face-to-face encounter is required for any request for medical, dental, or mental health care that involves symptoms.[465] This assessment is to be completed within 24 hours of receipt of the request unless it is emergent, which is addressed immediately.

Because the sick call process is fundamental to health care access in a prison the Defendants Implementation Plan includes the completion of a process improvement project facilitated by a process analyst. The sick call process improvement project was expected to result in the following:

1. Policy and procedure for sick call,
2. Clear definitions of the staffing and resource requirements needed to conduct sick call,
3. Training and supervision of nurses to ensure appropriate clinical assessment and decision making using the nursing protocols,
4. Limits on the use of protocols in patient populations requiring monitoring by clinicians, and
5. Audit methods to monitor and account for compliance with the Consent Decree, procedures and protocol.

This project was to be completed by March 2024. In June 2024 IDOC informed the Monitor that they were consulting with SIU on how to accomplish the process improvement project prior to EMR implementation.[466] Now, a year later, the Department has informed the Monitor that a process analyst for sick call still has not been established.[467]

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[464] This list corresponds to items 4, 108, 110, 111, 112, 113 in the Monitor's document request for the 9th report, dated 5/10/2025.

[465] Administrative matters such as requests for records, or medication refills, to request routine foot care do not require a face-to-face encounter.

[466] IDOC Responses to the Monitor's document request for the 8th report dated 6/28/24.

[467] IDOC Response to Lippert Monitor 9th Report Documentation Request, 112. " The Department's recently named interim Agency Medical Chief has not yet designated the process analyst responsible for the sick call process improvement project. Identification of this role is under consideration and any revised forms or templates for documenting sick call encounters will be provided to the Monitors once developed and finalized."

In the 7th Report the Monitor acknowledged that IDOC developed, distributed, and set expectations for implementation of a policy and procedure on sick call (E.06.01), in the absence of information to be gained from a process improvement project.[468] The policy and procedure was an improvement over previous written guidance but was not complete in that it does not:

- Specify that registered nurses conduct sick call as called for by III.A.10 of the Consent Decree.[469]
- Sick call is only to be conducted in clinical areas that provide for privacy and confidentiality consistent with III.I.F.1 of the Consent Decree.
- Prohibit restriction on the number of complaints addressed during a sick call appointment as stated in III.F.2 of the Consent Decree.
- Establish expectations for timely response to requests for health care that are consistent with NCCHC standards.
- Provide the attachment that is referenced in the policy and procedure that describes how patients who are unable to write are to request health care attention.[470]

The Monitor has submitted comments and suggested revisions to IDOC on E.06.01 and awaits receipt of the 2026 edition of the MPPM.[471]

Evidence of Appropriate Access to Primary Care

IDOC has established a log of sick call requests that includes information from which to monitor whether patient requests for health care attention are triaged timely, if patients' have their complaints assessed timely, and if referred to a provider, whether patients are seen timely. It is also possible to select episodes of care for qualitative review of the appropriateness of the assessment and clinical care provided.[472] Eighteen facilities submitted information using this database, apparently created by OHS.[473] Five additional facilities submitted logs of sick call that include fewer columns of information.[474] Six facilities produced no sick call log.[475]

Data entered on the database and logs is incomplete at many of the reporting facilities. They also include incorrect dates and include more types of encounters than those considered sick call but are scheduled treatments or procedures instead. Some of the data recorded differs from the policy and procedure. For example, why is there a column calculating the days from the date of the request to the date the request

[468] Health Care Monitor 7th Report Lippert v. Jeffreys, December 27, 2023, page 143.
[469] E.06.01 also does not specify that LPNs may be assigned to do sick call but only until the staffing plan for registered nurses is achieved and only if supervised as further stated in III.A.10.
[470] IDOC Response to Lippert Monitor 9th Report Request #113 email from the Agency Medical Coordinator to IDOC Chief Legal Counsel "No attachment exists at this time." Dated 7/15/2025. This means that patients who are unable to write must have someone else do this for them which is a risk for violation of patient privacy and possible victimization.
[471] Email to Robert Fanning, Chief Legal Counsel, dated 7/15/2025 with attachments E.06.01- E.10.01.
[472] Monitor Databases submitted by IDOC on 8/15/2025.
[473] The log provided by Big Muddy was not possible to open without a password.
[474] These logs are the same, with the exception of Logan and appear to be a log that the Monitoring team provided as an example of one used in another prison system. Logan's log provides the least information and appears to be a report assembled from data available in their electronic record.
[475] These were Lawrence, NRC, Robinson, Shawnee, Vandalia, and Vienna.

was triaged? The policy and procedure states that requests are to be triaged within 24 hours of *receipt of the request not the date the patient makes the request*.[476] Why is there a column calculating the days from triage to provider appointment? A more accurate reflection of performance consistent with the policy and procedure would be to measure the days from receipt of the request to the provider appointment.[477]

IDOC is applauded for launching the database and getting two thirds of facilities to use it. However, the Defendant's provide no evidence that they have used the logs to monitor performance against their own policy and procedure. For example, what percentage of referrals to a provider from nurse sick call are seen within 10 days of receipt of the original request? What percentage of patients who submitted more than one request for the same complaint in a two-week period are identified and seen within 72 hours of receipt of the second request? What percentage of requests are triaged within 24 hours? What percentage of requests require a face-to-face assessment and of those what percentage are seen within the time frame set out in the policy and procedure?[478] What percentage of patients are referred to a provider from sick call? [479]

The next steps the Department need to take are:

1. Identify and correct problems with the data collection tool to ensure the integrity and reliability of the data. As discussed in an earlier paragraph, if it is not measuring what was intended, corrections need to be made in the tool.[480]
2. Establish a definition for what information is to be entered in each cell and how it is to be recorded (how dates are entered, how names are entered etc.), create methods to prevent or display errors in data entry so they can be corrected, and sample some charts to review whether information on the database matches documentation in the patient record or other databases. For example, if a patient is referred to dental from NSC, is the patient on the Dental database and was the interval until they were seen consistent with policy and procedure?
3. Implement the tool at the remaining ten facilities,[481] and establish expectations for complete data entry by the facility.
4. Demonstrate that the data is analyzed, results are reported, deficient performance corrected and opportunities for further improvement identified.

The Department previously had a Clinical Performance Measure on timeliness in responding to sick

[476] The date the request was received is the point at which the clock starts for the purpose of measuring the timeliness of triage, not the date the request was written.
[477] E.06.01, Procedure XV.
[478] Currently E.06.01 states that requests requiring a face-to-face assessment are to be seen within 72 hours of receipt of the request. This is not consistent with the time frames defined by NCCHC and should be corrected in the Department's next edition of the MPPM.
[479] The data base submitted by Menard, logs 191 requests for health care attention in June 2025 and every request resulted in a referral to a provider. Of those referred only 18 had been logged as seen by a provider as of 8/14/2025 the date on the file. This is a very high rate of referral from nurse sick call and may reflect overutilization. This an example of why the database should be used to help monitor the sick call process.
[480] Another correction the Monitor suggests is to insert a column that indicates the credentials of the person who saw the patient for the face to face assessment. This would provide evidence of compliance with III.A.10 of the Consent Decree.
[481] The Department states that its goal is to have the remaining facilities using the database by mid-winter 2026. IDOC Response to Lippert Monitor 9th Report Request #169, dated 8/15/2025.

call requests.[482] However these measures have not been reported since June 2024.

Monthly CQI minutes were reviewed from 12 of the Department's 29 facilities between January and June 2025.[483] Several facilities reported noncompliance with ADs concerning sick call.[484] Five facilities reported results of CQI studies related to sick call. Lawrence reported that 43% of referrals to a provider from sick call were seen within 10 days of receipt of the request.[485] At Sheridan 58%[486] and at Hill 33%were seen within this time frame. At Hill 30% of the patients not seen by a provider within 10 days had made repeated sick call requests for the same problem.[487] Only Vienna reported 100% compliance with this metric.[488] Sheridan reported that only 50% of patients submitting requests were seen at nursing sick call within 72 hours of receipt of the request.[489] Decatur reported 100% on this metric but also found that nursing sick call rounds were not being completed in restrictive housing.[490] Backlogs for sick call are reported in the monthly CQI minutes of five facilities (Lawrence, Sheridan, East Moline, and Hill).

The Sick Call initiative was paused in November 2024 because of conflicting guidance in the E.06.01 and the Administrative Directive. Furthermore, facilities were reported as not following the guidance either provided.[491] The Department's Staffing Analysis submitted in August 2021 states that it was "considered a starting point with the understanding that the needs of IDOC's healthcare system are dynamic and modifications of this analysis will be required to accommodate those changes."[492] In the Lippert Monitor's 8th Report the Regional Coordinators for the North and Central Region stated that staffing was the primary barrier to implementation of the 2024 medical policies and procedures. This concern was also stated by the HCUA at NRC.[493] More recently concern about lack of adequate staff was discussed by the Northern Region Coordinator at a facility quality meeting. The HCUA also stated that they do not have the staff or tools needed.[494] At Lawrence similar concerns about staffing are documented in the discussion about poor results on a CQI study related to sick call and backlogs.[495] IDOC has not evaluated the staffing needed to implement its own policy on sick call (E.06.01) since it became effective despite concerns raised by Regionals and HCUAs that staffing is not sufficient. Defendants have not demonstrated access to an appropriate level of primary care (II.B.1).

Clinical Space, Privacy and Confidentiality to Conduct Sick Call

[482] Office of Correctional Medicine, Clinical Quality Performance Review: Summary FY 24, Measure 1 Percentage of sick call documentation with timely follow up by healthcare services, per policy/AD 04.03.1013 and NCCHC Standard P-E-07. Provided by IDOC in response to the Monitor's documentation request for the 8th report, item #40, dated 5/126/2024.
[483] Not all facilities produced minutes of these monthly meetings. A total of 58 out of an expected 174 minutes were produced by IDOC for the period of January through June 2025.
[484] Lawrence, Menard, and Sheridan reported noncompliance with the AD concerning use of treatment protocols and Lawrence also reported noncompliance with the AD on nonemergent requests for healthcare.
[485] CQI minutes March 2025.
[486] CQI minutes May 2025.
[487] CQI minutes February 2025.
[488] CQI minutes March 2025.
[489] CQI minutes May 2025.
[490] CQI minutes February and May 2025.
[491] SLQC minutes from November 2024 and April 2025.
[492] Staffing Analysis, Illinois Department of Corrections, Office of Health Services, Lippert Consent Decree, 8/17/2021, page 4.
[493] Health Care Monitor, Lippert v. Jeffreys, 8th Report dated 11/13/2024 page 91 and 144.
[494] Sheridan, CQI minutes, March 2025.
[495] Lawrence CQI Minutes, January and March 2025.

The Monitor has raised concerns about the adequacy of space to conduct sick call in a manner that affords the patient privacy and confidentiality in every report and at every facility that has been visited.[496] The Monitor has not visited any additional facilities since the 8th Report. However, lack of sufficient medical space was a key finding of the Department's Facility Master Plan issued in May 2023.[497] Jacksonville has submitted adverse event reports nearly every day since June 2024 that document …"a delay in delivery of care to the incarcerated population occurred due to lack of space to conduct adequate clinical care". Due to insufficient number of examination rooms to accommodate the number of clinical staff."[498] The sick call data base also provides evidence that patients are not seen as scheduled after submitting a sick call request because of lack of exam rooms and patients who refuse to be assessed cell front.[499] The CQI minutes from JTC also document discussion about assessments conducted cell front and in the day room as not acceptable.[500]

The Department stated in response to the Monitor's Special Report that "it is in substantial compliance with the Decree's requirements relating to facilities and equipment and denies that any additional steps are necessary to bring its facilities and equipment into compliance. The Department remains committed to pursuing its projected $1 billion in capital investments and ongoing maintenance and believes these steps are reasonable and appropriate."[501] Yet it has provided no data to show that there is adequate clinical space to conduct sick call with privacy and confidentiality protections and so III.F.1 remains not compliant.[502]

Staffing Nurse Sick Call

There is no uniform measure used by IDOC to document that only registered nurses conduct sick call per III.A.10 so this item of the Consent Decree remains noncompliant. Eight facilities were requested to provide the name and credential of every individual assigned to sick call on May 4-10, 2025. Five facilities responded with the requested information.[503] Only RNs conducted sick call at two facilities during the week reviewed.[504] IRCC, Logan, and Pontiac had assigned LPNs to sick call a majority of days for the week reviewed by the Monitor. These findings are unchanged from that reported in the 8th report.[505]

IDOC has taken no steps to account for the assignments of staff to complete sick call and has no statement in the MPPM prohibiting the assignment of anyone but RNs to complete sick call. Until IDOC achieves

[496] Health Care Monitor 2nd Report Lippert v Jeffreys (August 6, 2020) pages 87-88; Health Care Monitor 6th Report Lippert v. Jeffreys, March 13, 2023, page 87, Health Care Monitor 7th Report Lippert v Jeffreys, December 27, 2023, page 106, Health Care Monitor 8th Report Lippert v Jeffreys, November 8, 2024, pages 94-95, 101, 147-148.
[497] Facility Master Plan, Illinois Department of Corrections, Final Report – May 2023, pages 5, 26, 45, 47, 49, 51, 60, 62, 64, 66, 70, 72, 76, 80, 82, 87, 89, 90, 92, 94, 96, 98, 99, 101 - 102,
[498] Document provided in response to the Monitor's documentation request #68.
[499] Pinckneyville sick call database on 2/20/2025 and 2/22/2025.
[500] JTC quality minutes March 2025.
[501] Defendants Response to Lippert – Sept 2025 Special Report V (J) dated 11/14/2025, page 3.
[502] Defendant's Section V.G. Report, December 18, 2024, pages 30, 34 and the Department's response to the Monitor's documentation request, dated 5/10/2025, item 7.
[503] Lawrence provided no information. Western did not provide assignments for the requested week of 5/4-10/2025. The information provided by Centralia was incomplete. Five facilities that did respond with the requested information were IRCC, Lincoln, Logan, Pontiac, and Southwestern. Lincoln's information was misfiled with the information from Logan.
[504] Lincoln and Southwestern.
[505] Health Care Monitor 8th Report Lippert v Jeffreys, November 8, 2024, page 146.

substantial compliance with the nursing provisions of the staffing plan the Consent Decree allows LPNs to conduct sick call but only with appropriate supervision. IDOC provides no guidance as to what appropriate supervision is in its policy on sick call and no proof that LPNs performing this work are appropriately supervised.[506]

In the Monitor's opinion it is outside the LPN scope of practice to conduct sick call because it requires independent judgement, and the range of complaints presented at sick call require more advanced knowledge and clinical assessment skill to make these judgements.[507] Among 15 records of patients who died during this report period, that were reviewed by the Monitor, there were six that the M & M Committee concluded with findings that LPNs were working outside their scope of practice when conducting sick call.[508]

The Monitor has two recommendations to achieve compliance with III.A.10:

1. Establish the means to monitor what types of health care personnel are assigned to complete sick call. One way to do this is to add a column to the Sick Call Database after the date of the face-to-face encounter that indicates the credential of the person who did the assessment (RN, LPN, etc.). There may be other ways this could be accomplished but IDOC must determine how to provide satisfactory evidence of compliance with III.A.10.
2. Evaluate the staffing needed to complete sick call consistent with the requirements of the Consent Decree and the 2026 revised policy and procedure E.06.01. The Monitor has suggested that this could be done by calculating the average amount of time it takes to address a sick call request appropriately.[509] This average could then be used to determine the number of registered nurse positions that are necessary at each facility.[510] This same process could be used to determine the number of provider positions necessary to see patients referred from nursing sick call.

There may be inefficiencies in the current system, that if eliminated, would reduce the volume of sick call encounters that are necessary. This is one of the reasons why a process improvement project was suggested as part of the Implementation Plan; one facilitated by a process analyst experienced in systems design. For example, at a CQI meeting there was discussion about limitations seeing patients because of the availability of security staff.[511] There are also numerous examples among the sick call database of scheduled sick call visits that did not take place because of security constraints. A process analysis should consider the security resources needed to ensure appropriate access to sick call. Another example of the potential of a process improvement project is that if referrals to providers were seen more promptly it is likely that the volume of duplicate requests would be reduced, requiring less manpower to collect, triage, and assess each request. The following is an example of how a delay in care of a patient results in additional service volume:

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[506] The Agency Director of Nursing is documented in the January 2025 CQI minutes from Lawrence stating that LPNs cannot do initial assessments, sick call, infirmary, emergencies, and intakes. The HCUA responded that the facility staffing does not allow only RNs to run sick call. The Monitor has not been provided with any other information about how this guidance from OHS has been transmitted to other facilities.
[507] Health Care Monitor 8th Report Lippert v Jeffreys, November 8, 2024, page147.
[508] Mortality Review patients 1, 4, 9, 11-13.
[509] Health Care Monitor 8th Report Lippert v Jeffreys, November 8, 2024, page 147.
[510] The Monitor has offered to assist IDOC with such a calculation.
[511] CQI minutes from JITC for March 2025.

- 9/13/24 a request to be seen for possible urinary tract infection is received. The patient is not assessed by a nurse because of a Level 1 lockdown.
- 9/16/24 another request is received to be seen for a severe urinary tract infection. The patient is not assessed by a nurse at sick call but referred to a provider instead.
- 9/21/24 another request is received to be seen for a urinary tract infection. The patient is assessed by a nurse two days later and referred to a provider.
- 10/9/24 another request is received to be seen for a urinary tract infection. The patient is seen by a nurse the next day who notes that he already has been referred to see a provider.
- 10/13/24 another request is received to be seen for a urinary tract infection. The patient is not assessed by a nurse because of a scheduling conflict; however the nurse notes the existing referral to a provider.
- 10/23/24 the patient is seen by a provider for the possible urinary tract infection. This was 36 days after the original referral from nurse sick call. The delay resulted in three additional sick call requests and two additional nursing encounters.[512]

The Monitor still recommends a process improvement project be completed for sick call. The sick call database, even though the data is not all there and its reliability not tested, does provide some information from which to evaluate why delays in access occur and what some of the barriers are to implementation of the policy and procedure. Consideration of the database could inform sick call process improvements both at the facility and statewide levels.

Nursing Treatment Protocols and Training

Treatment protocols are not explicitly mentioned in the Consent Decree but are discussed here because they are the foundation that permits nurses to treat common conditions for which health care attention is sought through sick call.[513] Medical policy and procedure E.06.01 Non-emergency Health Care Requests and Services, effective 2/2024, states that nursing protocols may be used to address patients' health care problems when:

A. The assessments are appropriate to the level of competency and preparation of the nurses who will carry them out.
B. The nurse protocols and procedures are developed and reviewed annually by the nursing administrator and the OHS medical director.
C. The nurse protocols and procedures are accessible to nursing staff.
D. There is documentation of nurses' training in use of nursing assessment protocols and nursing procedures based on the level of care provided by the nurse.
E. Nursing assessment protocols for nonemergency health care requests include over-the-counter medications only.[514]

[512] Sick call patient # 1. A possible urinary tract infection is a serious health concern which needs prompt evaluation and treatment. This patient should have seen and been assessed by a nurse for each complaint and was not. A provider appointment should have been secured for the patient much sooner than 36 days later.
[513] Treatment protocols are also used by nurses to assess and respond to medical emergencies.
[514] It appears that AD 04.03.121 Treatment Protocols has been eliminated.[514]

The same treatment protocols that have been in place since 2019 were continued during the period covered by this report.[515] The Monitor has expressed concern about these since 2021, specifically that some protocols are based upon a diagnosis rather than a symptom or system complaint, the existence of an inappropriate and dangerous protocol for non-specific discomfort, use of protocols while patients are in the infirmary, and a number of protocols which should be eliminated because they are seldom used or have no nursing intervention.[516]

In June 2024 the Monitor was given to understand that revision of the treatment protocols would wait until OHS could review any templates that were already part of the electronic health record.[517] Defendants provided the Monitor three folders in response to the request for copies of any protocols or standing orders that are being considered for adoption by IDOC. The folders were named:

- IDOC Draft Standing Orders Under Consideration,
- IDOC Nurse Protocols Revised 2.25.25 for Consideration,
- IDOC Nurse Protocols SIU and Quality Management Under Consideration.

No further explanation of these documents was provided. Their provenance, references used, process of development, or rationale for the design and format were not explained or described. From review of the documents, it appears that in October 2024 the Agency Director of Nursing and one of the Deputy Chiefs Health Services completed a review of the existing treatment protocols. A proposed policy and procedure and documentation template for these encounters was distributed to OHS leadership along with a packet of 13 standing orders to be used in responding to incidents requiring emergent/urgent care and 21 nurse protocols to be used in responding to nonemergent health care requests.

At the Systems Leadership Quality Council in April 2025 updated treatment protocols were requested for allergic reaction and anaphylaxis. Also requested was a treatment protocol for sepsis. At this meeting it was reported that the new and revised protocols and standing orders were provided to SIU for final review and formatting. Once approved they were to be provided to the vendor to begin training staff in their use (there was no discussion of training state-employed nurses) before the electronic record was initiated. In July 2025 SIU provided drafts of nursing protocols for allergic reaction and anaphylaxis, burns, hypertension, and sepsis. There is no reconciliation of the drafts distributed by OHS with those received from SIU addressing these same four topics. The Monitor's input has not been sought on these drafts.

Fifteen charts of patients whose care was reviewed by the Morbidity & Mortality Committee were also reviewed by the Monitor. There were approximately 120 sick call encounters among these records. There were repeated instances when patients were treated using the protocol for nonspecific discomfort[518] when another protocol would have provided more clinically appropriate guidance and two patients were treated

[515] There is also one protocol which was distributed in 2020 that addresses COVID.

[516] See a thorough discussion in the Health Care Monitor 3rd Report Lippert v. Jeffreys, February 15, 2021, pages 10, 72-75, 77. Health Care Monitor 4th Report Lippert v. Jeffreys, September 16, 2021, pages 15, 106-109; Health Care Monitor 5th Report Lippert v Jeffreys (July 27, 2022) pages 12, 87-89, 91; Health Care Monitor 6th Report Lippert v. Jeffreys, March 13, 2023, page 91-93, Health Care Monitor 7th Report Lippert v. Jeffreys, December 27, 2023, pages 106-107, Health Care Monitor 8th Report Lippert v. Jeffreys, November 8,2024 pages 148-151.

[517] Interview with the Agency Director of Nursing on June 12, 2024, as cited in Health Care Monitor 8th Report Lippert v. Jeffreys, November 8, 2024, page 148.

[518] It does appear that the protocol on non-specific discomfort will no longer be used once the revised protocols are implemented. Mortality review patients 9 & 13.

multiple times with nursing protocols while receiving infirmary level care.[519] There were at least 15 encounters where the nurse's choice of a protocol was not appropriate for the complaint.[520] Nine patients had an incomplete nursing assessment of their health concern.[521] Incomplete or abnormal vital signs that were not acted upon were noted in 19 of the encounters reviewed.[522]

There were nine patients who had a sick call encounter where the nurse either did not follow the protocol or did not use a protocol at all. When nurses do not follow the protocol they risk acting outside the scope of practice. For example, one patient was given TUMS to address his complaint of coughing and chest pain. No protocol was used.[523] Another example was a nurse who dressed and bandaged a wound on a patient's lower leg without using a treatment protocol and without orders for wound care.[524] A third example is a nurse who used the protocol for non-specific discomfort to treat a patient who had abdominal pain. He had an indwelling foley catheter which was not draining. The nurse flushed the foley with sterile water. There are no directions for care of a foley catheter in the protocol for non-specific discomfort, there were no orders for the patient addressing the patency of the foley, and no nursing policy and procedure was referenced.

These are the same findings as reported previously.[525] The efforts to revise the treatment protocols are welcome although their adequacy has not been reviewed. Steps that are necessary going forward are the following:

1. Train the nurses in the new protocols. This responsibility falls not just to the new vendor but IDOC as well. Training needs to include a record of completion and verification of competency.
2. Provide more effective nurse supervision (vacant supervisory positions) to ensure on a daily basis that nurses are using the protocols appropriately. This means observing nurses conduct sick call, reviewing documentation and discussing the relationship between the complaint, objective and subjective data and other factors that contribute to the nurse's clinical decisions.
3. Focus vendor recruitment and retention on maintaining higher caliber physicians on-site who more actively manage patients' various health conditions.

Patients are not limited to a single complaint when seen in sick call (III.F.2)

IDOC provided no data or other evidence evaluating compliance with this item of the Consent Decree. E.06.01 has no language that prohibits limitations on the number of complaints to be addressed during a sick call appointment. The Monitor suggested in the last report that such language be added during the annual review and revision of the policy.[526] The Monitor has anecdotally reviewed sick call encounters while reviewing records for this report that included more than one health concern. Further the Monitor has not encountered any instances of requests being denied because the patient had more than one complaint.

[519] Mortality review patients 2 & 10.
[520]Mortality review patients 2, 4, 9, 13.
[521] Mortality review patients 2- 4, 7, 9 – 11, 13, 14.
[522] Mortality review patients 1 – 4, 7, 9, 12-14.
[523] Mortality review patient 14. TUMS is an antacid that is available as an over the counter medication. The nurse did not use a protocol that said TUMS should be given for the patient's complaint. There was no order for TUMS. The nurse acted outside their scope of practice.
[524] Mortality patient 1.
[525] Health Care Monitor 8th Report Lippert v. Jeffreys, November 8, 2024, pages 148 - 150.
[526] Health Care Monitor 8th Report Lippert v. Jeffreys, November 8, 2024 page 151.

The Monitor's recommendations have been revised so as not to duplicate those that are now part of the Defendants' Implementation Plan.

RECOMMENDATIONS:

1. Revise E.06.01 Non-Emergency Health Requests to incorporate the requirements of the consent decree specifically
   a. limitations on the assignment and necessary supervision of LPNs,
   b. specify that sick call may only be conducted in a clinical setting,
   c. prohibit any restriction on the number of complaints to be addressed in a single sick call encounter.
   d. revise the timeframe from receipt of a sick call request to the sick call encounter to be consistent with the NCCHC standard of one day.
   e. specify how patients who cannot read or write are to request health care attention via sick call.

   The Monitor's other comments on the draft policy and procedure sent to IDOC on 2/2/2024 and 7/15/2025 should also be considered during the review and revision of this policy and procedure.
2. Establish a method to audit compliance with E.06.01 and each of the elements of the Consent Decree related to sick call.
3. Fill vacant nursing leadership positions (Director of Nursing and Nurse Supervisors).
4. Provide the Agency Director of Nursing with the resources to establish the means and methods to provide clinical direction and supervision of nursing at facilities.[527]
5. The vendor needs to functionally fill[528] registered nurse and primary care provider positions and be held accountable for excessive vacancies at a facility and by type of position regionally. The vendor should also be accountable for delays in filling any individual position beyond 45 days.
6. Complete item 53 of the Implementation Plan, the process improvement project for sick call which includes identification of barriers to access (or barriers to the implementation of E.06.01), delineating the resources needed to conduct sick call (staffing as well as the designation of clinical space and equipment), revision of the Nursing Treatment Protocols, and improving the quality and focus of the training nurses receive in the clinical assessment of sick call requests.
7. Develop more robust training and monitoring of nurses' use of the treatment protocols. Additional training that is clinically meaningful about the assessment of complaints and nurses' decision making needs to be provided.[529] Training records documenting the content of

[527] At a minimum this would be regular meetings to monitor the implementation of policies and practices that nurses are primarily responsible for. It should also include authority to set and monitor standards of nursing practice, establish criteria and priorities for continuing education and competency development, and peer review.

[528] Functionally fill means that the nurse is capable of fulfilling all aspects of the assigned role including critical decision making in urgent care situations. Covering positions with overtime and agency nurses generally does not meet the definition of functionally filled because these staff have not been fully oriented to the position or are fatigued, both of which are associated with increased risk for error.

[529] The Monitor acknowledges the recent efforts by SIU to develop clinical education and training. These include videos on various subjects posted on the Health Matters website, monthly Grand Rounds and Nurse Roundtable hosted by the Office of Correctional Medicine. The Monitor urges SIU to report metrics to IDOC on the number of personnel participating in each of these educational sessions.

training, participants, and the results of tests for knowledge and skill in conducting sick call must be kept.

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:

The Monitor requested the following documents to review the provisions above.

- The name of the process analyst responsible for any process improvement project(s) on chronic care[530], and provide any reports or work product developed to date on improving the process of chronic care (document request # 115).
- Nursing personnel at each facility who are assigned the duties of Chronic Care Nurse. The information provided should include their name, licensure (RN, LPN), and percentage of time assigned to these duties (document request #114).

In addition, the Monitor reviewed the current policy and used chronic disease episodes from ten mortality review records to review chronic care. All chronic care episodes reviewed were after February, 2024 when the chronic care policy was made effective.

Policy

IDOC made policy F.02.01 Chronic Care effective in Feb 2024. The Monitor submitted suggested revisions to IDOC for its annual review in July, 2025. The policy requires the following:

- Nurses will ensure that a provider sees the following types of patients promptly and before the patient leaves the intake area:
  - On dialysis, diabetes on insulin, on chemotherapy, on immunosuppressive medication, on clopidogrel for stent, on continuous oxygen therapy
- Providers performing intake health assessments for those with chronic disease will document a history and physical for all diagnosed illnesses.
- Providers ensure the problem list is updated at each chronic care clinic.
- Patients with chronic illness are to be seen as frequently as needed by their least well controlled disease.
- The assessment and plan are to address every chronic condition.
- Patients following with outside specialists for a conditions are to have those conditions followed in chronic clinic.

[530] As required in Implementation Plan tasks 50, 52.

- Patients need to be evaluated whether vaccinations or cancer screening are necessary.
- The provider will review the current and prior month's medication administration record, permits and diet orders. Medications will be discussed with the patient.

Implementation Plan task 54 recommends a process analysis of chronic care and the Monitor requested any documents to verify that this had been completed.[531] IDOC responded that they have not yet conducted a process analysis.[532] The development of workflows for the EMR were not informed by the results of a process analysis which would have contributed to an improved workflow.

Nine of 28 facilities reported information on the nurses assigned the duties of chronic care nurses.[533] Three facilities[534] have a dedicated nurse, one of whom is an LPN. Six facilities[535] have assigned part time coverage to this assignment or did not give percent time of coverage. Coverage at these facilities included one or multiple nurses some of who are LPNs. The Monitor has recommended a dedicated RN.

The last V. G. Report makes multiple statements about the chronic disease program[536] that are unsupported with any data and are contrary to findings of the Monitor.[537] The Monitor's previous report suggested using national standards as guidelines for providing clinical care for medical conditions, including chronic diseases. The monitor recommended utilizing clinical reference sources, such as UpToDate. However, there is no evidence that UpToDate is made available to clinical staff. Staff do not have access to a reasonable clinical reference.

The Monitor reviewed ten records to evaluate chronic care. Episodes of chronic care reviewed occurred after the chronic care policy was made effective. Most of the items evaluated were policy requirements. The following is a table of results.

[531] Monitor's 9th report documentation request dated 5/10/2025, # 115. Proposed completion date 12/2022.
[532] IDOC Response to Lippert Monitor 9th Report Request #115, dated 8/15/2025.
[533] Document request #114.
[534] NRC, Shawnee, and Dixon.
[535] East Moline, Illinois River, Kewanee, Menard, Southwestern, and Sheridan.
[536] On page two of the 2024 V.G. report, IDOC states that facilities provide management of chronic diseases without any evidence of the quality of that care. On page 16 of the 2024 V.G report, IDOC states that it manages chronic illnesses by seeing patients periodically through the Chronic Care Program without any evidence of the quality of that care. It states that the program "ensures all of the patient's chronic health problems are managed at each visit" without any evidence that this occurs. On page 47 of the 2024 V.G. report, IDOC states that all persons with chronic disease are offered immunizations when SIU performance measures verifies that this is not an accurate statement.
[537] Defendants' V.G. Report dated 12/2024 pages 2, 16, 47.

10 Records Reviewed for Chronic Care Metrics	
Metric	**Percent completed**
Patient seen for all of their chronic diseases.	0%
Provider history was adequate for all of the chronic diseases of the patient.	0%
Provider physical examination was adequate for all of the patient's diseases.	50%
Medications were documented and evaluated for adverse reactions. All medications accounted for with an indication. Provider evaluated whether the patient actually received medication and addressed patient non-compliance.	0%
Assessment was appropriate for each of the patient's chronic conditions	0%
The therapeutic plan for each of the patient's chronic conditions was consistent with community standards	0%
The provider checks at least once a year in chronic clinic whether the patient's immunizations are up-to-date based on CDC guidelines.	40%
Over the past year the patient was appropriately referred for specialty consultation when indicated and specialty care referrals were followed up.	0%
Problem list is accurate	0%
Laboratory and diagnostic studies were ordered as needed and prior studies reviewed, acted on and integrated into the plan of care.	0%
Age/gender appropriate cancer screening is accomplished and followed up.	0%

These results show failure to implement IDOC policy F.02.01 Chronic Care. The chronic care program was previously governed by administrative directive 04.03.105 Chronic Illnesses which defined chronic illnesses into eight groups[538] which determined which clinic a patient would be evaluated in. Instead of seeing patients for all their diseases at one chronic clinic visit the patient will be seen multiple times each year depending upon which chronic conditions they have. Staff developed a practice of limiting nomenclature of diagnoses to these eight clinic types. The problem list becomes corrupt with clinic type names rather than diagnoses. Patients are monitored based upon the clinic type and not their actual conditions. There are failures to appropriately evaluate and assess certain diseases.[539] IDOC has not yet implemented its policy on chronic illness made effective in February of 2024. Practices of the prior administrative directive continue which result in failure to monitor all disease conditions appropriately.

Examples of Problems with Chronic Care Identified in Chart Review

The first patient[540] had chronic kidney disease, diabetes, COPD, and hypertension. The patient's primary care physician, while he was in the community, in April 2024 recommended vascular surgery referral, a duplex scan of the leg, a podiatry referral to rule out osteomyelitis, and several other tests. When the patient was incarcerated none of these recommendations was timely acted on. An urgent vascular referral was not ordered until 7/25/24, about three months after incarceration. Even though ordered as urgent, it did not occur until 10/11/24, or six months after incarceration. The surgeon recommended a CT

[538] TB, HIV, diabetes, asthma, hypertension, seizures, general medicine and hepatitis C.
[539] For example, patients with asthma and COPD are both seen in the asthma clinic which often results in providers taking a history of and assessing COPD as if it were asthma which results in inadequate care.
[540] Chronic care patient #1.

angiogram which was ordered urgently on 10/17/24 along with a follow up with the vascular surgeon. The CT angiogram was not scheduled and when the vascular surgeon saw the patient again on 1/2/25, he again recommended an angiogram which was scheduled for 1/8/25. At the chronic clinic visit, on 12/4/24, the provider (who had ordered urgent referrals for both the initial vascular surgeon consultation and the CT angiogram) noted that the CT angiogram results had not yet been received but failed to recognize that it had not been ordered. The patient's other medical conditions were not addressed at the 12/4/24 chronic clinic visit. COPD was not monitored with a symptom history or with a history of exercise tolerance. Though peak expiratory flow rate testing was low, there was no order for spirometry. The status and plan for his COPD was not documented. The patient's blood pressure was elevated (173/92 and 154/94). The patient also had persistently abnormal kidney function consistent with chronic kidney disease. Management of this disease requires a blood pressure goal of 130/80. The patient's current blood pressure warranted additional medication which was not provided. The patient's diabetes was also poorly controlled. No history of diabetes symptoms was obtained. There was no evaluation of capillary blood glucose values. The provider did increase medication for diabetes. The patient's blood sugar was very high (A1c 10) and warranted early follow up, which was not done. The provider failed to adjust the patient's blood pressure medication and over the entire eight months of incarceration the patient's blood glucose was poorly controlled. Both diabetes and hypertension are risk factors for stroke which this patient experienced less than a month after the chronic clinic visit in December. The patient's death was potentially preventable had his blood pressure and diabetes been better controlled.

Another patient[541] was housed at a facility with an uncredentialed physician who was covering multiple facilities and was not consistently available at his home facility. The patient had multiple serious conditions including cystic fibrosis, COPD, diabetes, prior heart attack treated with stents, hypertension, pulmonary fibrosis, high blood lipids, ischemic cardiomyopathy, and impaired mobility. His problem list in the medical record contained no medical conditions. The patient was actively followed by pulmonary and cardiology consultants. His last chronic clinic was on 12/6/23 eight months before his death. The patient was evaluated only for his hypertension. The chronic disease note included no history, no examination except to document vital signs, no evaluation of hospitalizations or specialty consults. There was no assessment except "good control" of the patient's hypertension. There was no plan for monitoring or treatment. None of the patient's severe chronic illnesses that required pulmonary and cardiology consultations were addressed. Management of this patient was by episodic care only rather than with a comprehensive plan that addressed all his conditions. The patient died 8/20/24 of respiratory failure, and severe systolic heart failure. The lack of physician time at this facility is noticeable.

Another patient[542] was housed at a facility without a full-time physician. The patient in this example was seen in chronic clinic by a mid-level provider on 3/12/24 for hypertension and high blood lipids. The patient was on warfarin, an anticoagulant. There was no documentation of a diagnosis or other indication for treatment with this medication. The chronic clinic visit did not address the condition the warfarin was being used to treat. Nearly three weeks later on 3/27/24, the physician gave a verbal order to stop the warfarin and start Eliquis, a different anticoagulant. The physician did not write a note indicating a rationale for the medication change or discuss it with the patient to obtain agreement and understanding of the reason for the change. This physician worked at the facility only a few hours a week with a condition of not engaging in direct patient care. Giving a verbal order for patient care contradicted the privilege record. The prescription for Eliquis continued unchanged and unaccounted for in the patient's treatment

[541] Chronic care patient #5.
[542] Chronic care patient #6.

regime for the next year. At the 3/12/25 chronic clinic, once again the provider did not take a history to find out why the patient was on the Eliquis. The patient had no chronic condition for which the Eliquis was warranted. The assessment included no mention of Eliquis and even though this anticoagulant can have significant side effects the plan for treatment with Eliquis was not discussed with the patient. Common problems in IDOC are that patients on medications for chronic illnesses are not always followed in chronic clinics and patients can be on medications for which there is no documented indication. These are not evaluated in chronic clinics. The physician in this case should not be practicing. Having a physician who has a privilege sheet that does not include direct patient care who gives verbal orders for medication is a significant credentialing failure by the organization.[543] The lack of sufficient physician coverage and an inappropriately credentialed physician at this facility affected the care of patients.

Another patient[544] had multiple chronic conditions including diabetes, hypertension, COPD, hypothyroidism, prior lung cancer with removal of a lobe of his lung, coronary artery disease, prior stroke with mobility impairment, heart failure, anemia, atrial fibrillation, and malnutrition. At the chronic clinic visit on 1/1/25 the patient was seen for only for some of his chronic conditions. These were documented as asthma, diabetes, hypertension, hypothyroidism, GERD, prior lung cancer, and on continuous oxygen therapy. The patient was evaluated for asthma when he actually had COPD. The patient was being followed by a UIC endocrinologist for his diabetes and the treatment plan had been recently changed. The provider at the chronic clinic visit did not document review of the specialist's visit or the updated plan of care. The patient had low albumin consistent with protein calorie malnutrition but this was not identified. The patient's problem list was not updated. None of his conditions were adequately evaluated and many of his existing problems were not attended to. The patient also had significant heart disease and was not being followed by cardiology. Even though the patient's lung cancer was documented as a reason for the visit, it was not addressed. He had part of his lung removed in 2023. Typical follow up requires periodic CT scans of the lung but this patient was lost to follow up. The patient developed a subsequent lung mass that was metastatic cancer causing his death. Failure to follow all of the patient's conditions in chronic clinic contributed to his death.

Another patient[545] with a very complex medical condition was received at Graham on 2/14/25. Upon arrival, a nurse documented only the diagnoses of "double pneumonia", COPD, prior heart attacks, a defibrillator, and diabetes. There was a medication record from the jail listing 32 medications for which the nurse obtained a verbal order. Eight of these medications required non-formulary approval. Routine intake labs showed the patient was positive for hepatitis C and the QuantiFERON indeterminate requiring follow up to rule out tuberculosis. There is no evidence that the patient received any of the medications that were ordered. Though the patient was on two immunosuppressive drugs (prednisone and etanercept) he was not immediately evaluated by a provider as required by F.02.01 Chronic Care. As mentioned in the medical reception section of this report, it takes an average of 35 days to complete an intake medical assessment at Graham. This is directly related to deficient staffing.

On 2/17/25 the patient developed chest pain and was sent to a hospital where he was transferred to a VA hospital in St. Louis. The patient returned from the hospital on 2/20/25. The hospital discharge summary

[543] A privilege sheet is a formal document that stipulates what type of practice the practitioner is authorized to engage in. This provider had a privilege sheet that documented he was not to engage in direct patient care.
[544] Chronic care patient #8.
[545] Chronic care patient #9.

had a problem list with 29 problems listed in addition to pneumonia and pulmonary embolism. The medication list included 32 medications.

After hospitalization the patient was placed in the infirmary as a chronic patient. Having experienced a pulmonary embolism and pneumonia the patient should have been an acute admission. A doctor's admitting note on 2/22/25 was perfunctory. It listed only "double pneumonia" and pulmonary embolism as problems. None of the other conditions were documented. No history was taken and the only examination was that the patient had crackles and wheezing in his lungs. The next day the patient was discharged from the infirmary to general population with the same depth of evaluation on the discharge summary as the admission note. This was dangerous practice.

There was no medication record documenting that the patient received medication during this time period. A month later, the first provider note wrote "post-infirmary stay FU, stated that he feels fine, [no] complaints". On 3/31/25, 45 days after incarceration, a nurse practitioner conducted the intake medical assessment. No history was taken and the hospital report and lab results were not reviewed. and the provider assessed the patients as having only COPD, hypertension, pacemaker, diabetes, hyperlipidemia, and GERD, and missed several other important medical problems the patient had. The patient was scheduled for several chronic clinics including asthma/COPD, hypertension, and general medicine clinic. This was contradictory to Policy F.02.01 Chronic Care which requires that all conditions be evaluated in a single clinic. This assessment failed to identify multiple serious conditions of the patient, neglected to discuss the immunosuppressive drugs or whether he was receiving his ordered medication and did not address the patient's pulmonary embolism. On 4/13/25, a nurse evaluated the patient for shortness of breath and found the patient had an oxygen saturation of 67% with crackles in his lungs. He was sent to a hospital. The IDOC mortality review noted that the hospital record documented that the patient had not received anticoagulation while housed at the prison. The patient died on 4/27/25. The provision of chronic care for this patient was incomplete and fragmented which likely contributed to his death. The lack of provider staff was a significant issue.

Summary:

- The lack of adequate providers affected the chronic care program adversely.
- Record reviews indicate that patients with chronic medical conditions do not receive adequate management of their clinical issues, putting them at significant risk of harm.
- IDOC has not yet completed a process analysis of their chronic care program (Implementation Plan task 54) and implemented changes based on the findings.
- Based on record reviews, the chronic care policy is not yet implemented.
- Based on having a chronic care policy, a partial compliance is warranted. However continued evidence that the policy has not been implemented may cause the provisions related to chronic care to revert to noncompliance.

RECOMMENDATIONS:

1. Assess the staffing requirements to support the chronic care program and allocate the necessary resources. IDOC must improve physician staffing as soon as possible.
2. Complete the chronic care process analysis and implement improvements to standardize provision of care and workflow, ensure reliability, and enhance safety.
3. Implement the chronic care policy F.02.01.
4. Specialty consultations must be integrated into the each chronic care visit.

5. A team approach to chronic care should be implemented. Daily and weekly huddles should be instituted to improve communication amongst staff. Huddles should include providers, nursing, schedulers and a pharmacist.
6. Institute supervisory oversight over the chronic care program. This should include regular review of clinical care and workflow with feedback back to responsible providers and staff
7. A pharmacist should collaborate with providers to evaluate medication use according to standard of care.
8. The medication practices of providers in the care of patients with asthma and diabetes should be evaluated and modified as necessary to be consistent with contemporary standards of care. The Monitor is particularly concerned about what appear to be legacy practices in the use of beta-agonist nebulization therapy in lieu of increasing controller medications in asthma and dependence on sliding scale insulin in the treatment of diabetics in lieu of more contemporary diabetic regimens.
9. Use national standards as guidelines for care instead of writing guidelines for all common health conditions. The Monitor recommends creating a link to UpToDate in the new electronic record so that this service can be accessed at any device that uses the medical record.

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 provider" 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 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 Monitor requested the following documents to evaluate compliance with provisions in the Consent Decree relating to urgent and emergent medical care for this report:

- List of all emergency medical response bags from Centralia, Danville, Dixon, Hill, Lincoln, Logan, Illinois River, Pontiac, Robinson, Shawnee, Southwestern, and Western. 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* listed above of inspections of emergency response equipment and supplies completed in May 2025. Typically, this would be a copy of the inspection logs for the emergency equipment.
- Log of persons seen for an emergency onsite since January 1, 2025, at Dixon, NRC, Graham, Menard, Logan, Lawrence, Illinois River, Pinckneyville, and Pontiac. This is the log referred to in E.09.01 Facility Emergency Response, Procedure, III. E and F.
- The medical emergency response plan and most current chain of command (D.01.01 Emergency Plans and Drills, Procedure Z and BB) from Dixon, NRC, Graham, Menard, Logan, Lawrence, Illinois River, Pinckneyville, and Pontiac.
- The date, time, location, and subject of any medical emergency response drills conducted at Dixon, NRC, Graham, Menard, Logan, Lawrence, Illinois River, Pinckneyville, and Pontiac since January 1, 2025.
- For each facility a list of persons hospitalized or sent to an emergency room since March 1, 2025, to include name, IDOC #, date of ED visit, date of hospital admission, date of discharge, discharge diagnosis, and date seen by provider upon return to the facility.[546]

Policy

It has been more than a year since OHS disseminated three policies and procedures concerning emergency response and facilities were instructed that they were to implement them as they were able. These are D.01.01 Emergency Plans and Drills, E.08.01 Emergency Services, and E.09.01 Facility Emergency Response. The Defendants most recent V.G. Report notes that a policy on medical emergency medical response has been developed but no information or data was provided to show that emergent medical care at the facility was provided consistent with this policy guidance.[547] Based upon review of the documents received in response to the Monitor's request, implementation of the policies and procedures concerning emergent/urgent care are incomplete.

Nine facilities were asked to provide a medical emergency response plan and the most current chain of command as required by D.01.01 Emergency Plans and Drills.[548] Six facilities provided copies of an Institutional Directive dated 4/1/2023, which preceded distribution of the medical policy & procedure manual.[549] These Institutional Directives do not address mass casualty events as required by D.01.01 Emergency Plans and Drills (i.e., how sites will be established for triage and care of victims, who and how evacuation will be determined, or the role of OHS in obtaining additional staff and supplies). The Institutional Directives also conflict with E.09.01 Facility Emergency Response in how often emergency equipment is to be checked and what equipment is required.[550]

One facility sent an Institutional Directive dated after the policies and procedures were distributed.[551] In

[546] Monitor's documentation request dated 5/10/2025, items 117 – 121 and 135.
[547] Defendants Section V.G. Report, 12/13/2024 pgs. 14, 34-35.
[548] Monitor's 9th report documentation request dated 5/10/2025 item 120.
[549] Dixon, Graham, Illinois River, Lawrence, Pinckneyville and Pontiac.
[550] The Institutional Directives state that the AED is to be checked daily and all other equipment is checked weekly while OHS policy and procedure require these checks to be done each shift. The equipment required for emergency response is listed in more detail in OHS' policy and procedure that is listed in the Institutional Directives.
[551] Menard ID 04.03.108 effective 9/1/2024.

this case the items required to be kept in the emergency bag do correlate with the list distributed by OHS as an attachment to E.08.01 Emergency Services but the frequency that equipment is to be checked still conflicts with the medical policy and procedure. The remaining two facilities sent documents that cover some of the same material but are not in the format of an Institutional Directive; it was not possible to ascertain their impact on changing the delivery of emergency services.[552] The Monitor has suggested adding more guidance to facilities in the revision of D.01.01 about the contents of the plan for emergency medical response, describing more clearly the responsibilities of the facility medical director, and specifics about how to critique emergency drills.[553]

E.09.01 Facility Emergency Response requires the HCUA to maintain a log of all emergency responses regardless of whether the patient was taken to an emergency room or treated onsite.[554] The log from January 1, 2025, to present was requested from the same nine facilities.[555] Only three facilities responded with a log of all emergencies.[556] Only one facility had a log that had been in place since January.[557] Another facility initiated a log only as recently as June 30, 2025.[558] The data kept on the log is incomplete, as listed in the policy, at three of the four facilities which responded.[559]

E.09.01 Facility Emergency Response also requires the facility to report at monthly quality improvement meetings the number of emergency responses, the number seen by a provider within 48 hours of return from the emergency room, and the number of emergency room reports that were received. The quality improvement meeting minutes from January through June 2025 were reviewed for the same nine facilities. No facility reports the number of emergencies responded to each month. Three facilities report the number of emergencies sent to the emergency room.[560] No facility reports the number of patients who were seen by a provider within 48 hours of return from an emergency room.[561] Facilities do not consistently report whether a record of treatment provided by the emergency room has been requested and received. Clinical review of the records of patients sent to the emergency room is to be completed quarterly by the facility's Medical Director to identify opportunities to improve primary care which are known to reduce emergency room use and to ensure oversight and follow up care for patients. The results of these quarterly reviews are to be discussed at facility quality improvement meetings. There is no evidence that this review and discussion takes place based upon review of the minutes of the facility quality improvement committee

[552] Logan sent three pages from an undated policy and procedure manual that dealt solely with disaster preparedness. NRC sent a memo written by the AW-Operations to all staff dated 7/29/2025 that addressed the contents of the emergency bag and had a medical chain of command. It is unclear what participation the HCUA or OHS had in preparation of the memo.
[553] Email dated 9/16/2025 to Kelley Lawshea and Robert Fanning.
[554] The requirement by the policy and procedure for such a log is appropriate given that the Consent Decree specifies that such a log be kept, preferably electronic, of all emergent/urgent services (III.G.1). The Defendants only reported in the most recent V.G. Report dated 12/18/2024 that a log of *offsite care* received for medical emergencies was kept (pg. 34). This is an acknowledgement of incomplete implementation of policy and procedure.
[555] Monitor's documentation request dated 5/10/2025 item 119.
[556] These were Dixon, Graham and Logan. NRC sent a log with only those emergencies that were sent to the emergency room. Illinois River, Lawrence, Menard, Pinckneyville, and Pontiac did not respond to the Monitor's request and are assumed to have no log.
[557] Dixon
[558] Graham
[559] Dixon. This facility has revised the log since January. The data for May is very well presented and complete. It can easily be used to identify trends and opportunities for improvement. It should be used as a model for other sites until such a report can be produced from the electronic record.
[560] Lawrence, Menard, and Pinckneyville.
[561] Some facilities report the number seen upon return from offsite care (which includes emergency room visits) but they report the number seen within five days of return to the facility, not 48 hours which E.09.01 requires.

meetings.[562]

Also required by E.09.01 Facility Emergency Response is documentation each shift that the emergency bag has an intact seal with a numbered tag, and that the AED, oxygen, and portable suction are present and operable, and a stretcher with backboard, wheelchair, and cervical collar are present and usable. The contents of the emergency bag are to be inventoried monthly. Twelve facilities were requested to provide documentation of these checks done in the month of May 2025.[563] All but one facility[564] appears to have adopted the list of items to be kept in the emergency bags that is specified in E.08.01 Emergency Services. The frequency and content of the inspection of emergency equipment and supplies vary from one facility to another. Only two facilities check each shift that the seal on the emergency bag is intact.[565] None of the facilities check the availability of all of the required equipment each shift.

Performance

Information about emergency drills was provided by 16 facilities.[566] Ten of these facilities have conducted at least two drills between January and July 2025. Menard, Pontiac, and NRC provided no record of emergency medical response drills completed for this time period. Drills are not yet as robust as described in D.01.01 Emergency Plans and Drills, which stipulates that drills are to include:

- a medical assessment of any patient identified with a medical emergency,
- the determination of medical interventions and the sequence with which they are to take place,
- use of equipment and supplies, and
- practice determining the need for EMS and summoning such help as well as notification of the chain of command.

It does appear that if the facility has a physician available then they do complete a critique of the response, although it is not always timely.[567] These critiques should be reviewed by OHS to determine statewide training and development plans.

Eight facilities[568] track the date the patient is seen by a provider upon return to the facility after being sent to the emergency department. The Consent Decree requires patients to be seen within 48 hours of return. Only Kewanee achieved 100% compliance with this requirement in E.09.01 Facility Emergency Response. The results for this measure from other reporting facilities are listed below:

- Jacksonville 61%
- Hill 60%

[562] The minutes from January through June 2025 were reviewed by the Monitor.
[563] Monitor's 9th report documentation request dated 5/10/2025 item 118. Responding facilities were Centralia, Danville, Dixon, Hill, Lincoln, Logan, Illinois River, Pontiac, Robinson, Shawnee, Southwestern, and Western.
[564] Hill provided a list that is checked but it does not correspond with the items listed in E.08.01.
[565] Dixon and Shawnee.
[566] Dixon, NRC, Graham, Menard, Logan, Lawrence, IRCC, Pinckneyville and Pontiac were asked by the Monitor explicitly for a copy of any drill performed since January 1, 2025 (documentation request # 121). Drills conducted by another seven facilities (Danville, East Moline, Hill, JTC, Kewanee, Sheridan and Vienna) were found in the minutes of monthly quality meetings.
[567] Logan has had two drills, one was completed in January the second was in February, however neither had a physician write a critique until June.
[568] Last report there were 11 facilities that tracked the date a patient was seen by a provider upon return from the emergency room. This is from the material provided in response to the Monitor's documentation request # 135.

- Dixon 47%
- Lawrence 33%
- Decatur 31%
- Vienna 25%
- Sheridan 23%

This is a measure that has been incorporated into the Clinical Quality Performance Reviews that are completed by SIU Office of Correctional Medicine. Statewide results are that physician follow up occurs timely 35% to 37% of the time. Follow up by nurses takes place immediately upon return to the facility from the emergency room only 67% to 69% of the time.[569] Every facility needs to track the timeliness of follow up after emergency room visits and performance on this measure should be better than 90%.

Findings from Chart Review

Eleven of the mortality review charts reviewed for this report included one or more responses to medical emergencies. All of the emergency responses took place after the OHS policies and procedures were made effective in February 2024. The dates of these medical emergencies range from June 2024 to January 2025.

Only one of the 11 records reviewed had some semblance of a timeline documenting the time of arrival, scene assessment, physical assessment, and what was done, by whom, when, how, and the patient's response to the intervention.[570] More often only one narrative note was written with nothing documented by the other healthcare staff who responded. A narrative note by each responder and a timeline are to be documented in the patient record.[571] This is not the current practice.

In eight of the records reviewed the vital signs were incomplete and only sporadically repeated rather than at 15-minute intervals as specified by OHS policy.[572] As an example, one patient was having trouble breathing and was experiencing heat stress.[573] At no time was his temperature taken, which would have helped drive cooling interventions. Another patient with difficulty breathing was not assessed at all before being transported by wheelchair to the HCU. He stopped breathing during the six minutes it took to make the transport to the medical unit.[574] D.09.01 states that first aid and CPR will be provided at the scene. When making the decision to transport by wheelchair rather than stretcher, an assessment would have provided better information about the patient's condition and the support that likely would be needed during transport. Two patients should have had a more thorough assessment of their neurologic condition.[575] Another patient should have had an EKG[576] and another should have had blood glucose checked.[577]

[569] Beginning in July 2024 through June 2025.
[570] Mortality review patient #4.
[571] E.09.01 Emergency Response at the Facility, Procedure II, A.-C.
[572] Urgent/Emergent Patients 1-9, 11.
[573] Urgent/Emergent Patient 4.
[574] Urgent/Emergent Patient 6.
[575] Urgent/Emergent Patients 1 & 4.
[576] Urgent/Emergent Patient 4.
[577] Urgent/Emergent Patient 5.

Very few of the interventions available by nursing treatment protocol were initiated. These include failures to use the AED timely[578], administer epinephrine[579], to start oxygen[580], to start an IV[581], to use aspirin in the appropriate dose[582], to initiate cooling of body temperature[583], and to provide cervical protection. [584] Delays in emergency care included not starting CPR promptly[585], not using the AED promptly[586], and not contacting the provider timely.[587]

Among the charts reviewed were two examples of failure to recognize red flag symptoms in a patient's condition which should have prompted an elevation in care. One of these was a 48-year-old man who died in June 2024.[588] He was seen by a nurse for chest pain radiating to the left arm three days before his death. The patient had hypertension and was obese. There are numerous chart entries documenting that his hypertension was not controlled. The nurse did document that he had a past history of heart problems but did not identify what they were. The nurse did not identify cardiac risk factors even though the chest pain protocol prompts the nurse to do this. No EKG was obtained, and the patient was not scheduled with a provider for follow up, both required by protocol. The nurse gave the patient TUMs which is not part of the chest pain protocol. This nurse was acting outside the scope of practice, exercised poor clinical judgement[589] and put the patient at immediate risk of harm.

Another example is a 54-year-old patient who gave a history of asthma who died in December 2024 from complications of emphysema. He was seen emergently by a nurse for inability to breathe. The nurse was unable to obtain a blood pressure; the patient's respirations were 28, with audible wheezing, use of accessory muscles with retraction. He was unable to complete a full sentence. This is a classic presentation of acute respiratory distress. The provider ordered a corticosteroid injection followed by additional steroid medication by IV every eight hours and placed the patient in the infirmary for observation. Infirmary observation was an inappropriate placement since the patient's condition was unstable, and it was a weekend. Closer medical oversight and access to hospital level care was necessary to address the exacerbation. Twenty minutes later the patient's oxygen saturation dropped to 79% on room air and he became unresponsive and pulseless. EMS was called and he died later that same day at the hospital. The physician should have recognized the patient's acuity and anticipated the need for higher level care.

The Office of Correctional Medicine at SIU has produced educational material for the health care staff in the IDOC on emergency medical care that addresses some of the findings from Morbidity and Mortality Review such as those discussed in preceding paragraphs. One of these was a video on chest pain that emphasizes the identification of cardiac risk factors and other criteria to simplify the decision to seek emergency room care. There also is a nursing roundtable that takes place monthly. Recent topics that are aimed at improving emergency medical care include allergic reaction & anaphylaxis which took place in

[578] Urgent/Emergent Patients 3, 5, & 6.
[579] Urgent/Emergent Patients 4, 6 & 7.
[580] Urgent/Emergent Patients 4-6, & 8.
[581] Urgent/Emergent Patients 1,2, 5-8.
[582] Urgent/Emergent Patients 2, 10.
[583] Urgent/Emergent Patient 4.
[584] Urgent/Emergent Patients 5 & 9.
[585] Urgent/Emergent Patients 3 & 6.
[586] Urgent/Emergent Patients 4, 5 & 7.
[587] Urgent/Emergent Patients 1 – 3, & 10.
[588] Urgent/Emergent Patient 10.
[589] Especially since a protocol was available to have guided the nurse's assessment and subsequent actions.

April 2025 and blood sugar emergencies which took place the following month. The impact of this training material on clinical performance in the near term is unknown. No records are kept of the participants at these training sessions so there is no way to evaluate how many staff have been exposed to this material. Aside from maintaining CPR certification no evidence has been provided that the competency of health care staff in delivering emergency medical care is evaluated.[590]

Summary

The changes required by the three policies concerning emergency medical care have been in effect for more than 12 months and still have not been implemented by facilities. OHS has not evaluated the need for staffing necessary to ensure urgent/emergent services are delivered consistent with these policies nor how competency in clinical response to medical emergencies will be evaluated.[591]

RECOMMENDATIONS:

1. Prioritize implementation of D.01.01 Emergency Plans and Drills, E.08.01 Emergency Services and E.09.01 Emergency Response on the Facility.
2. Address implementation of other improvements in urgent emergent heath care that are in the Implementation Plan, Items 72 and 94. In particular, these are the analysis of staffing needed and evaluation of employee competencies.
3. Expand staff training to include expectations for completion and demonstration of competency in emergency response. Providers need to be expected to participate in clinical training and refresher education, particularly the evaluation of need for higher level care.

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.*

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[590] II.B.6.q of the Consent Decree specifies that an assessment of competency and performance be completed annually on all medical, dental, and nursing staff. The Defendants' most recent Section V.G. Report provided only the vendor's evaluation tools and the IDOC AD 03.03.110 on Job Performance Evaluation. No actual evidence of competency assessment has been provided by IDOC. The Monitor's 8th Report dated 11/13/2024 reviewed both the Vendor's performance reviews and the Department's job performance evaluations and found little to no evidence of competency assessment or evaluation of clinical performance (pgs. 44-46).

[591] Implementation plan task 72, items 2 and 4; task 94, items 1, 2, 6.

III.I.5. *All infirmaries and HCUs shall have sufficient and properly sanitized bedding and linens.*

OVERALL COMPLIANCE RATING: Noncompliance

FINDINGS:

The Monitor requested the following from IDOC to evaluate compliance with the items listed above from the Consent Decree that concern patients' access to infirmary level care.

- Identify any expert brought on to evaluate the needs of the aged and infirm and include any reports.
- The daily log(s) or assignment roster(s) used to document infirmary staffing for the week of May 4-10, 2025, from Big Muddy, Centralia, Danville, Dixon, Hill, Lincoln, Robinson, Shawnee, Stateville, and Western as described in F.01.01 Infirmary Level Care, Procedure, VIII, C.
- For providers, identify who is responsible at each facility for infirmary rounds for the month of May 2025.
- The job description or post assignment of any correctional officer posts regularly assigned to cover the infirmary at Big Muddy, Centralia, Danville, Dixon, Hill, Lincoln, Robinson, Shawnee, Stateville, and Western.
- The log of admissions to the infirmary since January 1, 2025, from Big Muddy, Centralia, Danville, Dixon, Hill, Lincoln, Robinson, Shawnee, and Western as described in F.04.01 Infirmary Level Care, Procedure, VIII. A.
- List of patients remaining in the infirmary at Stateville in June 2025 with problem list, reason for placement in the Stateville infirmary, date of placement, and current plan of care.
- Any assessment completed on the utilization of infirmary beds or barriers to accessing infirmary level care.
- A copy of guidance from Environmental Services that is referenced in F.01.01 Infirmary Level Care regarding sanitizing and handling of bedding and linen used in the infirmary.
- A copy of any written guidance (memos or other written directives) provided to health care personnel about the Joe Coleman Medical Release Act.
- A list of persons who have applied for the Joe Coleman Medical Release Act for calendar year 2024.

In addition to the above, the Monitor reviewed information about progress on the implementation plan that pertained to infirmary services, new arrangements with academic centers, training available to health care staff at IDOC facilities, adverse events and corresponding corrective action, death records and mortality reviews, minutes of the System Leadership Quality Council, and facility quality improvement meetings.[592]

Appropriate Level and Scope of Infirmary Services (Secondary Care)

Infirmary care is considered a secondary level of care because it involves specialized evaluation or treatment beyond that provided in the primary care setting. It requires an order for admission by a primary care provider and there is 24 hour access to nursing care. IDOC does not operate the infirmaries consistent with the common understanding of secondary level of care. Staff assigned to work in the infirmary do not have any recognized special expertise and often there is no documentation of an admission order. Admission to the infirmary usually means that the patient needs some kind of protective housing, perhaps

[592] Monitor's documentation request dated 5/10/2025, items 7, 13, 18, 29, 36-38, 45 – 46, 48, 55, 68, 73, 122 – 129, 130.

monitoring of their condition or more immediate access to services provided by the Health Care Unit such as emergency response, dressing changes, and assistance with activities of daily living (feeding, dressing, hygiene).

The Consent Decree calls for changes in infirmary care to include appropriate staffing, physical conditions, and scope of services. In the second draft of the implementation plan written in 2020 IDOC stated " IDOC is committed to ensuring appropriate housing for the infirm population including those with memory deficits, disabilities, and those in need of assistance with activities of daily living." The Department went further to say that they were going to complete an assessment that would … "form the basis for the development of action steps to provide appropriate resources, programming, and housing for those with disabilities or those needing assistance with activities of daily living."[593]

It is now five years since IDOC made this commitment and there has been no assessment completed and no significant changes made in the resources, programming or housing of the aged and infirm population incarcerated in IDOC facilities based upon such an assessment.

The Monitor did not visit a correctional facility in the interim since the 8th report. However, the Monitor has not found any infirmary at the sites visited so far to have appropriate physical conditions.[594] See the discussion in previous sections of this report on clinical space, equipment and supplies, and sanitation.

Among the charts reviewed for this report were several patients who should have been cared for in the infirmary and were not. Each needed closer monitoring and more skilled clinical evaluation of their condition.[595] As examples, a patient[596] housed at Vienna had, on multiple occasions, severe asthma exacerbations which required higher level monitoring than could be provided in general population. Vienna has no infirmary. On one occasion he was placed in an observation cell but this did not include the monitoring that was clinically required by policy. The patient did not receive the necessary monitoring which placed the patient at risk. The patient ultimately had a respiratory arrest in general population and died after being sent to the hospital. Another patient[597] described on 8/31/22 as mentally slow started having difficulty walking on 9/21/22. He was initially admitted to the infirmary but within a few days was sent back to general population. By 11/26/22 he requested a walker due to difficulty ambulating. He had a physical examination in preparation for a procedure that identified weakness and unsteadiness. It was documented that the patient said he was very weak, had falls, and had an inmate helper. The patient had continued falls and developed increasing difficulty in activities of daily living. On 3/19/23 the patient had a fall hitting his head and was sent to an emergency room where amyotrophic lateral sclerosis was diagnosed. After hospital discharge he was admitted to the infirmary. This patient had evolving ALS with progressive weakness for months. Because of his inability to conduct activities of daily living he should have been admitted to an infirmary much earlier than he was.

Another example was a patient initially at NRC who transferred to Robinson. At intake the patient had a diabetic foot and was initially admitted to an infirmary but within a few days was sent to general

[593] Final Revised Lippert Implementation Plan, 6/12/2020, page 5-6.
[594] Monitor's 8th report, page 165. The facilities are Dixon, Lincoln, Logan, Robinson, Shanee, Graham, NRC and Stateville (now closed).
[595] Infirmary patients 1, 7, 10.
[596] Mortality review patient 5
[597] Mortality review patient 2

population to an ADA cell. He should have remained on the infirmary to offload the foot, be evaluated for osteomyelitis, and for wound care. Later, on 7/23/24, the same patient, who had COPD, diabetes, vascular disease, chronic kidney disease, and hypertension developed shortness of breath, fever, borderline low oxygen saturation, tachycardia and increased respiratory rate. This patient should have been sent to a hospital or placed on the infirmary and evaluated by a provider neither of which were done. On 7/27/24, a nurse saw the patient again for shortness of breath. An on-call physician ordered antibiotics, a chest x-ray to be done three days later, and a nursing check the following day. He was sent back to general population. This patient with presumed pneumonia and significant comorbidities should have been sent to a hospital or at a minimum admitted to the infirmary.

In addition, two patients were required to complete colonoscopy preparation in their cell or housing unit rather than the infirmary. One of these was eventually admitted to the infirmary because he was experiencing side effects from the preparatory solution.[598] The other patient did not do the preparation and so the procedure was cancelled.[599] Patients expected to prepare for a procedure (i.e., colonoscopy prep, NPO etc.) should be admitted to the infirmary the night before for monitoring and to avoid having to cancel procedures.

The Department informed the Monitor that issues with access are addressed by facilities when they arise, that no targeted assessment of the utilization of infirmary beds has been completed, and that they were well aware of individuals housed in the infirmary for longer periods of time.[600] Medical policy and procedure F.04.01 Infirmary Level Care requires the HCUA to maintain a log of all admissions to the infirmary and to report monthly the number of admissions and discharges, average length of stay, average daily population, the number of admissions whose length of stay exceeds one month, and any patients readmitted to the infirmary within one month of discharge.[601] No documentation was provided to the Monitor that shows implementation of this part of the policy and procedure on infirmary services. In essence there is no oversight to ensure that infirmary beds are utilized appropriately.

On or about 6/1/2025 80% of available infirmary beds were filled and nearly half the beds had been occupied by the same patient for more than a month based upon information provided by four facilities.[602] In the Monitor's previous report 65% of the infirmary beds in IDOC were occupied on 2/29/2024 and 40% had been occupied by the same patient for more than 30 days.[603] With the closure of Stateville, the Department reduced its infirmary capacity by 25 beds making utilization review more important in ensuring that the remaining beds are appropriately utilized. In planning the rebuilding of Logan and Stateville, leadership needs to advocate for better housing and facilities to accommodate prisoners with disabilities to free up infirmary space.[604]

The Department asserts that it met its commitment for change in infirmary care with the CGL report, plans developed by Introba, and the rebuild of Stateville and Logan Correctional Centers.[605] Significant as these

[598] Infirmary patient 1.
[599] Infirmary patient 9.
[600] IDOC Response to Lippert Monitor 9th Report Document Request, dated 8/15/2025.
[601] F.04.01 Infirmary Level Care, VIII. A.
[602] Documents provided by IDOC in response to the Monitor's 9th report documentation request #122. Infirmary census with date of admission was provided by Big Muddy, Danville, Hill, and Shawnee. Infirmary stays of more than a month for a contusion, MRSA infection, wound care, seizure and a new pacemaker are questionable as to the appropriateness of care and length of stay.
[603] Monitor's 8th Report, page 163
[604] Among a small sample of 49 beds were six patients whose reason for infirmary care was that they were oxygen dependent.
[605] Defendant's Response dated 11/14/2025 to the Monitor's Special Report dated 9/8/2025.

plans are, neither one is based upon an assessment of the needs of the elderly and infirm for appropriate resources, programming, and housing. The Monitor has provided extensive comments on the CGL and Introba plans in the last two reports.[606] While the Monitor supports the Department's efforts to address its aging infrastructure needs, the Monitor does not agree that these reports and the rebuild of Stateville and Logan demonstrate that IDOC has changed the physical conditions or scope of infirmary services called for by the Consent Decree.

Addressing the Needs of the Elderly in Illinois Prisons

At the present time IDOC has taken two small steps toward addressing the needs of the elderly. The first has been to establish a geriatric specialty clinic at JITC that is staffed by UIC clinicians. Sixty patients have been seen by these clinicians since September 2024 for a variety of medical concerns. Sixteen of these referrals were for cognitive evaluation.[607] The second is an initiative proposed by SIU in May 2025 to create a statewide palliative care/end of life program. A draft for the proposed program is scheduled to be completed by the end of 2025.[608]

Earlier efforts by the Department seem to have stalled or failed to proceed. One of these was a pilot project proposed by UIC in 2019 about Creating a Dementia-Friendly Prison Environment.[609] The project involved meeting with IDOC, a survey of the facility Wardens, and creation of a plan to train corrections staff to create dementia friendly prisons.[610] The Wardens identified facility layout as a key challenge to implementing improved services and support for incarcerated persons with dementia. There is no evidence in the literature, on the IDOC website, or in the material IDOC sent the Monitor that the pilot training program ever took place or that any of the dementia-friendly prison recommendations were made effective.

Another project was a study on the prevalence of dementia proposed by one of the same staff from UIC, dated December 2023.[611] The proposal states that after completing a pilot training at Taylorville they realized the *need to determine the actual prevalence* of the condition among older prisoners in custody. The proposed study was to take place at Stateville (which is now closed) and consist of prisoners 50 years of age or older who volunteered for cognitive screening. This proposal was made two years ago and there has been no further mention of it since. No data or report has been provided by IDOC and there is no evidence the results of the study were ever made public. It does not appear that the dementia friendly prison project has resulted in any information about the needs of the population or changes in programs to care for cognitively impaired, elderly Illinois prisoners.

An example of the unmet needs of this population is a man who was 75 years old at the time of death. He had diagnoses of hypertension, asthma, morbid obesity.[612] He had a history of deep vein thrombosis, cellulitis and edema of the lower leg. He also was vision impaired and used a wheelchair or walker. He

[606] Monitor's 8th Report, 11/13/2024, pages 96-103; Monitor's 7th Report, 12/27/2023, pages 71-76.
[607] Provided in response to the Monitor's documentation request #130.
[608] Provided in response to the Monitor's documentation request #29.
[609] This project was funded by a HRSA grant to Engage-IL, an organization which is committed to improving health outcomes and quality of life of older adults.
[610] Gruss,V. and Hasnain, M., Innovation in Aging, 2019, Vol.3, No. S1 page 433.
[611] Dementia Friendly Prison Program Prevalence of Dementia Research Protocol V2 dated December 2023 provided in response to the Monitor's documentation request, 5/10/2025, item 7.
[612] Infirmary patient 8.

had neuropathy, chronic kidney disease, COPD, coronary artery disease, and vitamin B12 deficiency. He was also treated for gout and GERD.

This man remained in general population until his death despite decline in both his physical and mental condition. He was assigned an ADA helper who frequently sought medical attention and advice on how to care for the patient. The patient was noncompliant with medication and did not regularly bathe. He was given compression stockings for lower leg edema but at no time did staff evaluate whether he could or would put them on. When seen by the doctor for medication noncompliance no examination was done nor was there any discussion with the patient about noncompliance. The resulting plan was simply nursing sick call as needed.

His ADA helper told the nurse that the patient was hard of hearing and did not know that his cell door had been popped open so that he could go for insulin and other medication. The nurse referred the patient to a provider. The nurse did not assess the patient's hearing or address the issue of missed medication because of not being able to hear.

The patient asked to be evaluated for Alzheimer's or dementia and stated that he had eaten someone else's food and that he had urinated in strange places. When seen the next day by the physician no mental status exam was completed and problems with the patient's declining cognition were not addressed. The patient was told to comply with the medications ordered and elevate his legs. The Mortality and Morbidity Committee found this patient's care was *another example of the poor care provided those experiencing cognitive decline in this setting*.

A study was published recently on the prevalence of cognitive impairment and dementia among prisoners in the Texas prison system.[613] This study was a random sample of prisoners 55 years of age and older. The results were that 35% met the threshold for mild cognitive impairment and 9.1 % met the threshold for dementia.

Using the study results from Texas, the following table estimates the number of persons 55 years or older who are incarcerated in Illinois prisons and have mild cognitive impairment or dementia. The elderly, alone, are a sizeable population in IDOC and are without any specialized services or programming. The number of persons estimated to have cognitive impairment is also sizeable, staff have developed little expertise in working with the elderly, and there are no specialized facilities or programs to support their wellbeing during incarceration.

[613] Baillargeon J. et.al. 2023 The Prevalence of Cognitive Impairment and Dementia in Incarcerated Older Adults, The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences. 78 (12), 2141-2146.

Estimate of the Prevalence of Cognitive Impairment and Dementia Among Persons Incarcerated in IDOC				
FACILITY	**ADP as of 6/30/2025**	**55 years and older**	**Estimated # with mild cognitive impairment**	**Estimated # with dementia**
MALE FACILITIES				
BIG MUDDY	1618	359	126	33
CENTRALIA	1263	219	77	20
DANVILLE	1703	290	102	26
DIXON	1023	310	109	28
EAST MOLINE	482	106	37	10
GRAHAM	1818	291	102	26
HILL	1367	267	93	24
ILLINOIS RIVER	1641	244	85	22
JACKSONVILLE	547	96	34	9
LAWRENCE	983	108	38	10
LINCOLN	798	80	28	7
MENARD	1880	296	104	27
MURPHYSBORO	122	0	0	0
NRC	1351	153	54	14
PINCKNEYVILLE	1540	247	86	22
PONTIAC	528	76	27	7
ROBINSON	1803	169	59	15
SHAWNEE	1231	157	55	14
SHERIDAN	1214	143	50	13
SOUTHWESTERN	391	40	14	4
TAYLORVILLE	1106	320	112	29
VANDALIA	641	63	22	6
VIENNA	696	117	41	11
WESTERN	1513	276	97	25
SPECIAL PURPOSE FACILITIES				
JITC	142	47	16	4
KEWANEE	187	21	7	2
FEMALE FACILITIES				
DECATUR	316	45	16	4
LOGAN	1102	148	52	13
Totals	**29,006**	**4,688**	**1,643**	**425**

IDOC has established an Administrative Directive for the administration of their duties under the Joe Coleman Act for compassionate medical release.[614] OHS provided training for health care staff on their responsibilities with regard to compassionate release applications. Thirty-nine staff, primarily facility HCUAs and physicians attended one of four sessions offered.[615] For calendar year 2024 there were 135 applications for compassionate medical release submitted to the Parole Review Board and 34 were granted.[616] The Monitor is aware of one patient who was granted compassionate medical release on 1/19/2024 and died in prison six months later, before he could be placed in the community.[617] The Monitor suggests that the database of Joe Coleman applicants, apparently kept by OHS, be expanded to include the actual date of release (and if not, the reason) and the location or type of location the person was released to (family, nursing home, etc.). This information would be helpful in identifying resources for this population.

Infirmary Policy and Actual Practice

OHS issued F.04.01 Infirmary Level Care in February 2024 and facilities were informed that the policy and procedure was considered in effect at that time and they were expected to implement them.[618] The policy and procedure is considered an improvement over the guidance provided by the Administrative Directive and is responsive to parts of the Implementation Plan related to infirmary care. [619]

There is almost no evidence of the implementation by IDOC correctional facilities of the policy and procedure. The Monitor requested nine facilities provide the log of admissions to the infirmary as described in F.04.01 Infirmary Level Care, Procedure VIII. A.[620] Of eight facilities which responded to this request, only Dixon has initiated a log of admissions that includes all of the information required by policy.[621] The information sent by the other facilities was either nonresponsive or incomplete and representative of continued legacy practices.

The records of six mortality patients were reviewed to evaluate compliance with documentation requirements outlined in F.04.01. These six records included 15 episodes of infirmary level care that took place from April through November 2024 or after the policy and procedure was in effect. The six patients received infirmary level care at six different facilities.[622] The type of admission was not specified in four of the infirmary stays. These appear to be patients who required some type of protective living situation.[623] In nine of 15 admissions to the infirmary there was no order for admission. Of orders that were written,

[614] Administrative Directive 04.50.157 Compassionate Medical Release, effective 3/1/2024.
[615] The training minutes provided in response to the Monitor's documentation request dated 5/10/2025, item 128 were excellent and should be considered an example for documentation of training in other policies and procedures.
[616] Information provided in response to the Monitor's documentation request dated 5/10/2025, item 128.
[617] Infirmary patient 3.
[618] Monitor's 8th Report page 90.
[619] Monitor's 8th Report page 162 states that "The completion of F.04.01 Infirmary Care accomplishes items 3, 6 and 8 included as part of part of task #71 in the Implementation Plan. Part of item 10 is accomplished with the new reporting requirements for infirmary services."
[620] Monitor's documentation request dated 5/10/2025 item 124. The nine facilities were Big Muddy, Centralia, Danville, Dixon, Hill, Lincoln, Robinson, Shawnee, and Western.
[621] Dixon sent an infirmary admission log providing information as listed in F.04.01 Procedure VIII. A. on 190 admissions from 1/1/2025 through 6/30/2025.
[622] Documentation from infirmary level care provided at Lincoln, NRC, Pinckneyville, Robinson, Taylorville and Western.
[623] Infirmary patients 2 & 3

only two included most of the information required by F.04.01.[624] There were three telephone orders, none of which were countersigned as required by Procedure V. B. [625]

The procedure also calls for the provider to write the first note within 24 hours of admission (48 hours on weekends) and that it include a patient history and findings from a physical examination and documents the reason for infirmary-level care, the expected outcome and length of stay in the infirmary; it addresses all of the patient's medical conditions in the assessment and plan and outlines the treatment and monitoring plan specific for the infirmary admission.[626] Only four provider notes were written within this timeframe[627], an additional four initial provider notes were written but were not timely.[628] None of the initial provider notes addressed all of the topics required by the procedure. No admission note was written by a provider for seven of the infirmary admissions.

Six admissions were of patients previously in the infirmary who returned there after discharge from hospital level care without ever being discharged from infirmary level care.[629] This practice conflicts with F.04.01 Procedure V. 1. A which states that "When infirmary patients are hospitalized and return to infirmary care after discharge from the hospital they must be re-admitted as described in this procedure."

A nursing assessment and nursing care plan are to be documented with each infirmary admission.[630] All but four infirmary admissions included an assessment by a nurse.[631] All but one of the admission notes[632], were incomplete most often because they did not include evaluation of the patient's risk for fall, or skin breakdown, provisions to maintain personal hygiene or an evaluation of the patient's understanding or ability to follow directions. A nursing care plan was absent or limited only to a repetition of ordered medical treatment in all of the nursing admission notes. Care plans that were present were incomplete, most often there were no short or long-term outcomes for nursing care in the infirmary stated. Instructions for skin care, dressing changes, colostomy care, assistance with

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[624] Infirmary patients 4 & 5. Procedure V. A. 1. B. "Admission requires a written order documented on a prescription order form. The admitting clinician is responsible for writing orders for the patient's care, including: 1. The reason and purpose for admission, 2. Medications, treatment, and diet, 3. Need for assistance and activity level, 4. Monitoring frequency including vital signs, 5. Diagnostic tests, and other therapeutic plans, 6. Parameters for notification of the provider."

[625] Infirmary patient 5.

[626] Procedure V. I.

[627] Infirmary patients 5 & 6.

[628] The initial note was written on the third day (Infirmary patients 3 & 5), the 6th day (Infirmary patient 1) and the 12th day (Infirmary patient 1) after admission to the infirmary. One admission was excluded from this evaluation because the patient was hospitalized within 24 hours of admission to the infirmary.

[629] Infirmary patients 1, 2, 3, & 5.

[630] Procedure V. D. and E. "The nursing assessment shall include the reason for admission to the infirmary and other relevant history, documentation of the evaluation of risk for skin breakdown, falls, inadequate nutrition, inadequate personal hygiene, and inability to understand and follow directions." The nursing care plan is to include: The expected short- and long-term outcomes of care provided in the infirmary, implementation of the provider's admitting orders, and directions for patient safety, observation of the patient's clinical condition, delivery of nursing care and provision of assistance with activities of daily living.

[631] Infirmary patients 2, 3 & 5.

[632] Infirmary patient 6.

ambulation or activities of daily living were also absent. At times the care plan was inconsistent with the patient's condition. For example, one patient had orders for fluid restriction and yet the nursing plan of care was to increase fluids.[633] Another patient had orders for no walking and yet the nursing care plan called for assistance with ambulation.[634] In four infirmary admissions the nursing care plan should have included obtaining additional orders or order clarification and did not.[635]

Policy F.04.01 Infirmary Level Care requires daily nursing documentation of care delivered, patient requests, and delegation of assignments to other caregiving personnel. There was great variation in the frequency and content of nursing documentation of infirmary care. A daily note was missing from some charts reviewed.[636] However there was no documentation by nurses about care delegated to other caregivers and other expected documentation is intermittent or incomplete. For example, one patient is documented by the provider as having stage 2 ulcerations at the coccyx, yet there is no similar assessment by nurses of the patient's wound or dressing changes that were completed. This same patient was on fluid intake and output monitoring, but this information is not documented consistently in the nurses' daily notes.[637]

The procedure also instructs nurses to notify the provider when the patient experiences new symptoms, their condition worsens, or their vital signs are abnormal. This was not done in several instances of infirmary care that were reviewed. On three occasions nurses used nursing protocols to treat patient complaints (scratchy throat, hemorrhoids, and headache).[638] The Monitor has previously recommended that nursing protocols not be used with patients receiving infirmary care and that all care of these patients be directed by the responsible provider.[639] According to procedure these were new symptoms or a worsening condition, and the provider should have been contacted. Two additional patients had symptoms of a worsening condition, and the provider was not notified; these included a critical lab value and a patient who was starting to have skin breakdown on his hips.[640]

In only one of the infirmary admissions was a discharge order written[641] and in only three cases a discharge note was written by the provider.[642] These discharge notes are very brief and do not address the topics that F.04.01 indicates are to be included in the provider's discharge summary.[643] The policy and procedure

[633] Infirmary patient 5.
[634] Infirmary patient 5.
[635] Infirmary patients 1, 3, 5, 6.
[636] Infirmary patients 1, 3, 4.
[637] Infirmary patient 5.
[638] Infirmary patients 1, 5, 6.
[639] See a thorough discussion in the Health Care Monitor 3rd Report Lippert v. Jeffreys, February 15, 2021, pages 10, 72-75 & 77. See also continuous reference to this problem in Health Care Monitor 4th Report Lippert v. Jeffreys, September 16, 2021, pages 15, 106-109; Health Care Monitor 5th Report Lippert v Jeffreys (July 27, 2022) pages 12, 87-89, 91; Health Care Monitor 6th Report Lippert v. Jeffreys, March 13, 2023, page 91-93, Health Care Monitor 7th Report Lippert v. Jeffreys, December 27, 2023, pages 106-107; Health Care Monitor 8th Report November 13, 2024, pages 148 - 149.
[640] Infirmary patients 2, 3.
[641] Infirmary patient 6
[642] Infirmary patients 4, 5, 6.
[643] F.04.01 Infirmary Level Care, Procedure VII C. and F. states that the provider shall write a discharge order on a prescription order form. The discharge summary shall include reason for admission, all medical conditions, the course of infirmary care, changes to the therapeutic plan since admission to the infirmary, pertinent diagnostic studies, current medications, future appointments, diagnostic studies, and treatments, supplies, assistive devices, and DME including items that are to be in the possession of the patient upon discharge, assistance with one or more activities of daily living, and disposition.

also requires a discharge note to be written by a nurse and lists the topics to be covered in the nurses' note. Only one patient had a discharge note written by a nurse, but it did not cover the topics listed in F.04.01.[644]

There are no performance and outcome measures for infirmary level care. There is an internal/external audit based upon the Administrative Directive (AD) 04.03.120 Offender Infirmary Services which focuses mainly on timeliness of documentation but does not evaluate the quality or appropriateness of patient care. Of the nine or so facilities which submitted minutes of their CQI meetings between January and June 2025, there were four facilities which reported noncompliance with the AD.[645] One of these facilities also did a CQI study to see if there was documentation of provider rounds on acute patients three times a week as called for in the AD. The results were that only one of four patients had the required documentation. The corrective action suggested was to change the patients' status to chronic.[646] This suggests that patient status does not reflect true patient need but can be arbitrarily assigned to lower the degree of medical attention required. One additional facility reported results of a CQI study that evaluated whether there was documentation of vital signs and a note written by a nurse and a provider each week.[647] This is the documentation standard required for patients assigned chronic status per the AD. No other documentation frequency was evaluated suggesting that all patients in the infirmary are to be documented on once a week, regardless of the patient's medical needs.

The practices of health care staff in delivery of infirmary care are unchanged from that reported previously by the Monitor. The quality and responsiveness of clinical care continues to be unsafe, inappropriate and nonresponsive to patient need.

Appropriate staffing in the infirmaries

A. Providers

The Monitor requested a list of providers responsible for infirmary rounds during the month of May 2025. The vendor did not provide the requested documentation until the due date of 8/15/2025. IDOC informed the Monitor that this information would be provided once it had been reviewed to determine its responsiveness and accuracy. However, IDOC has provided the Monitor with no additional information.[648] The Monitor's 8th Report found that the number of physician positions had decreased since the beginning of the Consent Decree and that many positions were filled with temporary or coverage physicians or were vacant.[649] No analysis has been completed to determine the FTE required to deliver infirmary care consistent with IDOC policies or the Consent Decree.

From January through June 2025 only a third of IDOC facilities have submitted minutes of monthly quality improvement meetings but of those that do, the absence of the facility medical director was noted by seven of the reporting facilities. The lack of physician availability is also documented in the audits of facilities for compliance with the documentation requirements of the AD on infirmary care and the Monitor's chart review findings regarding implementation of the infirmary policy and procedure.

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[644] Infirmary patient 2.
[645] These facilities were Danville (March 2025 minutes), East Moline (April 2025 minutes), Lawrence (May 2025 minutes), and Sheridan (April 2025 minutes).
[646] Sheridan (May 2025 CQI minutes).
[647] JITC (June 2025 CQI minutes).
[648] As of 11/10/2025 the Monitor has received no further information from IDOC relevant to this request.
[649] Monitors 8th Report, dated 11/13/2024, pgs. 166 -167.

Patient records as well as the morbidity and mortality reviews provide evidence of insufficient physician staffing in the care of patients placed in the infirmary. As an example, one was an 87-year-old man who had been in the infirmary since at least 2022.[650] The problem list notes that he was enrolled in the diabetic chronic clinic. Additional problems identified by the M& M Committee that were not included on the patient's problem list, included dementia, dyslipidemia, hypotension, cardiomyopathy, osteopenia, history of CVA, PEG tube, C6 fracture of the spine, CHF, dysphagia, DKA, vision impairment corrected with glasses, and sacral decubitus.

On 10/8/23 the patient was sent to the hospital with abnormal vital signs, including an oxygen saturation of 70%.[651] He was discharged and returned to the infirmary on 10/21/23. The discharge summary notes that the patient had been in diabetic ketoacidosis[652] and had a stroke. He also had bacterial pneumonia and cardiomyopathy.[653] He was deconditioned and had poor swallow reflexes, so was at risk of aspiration and a feeding tube was placed. Continued care recommendations included follow up with cardiology, cardiac monitoring, and IV antibiotics.

The first provider note was written by a nurse practitioner four days after his return to the facility. This provider did not appreciate how changed the patient's condition was after this hospitalization and did not order the specialty consult and failed to order all of the medications that had been recommended for continued care.[654] Care of the feeding tube was not specified; no arrangements were made to assess the patient for feeding intolerance and nutritional adequacy and there were no instructions given for oral care.

From 10/25/23 until 5/24/24 he was seen solely by a nurse practitioner weekly, with the one exception of a 21-day period in April-May 2024 when he was not seen at all. While on infirmary care he was fed via a feeding tube but never had a nutritional evaluation despite a documented weight loss of 48 pounds over the next seven months. He also had nine documented falls and developed two areas of skin breakdown. At no time during this period was the patient's condition and plan of care reviewed or commented on by a physician.

The patient fell on 5/26/25 and was hospitalized for a fracture of his spine at C6 or the base of the neck. He was returned to infirmary care the next day with a neck collar. There also was a recommendation for follow up in two weeks with the physician who treated him. There is no admission note or re-examination of the patient upon his return to the infirmary. Although the recommended follow up consult is noted by the nurse practitioner it was not ordered. The patient was scheduled to see a physician on 6/9/24 because of his declining condition but there is no documentation that this took place. The patient's skin was beginning to break down on his hips and coccyx, and he demonstrated obvious signs of discomfort when repositioned.

The first assessment of this patient by a physician was not documented until 6/30/2024 or a month after the patient returned to infirmary care. The physician ordered hospice care but did not specify what this

[650] Infirmary patient 3.
[651] His blood pressure was recorded as 80/60 and his pulse was 102.
[652] A1c was 15.2.
[653] Ejection fraction of 38%.
[654] Telephone orders were obtained to include all medications prior to hospitalization and did not include orders for clopidogrel, lisinopril, lansoprazole and 82 mg aspirin.

was meant to include. By this time the patient was described as non-verbal with stiff limbs and global decline. His history of dementia, stroke, diabetes, and hyperlipidemia was noted and a "do not resuscitate" order was in place. The patient died 15 days later. Physician involvement in this man's care was inadequate and did not take place timely.

Other patient charts were reviewed that documented a similar lack of physician involvement and oversight of the care received by patients in the infirmary leading the Monitor to conclude that provider staffing remains inadequate and patients are at risk of harm.[655]

B. Nursing Staff

F.04.01 includes the requirements for nurse staffing in the infirmary as specified in the Consent Decree. This policy and procedure also require that a daily log be kept to document staffing in the infirmary (Procedure VIII. C) that records the day and date, hours of covered or assigned, the name and credential of each staff member assigned, and their role or responsibility. The Monitor requested these logs from ten facilities for the week of May 4-10, 2025.[656] One facility did not respond and another sent incomplete information.[657] None of the remaining facilities provided an assignment log or roster that is consistent with that described in policy and procedure F.04.01. It is not possible to determine if the staffing requirements as stated in the Consent Decree are being met from the data IDOC provided.

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.[658] That trend continues. Two of the facilities that provided assignment rosters had the majority of the evening shift covered by overtime[659] and another[660] used agency staff to cover the majority of day shift and half of the evening shift. Two facilities[661] had two days when the infirmary had no one assigned to the infirmary for some or all of the night shift, and a third facility reported the absence of an on-duty registered nurse three days in April 2025.[662] Occasional use of agency personnel or overtime is an acceptable practice however repeated

[655] See for example infirmary patient 1 who was discharged from the hospital 4/27/2023 with a note in the discharge summary that the patient had a constellation of symptoms that were highly suspicious for ALS, a degenerative neurological condition. Over the course of the next 11 months he is only evaluated by a physician eight times while his condition progressively deteriorates and a definitive diagnosis of ALS is made in January 2024. The M & M committee concluded that there was "Little to no physician oversight over mid-level for the very complex care needed for this patient. No documented discussions regarding end of life care, DNR status, etc…". See also infirmary patient 5 who was returned to the infirmary 6/22/24 after hospitalization for acute on chronic heart failure, acute on chronic kidney disease, and ascites. He had a number of other comorbid conditions. Although admitted on acute status to the infirmary he was managed remotely by a regional physician until seen 14 days later by a covering physician. The regularly assigned physician returned from vacation and took over the patient's care three days later which also was the day the patient expired.

[656] Monitor's documentation request dated 5/10/25, item 122. No information was provided by Stateville since the facility had closed.

[657] Shawnee did not respond and Centralia sent data for only two of three shifts.

[658] Health Care Monitor 2nd Report Lippert v. Jeffreys, August 6, 2020, page 103, Health Care Monitor 3rd 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 5th Report, Lippert v Jeffreys, June 22, 2022, page 114; Health Care Monitor 6th Report Lippert v. Jeffreys, March 13, 2023, page 109; Health Care Monitor 7th Report Lippert v. Jeffreys, December 27, 2023, page 123, Health Care Monitor 8th Report Lippert v. Jeffrys, November 13, 20224, page 169.

[659] Lincoln (8 bed infirmary) and Western (15 bed infirmary).

[660] Hill (16 bed infirmary.)

[661] Dixon (28 bed infirmary) and Danville (15 bed infirmary).

[662] Adverse event reported by IRCC on 5/15/2025.

reliance on these staff resources is associated with staff burnout and increased risk for errors and omissions in patient care. Leaving an infirmary uncovered puts patients at risk of harm.

The following are areas of nursing care provided in the infirmary that were problematic among mortality records reviewed:

- Failure to address risk for skin breakdown, assess wounds and document dressing changes.[663]
- Failure to address fall risk adequately.[664]
- Abnormal vital signs not acted upon or inappropriate use of nursing protocols.[665]
- Failure to document periodic assessment of patient condition.[666]
- Treatment delayed or provided inconsistent with orders.[667]
- Basic daily monitoring and care not documented (I&O, repositioning, toileting etc.).[668]

Documentation of the nursing admission assessment is not consistent with F.04.01 which requires evaluation of risk for skin breakdown, falls, inadequate nutrition or hygiene, or impaired cognition. The plans for nursing care consist mainly of the implementation of medical orders and do not specify intervals for reassessment, detail arrangements to carry out activities of daily living, anticipation of and plans to manage symptoms, or interventions to prevent deterioration of the patient's condition. For example, a 52-year-old man was admitted to the infirmary after a brief hospitalization for chest pain and shortness of breath. He had a history of significant cardiac disease and had been referred to pulmonology for work up of lung disease. He also was diabetic and had hypertension. He was cared for in the infirmary for 16 months before his death in August 2024. There was no plan of care to manage his symptom progression over time which included air hunger, fatigue, occasional dizziness, and distress.[669]

The staffing requirements in the Consent Decree are minimal requirements and IDOC provides no data to show that these requirements are met. The nursing positions allocated at IDOC facilities are not based upon any staffing model, or analysis that considers the physical layout, patient acuity, or available support services. The Monitor has suggested that IDOC consider as a starting point using the Illinois regulations for skilled nursing and long-term care facilities to staff at least a portion of the infirmary beds that are occupied by patients for a month or more.[670]

C. Physical Therapy

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[663] Infirmary patients 1, 3, 5, 7.
[664] Infirmary patients 3, 5, 6.
[665] Infirmary patients 1, 3, 6.
[666] Infirmary patients 1, 2, 3, 5.
[667] Infirmary patients 3, 5.
[668] Infirmary patients 1, 3, 5.
[669] Infirmary patient 2. These are all symptoms that can be addressed by nursing and would include prioritization of ADLs, pacing of activity to avoid fatigue, positioning, cooling, restorative rest and relaxation techniques, emotional and psychosocial support.
[670] Administrative Code, Title 77, Chapter 1, Subchapter d, Section 300. Four facilities provided information about the patient census in the infirmary on or around June 1, 2025. Forty-seven percent of the beds were occupied by persons for a month or more, indicating need for long term nursing care. The Monitor's 8th report (page 163) included a similar finding that 40% of all infirmary beds at 21 reporting facilities were patients who had been in the infirmary for a month or longer. See also page 114 of the Monitor's 6th report for the recommendation to use this staffing calculation for staffing infirmaries. This staffing formula could be applied now as a pilot at one or more prison infirmaries before any workload analysis is completed.

One physical therapist and one physical therapy aide position were lost when the Stateville facility was closed. Access to physical therapy services remain problematic based upon the Monitor's review of patient records for this report. There were three patients who should have had a referral for evaluation by a physical therapist and possible follow up.[671] Two of these patients were housed in infirmaries at facilities which had no physical therapy staff (Taylorville and Western). Another patient with peripheral vascular disease and frequent falls was referred for PT but was transferred to a facility without these services and so he received no PT even though it had been ordered.[672]

There are 16 correctional facilities with a total population of 14,294 and 170 infirmary beds that have no on-site physical therapy services. The Monitor recommends, as in the past, that IDOC begin by assessing the actual need for access to physical therapy at these facilities. Facilities with populations of more than 900 should be the first focus of attention.[673] For example, East Moline documented in monthly quality meetings an average of 8 referrals a month for PT evaluation and 42 off-site PT appointments a month.[674] This is an example of a facility where it may be more cost effective to fund PT positions, considering the staff and resources necessary for offsite transport.

Facilities with Infirmaries Without Physical Therapy Services		
	Population [675] 7/1/2025	Infirmary Census
Centralia*	1,263	18
Danville*	1,693	15
Decatur	306	5
East Moline	490	16
IL River*	1,379	15
Jacksonville	553	8
Kewanee	186	4
Lincoln	792	8
Pontiac	494	12
Robinson*	1,072	8
Shawnee*	1,263	15
Sheridan*	1,207	10
Southwestern	369	5
Taylorville*	1,092	7
Vandalia	655	9
Western*	1,480	15
Total	14,294	170
* Facilities with population greater than 900.		

[671] Infirmary patients 1, 2, 3.
[672] Infirmary patient 7.
[673] Health Care Monitor 5th Report Lippert v Jeffreys, July 22, 2022 pages 114-115; Health Care Monitor 7th Report Lippert v. Jeffreys, December 27, 2023, page 124, Health Care Monitor 8th Report Lippert v. Jeffreys, November 13, 2024, page 172.
[674] East Moline Quality Improvement Committee Meeting Minutes from February – April 2025.
[675] Population data obtained at IDOC-Quarterly-Report-July-2025.pdf.

III.I.4 Access to Security Staff in the Infirmary

The Defendants policy and procedure F.04.01 Infirmary Level Care requires that the availability of security staff assigned to the infirmary be documented on a log.[676] These logs were requested for review for this report.[677] Unfortunately none of the material provided in response to this request documented security staff assigned to the infirmary. Therefore, IDOC is unable to provide evidence that each infirmary has necessary access to security staff at all times as specified in III.I.4 of the Consent Decree.

Each of ten facilities provided the requested descriptions of correctional officer posts assigned to the infirmary and HCU more generally and these are listed on the table below.[678] Seven of the facilities have posts that are specific to the duties of the officer assigned to the infirmary. Three facilities (Lincoln, Robinson, and Shawnee) have post assignments for the Health Care Unit generally which includes responsibility for the infirmary. Except for Lincoln, each of the requested facilities provided post assignments that indicate security coverage can be provided on all shifts.

[676] Procedure VIII. Monitoring and reporting on infirmary care, section C " The same or similar log shall be used to document the availability of security staff assigned to the infirmary."
[677] Monitor's documentation request, dated 5/10/2025, item # 122.
[678] Only those posts which include infirmary responsibilities are listed. Some facilities provided copies of other correctional officer posts associated with other aspects of the Health Care Unit operations such as the clinic, escort, or telehealth. These are not listed in the table.

Correctional Officer Posts with Infirmary Operation Responsibilities			
Facility	**Post name**	**Post #**	**Shift**
Big Muddy	Infirmary Officer	PD-50	All
Centralia	Infirmary Officer	PD-450	All
Danville	Infirmary Officer	PD-43	All
Dixon	Health Care Unit 2nd floor Rover	305	All
	Health Care Unit 2nd floor Rover	310	3p-11p
	Health Care Unit 2nd floor Rover	325	7a-3p
	Health Care Unit 3rd floor Rover	316	7a-3p
	Sergeant 2nd floor	817	7a-3p, 3p-11p
Hill	Infirmary Officer	PD-715	All
Lincoln	Health Care Unit Officer	155	11p-7a
Robinson	Health Care Unit Officer	409A	11p-7a
	Health Care Unit Sergeant	409	7a-3p, 3p-11p
Shawnee	HCU Sergeant	65	All
	Health Care	295	All
NRC	NRC Infirmary C/0	1375	All
		1376	All
Western	Infirmary Officer	PD-33	All

Although Western indicates that an officer post is assigned to the infirmary every shift it appears that staff are not always available. One of the mortality charts reviewed for this report from Western documented that security staff were not available in the infirmary on three occasions and as a result nursing care was delayed.[679] The Monitor recommends IDOC facilities implement OHS policy and procedure F.04.01 and document the availability of security staff on a log as a means of demonstrating compliance with III.I.4 of the Decree.

III.I.5 Bedding and Linens

The Consent Decree requires that all infirmaries and HCUs shall have sufficient and properly sanitized

[679] Mortality review patient #10; see progress note documentation dated 3/1/2024 and 7/3/2024.

bedding and linens. OHS Policy and Procedure F.04.01 Infirmary Level Care[680] states "The inventory and handling of linens and bedding used in the infirmary shall be in conformance with Environmental Services." Therefore, the Monitor inquired what guidance Environmental Services had provided as referenced in the policy and procedure.[681] The response was that Administrative Directives 04.03.116 Bloodborne Pathogens and 05.02.140 Safety and Sanitation Inspections were the guidance referred to in F.04.01. The Monitor has previously commented that 04.03.116 is not sufficient in that it does not address inventory or storage of linens used in the health care setting. 05.02.140 Safety and Sanitation Inspections also does not address these topics and is therefore insufficient.

The Monitor has recommended since the 7th report that OHS develop a policy and procedure on sanitizing and handling of bedding and linens used in the infirmary.[682] This feedback was also provided in the Monitor's comments on the draft of the infirmary policy and procedure and during the annual review in 2025.[683] OHS needs to develop a procedure that addresses the infection control standards to control transmissible disease to include inventory control, the conditions and practices for transport and storage of clean linen. Present guidance only addresses handling and laundering of dirty linen. References from the Centers for Disease Control have been provided before and are provided again here.[684] The Infection Control Coordinator should also have access to the APIC Text and the section on Healthcare Textile Services to use as a reference in this matter.[685]

Currently Defendants do not have policy, procedure or practice to ensure that infirmaries and HCUs have sufficient and properly sanitized bedding and linens and are therefore not compliant with III.I.5.

Summary

IDOC does not provide sufficient access to infirmary care, considered secondary level care. No changes have been made to the staffing, physical conditions, and scope of services for infirmary care. IDOC is unable to provide evidence that it meets the staffing requirements of III.I.1 – 4 and has not established practices or provided evidence that sufficient and properly sanitized bedding and linens are available in the infirmaries.

RECOMMENDATIONS:

1. Initiate the project to develop recommendations for housing and programming for the elderly, frail and infirm populations that are the focus of tasks #64-67 and 69 in the Implementation Plan and the accompanying narrative.
2. In planning the rebuilding of Logan and Stateville, leadership needs to advocate for better housing and facilities to accommodate prisoners with disabilities to free up infirmary space. OHS needs to provide evidence that it is managing the utilization of infirmary beds statewide.

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[680] Issued 2/1/2024.
[681] Monitor's documentation request # 127.
[682] Health Care Monitor 7th Report Lippert v. Jeffreys, December 27, 2023, pages 124-125; Health Care Monitor 8th Report Lippert v. Jeffreys, November 8, 2024, page 175 and recommendation #12, page 178.
[683] Monitor's comments on F.04.01 Infirmary Level Care sent to OHS 9/12/2023 and resent 7/15/2025.
[684] G. Laundry and Bedding | Infection Control | CDC and Appendix D - Linen and laundry management | HAIs | CDC.
[685] 112. Healthcare Textile Services | Infection Prevention for Support Services and the Care Environment | Table of Contents | APIC

3. Establish an expectation for when implementation of F.04.01 Infirmary Care is to be accomplished.
4. Complete the remainder of Task #71, items 1, 2, 4-7 and 10. This includes quantifying the number and type of positions that are necessary to comply with F.04.01.
5. Identify alternative means to obtain stable physician leadership when the vendor is unable to fill allocated positions.
6. Establish the means and methods to hold the vendor accountable for filling other clinical and support positions.
7. 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.
8. Develop guidelines for referral to physical therapy including the evaluation of patients with long infirmary stays to prevent falls and deconditioning.
9. Clarify the infirmary care provided at the renovated Joliet Inpatient Treatment Center.
10. 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.
11. Ensure that falls, decubiti, and accidental ingestion of non-food products are reported as adverse events.
12. Develop procedures to establish inventory control of linen for the infirmary, direct the conditions and practices for transport and storage of clean linen, and the handling and laundering of dirty linen that are in accordance with contemporary standards for control of transmissible diseases.
13. Expand use of 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.). Ensure that there is accountability for use of these resources that include documentation of attendance and acquisition of knowledge and skill.

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 provider'' 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: Partial Compliance

FINDINGS:

The Monitor's Comments on the Department's Evaluation of Performance in the V.G. Report

In its last V.G. Report IDOC provided statements related to progress in their compliance with each of the Consent Decree provisions related to specialty care.

II.A.: IDOC stated they have implemented sufficient measures to provide adequate care without providing any data or information,[686]

II.B.1.: IDOC defines secondary and tertiary care and then states that they provide access to this care without providing any data or information about their progress or compliance.[687]

II.B.6.e. This provision requires that *informed care* is to be provided after a patient sees an offsite service provider. To satisfy this provision, IDOC states that all patients returning for offsite care are immediately seen by a nurse with a provider follow up in five days and in 48 hours if it was an emergency visit. They state that all services are added to the patient medical record and that they maintain a log of all offsite services. These statements alone do not verify that this is accomplished. The documentation provided for this provision are policies D.04.01 Offsite Clinical Care and E.03.01 Intra-System (Transfers Within IDOC), Receiving, Transfer and Continuity of Care Screening and offsite tracking log. Policy D.04.01 describes the follow up in procedure XIV that is consistent with informed care but policy E.03.01 does not.[688] IDOC does not provide any evidence that these policies have been implemented or that the steps that they state are done are, in fact, done.[689]

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[686] Defendants' V.G. Report, Lippert, dated 12/2024, page 2
[687] Defendants' V.G. Report, Lippert, dated 12/2024, page 2.
[688] Policy E.03.01 states, "A physician or mid-level provider will review the completed screening, in addition to any pertinent health record information within 48 hours when the patient is received Sunday through Thursday and 72 hours when received Friday." This is not consistent with informed care. Policy D.04.01 states, "At the follow-up appointment, the provider shall discuss the specialty provider's findings and recommendations with the patient, as clinically appropriate, and document the discussion in the health record. Changes to the therapeutic plan are discussed with the patient and the patient's understanding and agreement to plan of care sought. Any refusal is documented. The provider shall order any new consultations, referral, tests, medications, or other changes to the therapeutic plan recommended by the consultant. If the provider does not act upon or changes a specialist's recommendation the rationale shall be documented in the notes of the follow up encounter". The policy statement in D.04.01 is consistent with informed care. The policy statement in E.03.01 is not.
[689] Defendants' V.G. Report, Lippert, dated 12/2024, page 35.

The offsite logs provided have a space to record whether a follow up visit with a provider occurred but this information is optional and not always filled out.[690] The offsite logs do not verify hospitalization or emergency room follow up care and IDOC provided no other data for these events. When the offsite log records that a five-day follow up occurs, there is no confirmation provided that this visit includes informed care as required by policy.

II.B.6.g. This provision requires IDOC to make changes so that inmates have *timely* access to specialty care. The V.G. Report makes a statement from policy D.04.01 that patients are required to be scheduled for specialty health services in a timely manner.[691] They provide no evidence that the policy has been implemented or that patients are scheduled timely. Policies A.01.01 Access to Care and D.06.01 On-Site Diagnostic Services are also offered as evidence but IDOC does not explain how these policies alone verify this provision. Additional documentation provided is the offsite tracking log[692] that had been in place since prior to the Consent Decree; it is unclear what change has occurred to this document that demonstrates specialty care is timely.

III.E.4. This provision involves ensuring medical records staff obtain consultant reports, track the receipt of these reports, and ensure that the report is filed in the medical record. IDOC, without providing any information or data verifying that this is accomplished states,

> This is complete. Reports regarding offsite services are filed in the appropriate patient's medical records. While substantially complete now, the implementation of EHR will prevent any inadvertent noncompliance.[693]

The Monitor has verified in multiple record reviews discussed in multiple reports that consultation reports are often not present. Merely stating that something is so, does not verify that it is so.

III.H.1 This provision requires a log be present to document when an appointment is made; the date the appointment was scheduled; the date the appointment occurred; and when the patient returned to the facility.

In the V.G. Report, IDOC verifies its progress with this provision by stating that all facilities maintain a log of all offsite services.[694] They do not verify that these logs are accurate or filled out. IDOC does not give evidence that the HCUA maintains the log. This log is discussed below.

III.H.2. This provision requires that providers review reports of offsite care within three days and that follow up with the patient occurs within five days. IDOC again refers to policies D.04.01, E.03.01 and the offsite tracking log[695]. Policy D.04.01 requires that follow up is to occur within five days and gives direction in procedure XIV for what is to occur at the visit. IDOC provides no data or information to verify that these visits are done or that they are accomplished according to policy. Documenting that the

[690] Documentation provided by IDOC in response to the Monitor's documentation request 133.
[691] Defendants' V.G. Report, Lippert, dated 12/2024, page 18. Policy D.04.01, policy statement III states, "Patients shall be scheduled in a timely manner for specialty health services evaluation and or treatment as determined by the referring provider".
[692] Documentation provided by IDOC in response to the Monitor's documentation request 133.
[693] Defendants' V.G. Report, Lippert, dated 12/2024, page 33.
[694] Defendants' V.G. Report, Lippert, dated 12/2024, page 35.
[695] Ibid.

report was received and that the five-day follow up occurred is only optionally recorded on the tracking log. IDOC provides no data or information to verify the quality of the visit or whether it was informed care. SIU has initiated a performance measure to track whether emergency room and specialty care times for follow up were met but not whether the quality of the care was appropriate or consistent with II.B.6.e.

III.H.3. This provision requires that IDOC to document why records of offsite encounters cannot be obtained when they are unable to obtain these. IDOC states that documentation for this is policy D.04.01 which states:

> All documentation from off-site visits shall be added to the patient's health record. These medical records shall be requested in a timely manner from the treating facility. When not obtained the health record shall contain documentation of any attempts by health staff to obtain these results.

IDOC verifies this provision by merely stating that they ensure documentation of all offsite services is added to the record without any data or information to prove this is done.[696] There is no evidence that the policy has been implemented.

III.H.4 This provision requires that findings and recommendations of offsite care be documented in the record. IDOC cites policy D.04.01 as documentation that this occurs.[697] As given above, the policy does state this as a requirement, but IDOC provides no evidence that the policy was implemented.

The V.G. Report as documented above does not provide sufficient data or information to verify Defendants' progress towards compliance. Policy is not implemented. The tracking log is not consistently completed and is not verified for accuracy. Quality of offsite care and follow up is not evaluated.

Policy

The Monitor submitted suggested revisions to Policy D.04.01 Offsite Clinical Care during the annual review on 8/25/25. One suggestion is that the policy revision include a huddle between providers, the scheduling clerk and others to ensure sufficient communication between providers and the scheduling clerk occurs in order to make scheduling more effective. This is because there is such poor communication between these staff that significant delays in scheduling and other errors occur. The Monitor also recommends that a standardized format be used for the tracking log. Currently, there is no standardized process for tracking specialty care and facilities can create their own tracking logs. By setting no standard, errors more easily occur.

The Monitor requested the following from IDOC to evaluate compliance with the provisions from the Consent Decree listed above.

- List of patients seen by UIC, as part of the JITC expanded specialty care program, reason seen, subspecialty seeing the patient, and date.
- Identify the process analyst responsible for any process improvement project(s) on improving access to specialty care. Provide any reports or work product developed to date.
- Any reports or audits of the performance of specialty care as required in policy D.04.01 Offsite Clinical Care policy item X completed by facilities in the Central Region.

[696] Defendants' V.G. Report, Lippert, dated 12/2024, page 36.
[697] Ibid.

- Each facility's specialty care tracking log for those patients referred up to June 2025.[698]
- Any tracking log verifying physician evaluation of the patient with the report within 5 days. [699]

For the list of patients seen by UIC as part of the JITC specialty care program, IDOC sent two files.[700] One file had 474 consultations and the other 657 consultations. Both were dated as provided to the Monitor 7/22/25. One file had consultations from 7/17/24 through 4/29/25 and the other had consultations from 7/17/24 through 9/6/25. The file with dates through September 2025 was used which contained 657 consultations. The file was provided to the Monitor on 8/15/25 but there were three consults listed as taking place after that date, assumed to be data entry errors.[701]

Seven facilities used this UIC service. The number of consults per facility is listed below and includes telehealth visits and in-person visits. For telehealth the consultant is at JITC and the patient at the home facility; in-person visits were completed in person at JITC.

- Dixon 411 visits; all telehealth
- JITC 15 visits; 14 in-person and one telehealth
- JTC 22 visits; 13 in-person and nine telehealth
- NRC 28 visits; six in-person and 22 telehealth
- Pontiac 47 visits; 12 in-person and 35 telehealth
- Sheridan 93 visits; 48 in-person and 45 telehealth
- Stateville 41visits; 2 in-person and 39 telehealth
- Total 657 visits; 95 in-person and 562 telehealth

These numbers are consistent with offsite volumes at these facilities. Dixon has had long backlogs for specialty care for several years and it is not surprising to see the high numbers at Dixon. IDOC has told the Monitor in their monthly call that the UIC specialty care project doesn't necessarily increase the number of patients seen because these patients would be going to UIC anyway. This project does make specialty care more effective and efficient especially by reducing transportation costs for IDOC custody.

In another document request the Monitor asked to identify the process analyst responsible for any process improvement project(s) on improving access to specialty care and any reports. IDOC responded that "The Department has not yet designated a process analyst for a process improvement project focused on improving access to specialty care. The Department will provide relevant documentation to the Monitors once the project is initiated, and materials become available."[702]

Task 52 of the Implementation Plan is an analysis of the process of specialty care. The Implementation Plan tracker, provided to the Monitor recently, documents that the Southern Deputy Medical Director and

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[698] The log is to include: 1) every referral 2) patient name, 3) IDOC #, 4) original date that a provider requested specialty services, 5) the reason for referral, 6) the date the appointment was made, 7) the date the appointment occurred, 8) cancellations and re-appointment dates and reasons, 9) the date a full consultant or testing report was received, 10) the date the provider saw the patient in follow up to discuss the consultation, and 11) whether the patient is on "transfer hold" status.

[699] Monitors 9th Report documentation request dated 5/10/2025 items 130-134.
[700] Documents provided by IDOC in response to the Monitor's documentation request item 130.
[701] 8/27/25; 8/28/25; and 9/6/25. These were in the 2024 section so we presume these were misdated.

the Southern Regional Coordinators are the "owners" of this project. Four tasks are documented as being in the "execution" status and one task is documented as "completed". The completed task was an analysis of primary care physician referral patterns for specialty care and utilization of consultant services. IDOC has not provided this document to the Monitor despite the request for any reports. The Monitor has not been able to follow up on the Implementation Plan tracker because IDOC has now denied the Monitor access to this document.[703]

The Departments' response to the Monitor's request for any reports or audits by the HCUA of the performance of specialty care as required in policy D.04.01.[704] was that because of the newly implemented Quality Manual and Plan facilities had not had the opportunity to do any reports and studies of specialty care.[705]

The Monitor also requested each facility's specialty care tracking log.[706] IDOC produced 41 files for 23 facilities. Ten of these facilities provided multiple files. Six facilities provided no information.[707] The following were the findings from review of the material provided by IDOC:

- Eight files could not be opened due to error message on a protected document[708].
- Eleven files were either calendars or lists of offsites sent out by either week or month. These were non-responsive as they were not a tracking log.[709]
- Eleven files were usable but not all the fields were filled out.
- The remaining 11 files were tracking logs that were not usable for the following reasons:
    - The file had appointments until February of 2025 when referrals until June were requested.[710]
    - The file was unsortable and the dates presented in the file were not chronological.[711]
    - The file contained only four entries and was nonresponsive.[712]
    - The file was a PDF that couldn't be sorted.[713]

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[703] Email from Katie Anderson to the Monitor and Consultants, 1/7/26 stating, "Access was denied because I have addressed the issue of the tracker internally with IDOC and OAG. The purpose of the monthly implementation plan meetings is to address progress on items included within the implementation plan. The tracker was designed for IDOC's internal use, and there are logistical challenges with sharing it in a real time format. We believe the monthly meetings provide the monitor team an opportunity to discuss ongoing progress with the implementation plan. Additionally, as you know, the implementation plan itself is the subject of current litigation. IDOC has agreed to have the monthly implementation plan meetings in good faith to discuss various items listed in the plan. If the monitoring team has questions about a particular item in the implementation plan and its status, those questions can be conveyed to IDOC so they can be addressed at any upcoming meeting." However, IDOC does not permit discussion of certain items at the Implementation Plan meetings so the meetings were discontinued. The Monitor found them unproductive as IDOC did not permit open discussion with the Implementation Plan Project Manager.

[704] Policy item X of D.04.01 states, "The HCUA, or designee, is responsible for the oversight of routine offsite clinical encounters. This includes scheduling, transmission of medical information, transportation, maintaining a tracking log, equipment and staffing support, **auditing performance**, and reporting results at the facility quality improvement council.

[705] IDOC Response to Lippert 9th Report Document Request dated 8/15/2025, item 132.

[706] Monitor's 9th report documentation request dated 5/10/2025, item 133.

[707] Decatur, Lawrence, Logan, NRC, Shawnee, and Taylorville.

[708] Big Muddy River, Centralia, East Moline, Hill, Illinois River, Lincoln, Menard, and Robinson.

[709] Big Muddy, Centralia, Dixon, two files from East Moline, Hill, two files from JTC, and three files from Southwestern.

[710] Danville.

[711] Dixon.

[712] Jacksonville.

[713] Kewanee.

- The file was only from December of 2024 to April 2025 which was nonresponsive.[714]
- The file was a specialty log for a single person with 18 entries.[715]
- The file was a specialty log for a single person with 27 entries.[716]
- The file had 72 consults without entries for referral dates, appointment-set date entries, and date appointment completed.[717]
- The file had multiple entries for April or May appointments which did not have date-of-completed-consult filled in.[718]
- The file was a spreadsheet with 171 entries without titles to the columns so the data was unrecognizable.[719]
- The file ends in January 2025 and is nonresponsive because dates through June were requested.[720]

IDOC has not established a method to assess performance with III.E.4 which requires tracking receipt of consultant reports. In the Departments' response to the document request they indicated that a unified Medical Database had been initiated across facilities to bridge the gap between paper records and an electronic health records system.[721] Nineteen facilities were using the medical database. A copy of the Medical Database showing offsite referrals (specialty care tracking) was provided but upon review it does not appear to resolve the problems with the previous log.

The Monitor has recommended that receipt of a consultant's report be tracked on this log to facilitate evaluating compliance with III.E.4. (receipt of consultant reports). The logs do not have this question. The Monitor strongly recommends using the offsite tracking log to do so. The details of the consultants' opinion and recommendations in a report is needed to inform providers responsible for the patient's follow up at the facility. Comments written on the referral form or HSTS form are not sufficient for this purpose.

However, the tracking log cannot be used to evaluate "informed care" which occurs after patients return from offsite visits required by II.B.6.e of the Consent Decree. Patients must be informed of the results of the specialty care encounter. The patient must also understand how IDOC intends to modify their treatment plan in response to the consultation and agree with the plan. Records must be reviewed to determine if the five-day visit documents completion of procedure XIV. in policy D.04.01 that addresses "informed care". The Department has not established the means and method to demonstrate their performance in relation to II.B.6.e..

To evaluate II.B.6.g (timeliness of care) the Monitor reviews whether the date of referral and the date the appointment is completed is appropriate based on the reason for the consultation. This requires that the referral date be identified, the reason for the consultation is given, and the completed consultation date is provided. The referral date is sometimes not present on the log or is filled out when the scheduling clerk makes the appointment rather than the date the provider refers the patient. The reason for the consult has

[714] Kewanee.
[715] Pontiac.
[716] Sheridan.
[717] Vandalia.
[718] Vienna.
[719] Western.
[720] Pinckneyville.
[721] IDOC Response to Lippert 9th Report Document Request dated 8/15/2025, item 133.

not been indicated on the tracking log.[722] For most consults, these three data elements can be used to assess timeliness. Some specialty referrals require a record review. If IDOC wants to use the tracking log to determine timeliness, the log should be modified accordingly. If not, IDOC will need to determine another method to determine timeliness.

Provision III.H.2 requires a three-day provider review of a consultation report and a five-day provider follow up with the patient for informed care. The question for both the three-day review of the report and the five-day follow up are optionally present on each facility's tracking log and often not filled out. When the question is answered it is filled out with a "Y". This makes it impossible to measure against the five-day requirement because a date is required.

The information provided by IDOC as described below was not standardized or complete and was otherwise nonresponsive to the request.

- One facility utilized a "Y" "N" response.[723]
- The question was present but not always filled out.[724]
- The question was present but not filled out.[725]
- The question was usually filled out.[726]
- Five files could not be opened.[727]
- One file had only four entries in the entire file which is nonresponsive.[728]
- One file only gave dates from March through June which was nonresponsive.[729]
- One file had only 18 entries all for the same person so was not a responsive file.[730]
- One file had only 27 entries all for the same person so was not a responsive file.[731]

Policy D.04.01 Offsite Clinical Care provides insufficient guidance with respect to the specialty care tracking logs (III.H.1.). The policy does not provide guidance on definitions for what information must be included on the log and how staff are to enter the data.

There is no evidence that the HCUA maintains the log as required by the Consent Decree or that the HCUA oversees the log as required by policy D.04.01. IDOC needs to determine how it will track data necessary to provide data and information to help verify provisions II.B.6.e., II.B.6.g., III.E.4.,III.H.1., III.H.2., and III.H.3. Provision III.H.1. requires a log and the Monitor recommends expanding it to provide data to assist in verifying these other provisions. In addition to data from this log, there are quality of care elements that need to be addressed in II.B.6.e. and III.H.2. that require record review to evaluate performance.

[722] It appears to be a data field on the proposed Monitor database for Specialty Care.
[723] Danville.
[724] Dixon, JTC, Murphysboro.
[725] JITC, Pinckneyville, Western.
[726] East Moline.
[727] Hill, Illinois River, Lincoln, Menard, and Robinson.
[728] Jacksonville.
[729] Kewanee.
[730] Pontiac.
[731] Sheridan.

IDOC contracted with Health Management Associates (HMA) to monitor their vendor's performance. HMA provided an overview of their work to IDOC.[732] This included HMA's discussion of furloughs and utilization which is discussed in detail in the vendor monitoring section of this report. The Monitor emphasizes the importance of a thorough process analysis of specialty care in conjunction with any evaluation of utilization review.

Quality and timeliness of specialty care appears unchanged and appears to be worse in facilities without adequate physician coverage. Multiple deficiencies were identified on mortality reviews. Some of them are provided here.

- A patient recently saw a community physician who recommended an ankle X-ray, a right foot X-ray, and an MRI to rule out osteomyelitis; an ultrasound of the left leg to evaluate vascular flow; antibiotics; and referrals to vascular surgery and podiatry. None of these recommendations were picked up at the IDOC receiving facility and the patient was not referred.[733]
- A patient had wheezing. He had been diagnosed in the community with COPD which was unrecognized at the prison and instead asthma was diagnosed. Community standard is to obtain a pulmonary function test but he was not referred for this test.[734]
- A patient had long-standing diabetic foot ulceration and was not sent for an MRI to rule out osteomyelitis.[735]
- A patient has uncontrolled diabetes and seven grams of urinary protein with elevated creatinine (1.64) which qualifies for nephrotic syndrome. This presentation warranted referral to a nephrologist which did not occur. Notably there was a lack of physician coverage at this facility.[736]
- In January of 2023, a patient began having neurologic symptoms (falling and shaking). He was 58 years old. He shortly thereafter needed a walker for mobility and another individual in custody "assistant" to help him with activities of daily living. He also started losing weight. By 2/1/23 the patient had a 39-pound weight loss. He continued to deteriorate neurologically and losing weight. The patent had repeated falls. The patient developed a bowel obstruction and was hospitalized. A discharge recommendation was to send the patient to neurology for electromyogram (EMG) and nerve conduction studies (NCS) to rule out amyotrophic lateral sclerosis (ALS- Lou Gehrig's disease). The patient went to a neurologist a few weeks later who recommended EMG, NCS, and an urgent pulmonary function test. The pulmonary function test, EMG and NCS were never done; instead, spirometry was done but the results never reviewed. The patient died in June of 2024 without appropriate specialty follow up of his ALS.[737]
- Three patient deaths from asthma occurred over the past year. All were preventable. One patient had a diagnosis of asthma but was identified with emphysema as well on autopsy. None of the three had referrals for spirometry or pulmonary function testing which is standard of care for persons with these diagnoses. [738]
- Another patient had severe sickle cell disease complicated by acute chest syndrome, avascular necrosis of the hip, prior pulmonary emboli, asthma, and congestive heart failure. His conditions warranted pulmonary and hematology consultations. These were serious complications for a

[732] Material provided by IDOC in response to the Monitor's document request 73.
[733] Mortality review patient 1.
[734] Mortality review patient 1.
[735] Mortality review patient 1.
[736] Mortality review patient 1.
[737] Mortality review patient 2.
[738] Mortality review patient 3, 4, and 5.

person with sickle cell disease. He arrived at NRC in April of 2024. The patient did not receive adequate pain medication and after an acute sickle crisis, was hospitalized. Upon discharge on 4/22/24, a hematology consultation was recommended. A provider documented ordering a hematology consult but a referral was not located. The patient was not sent to a hematologist when he was transferred to Lincoln in May, 2024. In August the patient had still not seen a hematologist as recommended nor a pulmonologist that was warranted. The patient died on 8/7/24 not having been referred to a hematologist recommended by a hospitalist nor referred to a pulmonologist that was warranted.[739]

The Monitor met with IDOC and the new vendor on 9/9/25 in Chicago. At this meeting the new vendor questioned why utilization review was not done and whether they could resume. The Monitor gave the new vendor a history of utilization deficiencies and deferred to IDOC on whether to resume utilization. The Monitor explained that the lack of physicians and a broken specialty care process, resulting in a patient safety issues were the reasons its discontinuation was originally recommended by the Monitor. If IDOC should re-initiate this process, Parties will need to discuss whether provision III.H.5. should be re-instituted as part of the Consent Decree monitoring.

Summary

- IDOC's last V.G. Report failed to provide sufficient data and information to demonstrate its progress toward compliance.
- IDOC has begun a program to have UIC perform telehealth and in person specialty care at JITC. It is unclear whether this is increasing the number of specialty care visits or not. This program will create efficiencies for custody. Its effect on increasing access to specialty care remains unclear.
- The Monitor continues to recommend changes to IDOC's policy D.04.01 Offsite Clinical Care to include a huddle to improve communication between the scheduling team and providers; to standardize the offsite tracking log; to include definitions to data elements used on the tracking log with instructions on data entry to the log; and that receipt of a consultant's report be a required data element.
- The tracking log is not standardized. It needs definitions for all data elements; ; instruction on how to enter data into the tracking form; and addition of a question about receipt of the consultant's report.
- Review of the tracking form shows deterioration since the last visit. The HCUA still does not appear to be involved in management or oversight over this document.
- The Monitor has not received sufficient information on the process analysis of specialty care to determine what progress has been made.
- Specialty care remains unchanged with poor quality of care.

This section was given a partial compliance when the collegial review process was discontinued. A partial compliance will continue but no improvement has occurred in either the process of managing offsite care or in the quality of specialty care.

RECOMMENDATIONS:

1. Opportunities for Improvement (OFIs) related to specialty care and the Monitor's mortality

[739] Mortality review patient 11.

reviews should be used to analyze and correct deficiencies in specialty care.

2. The workload analysis should include whether the number of budgeted physicians, schedulers, nurses, and correctional officers are sufficient to address clinical needs including coordinating, managing, and transporting patients with specialty care needs.
3. IDOC should complete Implementation Plan task 52, a process analysis of specialty care. This should include a root cause analysis 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.
4. 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; review reports; and update on all pending reports, pending consults that exceed expected time frames; and any other specialty care question impacting clinical care.
5. IDOC should evaluate adequacy of transportation vehicles and the availability of transportation officers to ensure that sufficient officers and vehicles are available to ensure inmates have access to timely specialty care appointments.
6. When specialty care appointments to UIC or any other consultant are delayed, alternate local appointments must be used.
7. Reimbursement rates and payment processes for specialty care should be evaluated to determine these contribute to delays in care.
8. IDOC should consider using a primary care medical home model as a methodology to improve coordination of care.
9. IDOC should expand the utilization of telehealth with UIC or other academic centers to increase access to specialty care.[740]
10. IDOC should also begin to explore initiation of specialty e-consults[741] and advice without the need for appointments.
11. IDOC should evaluate data on delayed specialty care to assess why delays occur. For northern facilities, delays related to use of UIC for free care should be particularly examined.
12. IDOC should configure the electronic record so that data needed to be presented on a log or on referral forms can be captured automatically.

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.*

[740] UIC currently provides telehealth care and consultation for HIV, Hepatitis B and C, and the management of uncontrolled and difficult to control diabetes.

[741] E-consults are emails to a specialist for advice or a brief consultation.

OVERALL COMPLIANCE RATING: Noncompliance

FINDINGS:
Regarding provision II.A., the last IDOC V.G. Report stated that the Department has implemented sufficient measures to provide adequate care. IDOC provided no data or information to support that statement. None of their statements discussed hospital care.

Regarding provision II.B.1, IDOC stated:

> Finally, tertiary care is provided for patients with severe, complex, or life-threatening medical conditions, often requiring external hospitalization and specialized care tertiary care.

Nothing other than this statement is provided in the section on II.B.1. related to hospital care.

Regarding III.G.4., IDOC refers to II.B.6.e. which documents that if offsite services are an emergency they must be followed-up within 48 hours. The Monitor views "offsite documentation" referred to in III.G.4. as consisting of consultant and hospital reports which are to be added to the medical record. The information IDOC provides to support its compliance is policy D.04.01 Offsite Care and the facility hospital and offsite tracking log.[742] The tracking logs vary at each facility in format and the information recorded. Some logs track whether a provider visit took place and some do not. Some facilities track whether a report from the hospital was received and some do not. There are no definitions or instructions as to what information to record or how to record it, and no evidence that the logs are reviewed for completeness and accuracy. With the advent of the electronic record a report of hospitalizations should be possible to produce that includes enough information to serve as evidence of performance consistent with III.G.4 of the Consent Decree and to select charts for audit to evaluate progress toward compliance with II.A. and II B.1. At this time IDOC has produced no evidence that it is compliant with the requirements of the Consent Decree related to hospital care.

<u>Policy</u>

Policy D.04.01 was initially drafted to include hospitalization.[743] The Monitor recommended that one policy address hospital, urgent care, and emergency care. D.04.01 was revised so that it addresses only offsite specialty care. However, hospital care was not incorporated into any of the other policies. During the annual review of the MPPM the Monitor recommended to OHS that a separate policy on hospitalization be developed. [744]

<u>Preventable Hospitalizations and Continuity of Care</u>

Hospital care has two major components important to monitor in quality assurance. One is the identification of potentially preventable hospitalizations that result from poor primary care with corrective action as necessary. The second is to ensure continuity of care after hospitalization and that hospital

[742] Facility hospital logs were requested on 5/10/25 by the Monitor and returned by IDOC on 8/15/25 in response to the Monitor's documentation request 135.
[743] The original draft policy was titled Hospital and Ambulatory Specialty Care,
[744] Monitor's annual review of D.04.01 with comments submitted to IDOC on 8/25/25.

recommendations are considered in establishing the plan of care upon return to the facility and if not, the rationale is documented in the patient record.

HMA reported that almost half of emergency room visits were for exacerbation of chronic disease.[745] They recommended introduction of a metric of percent reduction in preventable hospitalization aligned with Agency for Healthcare Research and Quality (AHRQ) standards on this issue.[746] The Monitor agrees with this recommendation. For this purpose, the Monitor recommends the following diagnoses be tagged as potentially preventable with the number of potentially preventable hospitalizations used as a metric on a dashboard.

- Angina without procedure,
- Heart failure,
- Hypertension,
- Adult asthma,
- Hypoxic respiratory failure,
- Chronic obstructive pulmonary disease,
- Diabetes short-term complication,
- Diabetes long-term complication,
- Uncontrolled diabetes,
- Lower-extremity amputation among patients with diabetes,
- Seizure,
- Sepsis or any diagnosis of significant infection (e.g., endocarditis, fasciitis, etc.),
- Altered mental status,
- Soft tissue infection,
- Uncommon illnesses requiring specialized care (e.g., ulcerative colitis, sickle cell disease, myasthenia gravis, etc.),
- Bacterial pneumonia,
- Dehydration,
- Urinary tract infection, and
- Perforated appendix, bowel, or ulcer..

These conditions are ones that result in hospitalization when primary and chronic care is deficient. For that reason, charts of those patients hospitalized for any of these reasons can be audited for the purpose of quality improvement. As an example, the following paragraphs describe a patient's care and his eventual hospitalization which could have been avoided if he had received appropriate primary care.

A 54-year-old man with asthma was admitted to NRC but failed to receive intake screening.[747] Several days later, he experienced an exacerbation of his asthma which was treated with prednisone. He was started on two inhalers (albuterol and Alvesco).

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[745] Slide number 3 in HMA PowerPoint Monthly Task Meeting 6.25.25 provided in document request 73.
[746] Slide number 37 in HMA PowerPoint Monthly Task Meeting 6.25.25 provided in document request 73. The Prevention Quality Indicators are indicators that capture potentially preventable hospitalization by appropriate outpatient care management. While these indicators are for civilian populations, additional indicators for correctional populations and even IDOC specifically can be developed. As an example, all of the red-flag mortality review findings can be reviewed and from these additional indicators identified. The AHRQ prevention quality indicators can be found at: https://qualityindicators.ahrq.gov/measures/pqi_resources.
[747] Mortality review patient 5.

He was transferred to Vienna about a month later. After arrival to Vienna, nurses saw the patient on two separate occasions for exacerbations of his asthma. For the first exacerbation an on-call physician ordered a one-time dose of steroid medication. For the second exacerbation, though the patient was still wheezing the nurse did not consult a physician. For both episodes the long-term controller medication was not increased. This was not standard of care which calls for step-increases of medication when the patient is uncontrolled.

At the first chronic clinic, the patient gave a history of 40 years of smoking. The provider did not take an adequate symptom history and the PEFRs were 33% of predicted, which is very low. The patient was wheezing. The provider ordered rescue medication by nebulization three times a day for three months. This is not standard of care. Controller medication was not increased, a pulmonary function test or spirometry should have been ordered, and the patient should have been admitted to the infirmary until his asthma was controlled.

Two weeks later the patient's asthma was not in control with increased shortness of breath and cough A provider increased the controller medication but for only ten days. Controller medication is not intended to be used as a temporizing treatment but is intended as long-term medication. This was not standard of care. A subsequent provider visit for trouble breathing only resulted in an increase of the rescue medication to every 4-6 hours. Increasing rescue medication is not standard of care as a step increase. Two months later, a nurse saw the patient for another severe asthma exacerbation with shortness of breath. The nurse gave the patient a nebulization treatment but did not assess the patient after treatment to see if he improved. A provider was contacted and sent the patient back to his housing unit with an "as needed" follow up. An hour later a different nurse saw the patient who was tachycardic (112), breathing fast (24), and had oxygen saturation of 91% which are all red-flag signs. The nurse called a doctor who ordered intravenous steroids with observation. Immediate rescue medication was not provided. This was not standard of care. The patient should have been sent to an emergency room because of the low oxygen saturation.

Within 15 minutes, the patient became unable to breathe and was able to speak only in small sentences without "gasping for air". A nurse practitioner evaluated the patient and ordered steroid medication which was not subsequently documented on the MAR as given. The practitioner also ordered an increase of the steroid inhaler but wrote the prescription inaccurately resulting in less than expected medication to be given.[748] A week later the patient wasn't better and was emergently seen for shortness of breath. The patient had not received previously ordered asthma medication but this wasn't checked. The practitioner ordered steroid medication again but no increase in controller medication which is not standard of care.[749] The provider wrote an order for prednisone that a nurse transcribed differently on the MAR than was ordered. An inaccurate number of KOP pills were given to the patient.

[748] The practitioner ordered Alvesco 320 mcg inhaler one puff twice a day. However, Alvesco does not come in a 320 mcg per puff dose only a 160 mcg per puff dose. So the directions should have been two puffs twice a day instead of one puff twice a day. As a result the patient only received half the expected dose. This error continued for at least two months and possibly longer. There was no evidence that anyone explained to the patient after or before the pharmacy corrected MAR arrived that he was to take two puffs twice a day.

[749] Standard of care in this instance is what is referred to as step care. If the medication does not control asthma symptoms then a step up in controller medication is used until the patient is stabilized.

As a result of all these errors, the patient was not receiving ordered medication and providers were not adhering to step-therapy in controlling the patient's asthma. About six weeks later the patient experienced shortness of breath with oxygen saturation of 86% and could not speak. The patient should have been immediately sent to a hospital. Initially the on-call doctor ordered IV solumedrol and nebulization every six hours. The nurse called the doctor back a half hour later because the oxygen saturation was 85% and the patient had to bend over to breathe. The patient was sent to a hospital. If providers had practiced consistent with the standard of care this hospitalization would most likely not have occurred. This patient died as a result of his asthma.

Continuity of care after hospitalization requires a handoff from the hospital to the prison. This handoff has important process steps. These include:

- Obtaining the hospital discharge summary and hospital record promptly to ensure the receiving facility identifies hospital diagnoses and acts on recommendations when the patient returns.
- Ensuring a nurse reviews the discharge summary and communicates hospital orders to the provider so medication, disability accommodations, activity of living, dietary recommendations and other needs are ordered as appropriate to continue the patient's care.
- The provider performs a history and physical examination within the next working day, considers all hospital diagnoses and existing conditions and designs a plan of care that addresses all conditions.

Continuity of care is placed in jeopardy if a hospital discharge summary is not available. The following three examples demonstrate the importance of the hospital report.

A 58-year-old man developed blood in his urine and was sent to an emergency room. He returned from the hospital with an indwelling catheter. There was no hospital report in the medical record. The nurse at the prison noted that the patient was to return to urology but a time-frame was not documented. The provider did not document review of the hospital record in his follow up note. The purpose of the catheter was not documented. The follow up with urology should have been urgent but did not occur for three months during which time the patient developed urosepsis requiring hospitalization. This second hospitalization was preventable. The emergency room follow up did not address transfer of care appropriately.

The same individual was subsequently sent to a hospital for rectal bleeding.[750] On return there was no hospital report. Apparently, the hospital performed a urine culture and started an antibiotic. Later the hospital called the prison to recommend changing the antibiotic. However, because no record had been obtained from the hospital, the patient hadn't been placed on any antibiotic.

After the call from the hospital the provider ordered a urine culture and ordered the hospital record. Amoxicillin was ordered about a week after the patient returned from the hospital. About a month later the patient, who still had the indwelling catheter in place, developed fever and hypotension and was admitted for urosepsis. When he returned to the facility three days later the hospital report was not obtained for a second time. The lack of reports meant the provider was uninformed and this affected care of the patient.

[750] Mortality review patient 2

A third example discusses the issues with handoff of medication recommendations by the hospital to the prison. This patient was a 63-year-old man with asthma, hypertension, chronic rhinitis, and osteoporosis.[751] He was being treated with a high dose of nonsteroidal medication for his osteoporosis complicated by vertebral fractures in May of 2024.[752] In August, he had an episode of vomiting with hypotension and was sent to the hospital where a gastric ulcer, cirrhosis, and esophageal varices, a complication of cirrhosis, COPD, and pneumonia were diagnosed. Naproxen has a black box[753] warning for potential serious gastrointestinal bleeding, ulceration, and perforation. This hospitalization was therefore likely a result of a drug reaction to Naprosyn. The discharge summary documented possible liver cirrhosis (identified on imaging only), a non-bleeding ulcer, esophageal varices, and esophagitis. New medications included an oral antibiotic for the pneumonia, a medication likely for the esophageal varices (beta-blocker) and omeprazole for his ulcer. The after-care instructions specifically stated to avoid all non-steroidal medication including naproxen to avoid further bleeding.

The first physician visit noted that the patient was on the infirmary for 23-hour observation post hospitalization. The doctor noted the diagnoses of cirrhosis, esophageal varices, non-bleeding gastric ulcer and pneumonia. The doctor continued the antibiotic, started the beta blocker, and referred to gastroenterology for a follow up EGD. The doctor updated the problem list but did not reconcile medications. The doctor did not stop the naproxen or start the omeprazole[754] as recommended by the hospital. It is unclear if the physician reviewed the hospital record.[755]

Later that month, the doctor evaluated the patient because he complained of pain. The doctor increased the patient's prescription for Tylenol. The provider also *acknowledged that the patient was still on naproxen and told the patient to limit it to one tablet twice a day to prevent adverse effects.* This ignored the recommendation of the hospital and was contrary to standard of care which placed the patient at serious risk of harm. The doctor did not review the patient's other medications and failed to notice that the patient was not taking omeprazole. A month later, the patient had a sudden death and was unable to be resuscitated at the facility. The autopsy showed a gastrointestinal hemorrhage due to a ruptured duodenal artery on a duodenal ulcer. This death was preventable and likely due to a combination of not prescribing omeprazole and continuing use of naproxen.

Summary

- IDOC provides no data or information to demonstrate their compliance with provisions II.A; II.B.1; or III.G.4.
- IDOC does not have policy that adequately covers hospitalization particularly handoff of care to and from hospitals including obtaining hospital reports.
- HMA identified preventable hospitalization as a problem and recommended alignment with AHRQ to classify potentially preventable hospitalizations. The Monitor agrees and further

[751] Mortality review patient 7.
[752] The prescription was for naproxen (500 twice a day) written for duration of a year.
[753] This is the strongest of FDA warnings for prescription drugs. It signifies that there is substantial clinical data that indicate the drug has serious, life-threatening, or permanently disabling risks.
[754] Omeprazole is an anti-ulcer medication.
[755] The recommendation to stop naproxen and start omeprazole are standard of care after hospital admission for a gastric ulcer.

recommends that IDOC use hospitalizations for potentially preventable diagnoses as a metric on a dashboard.

- There is no evidence that IDOC tracks receipt of in-patient hospitalization discharge records which should be done (III.G.4.).
- Handoff of care from the hospital to the prison is still inadequate.
- IDOC has no current plan to correct this problem.
- The preventable hospitalizations and lack of accurate information about patient care upon return from hospitals remain problematic causing harm and risk of harm to patients. For this reason, this provision remains noncompliant.

RECOMMENDATIONS:

1. IDOC should analyze why providers not complete post-hospital evaluation of patients effectively. The Monitor believes this is due to the absence of reports as well as insufficient providers on staff. Providers must continue orders promptly after hospitalization or document why recommendations are not followed. 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. When mortality review identifies delay in hospitalization the statewide quality unit should perform a process analysis to determine he reason why and correct problems identified.

Preventive Services

Addresses items III.M.1.a-c
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.*

Influenza Vaccinations

Overall Compliance: Partial Compliance

Findings:
Policy G.08.01 Immunization states that vaccinations will be offered in accordance with the CDC Recommended Adult Immunization Schedule for ages 19 years or older. CDC recommends the influenza vaccine for all eligible individuals annually. CDC recommends those 65 years of age and older and those

under 65 with solid organ transplants receive a higher-response vaccine. IDOC does not have policy on influenza vaccine specifically and each facility establishes its own process for vaccination.

To verify influenza immunization the Monitor requested any log or tracking mechanism verifying all persons eligible for all immunizations.[756]

In response to this request, IDOC provided a spreadsheet of the entire IDOC population separating individuals at each facility into the following categories: 1) <50 years of age; 2) 50 years of age and older; 3) 60 years of age and older; and 4) the number of males and females. IDOC also provided total numbers. Instead of tracking all persons vaccinated, DOC used sampling data (10 charts per facility) to pro-rate against the entire population and portrayed that as the total population vaccinated. This material is not responsive to the request. IDOC still does not maintain a vaccine tracking log and is unable to document compliance with III.M1.a or b.

IDOC maintains a performance and outcome measure for influenza vaccination. For past reports, IDOC reviewed ten charts per facility and reported the total number of individuals who were offered the vaccine quarterly from August 1st to July 31st. The Monitor asked in the past that this measure report those who accepted and those who refused the vaccine. For this report, IDOC reported this information as well as those who were excluded.[757]

The time-period was vaccination within the past twelve months. IDOC measures influenza vaccination by sampling on a continuous basis but influenza vaccine is intended as a ***seasonal*** intervention not as a continuous intervention. Vaccine is manufactured in early spring and is not distributed until late July to August. IDPH surveillance for influenza infections tracks the months of circulating influenza infection in Illinois only from October through March.[758] It is unclear what is assessed in the 4th (April to June) and 1st (July to September) quarters in IDOC as there is typically no circulating virus.[759] The Monitor recommends consulting with IDPH on the best metrics to monitor this vaccination and the optimal time to vaccinate. The Monitor suggests monitoring the numbers of those over 65 and those under 65 with solid organ transplants who are given the higher dose vaccine and for all others to measure the numbers who accepted and offered vaccine by month. The number of those 65 years of age and older who receive the high dose vaccination is not tracked. It is not clear that the high-dose vaccine is even used. The high-dose vaccine should be available consistent with CDC vaccination recommendations which is a policy requirement. The number vaccinated should also document the month the person was vaccinated to assess the effectiveness of timelines for vaccination.

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[756] Monitor's documentation request 9th report, dated 5/10/2025, item 136 to include current vaccination status, including reports tracking the percentage of eligible candidates for each adult immunization recommended by the CDC, listed by name, identification number, date of birth, age, risk, type of immunization, dates offered, refused, administered, next anticipated time of repeat vaccination, and facility.

[757] The Monitor is unsure what the excluded group consists of. It should be defined because it is a significant proportion of individuals.

[758] See Illinois Department of Public Health Influenza surveillance reports 2020-2021 as found at https://dph.illinois.gov/content/dam/soi/en/web/idph/files/cdcs-influenza-surveillance-reports-2020-2021-week-53.pdf.

[759] The Monitor is unclear whether IDOC is assessing vaccines given during this period or vaccines given in prior months of the same year. UpToDate does not recommend more than one dose of seasonal influenza vaccine in a single season. While the ideal time for vaccinating is uncertain, there is little circulating influenza infections from May through July and vaccination is not emphasized during this period.

The table below shows the results of the influenza performance and outcome measure.

IDOC Influenza Performance Measure July 2024 to June 2025					
	July to Sept 2024 1st fiscal quarter	Oct to Dec 2024 2nd fiscal quarter	Jan to Mar 2025 3rd fiscal quarter	April to June 2025 4th fiscal quarter	Total
Charts sampled	280	280	280	280	1120
Vaccine given	70	70	75	50	265
Vaccine refused	95	94	136	145	470
Excluded	115	116	69	85	385
Statewide performance measure score	59%	59%	75%	70%	66%
% of individuals vaccinated	25%	25%	26%	18%	24%
% who refuse vaccine	34%	34%	49%	52%	42%
% excluded	41%	41%	25%	30%	34%

Based on the data provided, almost half of individuals refused influenza vaccine. Approximately a third of the sample were "excluded" which is undefined. The FY25 statewide average vaccination rate through Q4 is 24% when refusal data are excluded. The high number of refusals suggests the need for focused efforts to better understand reasons for refusal and to strengthen patient education, and counseling. Refusal trends should be routinely analyzed and targeted strategies implemented to reduce refusals and improve overall vaccination uptake. The high number of persons who have no offer of vaccination suggests efforts to vaccinate are not reaching all individuals.

Review of individual facility-level data shows substantial variability between facilities, as well as variability in compliance within the same facilities across reporting periods. With the implementation of the electronic medical record system, all eligible patients should be included in the calculation to allow for more complete and reliable performance measurement.

The facility lacks a clear mechanism for identifying high-risk patients, which prevents their prioritization for influenza vaccination. This is essential to ensure timely vaccination of individuals at greater risk of complications and to support efficient allocation of vaccines.

RECOMMENDATIONS:

1. IDOC should establish a standardized electronic process to identify, track, and report influenza vaccinations for all eligible patients.
2. IDOC should periodically address gaps in annual influenza vaccination as discussed in this section and take focused corrective actions to close these gaps.
3. IDOC should implement an annual health information campaign to educate the incarcerated population on the benefits of the annual influenza vaccine to help reduce refusals.
4. IDOC should consult with IDPH to determine what are optimal metrics to monitor with respect to vaccination for influenza. Suggestions include: the number and percent of those 65 years of age and older and all others with solid organ transplants given the high-response vaccine, the number and percent of all individuals who receive the vaccine and the total number offered the vaccine. Vaccinations given should be tracked by the month given.
5. IDOC should define the methodology of the measure to include what excluded means.

Adult Immunizations

Overall Compliance: Partial Compliance

Findings:

Policy

IDOC has agreed to follow CDC recommendations for other adult vaccinations. In order to accomplish this IDOC has developed the following policies.

Policy G.01.01 Infection Control Program requires:

1. The Agency Infection Control Coordinator to develop procedures:
    a. For nurses to vaccinate via protocols;
    b. To track vaccinations provided to individuals in custody to include age, reason for vaccination, individual in custody name and IDOC number;
    c. For vaccination and training procedures for individual in custody workers whose work exposes them to blood and body fluids, including fecal material; and
    d. To develop standardized communicable disease data reporting requirements for the numbers of individuals by name, who are offered and received vaccination by condition;
2. The facility Infection Control Coordinator is to:

a. Train and oversee the nurses who perform vaccinations in consultation with the IDPH consultant. The HCUA and Director of Nursing are to assign nurses to provide vaccinations;
b. Maintain documentation of vaccination status for hepatitis B and hepatitis A for those at risk for exposure to blood and body fluids as well as post-exposure management; and
c. Provide cumulative monthly data of the above items to the Agency Infection Control Coordinator.

Policy F.02.01 Chronic Care requires:

1. The nurse assisting with chronic care shall:
    a. Evaluate persons scheduled for upcoming chronic care clinics regarding whether vaccinations or cancer screening are necessary;
    b. When these are identified as needed the nurse will act under protocol to ensure completion of vaccinations or cancer screening; and
    c. When protocol does not permit nurses to complete the vaccination or test, the need is brought to the attention of the provider at the upcoming clinic for orders.
2. The physician will document preventive measures provided.

Policy E.05.01. Intersystem Receiving Screening requires:

1. Patients should have a history of their vaccination and health maintenance status obtained during the intake process and legibly documented;
2. A vaccination history for all patients should be requested from ICARE; and
3. The information received from ICARE and the patient's reported medical history should be assessed to determine preventive health and vaccine needs. These should be offered at the time of intake evaluation by the provider or scheduled for when they are due.

Policy G.08.01. Immunization requires:

1. Only written records (including electronically stored and accessed) which include the dates of administration will be acceptable documentation of previous vaccination. However, a patient's verbal history of prior tetanus vaccination, including date, can be accepted. If a verbal history of tetanus vaccination is obtained, the date of the vaccination must be recorded on the Abstract of Immunization as "verbal history".
2. 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.
3. The Illinois Comprehensive Automated Immunization Registry Exchange (I-CARE) should be consulted as needed to identify and verify a patient's immunization history.
4. Requirements are established for vaccine storage, handling, administration, and documentation.
5. Vaccines must be properly stored and handled to maintain effectiveness, administered with patient consent, and documented in the medical record as well as required immunization systems.
6. Patients must receive required vaccine information, adverse events must be reported, and immunizations are administered according to the applicable adult immunization schedule.

A confusing detail in the policy G.08.01 item D. states, "The administration of each vaccine dose shall be recorded on the Abstract of Immunization Form". The Monitor has not encountered this form in any record reviews to date. IDOC needs to clarify that this form is to be used (and if so, numbered) and include it as an appendix to the policy.

Policy B.01.01 Preventive Services and Periodic Health Assessment requires:

- Hepatitis B surface antibody screening be obtained for patients who have not previously been screened. If the surface antibody result is negative, hepatitis B surface antigen screening is required. If the patient is negative for both the surface antibody and surface antigen, the policy states that the patient should receive the hepatitis B vaccination.
-

Policy G.06.01 Prevention of Hepatitis B in Employees requires:

- A three-dose Hepatitis B vaccine series is available to IDOC and vendor employees for workplace safety.

The distributed and diffuse responsibilities in these policies makes vaccination policy more difficult to implement and there is no evidence that they have been. The Monitor has provided IDOC with comments and suggested revisions during the annual policy review on each of the policies abstracted above.[760]

Data and Information Provided About Vaccination

To evaluate compliance with III.M.1.b. the following information was requested: any log or tracking mechanism verifying all persons eligible for all immunizations with current vaccination status.[761] . The information provided in response to this request was non-responsive. IDOC does not have a mechanism to track vaccinations that are administered. Instead, IDOC uses three performance and outcome measures that consist of a sample of charts to provide pro-rated data on the number of individuals estimated who remain to be vaccinated. The information IDOC provided is shown below.[762]

[760] G.01.01 Infection Control Program returned to IDOC with comments on 9/23/25; F.02.01 Chronic Care on 7/15/25; E.05.01 Intersystem Receiving Screening on 7/15/25; G.06.01 Prevention of Hepatitis B in Employees on 9/23/25; B.01.01 Preventive Service and Periodic Health Assessment on 8/22/25; and G.08.01 Immunization on 9/23/25.

[761] Monitor's documentation request 9th report dated 5/10/25, item 136 to include the percentage of eligible candidates for each adult immunization recommended by the CDC, listed by name, identification number, date of birth, age, risk, type of immunization, dates offered, refused, administered, next anticipated time of repeat vaccination, and facility.

[762] Documentation provided by IDOC on 8/15/25 in response to the Monitor's documentation request 136 "Patient Eligibility by Vaccine Type".

IDOC Vaccine Info Spreadsheet				
Vaccination Type	**Eligibility Criteria**	**Number of Potentially Eligible Patients based on Criteria**	**FY25 Statewide Average Data Thru Q3 (Excluding Refusal Data)**	**Estimated Eligible Patients with Outstanding Vaccinations**
Covid 19 vaccine	Recommended for all per CDC guidance	28842 (ALL)		
Influenza vaccine	Recommended for all during the flu season- annually	28842 (ALL)	23.5%	22078
RSV vaccine	Adults 60 and older at increased risk- during seasonal flu	2715 (60+)		
Pneumococcal vaccine	Recommended for high-risk population and all age 50+	6738 (50+)	29.6%	4743
MMR vaccine	Recommended for all adults without documentation evidence of immunity	Unable to determine eligibility		
Varicella/ Chicken Pox	Recommended for all adults without documented evidence of immunity	Unable to determine eligibility		
Tetanus (Tdap/TD)	Recommendation for all adults- I dose every 10 years	28842 (ALL)		
Zoster/Shingles vaccine	Immunocompromised adults and age 50+	6738 (50+)	14.5%	5763
Hepatitis A/ Hepatitis B	Recommended for all adults at risk	Unable to determine eligibility		
HPV	Recommended for female patients	1455 (FEMALE)		

The Monitor's comments on this information are as follows.

- IDOC does not have a method to track vaccinations given.
- IDOC does not have a current process to document or verify that necessary vaccines are offered to patients.
- IDOC projects the numbers vaccinated by applying the average results from a small sample of charts to the entire population of eligible persons at a single static point in time. The population of IDOC is not static, it is dynamic, people are newly incarcerated and leaving continuously. The sample size is too small for this prediction. As discussed in the previous section the sampling method is also ineffective for influenza because influenza is seasonal and vaccine is not given year-round.
- Paper records of vaccination are not useful to verify compliance because they are poorly maintained. The vaccine performance measures are obtained by chart review and consists of a

small sample size. IDOC must establish the electronic record with capacity to determine vaccine eligibility and vaccine status.

- In the data provided by IDOC, they presumed vaccine eligibility only by age and not other criteria (comorbid disease, other risk, etc.). IDOC has no current way to determine vaccine eligibility except by record review.
- The data as presented and the methodology used (pro-rating from a small sample size) is insufficient to demonstrate progress toward compliance with III.M.1.a or III.M.1. b..

The results of charts review for the three vaccines[763] monitored by IDOC are listed below.[764]

Quarters FY 2025 Performance Measures Combined Data*				
	Influenza**	Pneumococcal	Shingrix	Total
Eligible population	28842	6738	6738	
Charts sampled	1120	947	799	2866
Vaccine given	247	278	111	636
Vaccine Refused	480	65	42	587
Excluded	393	604	646	1643
Average statewide performance measure score for 3 quarters	68%	37%	20%	42%
IDOC goal	90%	90%	90%	90%
Percent of sample vaccinated	22%	29%	14%	22%
Percent of sample refused	43%	7%	5%	20%
Percent of sample excluded	35%	64%	81%	58%
* Performance and outcome data was provided in response to document request 59 regarding dental QI and not provided in response to document request 66 for performance and outcome data since April 2024.				
** Charts for influenza are sampled year-round and include during months when vaccination is ineffective. IDOC needs to clarify the methodology to ensure that months monitored are consistent with CDC recommendations.				

Observations about this data are as follows:

- See the Monitor's comments on tracking the influenza vaccine in the previous section.
- The data show that the number of individuals not offered pneumococcal and Shingrix vaccines are considerably more than the number vaccinated which warrants further evaluation.

[763] Vaccine information provided is obtained by SIU reviewing a sample of 10 charts at each facility quarterly.
[764] The eligible population was taken from data provided by IDOC in document request 136: IDOC Patient Eligibility by Vaccine Type. The remaining data was taken from the July-September 2024; January – March 2025; and April – June 2025 quarters as provided in document request 65. Notably, one quarter of data was missing.

- The number of completed vaccinations was dwarfed by refusals and individuals not offered the vaccine. This demonstrates an ineffective vaccination program and reflects on the inability to implement policy and demonstrates that compliance with III.M.1.a and III.M.1.b. is not attained.
- The factors contributing to refusal and not offering vaccines could be identified by root-cause analysis. This would help in developing targeted interventions to increase vaccination rates.
- The sample size used for these measures is relatively small, which limits the reliability of the results. With the implementation of the electronic medical record system, all eligible patients should be included in the calculations of the vaccination rate.

Implementation of Policy

The OHS Quarterly Infection Control Presentation from January 30, 2025,[765] provided updates on adult vaccination practices and program implementation. The presentation further gave directions to reception nurses and providers about how to conduct an immunization history and examination. The slides stated that:

- The nurse completes the adult vaccination history which "shall be marked, YES or NO or Unsure".[766]
- The nurse taking off the orders shall schedule the immunization(s) ordered and **update the Problem List.**[767] [IDOC's emphasis]

After the immunization the nurse is to "**Update the Database and Problem List".**[768] [IDOC's emphasis] These directions contradict G.08.01. Immunizations policy section IV.A. -C. the contents of which were abstracted in the first paragraphs of this section of the report. The directions also contradict F.02.01 Chronic Care which requires that only providers update the problem list. Misinformation provided at the quarterly meetings add to the already confused and delayed implementation of the policies.

The OHS Quarterly Infection Control Presentation from April 25, 2025[769], focused on measles and addressed vaccination in the context of prevention and outbreak response. The presentation noted that most adults are recommended to have at least one dose of MMR and emphasized related infection control measures, reporting requirements, and response actions for measles exposure and suspected cases. There were no comments or guidance about how to update measles vaccine for the incarcerated population. This was a lost opportunity.

The Monitor has made the following recommendations to IDOC regarding the process of vaccination.

- Place the immunization program under the administrative umbrella of nursing leadership so that nursing can give vaccinations based on protocol. [770]

[765] Infection Control, OHS Quarterly Presentation, January 30, 2025 provided in response to the Monitor's document request 150 Infection Control Meetings.
[766] Slide 5.
[767] Slide 6.
[768] Slide 7.
[769] OHS Quarterly Meeting, Infection Control Presentation, 4.25.25 provided in document request 150.
[770] Health Care Monitor, 3rd Report, Lippert v. Jeffreys, February 15, 2021, page 117, recommendation 2. Notably, the recommendation is not different from the community in that individuals can obtain most any vaccination from a pharmacy without a physician order.

- Incorporate data points and clinical prompts which electronically remind, record, track, and report the number and percentage of eligible candidates for each adult vaccine and all immunizations offered, administered and clinical indication.[771]

At this point in time IDOC policy distributes responsibility for vaccination to multiple, parties and in a manner that is difficult to implement. To illustrate the existing policy requirements are:

- G.01.01 Infection Control Program requires the facility infection control coordinator to oversee nurses who provide vaccinations. However, there are no infection control coordinators.
- F.02.01 Chronic Care requires the nurse assigned to chronic care or provider conducting chronic care to identify and vaccinate those in need. As described in the chronic care section of this report, most facilities do not have dedicated chronic care nurses.
- E.05.01 Intersystem Receiving Screening requires the intake screening nurse to take a history of vaccination; requires an unspecified nurse to request a vaccination history from I-CARE; and an unspecified person to assess the ICARE information to determine vaccination needs which are to be offered at the time of the provider intake assessment.

None of these policies requirements have been implemented. The Monitor continues to recommend a nursing-based vaccination program managed under the supervision and direction of the Agency Infection Control Coordinator. The Monitor's suggested revisions to E.05.01 Intersystem Receiving Screening and B.01.01 Preventive Services and Periodic Health Assessment are consistent with this approach. It is the Monitor's opinion that this would be the most efficient and cost-effective way to attain compliance III.M.1.a and III.M.1.b.[772] The Monitor is encouraged by IDOC's commitment to utilize the EMR to track vaccination and to integrate data from ICARE with an interface into the EMR.[773]

Summary:

- IDOC cannot now track the eligible numbers of patients who need vaccination nor the numbers of persons vaccinated. The Monitor has long recommended that tracking vaccinations be accomplished using the EMR. IDOC has begun this process by committing to including an interface with ICARE in the EMR and using the EMR for tracking purposes.
- The results of performance and outcome measures for three vaccinations show none are at goal.
- Multiple vaccines have no associated metrics.
- The current IDOC policy on vaccination distributes responsibility for vaccination widely and ineffectively. The opportunity to vaccinate is greatest and easiest as part of intake and at the periodic examination. These episodes of vaccine intervention should be managed by nursing via protocol. The intake nursing vaccination encounter should be separate from intake receiving screening and connected to the infection control program. Changes in clinical care that have

[771] Health Care Monitor 3rd Report, Lippert v. Jeffreys, February 15, 2021, p13 and in recommendation 4 on page 117 which states, "The New EMR vendor should incorporate data points and clinical prompts which electronically remind, record, track, and report all adult immunizations offered and administered and the identified clinical indication (age, clinical condition, etc.)".

[772] Monitor's suggested policy revisions to E.05.01 Intersystem Receiving Screening submitted to IDOC on 7/11/25 and B.01.01 Preventive Service and Periodic Health Assessment submitted to IDOC on 8/22/25.

[773] Defendant's 2024 Report Under Section V.G. of the Lippert Consent Decree, page 47 where IDOC states, "The Department is working to implement changes to better document the offering of influenza vaccination, which will also be supported by the EHR. The Department has already collaborated with IDPH and the EHR vendor to establish an interface for sharing of iCARES data within the Department's EHR system."

vaccination requirements should be addressed by providers and missed opportunities should be addressed at periodic evaluations.

- To verify vaccination, IDOC must configure the electronic record according to recommendation 6 below and interface with I-CARE so that vaccine eligibility is known.

RECOMMENDATIONS:

1. Offer all individuals housed in the IDOC adult vaccinations recommended by the Centers for Disease Control and Prevention (CDC) Adult Vaccination guidelines.
2. The IDOC immunization guidelines must be reviewed and updated as needed to ensure that the most recent recommendations for adult immunizations from the Centers for Disease Control and Prevention are expeditiously incorporated into the IDOC guidelines.
3. Institute an immunization program that has standardized practices, staffing, equipment, supplies, and training with standardized documentation of vaccination, tracking and reporting.
4. Institute statewide training of nurses on safe immunization practices and updated immunization procedures.
5. Place the Immunization Program under the umbrella of nursing leadership overseen by the Agency Infection Control Coordinator and each facility's infection control nurse using approved protocol to administer recommended adult immunizations.
6. Ensure that the new EMR vendor incorporates data points and clinical prompts that electronically remind, record, track, and report the number and percentage of eligible candidates for each adult vaccine and all immunizations offered, not offered, administered, refused, and the identified clinical indication (age, clinical condition, etc.).
7. Ensure the EMR can access the I-CARE immunization report for all new admissions to the IDOC and that the I-CARE report is updated in the patients' medical record.
8. Offer HPV vaccination to all incarcerated individuals as recommended by the CDC adult vaccination guidelines. Special emphasis on increasing HPV vaccination uptake among eligible males.
9. Initiate a universal Hepatitis B screening and vaccination program, preferably in conjunction with a triple panel (HBsAg, antibody to HBsAg, and total antibody to hepatitis B core antigen). Hepatitis B is also one of the few vaccines that can prevent chronic hepatitis that can progress to advanced fibrosis and cirrhosis, ultimately causing hepatocellular cancer.
10. Provide Hepatitis A immunization to all porters, hospice workers, and staff lacking immunity who are exposed by their duties to fecal-oral pathogens, and to kitchen workers who prepare and handle food.

Colorectal Cancer Screening

Overall Compliance Rating: Partial Compliance

Findings:

The USPSTF recommends colorectal cancer screening for all adults aged 50 to 75 years with a Grade A recommendation, recommends screening for adults aged 45 to 49 years with a Grade B recommendation, and recommends selectively offering screening for adults aged 76 to 85 years, noting the overall net benefit is small and decisions should consider overall health, prior screening history, and patient preferences, with a Grade C recommendation.

Policy

III.M.1.c of the Consent Decree requires all prisoners ages 50-75 be offered annual colorectal cancer screening and PSA testing. IDOC Policy B.01.01 Preventive Service and Periodic Health Assessment[774] is consistent with the colorectal cancer screening requirement and gives the following direction on colon cancer screening.

> All patients age 45-75 will be screened for colon cancer using a Fecal Immunochemical Test (FIT), which is approved as a screening method by the USPSTF. Patients with a family history (first-degree relative) of colon cancer or who have Inflammatory Bowel Disease (Crohn's Disease or Ulcerative Colitis) will be screened at an age 10 years younger than their relative was at the time of diagnosis with FIT and a colonoscopy. Patients over the age of 75 should be considered for screening on a case-by-case basis.

FIT testing is for average risk patients and not patients with inflammatory bowel disease.[775] IDOC should consult with a gastroenterologist at SIU or UIC to determine appropriate clinical direction for colorectal cancer screening for patients with inflammatory bowel disease. Typically, a gastroenterologist who is following the patient would determine the manner and frequency of surveillance based on unique disease characteristics of the individual.

The Monitor requested any log or tracking mechanism that verifies all cancer screening and AAA as recommended by the United States Preventive Services Task Force (USPSTF) at all facilities. [776]

The documents sent in response to this request were not responsive because they were not understandable. IDOC provided five Excel files, one for each of five months from January to May, 2025. Each of the five spreadsheets contained 32 worksheets (one for each facility, a dashboard, and a cumulative summary of the number of patients eligible and seen by month) for a total of 160 worksheets. There were an estimated several thousand data points in the facility worksheets. Each data point was not defined so the information provided was not understandable.

A summary dashboard used data elements that did not correspond to the facility worksheets. Each of the five dashboards had six data points that were not defined and were mostly unintelligible. These data points were "total seen", "not seen", "no outcome identified", and "did not receive tool". This information was unintelligible and was not defined. This apparently represents data collection related to the colon cancer initiative.

The Monitor also is suspect of the integrity of the data after review of intake records from Menard. Colorectal cancer pre-screening questionnaires were completed and filed in all 10 medical records

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[774] B.01.01 Preventive Service and Periodic Health Assessment made effective 2/9/24.

[775] Average risk excludes those patients with a history of colorectal cancer, adenomatous polyps, or inflammatory bowel disease, or those with a diagnosis or family history known genetic disorders that predispose them to a high lifetime risk of colorectal cancer. Recommendation: Colorectal Cancer: Screening | United States Preventive Services Taskforce.

[776] Monitor's documentation request 9th report dated 5/10/25, item 139 to include name, identification number, date of birth, age, type of screening (e.g. for colon cancer screening was FOBT x 3, FIT, multi-target stool DNA, colonoscopy, or other used), if testing was offered, refused, performed, date screened, next screening interval, and facility.

reviewed for intake screening at Menard.[777] Only one patient was above age 45 indicating that age is not used to determine patients who should complete the pre-screening questionnaire for colorectal cancer. The two patients who accepted screening were 37 and 26 years of age and cancer screening was not indicated. Numbers offered and accepting colorectal cancer screening reported at Menard appear to include persons who should not have been included. Though this data submitted by IDOC represents a considerable amount of work the data integrity is poor and the reports are unintelligible. The Monitor's recommendation to acquire expert data support is reemphasized.

IDOC provided the following in response to the Monitor's request was for results from performance and outcome measures for colon cancer screening. [778] This data is shown in the table below.

Statewide Performance and Outcome Measure for Colon Screening FY 2025								
	July-Sept 2024, 1st QRT		Oct-Dec 2024, 2nd QRT		Jan-Mar 2025, 3rd QRT		April-June 2025, 4th QRT	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Charts sampled	253	100%	275	100%	266	100%	277	100%
Screened	46	18%	69	25%	94	35%	81	29%
Refusals	24	9%	61	22%	65	24%	93	34%
Screened + Refusals	70	28%	130	47%	159	60%	174	63%
Excluded	183	72%	145	53%	107	40%	103	37%
Score on Measure		28%		47%		60%		63%

The Monitor has several comments on this data.

- The scores include both refusals and those who accept screening. IDOC is appropriately credited for persons who are offered and refuse. However, the community and correctional health care benchmarks only include those who accept screening because the goal is to increase the number of eligible people effectively screened for cancer. IDOC should have the same goal and measure accordingly.
- The scores, including the rate of those screened, increase quarter over quarter which is commendable though not near the goal.
- The actual rate of people screened is very low. Efforts must be made to improve acceptance rates.
- The refusal rates in the last quarter was greater than the rate of acceptance. IDOC should evaluate how this test is conducted to identify why patients refuse and identify ways to improve acceptance.
- As discussed in the influenza section of this report, the number excluded should be defined as it is a large number. This explanation should be included with the definition for each measure.

The performance and outcome scores for individual facilities showed considerable variability quarter to quarter. About two thirds show improvement from the 1st to 4th quarters. These improvements are consistent with the initiation of the colorectal cancer initiative.

[777] Monitor's documentation request 9th report dated 5/10/25, item 107.
[778] Information provided by IDOC dated 8/15/25 in response to the Monitor's documentation request item 59.

Colon Cancer Screening	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Big Muddy River	0%	20%	30%	50%
Centralia	50%	50%	0%	40%
Danville	0%	13%	60%	90%
Decatur	30%	60%	100%	100%
Dixon	20%	50%	70%	70%
East Moline	70%	100%	100%	90%
Graham	0%	11%	30%	50%
Hill	67%	20%	43%	50%
Illinois River	0%	30%	50%	60%
Jacksonville	83%	40%	90%	60%
Joliet	30%	20%	60%	25%
Kewanee Life Skills	71%	100%	100%	100%
Vienna	11%	20%	60%	90%
Western	30%	60%	90%	40%
Shawnee	63%	50%	90%	60%
Vandalia	0%	20%	50%	90%
Taylorville	20%	60%	70%	90%
Lawrence	10%	10%	20%	40%
Sheridan	30%	60%	90%	50%
Southwestern	10%	40%	70%	80%
Lincoln	10%	40%	50%	60%
Pontiac	25%	60%	30%	10%
Robinson	30%	70%	33%	50%
Pinckneyville	70%	90%	29%	70%
Logan	70%	80%	90%	70%
Menard	10%	20%	0%	40%
Murphysboro Re-Entry	100%	75%	100%	78%
Northern Reception and Classification	10%	50%	80%	50%
STATEWIDE	**29%**	**47%**	**60%**	**63%**

Summary:

- Performance and outcome measures have recently improved but are not near to the goal.
- Colon cancer performance and outcome measures have a high rate of refusal, the reasons for which should be examined.
- Since patients at Menard who are less than 45 years of age are offered colorectal cancer screening IDOC should evaluate whether the colorectal cancer initiative was implemented correctly at each facility.
- The policy statement that those with inflammatory bowel disease should have FIT testing and colonoscopy screening it is not standard of care and may give improper surveillance advice. Consultation with a gastroenterologist is recommended with any policy necessary revision completed as soon as possible.
- A high percentage of those records reviewed for colorectal cancer are excluded without definition of the term “exclusion” or explanation of methodology for data collection.

- The log tracking colorectal cancer screening does not include definitions of data elements used nor is a methodology provided about how data is obtained. The data is not useable in its current state.

RECOMMENDATIONS:

- Ensure colorectal cancer screening is offered to all eligible patients in a timely manner in a proper setting.
- Study and document reasons for screening refusals and implement initiatives to improve FIT test acceptance.
- Ensure timely follow-up and referral for patients with positive screening results.
- Maintain accurate tracking and reporting of all eligible patients.
- Strengthen oversight and monitoring to identify and address compliance issues.
- The data collection for the colorectal cancer project needs data definitions, methodology for data entry and collection, specified data entry devices to avoid multiple disconnected systems, and presentation of data that is understandable. A data manager is recommended to ensure data integrity.
- IDOC must consult with a gastroenterologist regarding their policy statement in B.01.01 regarding colorectal cancer screening for those with inflammatory bowel disease. Typically, this group undergoes surveillance at intervals determined by their disease status and are not screened as a normal risk patient.

Prostate Cancer Screening

Overall Compliance Rating: Non-Compliance

Findings

Policy

B.01.01 Preventive Service and Periodic Health Assessment policy states that for men aged 55 to 69 years, the decision to undergo periodic prostate-specific antigen-based screening for prostate cancer should be an individual one, per USPSTF guidelines. For men aged 70 years or older, PSA screening for prostate cancer is not recommended. This aligns with the USPSTF recommendation that for men aged 55 to 69 years, the decision to undergo periodic PSA based screening should be an individual one with a Grade C recommendation, allowing men to discuss potential benefits and harms with their clinician and incorporate their values and preferences, and that clinicians should not screen men who do not express a preference for screening.

Performance Review

Sixty-one records were evaluated to determine whether prostate cancer screening was performed and whether it was informed care.[779] A table of those results is below.

[779] Eligible patients from charts provided by IDOC on 8/15/25 in response to the Monitor's document request item 141.

Prostate Cancer Screening (Chart Reviews)				
Facility	PSA Done - No	PSA Done- Yes	PSA Not Indicated	Documented Discussion of Pros/Cons of PSA* Testing
Danville	6		5	0
Graham	2	1	7	0
Illinois River	2	1	7	0
Lincoln	6		4	0
Taylorville	8		2	0
Western	7	1	2	0
Grand Total	**31**	**3**	**27**	**0**
*PSA = prostate specific antigen, a test used to evaluate for prostate cancer				

Audits of the medical records revealed that provider documentation did not reflect any discussion with the 34 eligible patients regarding prostate cancer screening. This included the absence of documentation related to prostate cancer risk, the potential benefits of PSA screening, or the clinical rationale for not offering PSA testing during the visit. The current physical exam form template includes check boxes for several health screening and examination elements that help ensure required topics are reviewed, discussed, and addressed, but it does not include prostate cancer screening. The absence of prostate cancer screening on the form may contribute to it not being consistently addressed or documented during visits. At Taylorville, a digital rectal exam was documented as offered to patients as part of the physical exam. Most of the patients refused the exam and signed the refusal form. This is contrary to written direction provided to facilities by OHS and B.01.01 Preventive Service and Periodic Health Assessment policy.

IDOC's System Leadership Quality Council determined that prostate cancer screening would become a systemwide performance and clinical outcome measure beginning in late 2024 or early 2025[780]; however, it is not yet included as a defined measure.

Summary

There is currently no standardized tracking process to ensure that eligible patients are consistently identified, educated about prostate cancer screening, and offered screening when appropriate. There is also no formal mechanism to monitor or verify that this practice is applied consistently across providers and facilities. As the EMR is implemented, prostate cancer screening should be incorporated into workflows to support standardized identification of eligible patients, documentation of patient education and shared decision making, tracking of screening and outcomes, and ongoing compliance monitoring.

Recommendations:

1 Educate providers on the 2024 USPSTF (C Grade) recommendation and IDOC policy B.01.01[781] to discuss with eligible patients the risks and benefits of prostate-specific antigen (PSA) testing.

2. Continue with the plan to review Prostate Cancer Screening as a new performance and clinical

[780] OHS-Monitor Monthly Conference Calls: 7/18/24, 9/19/24.
[781] B.01.01 Preventive Service and Periodic Health Assessment.

outcome measure and create a definition of specifically what will be measured and the methodology to obtain the data.
3. In collaboration with the SIU Office of Correctional Medicine, report and analyze the quarterly results of this new performance and outcome measure.
4. Clearly communicate to providers that the digital rectal exam is not a recommended screening test for prostate cancer.
5. Standardize the identification of eligible patients, document patient education and shared decision-making, track screening and outcomes, and monitor ongoing compliance using the features of the new EMR.

Mammography Screening

Findings:

The USPSTF recommends biennial screening mammography for women aged 40 to 74 years with a Grade B recommendation.

Policy

B.01.01 Preventive Service and Periodic Health Assessment policy states that an annual mammogram will be offered for all women aged 50 to 74 years. Women with increased risk of breast cancer should be offered annual mammography starting at age 40 or 10 years younger than the age of their relative at diagnosis. The policy also states that biennial mammography should be offered to patients aged 75 and older who have little comorbidity.

IDOC should revise the Breast Cancer Screening section of Policy B.01.01 Preventive Service and Periodic Health Assessment policy to align age criteria and screening frequency with the updated USPSTF recommendation that this screening be done *biennially* starting at age *40*.

Performance

The Monitor notes that scores for mammography screening for the three quarters of 2025 were below IDOC expectations of 90%.

- July – September 2024 was 70%.
- October to December 2024 was 67%
- January to March 2025 was 64%.
- April to June 2025 was 86%.

The scores include both refusals and those who accept screening. See comments made earlier about the colorectal cancer screening measure. The goal should be to increase the number of eligible women effectively screened for breast cancer.[782] The Monitor recommends that a statistical expert be consulted to ensure that the sample size is appropriately powered to measure performance on this measure. More importantly the electronic record should be used to sample the entire eligible population and report performance on screening mammography for breast cancer in women.

[782] The community and correctional health care benchmarks only include those who accept screening. IDOC should measure performance toward the goal the same as the benchmarks used.

Recommendations:

- Monitor and report the offering, provision, and refusal of breast cancer screening to the facility Quality Improvement Committees using 100% sampling from the electronic health record.
- Report data to the facility Quality Improvement Committees on the percentage of eligible incarcerated women who receive breast cancer screening within the nationally established time intervals.
- Revise the IDOC Policy B.01.01: Preventive Services and Periodic Health Assessment, Breast Cancer Screening to align with the updated April 2024 USPSTF guideline.

Cervical Cancer Screening

Overall Compliance Rating: Partial compliance

Findings:

The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus testing alone, or every 5 years with hrHPV testing in combination with cytology.

Policy

Policy B.01.01 Preventive Service and Periodic Health Assessment states that cervical cytology will be offered every 3 years in women aged 21 to 65 and aligns with the USPSTF recommendation.

Performance

Cervical Cancer Screening is a systemwide performance and clinical outcome measure. This measure is based on review of 10 charts and the results are reported on a quarterly basis. The following table summarizes results for fiscal year 2025.

Cervical Cancer Clinical Quality Performance Review[783]: Summary Fiscal Year: FY25				
Cervical Cancer Screening	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Decatur	90%	100%	80%	80%
Logan	70%	80%	90%	70%
Measure – Cervical Cancer Screening [IDOC goal = 90% & C.S. goal = 85%] Percentage of women and transgender individuals 21-65 years of age who were offered, received, refused, and/or excluded from at least one cervical cytology screening (i.e., Pap smear) to screen for cervical cancer in the past three years, per policy/AD 04.03.101 (G.2.a.3.f.vi) (G.2.b.3).				

The IDOC goal for this measure is 90%. Decatur met the IDOC in the first and second quarters but fell below goal in the third and fourth quarters. Logan met the IDOC goal only in the third quarter. The scores however include both refusals and those who accept screening. See comments made earlier about the colorectal cancer screening measure. The goal should be to increase the number of eligible women

[783] CQPR Quarterly Summary provided by IDOC on 8/15/2025 in response to the Monitor's request 59 for Dental in QI.

effectively screened for cervical cancer.[784] The results of the systemwide performance and clinical outcome measures are reported in the System Leadership Quality Council meeting however these results are not reviewed or discussed in any detail during the meeting[785].

A facility specific breakdown of the data from performance and outcome measures for cervical cancer screening is provided in the table below. [786]

Cervical Cancer Screening Fiscal Year 2025: July 2024 to June 2025							
Facility	Quarter FY25	# Charts Sampled	Measures Completed	Documented Refusals	Measures Completed and Refused	Number Excluded	Facility Score = (Completed + Refused) / # Charts Sampled
Decatur	1st Quarter	10	7	2	9	1	90%
Decatur	2nd Quarter	10	7	3	10	0	100%
Decatur	3rd Quarter	10	7	1	8	2	80%
Decatur	4th Quarter	10	8	0	8	2	80%
Logan	1st Quarter	10	7	0	7	3	70%
Logan	2nd Quarter	10	7	1	8	2	80%

SIU reviews ten medical records per quarter for this measure. This small sample is far below the full population of eligible patients, which limits the accuracy of the results and makes it difficult to assess overall performance. As the electronic medical record system is implemented, all eligible patients should be included in the measure to provide a more comprehensive view of screening practices and support more reliable and meaningful performance monitoring. IDOC should work to ensure the electronic record is implemented to capture this data. The population that is excluded when the 10 charts are reviewed is not defined and contributes to an even smaller sample. The definition of excluded should be included in the definition and methodology of the measure.

Recommendations:

1. Monitor and report the offering, provision, and refusal of cervical cancer screening to the facility Quality Improvement Committees.
2. Report data on the number and percentage of eligible incarcerated women who receive cervical cancer screenings within the nationally established time intervals.
3. Audit the results of HPV cervical screenings to ensure that HPV results are being transcribed into the database and women with negative HPV tests are scheduled for "every 5 years" cervical cancer screening appointments.
4. Ensure that the electronic record is implemented so that it can capture the eligible population of

[784] The community and correctional health care benchmarks only include those who accept screening. IDOC should measure performance toward the goal the same as the benchmarks used.

[785] SLC Mtg Minutes since Jan 24 provided by IDOC on 8/15/2025 in response to the Monitor's request item 48.
[786] Decatur and Logan CQPR Quarterly Summaries provided by IDOC on 8/15/2025 in response to the Monitor's request 59 for Dental in QI.

all preventive measures so that data on screening can be automatically captured.

Lung Cancer and Abdominal Aortic Aneurysm (AAA) Screening

Overall Compliance Rating: Non-compliance

Findings:

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 within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. The USPSTF also recommends a one-time screening for abdominal aortic aneurysm (AAA) with ultrasonography in men who have a history of smoking.

Policy

Policy B.01.01 Preventive Service and Periodic Health Assessment states that patients aged 50 to 80 who have a 20-pack-year smoking history and currently smoke or have quit within the past 15 years will have a low-dose CT scan annually. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. The facility policy aligns with the USPSTF recommendation. The policy also aligns with the USPSTF recommendation that men ages 65 to 75 who have a history of smoking be screened once with an ultrasound of the abdominal aorta.

Performance

The findings in the table below are based on review of sixty medical records for smoking history.[787]

Documented History of Smoking (Chart Review)	
No Smoking History	25
Information not documented	20
Smoking History- yes – but no details documented	8
Smoking History- yes 1 PPD - for 30 yrs. - no details	1
Smoking History- yes- 1 PPD - no details documented	2
Smoking History- yes- 1.5 PPD - no details documented	1
Smoking History- yes- quit 15+ yrs.	3
Total	**60**

Multiple medical records identified a consistent lack of complete documentation of tobacco use history, including years of smoking, packs per day, total pack years, and whether the patient had stopped smoking for 15 years or longer.

[787] Eligible patients from charts provided by IDOC on 8/15/25 in response to the Monitor's document request item 141.

The current physical exam form template includes checkboxes for multiple health screening and examination elements to help ensure that required topics are reviewed, discussed, and addressed during the visit; however, it does not include the fields listed above to document tobacco use history. The absence of these fields may contribute to inconsistent assessment, documentation, and identification of patients eligible for tobacco-related screening.

Of the sixty patients reviewed, five men had a documented smoking history, were within the age range of 65 to 75 years, and met criteria for one-time abdominal aortic aneurysm screening. None of them had the screening completed or documentation explaining why it was not considered.

For lung cancer screening, eligibility could not be determined due to incomplete documentation of required smoking history elements. Most records lacked documentation of total pack years, duration of smoking, and whether the patient currently smokes or quit within the past 15 years. Review of the charts revealed that *none* of the patients with a documented smoking history had documentation showing that lung cancer screening was completed or that patient education regarding lung cancer screening was provided.

Recommendations:

1. Revise the medical history form to capture the smoking history and all relevant details. Ensure with implementation of the new electronic record that the record facilitates an adequate smoking history.
2. All patients who meet the age and smoking criteria should be offered annual lung cancer screening and one-time screening for AAA.
3. Train nurses and providers on the comprehensive gathering and documentation of data on tobacco use and its importance in identifying individuals eligible for lung cancer screening and AAA screening.
4. Add lung cancer screening and abdominal aortic aneurysm screening to the systemwide performance and clinical outcome measures.

Hepatocellular Cancer (HCC) Screening

Overall Compliance Rating: Partial compliance

Findings:

The standard of care in the United States for early detection of hepatocellular (primary liver) cancer continues to be performing semiannual ultrasound liver screening with or without alpha fetoprotein testing in patients with Child-Pugh class A and B cirrhosis, class C if awaiting transplant or certain groups with hepatitis B infection.[788] UIC adds certain patients with advanced fibrosis into this category which is consistent with standard of care.

Identification of those at risk and in need of surveillance can be improved by accurate problem lists that identify cirrhosis and active hepatitis B infection and monitoring of cirrhosis as a problem in chronic care clinics.

[788] UpToDate Surveillance for hepatocellular carcinoma in adults as updated 10/20/25.

Performance

Only four facilities provided hepatitis C records in response to the Monitor's requested for 10 records of patients with Hepatitis C from 10 facilities in the Central region. [789] One facility[790] provided no records stating they had no records responsive to the request. Two other facilities provided records but they were not patients with cirrhosis or advanced fibrosis.[791] The table below gives the results of the record review.

Review of 10 Charts from 10 Facilities to Evaluate Patients with F3/F4 Fibrosis Who Obtain HCC Screening							
Facility	Hep C charts Provided	Charts not responsive to Request	Problem list includes Hep C	Fibrosis level in record.	Cirrhosis or advanced fibrosis on Problem list	Followed in chronic clinic for cirrhosis or advanced fibrosis	Q 6-month screening completed
Graham	4	0	4	0	0	0	1
Ill River	7	3*	7	4	0	0	0
Jacksonville	1	0	1	1	0	0	0
Western	2	1**	1	0	0	0	1
Totals	14	0	13	5	0	0	2
* These were unresponsive because they were F2 fibrosis which does not require surveillance							
**This was unresponsive because the patient had hepatocellular carcinoma from apparent hepatitis C and no longer needed surveillance.							

Comments on results of chart review are as follows.

- Cirrhosis and advanced fibrosis[792] are not diseases that are tracked and managed in chronic clinic but should be.
- Cirrhosis and advanced fibrosis are not considered medical problems and are rarely placed on the problem list.
- Training should be conducted to ensure providers are aware that cirrhosis is a disease that requires management including:
    - Managing these patients in chronic clinic;
    - Upper endoscopy to exclude and manage esophageal varices;
    - Attention to renal function, ascites, peritonitis, and portal hypertension;
    - Consideration for beta blockers;
    - Increased attention to drugs with adverse effects on the liver; and
    - Screening for hepatocellular carcinoma.

[789] Information provided by IDOC dated 8/15/25 in response to the Monitor's document request item 116 to include patients (treated or not yet treated) with fibrosis scores of F3 or F4 who have been in IDOC for at least 2 years. The required components of the chart will include database, problem list, annual/biannual health visits, diabetes and/or hypertension chronic care visit notes, MAR, lab results, abdominal CT/abdominal and liver ultrasound results for previous 12 months.
[790] Lincoln.
[791] Danville and Hill.
[792] Surveillance for hepatocellular carcinoma is for patients with cirrhosis and includes some with advanced fibrosis. Advanced fibrosis, in this context, refers to select persons with chronic hepatitis B infection regardless of fibrosis stage. UIC has recommended surveillance for certain patients with F3 fibrosis.

IDOC does not track advanced fibrosis or cirrhosis. IDOC provided a document list of all patients who were treated at UIC.[793] The table below is taken from the UIC Treatment List. UIC tracks fibrosis scores of those patient treated for Hepatitis C infection.

UIC Hepatitis C Treatment List by Fibrosis Score				
Fibrosis Score	Do not follow-Do not qualify for Tx	Do not follow-Finished Tx	On liver medication	Total
F0			1	1
F0-F1	1	180	62	243
F1		3		3
F2		41	13	54
F2-F3			1	1
F3		17	3	20
F4		17	5	22
S1		1		1
Total	**1**	**259**	**85**	**345**

At least 42 patients are potential candidates for hepatocellular carcinoma surveillance. The Monitor is unaware of a mechanism tracking cirrhosis or advanced cirrhosis. The electronic record should be capable of tracking all patients with cirrhosis and prompting for hepatocellular cancer screening.

Recommendations:

1. Track the number of individuals with advanced fibrosis or cirrhosis (eligible for semiannual HCC screening) and the percentage who were offered, accepted, refused, or not offered. This data should be reported to the facility Quality Improvement committee at least every six months. This screening should be completed for all those with cirrhosis, advanced liver fibrosis, and other high-risk liver conditions.
2. Add Hepatocellular Cancer (HCC) screening to B.01.01Preventive Service and Periodic Health Assessment for individuals with advanced liver fibrosis/cirrhosis.
3. Add HCC screening to the systemwide performance and clinical outcome measures.

Section Summary:

Lung cancer, colorectal cancer, hepatocellular cancer, and prostate cancer are common causes of mortality in the IDOC. These four 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 develop and track the effectiveness of its cancer prevention screening program. Effective cancer and RHM screening in the IDOC for at-risk incarcerated persons has the potential to positively impact avoidable morbidity and mortality in the IDOC and ultimately in the community.

General Section Recommendations:

[793] Documentation provided by IDOC on 8/15/25 in response to the Monitor's documentation request item 161.

1. Ensure all adult immunizations and routine health maintenance (RHM)/cancer screenings, as respectively recommended by Center for Disease Control and Prevention (CDC) and the USPSTF (A and B recommendations), are being offered to all at-risk patients. (The USPSTF Prostate Cancer Screening (C recommendation) is also currently recommended in the IDOC Policy B.01.01, Preventive Services and Periodic Health Assessment).
2. The IDOC Cancer and Routine Health Maintenance (RHM) screening program guidelines must be reviewed and revised as needed to assure that updates to United States Preventive Services Taskforce A and B recommendations for routine health maintenance and cancer screening and Adult Immunization guidelines of the CDC are expeditiously incorporated into the IDOC guidelines.
3. Monitor and report adult immunizations and RHM/cancer screenings by facility, tracking number of eligible candidates, number and percent offered, number and percent accepted, and number and percent refused.
4. Ensure that the implementation of the electronic medical record (EMR) includes requirements to prompt, record, track and automatically report immunization and RHM/cancer screening data listed above in recommendation number 3.
5. Develop and implement an interval immunization and RHM/cancer tracking solution, optimally an electronic database, until the EMR is fully developed and functional.
6. Establish statewide training of providers and nurses on IDOC Policies and Procedures that provide guidance and direction on adult immunizations and RHM/cancer screenings and on the national standards as recommended and updated by the and by the United Preventive Services Task Force (USPSTF).
7. Discontinue counting both refusals and those who accept screening as completed in the scoring of performance and outcome measure for immunization and cancer screening. The goal should be to increase the number of eligible persons *receiving* immunization or *being screened* for cancer. Those who are offered and refuse the test should be tracked but not scored as completed.
8. Each performance and outcome measure needs to include a definition of the persons who are excluded from the intervention being measured.
9. Proceed with auditing a) Annual weight monitoring, b) Smoking history screening, c) Cervical cancer screening, d) Prostate cancer screening with the performance and clinical outcome measures. Each of these four additional measures have the potential to increase the early detection and even the prevention and treatability of cancers.

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 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:
The following documents were requested by the Monitor to evaluate compliance with the Consent Decree concerning medications.

- For central region facilities provide 1) times at each facility designated for medication administration, 2) times at each facility designated for insulin administration.
- List training completed since July 1, 2024, by nurses employed by either the state or the vendor at Big Muddy, Centralia, Danville, Dixon, Hill, Lincoln, Robinson, Shawnee, and Western.
- Logs from each facility documenting the results of temperature checks of refrigerators in the pharmacy since May 2025.
- The pharmacy inspection reports and medication administration audits documented by the consulting pharmacist on the Wexford Pharmacy Inspection form and MAR Audit form for the months of January through June 2025.
- Provide a copy of the pharmaceutical administration manual, the ten training modules and the polypharmacy and medication usage report included in the OCM/IDOC initiative for Pharmaceutical Administration Consultation. If this work is not complete provide a status update.[794]

The Monitor also reviewed the morbidity and mortality reports completed by SIU, reported adverse events, and the monthly quality improvement minutes. The Monitor also reviewed the records of individuals who died during this report period, examined medication orders, and the documentation of medication administered.

Medication management is listed in several areas of the Defendants Implementation Plan[795] including:

- A process improvement project on medication management in its entirety.[796]
- Part of another improvement project on chronic disease management and the evaluation of medication compliance.[797]
- A method to monitor medication adherence as part of the implementation of the electronic health record.[798]
- Improving medication safety as part of adverse event reporting, training, and process improvement projects.[799]

Progress Toward Compliance with II.B.6.c. and d.

There has been virtually no change since the Monitor's 8th Report with regard to how the Department manages medication delivery or the manner in which medication refusals are addressed. OHS elected to distribute in February 2024 two policies and procedures[800] related to medications as part of its Medical Policy and Procedure Manual without review and input from an expert in pharmacy operations[801] and

[794] Monitor's 9th report document request dated 5/10/2025, items 4, 46, 142-144.
[795] Defendant's Implementation Plan, Lippert Consent Decree, Case: 1:10 -cv-04603, Document #:1688 Filed 8/1/23.
[796] Items 54 (subpart 14) (completion date March 2024).
[797] Item 55 (completion date February 2024).
[798] Item 29 (completion date August 2024).
[799] Items 7 (3) (completion date September 2023), 36 (completion date November 2023), 50 (completion date December 2023), 51 (completion date January 2024).
[800] C.05.01 Medication Administration/Delivery, Count Process, and Training and D.02.01 Pharmaceutical Operations.
[801] The Monitor suggested that any drafts of 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. Email from Monitor to Janette

without completing a process improvement project on medication administration as outlined in the Implementation Plan.[802] The Monitor considers neither of these policies sufficient or comprehensive enough to guide medication practices at the IDOC facilities. In addition to having a pharmacy expert develop policy and completing the process improvement project other recommendations from the Monitor were:

- The vendor's subcontract pharmacy manual should not be used as policy guidance for IDOC facilities.
- Additional policies and procedures need to be developed to include how orders are obtained, use of "as needed" medication, medication errors, etc.
- Medication adherence should be addressed in a separate policy because the process is significantly different from medication administration and more guidance needs to be provided about supporting patient adherence and documentation thereof.
- The responsibilities of all the parties (UIC and subcontract nephrologists etc.) treating patients with medication at IDOC facilities need to be addressed.[803]

A third policy on chronic care[804] was also distributed as part of the MPPM which directs providers to review medication adherence and address barriers to patient adherence with prescribed medication.

The Department provided no evidence of compliance with its own policies and procedures.[805] Policy C.05.01 requires initial and annual training in medication delivery to be documented and kept on file by the HCUA. Training must cover at a minimum 14 topics, and the program must be approved by the Agency Medical Director. The Monitor requested training records since July 2024 for nurses employed by either the state or the vendor from nine correctional facilities. Only two facilities responded.[806] Records from neither facility document training in medication delivery at the time of initial hire or annually thereafter as described in the IDOC policy. One facility documented 24 hours of yearly nurses training, but it was without any description of the topics addressed.[807] The training requirements of C.05.01 are not documented and therefore compliance with policy cannot be verified.

The Pharmacy Inspections done monthly at each facility by subcontracted pharmacists are another source of data to evaluate compliance with IDOC policy and procedure. These reports do not appear to be reviewed by anyone but the staff at the facility and the results may be reported at the monthly facility QI meeting. The Pharmacy Inspection reports from 29 facilities for the period January through June 2025 were reviewed by the Monitor for this report.[808] Clearly there is a system wide failure to bring practices

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Candido dated 2/25/2022. OHS-Monitor Monthly Call, 10/18/2023. The Monitor provided feedback on two earlier policies in February 2022. See also page 146 of the Health Care Monitor 6th Report Lippert v. Jeffreys, March 13, 2023.

[802] Defendants' Implementation Plan, Item 54

[803] Monitor's feedback to OHS on C.06.01 Medication Administration/Delivery, Count Process, and Training dated 1/31/2024, D.02.01 Pharmaceutical Operations dated 1/2024. See also Health Care Monitor 8th Report, Lippert v. Jeffreys, November 13, 2024, pages 214-215.

[804] F.02.01 Chronic Care.

[805] Defendants' Section V.G. Report, December 18, 2024, states that it standardized the policy for medication administration C.05.01 but provides no evidence of implementation since it was made effective in February 2024.

[806] Monitor's documentation request for the 9th Report, dated 5/10/2025, item 46. Centralia and Dixon sent training records.

[807] Dixon training records.

[808] Material provided in response to the Monitor's documentation request for the 9th report, dated 5/10/2025, items 143 and 55.

into compliance with current procedures for medication management.

Findings from the Pharmacy Inspections	# of facilities not meeting the requirement at least once in the 6 months reviewed
• Vials of medication opened and undated or outdated.	20/29 facilities
• Refrigerator temperatures are not recorded.	12/29 facilities
• Medications in the cart for a patient that are not listed on the MAR.	13/29 facilities
• Medications are listed on the MAR but are not in the cart for a patient.	15/29 facilities
• Missing documentation of medication administered or issued.	25/29 facilities

It was two years ago the Monitor first noted that SIU had been engaged to evaluate the medication system.[809] The following actions and timelines are listed in the charter for the initiative:

Actions/Milestones	Target Date
1. Recruit and hire five (5) PharmDs	4/1/2024
2. Collect and analyze medication error data	9/1/2025
3. Create industry standard process for reporting medication errors	9/1/2025
4. Review and draft recommendations for pharmaceutical administration manual	12/1/2025
5. Create a minimum of ten (10) training modules for IDOC	12/30/2025
6. Polypharmacy and medication usage review and report	TBD

The target dates for items 2-5 have each been extended by a year.[810] Since the last report the pharmacy team has visited each correctional facility to observe medication administration and to complete a process map. The last facility site visit was completed in April 2025. No recommendations have been provided regarding best practices, policies or procedure, there has been no polypharmacy review, no performance measures have been proposed, and no analysis of medication usage or medication errors has been produced. The target dates for these actions were September and December 2025 and were not made available to the Monitor for review as part of the 9th report.

SIU has developed two of a minimum of 10 training videos. These were to teach nursing staff how to use the new diabetic pens and GLP-1 injections that are now prescribed by the diabetic specialty clinic operated by UIC. The Agency Director of Nursing assigned all nursing staff to view these two videos

[809] Health Care Monitor 6th Report Lippert v. Jeffreys, March 13, 2023, page 146.
[810] Charter provided by SIU in response to item 144 in the Monitor's documentation request for the 9th report dated 5/10/2025 compared to the document provided in response to item 129 in the Monitor's documentation request for the 8th Report dated 2/29/2024.

with completion by August 15, 2025.[811] No records were provided that document that this training expectation was accomplished and neither video included a test of knowledge or demonstration of competency. The Monitor has suggested since the 7th Report that the findings from mortality and morbidity reviews, adverse event reporting of medication errors, as well the pharmacy inspection reports inform the development of the curriculum to train nurses and providers about medication management. Topics suggested include patient safety and advocacy, medication reconciliation, standards of practice for "as needed" medication, communication with providers regarding orders and order clarification, how to deliver patient education about medications, factors that influence adherence, and techniques to support patient adherence with medications.[812]

Both computerized provider order entry (CPOE) and an electronic medication administration record (eMAR) are core components of Fusion's project and are expected to address many of the error prone and inefficient practices in medication management currently in place. However, implementation has been delayed. It was originally scheduled for statewide roll out the end of February 2025, but the initial pilot was only initiated in early December 2025.[813] In the 8th report the Monitor commented that the workflows for pharmacy services[814] must achieve tasks 1-4 of Implementation Plan item #55 and are listed below:

1. The use of two-part patient identification with the medication administration record.
2. The elimination of handwritten 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.

It is recommended that the Department evaluate whether these tasks are being accomplished during the pilot of the electronic health record.

Medication Error Reporting

Almost half of the 462 adverse event reports logged since 5/3/2024 involve medications (47%).[815] The Monitor has been provided no evidence of any trending or analysis of these reports to identify facility specific or systemic opportunities for improvement. It appears that corrective action has been initiated at several facilities for deficiencies in medication management although none appear to have been completed.[816] Many medication errors continue to be identified in mortality reviews as well. These findings and opportunities for improvement do not appear to have been analyzed to identify more specifically concrete steps to improve the safety and efficacy of medication treatment.

Findings Regarding Medication Administration and Delivery

In order to achieve the therapeutic intention of ordered medication, doses must be taken at the time and

[811] Email dated 7/11/2025 to HCUAs with follow up email dated 8/11/2025 requesting training completion forms. Provided in response to The Monitor's documentation request dated 5/10/2025 item 46.
[812] Health Care Monitor 7th Report Lippert v. Jeffreys, December 27, 2023, pages 172-173. Health Care Monitor 8th Report, Lippert v Jeffreys, November 13, 2024, page 218. Training of nurses, including medication administration is part of item 7 in the Implementation Plan.
[813] Meeting between the Monitor and the Agency Dental Director, December 5, 2025.
[814] Health Care Monitor 8th Report, Lippert v. Jeffreys, November 13, 2024, page 217.
[815] Adverse events list provided by IDOC on 8/15/25 in response to item 68 of the Monitor's documentation request.
[816] Material provided by IDOC on 8/15/25 in response to item 51 of the Monitor's documentation request.

interval for which they have been prescribed. For example, a medication ordered to be taken before meals needs to be available to the patient at or immediately before the meal. Medication ordered to be taken three times a day needs to be available to the patient every eight hours (i.e., 6am, 2pm and 10pm). The National Commission on Correctional Health Care states that the responsible physician in coordination with the health administrator and facility administrator determine all prescribing practices within the prison facility or system. Prescribing practices include *policies and procedures pertaining to the frequency and timing of medication administration* in all areas of the facility including restrictive housing and satellite facilities. It is further recommended that these policies and procedures identify those medications that are time critical and establish allowable time variance for time critical and those medications which are not time critical. [817]

The time for administration of directly administered medications is set forth in the Department's Administrative Directive 05.03.106 Control of Individual in Custody Movement.[818] Medication pass at medium custody facilities takes place at 7:30 am and 7:30 pm and at minimum custody facilities it is at 8 am and 7:30 pm. At maximum custody facilities medication pass takes place at 7:30 am only. Neither C.05.01 Medication Administration/Delivery, Count Process, and Training and D.02.01 Pharmaceutical Operations provide any direction about the timing or frequency of medication administration. *There is no evidence of any clinical input by the Agency Medical Director into the frequency and timing of medication administration*. The SIU pharmacy initiative needs to address the frequency and timing of medication administration in its recommendations for the pharmaceutical administration manual.

The Monitor requested facilities in the Central Region provide the times medication pass is scheduled at each facility and the results are listed in the following table. [819]

[817] NCCHC Standards for Health Services in Prisons, 2026, P-D-01 Pharmaceutical Operations, Interpretive Guidance, page 97. This guidance follows that of CMS and The Joint Commission. Time critical medications typically include insulin, anticoagulants, IV antibiotics, anticonvulsants, and medications for Parkinson's disease. The standard allowance is 30 minutes before and after the scheduled time. Other medications that are not time critical the allowance is generally 1-2 hours before and after the scheduled time. The allowable time allowance for medications related to meals is based on physiology, not clock time. For example, short acting insulin should be given within 30 minutes before meals.
[818] Effective 6/1/2025.
[819] Monitor's documentation request for the 9th report dated 5/10/2025, item 4.

FACILITY	AM Medication		Noon Medication	Evening Medication	HS Medication
Danville	7:30 AM			7:30 PM	
Decatur	4:00 AM & 6:40 AM	8:00 AM	12:00 PM	4:00 PM	8:00 PM
Graham	4:00 AM	9:00 AM	1:00 PM	4:00 PM	7:00 PM
R&C	3:00 AM	8:00 AM	1:00 PM	4:00 PM	
Hill	8:00 AM		12:00 PM	6:00 PM	
RHU	6:00 AM		12:00 PM	6:00 PM	
IRCC	8:00 AM		12:00 PM	7:00 PM	
RHU	5:00 AM				
Jacksonville	5 am MOUD, 6 am School	8:00 AM	12:00 PM	8:00 PM	
Lincoln	7:30 AM			7:00 PM	
Logan	6 am MOUD	8:00 AM	2:00 PM	8:00 PM	
Taylorville	8:00 AM		1:00 PM	8:00 PM	
Western	5:00 AM		11:00 AM	4:00 PM	6:00 PM

The first observation is that times for medication pass at several facilities do not even coincide with the Department's AD 05.03.106. A second observation is that the times for evening medication administration at Decatur, Jacksonville, Logan, and Taylorville are late enough to be acceptable for HS medications; the others are not. Evening medication time should coincide with the time-of-day incarcerated individuals prepare for sleep. Incarcerated persons are reluctant to take medications which make them feel sleepy or groggy (often these are medications for mental health conditions) if the day room, recreation or other movement is still permitted. According to the Department's AD 05.03.106 gym or recreation continues as late as 8:30 pm which is much later than the last medication pass scheduled at Danville, Hill, IRCC, and Lincoln.

Medication times should be based upon the dosing needed to maintain an appropriate concentration of the drug in the body, not convenience. For example, at Hill there is only 10 hours between the morning and evening dose of any medication ordered to be taken twice a day. The next dose is given 14 hours later or at 8 am. Medications ordered to be taken twice a day should be spaced 12 hours apart. Lincoln and Danville do not have midday times established for administration of any medication ordered more than twice a day. The midday time should be such that it is evenly spaced between morning and evening doses so that therapeutic drug levels are maintained throughout the day. Spacing of times for medication administration should be adjusted at Graham, Hill, IRCC and Taylorville to achieve more even distribution of medication throughout the day.

With regard to insulin, we have already commented in the earlier section on Dietary that schedules for insulin are not consistent with mealtimes. The timing of insulin will vary dependent upon the type prescribed for the patient. Danville, Graham, Hill, and Western need to adjust timing for meals and insulin to protect patients from hyperglycemia and hypoglycemia. We know from interviews with diabetic patients at Graham that they were fearful of taking insulin and the risk of experiencing hypoglycemia

from not being fed timely. The majority described having significant hypoglycemic episodes. To avoid these episodes diabetics reported that they rely on eating items from commissary instead.[820]

There does not appear to be any prevailing authority at the Department to establish consistent scheduling for meals and medications much less schedules that are consistent with ordered medical care or that support the patient's adherence to prescribed treatment.

The Monitor's 8th report described problems with medication treatment and management found during record review that included:

- Discontinuity of care[821]
- Failure to address pain and care at the end of life appropriately
- Inappropriate prescriptions and lack of meaningful pharmacy consultation.[822]

From the review of mortality records for this report these problems persist even after the distribution of the MPPM in early 2024.[823] Nearly any record reviewed of a patient with a chronic disease or other significant medical condition will provide evidence of discontinuity of care and/or inappropriate prescribing. For example, among mortality records reviewed for this report is a patient who died in September 2024 at the age of 41of an acute asthma exacerbation. He was never prescribed anything but a rescue inhaler during his incarceration, despite an extensive record of treatment for asthma during a previous incarceration at IDOC less than a year earlier. This was a completely preventable death.[824]

Palliative and end of life care has been identified by the Morbidity and Mortality Review Committee as an area in need of improvement[825] and an initiative charter was drafted in May 2025. The initiative is to create a standardized statewide program for palliative and end of life care with deliverables beginning in December 2025.[826] There were three patients among the records reviewed for this report who did not receive timely or responsive end of life care.[827]

Failure to Monitor Patient Adherence with Prescribed Medication

IDOC policy and procedure C.05.01 states that nonadherence with medication will be monitored by nursing but does not establish a means or method by which this will be done. Nurses are to notify the prescribing provider of any patient identified as non-adherent, but the policy also does not state how such

[820] Health Care Monitor 7th Report, Lippert v Jeffreys December 27, 2023, page 84.
[821] There are many reasons for lapses in continuity of prescribed medications. These include medication that is not sent from the pharmacy when ordered, expiration or delay in non-formulary approval, the patient not picking up issuable medications, orders expire without renewal being considered, failure to transcribe orders from one MAR to another, patient specific medications were not moved when the patient's location changes, failure to reconcile medication orders on patient transfer or change in housing location, etc.
[822] Health Care Monitor 8th Report, Lippert v. Jeffreys, November 13, 2024, pages 221-223.
[823] Mortality patients who experienced discontinuity in prescribed medications were # 1, 2, 4, 7, 8, 9, 10, 11, 13, 14, 15. For examples of patients who had inappropriate prescriptions see mortality patients 1, 4, 5, 6, 7, 8, 9, 10, 12, 14, 15.
[824] Mortality patient 4.
[825] Mortality & Morbidity Committee Meeting Minutes November and December 2023 provided in response to the Monitor's documentation request for the 8th report, dated 2/29/2024, item 45.
[826] OCM Initiative Charter Palliative and end of life program, provided in response to the Monitor's documentation request for the 9th report, dated 5/10/2025, item 29. Establishing additional resources to address the needs of the frail and/or elderly such as end of life care has been identified as one step in the Implementation Plan Task 70.
[827] See mortality patients 2, 6, 10.

notification takes place or that it is to be documented.[828] IDOC has provided no evidence that the policy has been implemented by the facilities.[829] The Department intends to use the electronic health record to automate notification of prescribers of patient nonadherence, but the automated record has yet to be distributed to every facility.[830] There has been no evaluation of the staffing necessary to monitor patient adherence with prescribed medication.[831]

The review of records for this report show that medication adherence is not effectively addressed when providers see patients.[832] The review of mortality records documented numerous chronic care encounters where there was no evidence that the provider had the MAR to review at the time of the visit as required by F.02.01 Chronic Care. Further, the records document episodes of nonadherence with prescribed medication which were never reported to the provider as required by C.05.01. Finally, the records reviewed document ineffective efforts by providers to address patient nonadherence, no discussion of barriers patients experienced in adhering to the prescribed treatment, or an evaluation of patients' knowledge and cognitive ability to comply with the treatment regime.

Summary

No changes as described in II.B.6.c&d. of the Consent Decree have been achieved with regard to medication administration and medication refusals. Two policies and procedures were distributed over the Monitor's objection and without review by a pharmacy expert. No evidence of compliance with these directives in actual practice has been provided.[833] While there is an adverse event reporting system there has been no analysis or trending of medication errors which comprise nearly half of these reports. Efforts to address issues with medication management have stalled or been delayed with no visible outcomes, except two training videos. There is no accounting of how many staff watched the videos, assessment of knowledge attained or demonstrated competency. The Monitor's review of records for this report showed that problems identified previously with medication management continue to persist and patient care outcomes compromised.

RECOMMENDATIONS:

1. Move forward with the Implementation Plan items 7 (step 3), 29, 36, 51, 54 (step 14), and 55 pertaining to medication management.
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. The timing and frequency of medication administration needs to be addressed by this group and AD 05.03.106 Control of Individual in Custody Movement revised accordingly.

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[828] Task 2 of item #29 in the Implementation Plan is to establish a process within the electronic health record to accomplish notification and documentation of provider actions in response to notification of medication nonadherence.
[829] Defendants' Section V.G. Report, December 18, 2024, page 15 offers documentation that C.05.01 has been developed but no evidence of its implementation.
[830] At the time this report was written the electronic record was being piloted at three IDOC facilities.
[831] 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.
[832] See Mortality patients 1,3, 8, 9, 10, 12, 13.
[833] Nor was any evidence provided demonstrating implementation of a third policy and procedure, F.02.01 Chronic Care, which addresses provider review of patient adherence with prescribed medication.

3. The pharmacists 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 communication of drug-drug interactions, medication combinations to avoid, drug warnings and contraindications with prescribing providers. The pharmacy should also assist providers in evaluating polypharmacy.
5. Revise C.05.01 and D.02.01 based upon review by a licensed pharmacist. Identify additional topics related to pharmaceutical management that need to be addressed in policy and procedure.[834] 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 time necessary to carry out orders for medication treatment.
7. Analyze medication error reports and identify recurrent types of errors. Conduct root cause analysis to understand systemic causes and develop solutions to eliminate these. The M&M findings should be similarly analyzed.
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 provide notification to prescribing 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.
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.
12. Establish performance and outcome metrics for medication management. Consider timeliness of order to first dose, timeliness of administration, issuable received by patients, refusals, non-formulary prescriptions.[835] These should be implemented with the advent of the electronic health record.

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*

[834] NCCHC Standards for Health Services in Prisons, 2026 should be reviewed and IDOC policies and procedures revised to be consistent with the extensive guidance provided by the standards for pharmacy services, medication administration and delivery of chronic care services.

[835] Consider using items on the Health Care Dashboard for California Prison Health Care Services at Dashboard - CCHCS.

medically appropriate.

OVERALL COMPLIANCE RATING: Partial Compliance

FINDINGS:

The Monitor requested discharge planning records for 10 individuals on the chronic care roster who have been released from Decatur, Dixon, Graham, Lincoln, Lawrence, Logan, Menard, Southwestern, Taylorville, and Western in the month of May 2025.[836] Also requested were monthly reports from the same facilities of the number of patients who received discharge planning and medications at provided at release since January 1, 2025.[837]

IDOC Self Evaluation in the V.G. Report

The Department states in their last V.G. report that their Policy E.01.01 Health Care Discharge Planning gives instruction that all persons with serious health needs have discharge planning completed in advance of discharge. Patients are to meet with a nurse to complete an assessment and if the nurse refers them as needing a plan of care, the patient meets with a provider. Orders for discharge medication are written, and the provider may refer the patient to a specialist in the community. Per vendor contract patients are provided with 30 days of discharge medications and notes that the policy requires patients receive 14 days of medication with a prescription for two additional weeks with one refill.[838]

The Department provides no evidence of compliance with the three items listed above or evidence that its practices are consistent with their policy and procedure on discharge planning. There is no internal/external audit of discharge planning and no CQI studies have been reported about discharge planning in the monthly minutes reviewed by the Monitor.[839] There are no Clinical Quality Performance metrics that address any aspect of discharge planning. It was over two years ago that the Monitor provided IDOC with an example of an audit tool to evaluate discharge planning.[840] There is no evidence yet that IDOC audits or monitors its practices regarding adequate continuity of care upon discharge.

Comments submitted by the Monitor during the Department's annual review of E.01.01 are to:

- Add an acknowledgement that sometimes notice of release is insufficient to accomplish discharge planning as described in policy.
- Provide more specific instructions about the documentation of medications provided to patients at the time of release.

[836] Monitor's document request 9th report, dated 5/10/2025, item 145. Documents requested were to 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.
[837] Monitor's document request 9th report, dated 5/10/2025, items 146-147.
[838] Defendants" Section V.G. Report, December 18, 2024, page 23. OSH policy E.01.01 differs from that stated in the V.G. Report " … patients with ongoing health care needs will receive a 14-day supply (or the remaining supply for a prescription that ends before the 14-day window) of ordered medications, prior to release to the community or Mandatory Supervised Release. The patient will also receive a written prescription for an additional 30-day supply of medication, which can be filled by the patient after discharge."
[839] The Monitor reviewed all CQI minutes received from facilities from January through June 2025 in response to the Monitor's documentation request 9th report dated 5/10/2025, item 55.
[840] Email to Melissa Jennings and Steve Bowman dated 7/12/2023.

- Reconcile the discharge medications and any written prescriptions to the current orders before they are given to the patient to take with them.
- Report monthly the number of patients discharged, the number who had a discharge planning needs assessment completed, the number seen by a provider for development of a discharge plan of care, and the number receiving medications at the time of discharge.

The last item has been suggested by the Monitor to demonstrate compliance with the Consent Decree.[841] The need for this information should have been made known to the vendor responsible for the electronic health record and be one of the reports the system is capable of generating.[842]

Discharge Planning

The Monitor requested lists since January 1, 2025 of patients who received discharge planning and those who received medications at discharge from the 10 facilities in the Central Region.[843] Of six facilities which responded only one tracks the number of patients who received discharge *planning*.[844] Of four facilities that provided a list of patients receiving medication at the time of discharge only one provided a month by month count of the number of persons released and the number released with medication.[845]

The Monitor reviewed 38 records provided by ten facilities of patients who were discharged in May 2025.[846] The review evaluated IDOC compliance with policy E.01.01 which had been in effect for more than a year.[847]

Discharge planning is documented as completed in advance by five facilities however it is usually done only a day or so before the release.[848] The policy requires this planning assessment to be completed no later than 60 days prior to release. This is so that if the patient has needs for discharge orders and/or review of their plan of care there is ample time to see a provider and arrangements made as necessary for referral and communication with community providers. None of the facility health care programs provided documentation that indicates compliance with the policy's guidance for an assessment of need and planning for discharge.

No one was identified among the 38 records reviewed as needing referral to a provider for discharge orders or a review of the patient's plan of care. Dixon was the only facility that requested prescriptions from

[841] These metrics were identified as needed in the Implementation Plan, task 31, subtask 5.
[842] Health Care Monitor 8th Report, Lippert v. Jeffreys, November 8, 2024, page 227.
[843] These were items 146 and 147 on the Monitor's documentation request 9th report, dated 5/10/2025.
[844] Hill reports the number receiving discharge planning. Decatur, Jacksonville, and Graham provided lists of people discharged – not those who received a pre-release planning visit. Danville only reported one person received discharge planning since January 1, 2025. Decatur's folder also included dental statistics which were not responsive to the request and may have been misfiled.
[845] This was Graham. Danville provided what looked like a handwritten working list. Hill provided copies of actual medication receipts and Logan provided a copy of their controlled substance and inventory sheet.
[846] Provided in response to the Monitor's documentation request, dated 5/10/2025, item 145. Records provided by Logan and Lincoln were incomplete and therefore not considered. Records were reviewed from Decatur, Dixon, Graham, Lawrence, Menard, Southwestern, Taylorville, and Western.
[847] These were discharges that took place in May 2025 or 14 months after the effective date of the policy.
[848] Decatur, Dixon, Graham, and Menard. Dixon uses a Health Status Transfer Sheet to document pre-release discharge assessment. This form has been found to be an inadequate form of communication with other health care providers (see M&M reviews) and is not recommended for a pre-release discharge assessment.

providers for discharge medications. These prescriptions appear to be written by nursing staff based upon existing orders and then signed afterward by providers. There is no evidence that providers have any meaningful role in ensuring the clinical appropriateness of the care patients receive at the time of discharge and immediately after.

Practices at individual facilities that should be considered for statewide adoption are pre-printed templates for documentation of discharge planning.[849] Menard has a pre-printed template that apparently is used to identify patients who need discharge planning. This is a novel idea and with some modification could be an effective means to identify patients that should be referred to a provider for review as part of the discharge planning process.[850]

The majority of facilities provide patients who are being discharged with a copy of DOC0433 Discharge Medical Summary. These are completed by registered nurses at all facilities except Southwestern and Western.[851] These summaries do not have space in the template to document follow up recommendations for the patient. None of the discharge summaries reviewed had an outside appointment scheduled for the patient.

While incarcerated, the majority of the 38 patients whose discharge paperwork was reviewed were enrolled in chronic clinic and many also were on the mental health caseload. The majority had ongoing health care needs and there should have been more specific documentation of plans to continue their care in the community. For example, patients who are being followed for HCV should have documentation of how ongoing care will be provided in the community.[852] Diabetic patients who take insulin will need ongoing health care in the community. Documentation on the Discharge Medical Summary is that they are to make an appointment with their primary care provider. There is no inquiry to document whether the patient has a primary care provider and if not, documentation that the patient was given information about how to obtain a primary care provider.[853] Decatur is the only facility that documented informing patients about services provided by the local health department and how to access them.

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[849] The one used at Southwestern should be modified slightly to ensure that all areas are discussed with the patient (how to access care in the community, resources of the local health department, and preventive health recommendations to include vaccine history etc.). The Health Care Monitor's 8th report commented that Stateville used a pre-printed DOC 0084 that provided more guidance about what is to be covered in discharge planning than the one used at Decatur, page 227. In previous reports the Monitor has suggested that the discharge planning worksheet used at Lawrence was also a good tool but based upon the records submitted from Lawrence for this report does not appear to be in use currently (Health Care Monitor 3rd Report, Lippert v. Jeffreys, February 15, 2021, page 131). This worksheet has a place for physician and psychiatry review and entry of information into the Offender Tracking System (OTS) about release needs. Use of this worksheet could 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.

[850] The form is labeled MD./Psych Note but appears to instead be completed by a nurse. None of the records submitted by Menard were for patients identified as needing health care planning prior to discharge so it is not possible to know how health care planning is documented and by whom.

[851] Licensed practical nurses may also complete them at Southwestern and Western.

[852] Many patients with HCV are monitored through UIC and have access to pre-release planning but there is no documentation of this on the Discharge Medical Summary or in the discharge planning progress note. The same is true of patients with HIV.

[853] It may be that another part of the IDOC organization addresses enrollment in health care coverage and access to ongoing health care in the community. If so, the medical program should be able to document that the patient's ongoing health care needs are being addressed and by what department or program.

The Discharge Medical Summaries were too general and incomplete to be useful information for a provider in the community to assume care of the patient. For example, patients were described as having asthma[854] without any information about severity, last exacerbation, triggers, peak flow etc. or as being a diabetic[855] without specifying the last available HbA1c, eye exam etc. One patient is listed on the discharge summary as having hepatitis C.[856] The discharge summary included no information about patient's fibrosis score, lab tests, etc. Abnormal lab results are sometimes documented on the Discharge Medical Summary, but other results that were appropriate to include as a baseline were not.[857] No information is provided on the Discharge Medical Summary about patients' vaccine history nor are recommendations made for preventive health care such as vaccines, screening exams, and diagnostic tests. The Medical Discharge Summaries from Decatur do document discussion of resources for contraception.

Patients leaving IDOC do receive a discharge summary, but it is not an accurate and complete summary of the patient's condition, care provided, and recommendations for ongoing care therefore II.B.6s remains partially compliant.

Receipt of Medication Upon Release

A 30-day supply of active medications orders is typically provided at the time of discharge. DOC0490 is used to document the patient's receipt of discharge medication at each of the facilities that provided responsive documents with the exception of Graham. Graham uses a MAR to document issuance of medication just as they do issuance of Keep on Person medication. It appears that patients releasing from Graham are provided whatever medication remains from the last issue on the day of discharge. No receipt for medication was signed by patients releasing from Graham. It does not appear that discharge medication is reconciled with current orders, a step which is recommended in the next policy revision. Dosing, frequency, route, and other directions for the patient are not consistently documented on DOC0490 and should be.[858] The 30-day supply of medication that is provided is more than the 14 days specified in the Consent Decree. Based upon Defendants' last VG Report this practice appears to originate from a vendor contract requirement.[859]

Only Dixon provided patients with a prescription for medication to be filled at a pharmacy in the community. Two of these were patients who received monthly injections for psychiatric disorder.[860] One patient was due for an injection seven days after release. No refill for the injection required the following month was allowed. This is a short period of time to establish a mental health provider in the community and there was no documentation that this was done in advance of release. None of the other facilities which provided responsive records for review, document providing a prescription to fill in the community after release as required by II.B.6.t of the Consent Decree.

[854] Discharge patients 4, 7, 17, 19, 30, 36.
[855] Discharge patients 1, 19, 21, 34 -36.
[856] Discharge patients 13.
[857] Southwestern consistently documented abnormal lab results but gave no recommendations for follow up testing or other diagnostic tests. Discharge patient 14 was being treated for anemia – recent lab results should have been provided. Discharge patient 18 had hypertension and chronic kidney disease. The stage of kidney disease is not listed and no GFR results were provided. This patient also had a colonoscopy, and the results were not documented on the Medical Discharge Summary.
[858] The Monitor has recommended that these instructions be added to D.01.01 in the next revision.
[859] Defendants'' V.G. Report, December 18,2024, page 23.
[860] Discharge patients 3 & 5.

Compliance with II.B.6t has not yet been demonstrated by IDOC. While a new policy and procedure on discharge planning has been distributed it has not been implemented yet based upon the records reviewed from seven facilities.

Summary

There is considerable variation among facilities in the practice and documentation of discharge planning. There is no evidence of provider [861] involvement in discharge planning or clinical review of need for medications or referral. Medical summaries are incomplete or inaccurate, there is no information on 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 is 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. IDOC needs to establish metrics for reporting discharge planning and develop a tool to audit compliance with the Consent Decree.

The Monitor noted that Dixon, Decatur, Lawrence, and Menard document providing Narcan to some patients when they discharge. This is good practice. Revisions to E.01.01 should include directions for which patients are offered Narcan, information provided on its use and expectations for documentation that it was offered as part of the discharge paperwork.

RECOMMENDATIONS:

1. Provide more guidance for nursing staff on how to conduct discharge planning than is present in the policy and procedure. This guidance could be in the development of screen templates to address the subjects that should be covered with the patient and/or other caregivers.
2. Nurses also need training in how to do discharge planning with patients and caregivers including how to assess their capability to provide for themselves in accordance with the recommended plan of care. They also need more guidance about which patient conditions or circumstances define patients who need to be seen by a provider before release.[862]
3. Providers need to be informed of their role in discharge planning, have the opportunity to discuss their concerns and have questions answered. HCUAs and the facility Medical Director need to determine how this workload will be accomplished and provide direction to providers.
4. Standardize the documentation of discharge planning and the discharge summary. Standardize what material in addition to the discharge summary and medication instructions needs to be included (vaccine history, most recent chronic clinic notes, most recent labs etc.).
5. Establish the means and methods to provide data and analysis to evaluate compliance with the Consent Decree and E.01.01 Discharge Planning.
6. Request assistance from the Director of Pharmacy Standards and Operations to develop guidelines for determining which medications and amounts are appropriate to be provided at discharge and

[861] Specifically, physician, nurse practitioner, or physician's assistant.
[862] The Monitor suggests that this would be a topic that SIU could provide training on for nurses and for providers and could be put on the Health Matters website. An educational video could also be made for incarcerated persons in preparation for release about application for health coverage, primary care resources in the community, services provided by the local health department, and the importance of preventive health maintenance.

to recommend best practices for documentation of discharge medication.
7. Clarify and establish policy on transferring responsibility for patient care to a jail or another prison system outside the IDOC when individuals are released from IDOC custody.
8. Revisions to E.01.01 should include directions for which patients are offered Narcan, information provided on its use and expectations for documentation that it was offered as part of the discharge paperwork.

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 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:

Policy

IDOC established a number of infection control policies effective February 2024. The Monitor has submitted suggested changes to IDOC during the annual review cycle.[863] IDOC included several policies on infection control in dental services that duplicate other infection control procedures. These are displayed next to each other in the table below.

G.01.01 Infection Control Program	G.18.01 Infection Control in Dental
G.07.01Medical Management of Infectious Exposure	G.18.03 Dental Occupational Exposures
G.11.01 Handwashing	G.18.05 Dental Hand Hygiene
G.14.01 Potentially Infectious Waste Management	G.14.01 Dental Sharps and Biohazards
G.16.01 PPE & Other Supplies	G.18.02 Dental PPE

Maintaining two sets of infection control policy on handwashing, for example, (one for dental and another for everyone else) runs the risk of contradictory directions. The Monitor suggests that IDOC consider

[863] The Monitor submitted the results of its annual review and suggested revisions to G.01.01 – G.18.11 to IDOC on 9/23/25.

consolidating infection control policies and procedures that appear to duplicate guidance on topics such as the areas listed in this table.

The Agency Infection Control Coordinator indicated that additional policies and procedures are being developed to address management of negative pressure rooms and linen control for the infirmary units.[864] These would be welcome policy additions. The Monitor also suggests IDOC develop a policy on facility and statewide maintenance of surveillance data for infection control which would expand on what is briefly described in G.02.01 Disease Reporting procedure section VI. and procedure section VII. The Monitor also recommends establishing a policy specific to vaccination of individuals in custody who are workers who may be subject to exposures to body fluids.

IDOC has not fully implemented the current infection control policies.

Infection Control Program

It has been difficult to move the infection control programs forward as there is only one position dedicated to infection control in the entire IDOC health program; this is the Agency Infection Control Coordinator. There are no budgeted positions for facility infection control coordinators. IDOC assigns nursing staff to complete infection control duties as part of their other regularly assigned duties. These individuals do not have any training or expertise in infection control and have no organizational relationship to the Agency Infection Control Coordinator. This makes it extremely difficult for the Agency Infection Control Coordinator to implement changes or new efforts in infection control. The Monitor recommends that the Agency Infection Control Coordinator supervise dedicated infection control positions at facilities.[865] The Monitor also congratulates the Agency Infection Control Coordination on receiving Certification in Infection Control from the Certification Board of Infection Control and Epidemiology since the 8th Report[866] and is fully qualified for the position he holds at IDOC. This accomplishment achieves compliance with II.J.1 of the Consent Decree.

Typically, a prime responsibility of the infection control program is to produce and maintain an infection control manual. The last report noted that an infection control manual was being developed for IDOC.[867] The SLQC minutes reflect ongoing updates on the status of this effort however to date the Monitor has not received any drafts to review.[868]

Infection Control Committee

Policy G.04.01 Infection Control Committee establishes a multi-disciplinary committee chaired by a physician to oversee the Agency's Infection Control Program. This committee is directed by policy to establish an Exposure Control Plan, plan responses to public health emergencies, and analyze 1) all monthly facility reports on communicable disease, 2) safety and sanitation reports, 3) occupational exposures, 4) standardized disease statistic reports, 5) monitoring data for negative pressure rooms, 6)

[864] Meeting with IDOC regarding infection control on 11/13/25.
[865] These positions would be accountable to the HCUA for attendance and coordination of operation.
[866] HealthCare Monitor, 8th Report, Lippert v. Jeffreys, November 8, 2024, page 234.
[867] HealthCare Monitor, 8th Report, Lippert v. Jeffreys, November 8, 2024, page 233.
[868] Work with SIU on an infection control manual is listed as a topic of discussion in the System Leadership Quality Council meeting minutes in January 2024, May 2024, June 2024, November 2024 and April 2025. The April 2025 update was noted as "still working on the manual".

sterilization of instruments, 7) vaccinations, and 8) any outbreaks. IDOC's response to the Monitor's request for the minutes of infection control meetings was that they "do not have an infection control committee yet because of our staffing shortage, but its plan is to create one".[869]

Instead, infection control updates have been incorporated into the OHS Quarterly Meetings, attended by general administrative and clinical leadership. Copies of two presentations from January and April 2025, covered vaccinations, measles, and plans for infection control in 2025.[870] However, these meetings do not reflect analysis or discussion of surveillance data or any of the topics described in G.04.01. The quarterly OHS meetings are not a satisfactory substitute for the infection control committee. The committee needs to address all aspects of the infection control program, including identifying root causes, developing corrective actions for systemic failures, and the status of the improvement efforts. The current pressing problem of the infection control program is the lack of staff to implement the program but there is no evidence that this has been discussed at OHS meetings.

Infection Control Report and Monitoring

Infection control requires, but does not have, an effective surveillance system to provide essential data for quality control and oversight. This system should follow an active, data-driven approach that includes mechanisms for monitoring and implementing corrective actions. Additionally, the program needs to collect, manage, and analyze health data related to surveillance and incidence.[871] The Monitor has recommended hiring data analysts to satisfy this need.

IDOC policy G.02.01 Disease Reporting concerns primarily the reporting of infectious diseases as required by State regulation. The policy mentions that the Infection Control Committee may identify additional conditions or diseases for internal monitoring and that these are reported to the Agency Infection Control Coordinator using the method and within the period specified by the committee. However, IDOC has yet to establish an Infection Control Committee.[872] There are no more specific instructions on acquiring, maintaining, and reporting surveillance data. The Monitor recommends that IDOC develop a more specific policy guidance on standardized statewide surveillance data reporting.

The IDOC response to the Monitor's request for surveillance data and a log of orders for testing for infectious diseases was that no surveillance data was received from facilities and that no tracking log of orders for testing was maintained.[873]

IDOC should report surveillance data for any required infectious disease screening that IDOC currently obtains and any other data that requires continuous monitoring. IDOC should maintain the following surveillance data.

- QuantiFERON testing of inmates coming through reception;
- Annual tuberculosis skin testing for individuals who are incarcerated as well as employees

[869] Documents provided by IDOC 8/15/25 in response to the Monitor's document request #150.
[870] One PowerPoint for the 1/30/25 meeting included seven slides covering updates on the vaccination program and plans for an infection control plan in 2025. A second PowerPoint for the 4/25/25 meeting included seven slides covering updates on measles.
[871] Newton Kendig, Sarah Bur, and Justin Zaslavsky; Infection Prevention and Control in Correctional Settings, Emerging Infectious Disease; 2024 April 30 (Supplement 1): 588-593 as found at https://pmc.ncbi.nlm.nih.gov/articles/PMC10986825/
[872] Section VI of the policy and VII of the procedure.
[873] Response from IDOC dated 8/15/25 to the Monitor's documentation requests 154 and 155.

- Syphilis;
- Gonorrhea (females);
- Chlamydia (females);
- Hepatitis C;
- Hepatitis B;
- HIV;
- Tuberculosis conversions[874] on annual testing (employees and inmates); and
- Culture positive and presumptive MRSA.[875]

IDOC should establish a process for using the electronic medical record to track surveillance data. This would require the expertise of a data analyst but would save facilities time spent reporting and greatly facilitate infection control oversight across the state.

For intake screening surveillance data[876], the Monitor recommends IDOC track all patient's screened with name, number, facility, date of the test, and result of test. Reported data should include the number of persons screened for a particular day, the number of eligible persons entering IDOC on each particular day, and the total number who are positive on that date.

For annual tuberculosis screening of employees and inmates, IDOC should report the name, date of testing, result of skin test or QuantiFERON, and facility. Reported data should include the number and percent of persons screened and the number and percent positive. For inmates, the electronic record can be used. For employees IDOC should develop a tracking log.

IDOC should report MRSA[877] surveillance data to include the patient's name, IDOC number, facility, housing location, antibiotic used for treatment, if the case was presumptive, and the date and result of the culture, if completed. IDOC should also track any new case reports of infectious diseases including measles, RSV, COVID-19, norovirus, candida aureus, etc., as they occur.[878]

IDOC should annually review their panel of screening tests with IDPH and adjust it as recommended by IDPH.

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[874] A conversion is a tuberculin skin test or a QuantiFERON test that becomes positive after being documented as being negative on a prior test.
[875] Presumptive MRSA is a purulent skin or soft tissue infection, "spider bite-like" lesions, rapidly progressive cellulitis with purulence, recurrent skin or soft tissue infections in a housing unit, or use of an antibiotics used in treating a MRSA skin or soft tissue infection for a purulent infection. All skin and soft tissue infections with purulence or as listed above should be cultured for MRSA but frequently are not and are therefore called presumptive.
[876] QuantiFERON, syphilis, gonorrhea, hepatitis C, hepatitis B, and HIV.
[877] Facility CQI reports do reflect that some facilities do report suspect and confirmed cases of MRSA and other infectious diseases. However, each facility makes its own determination of what to track and report with regard to infectious disease, so no trending or analysis is possible. MRSA is important to report because infections are often reflective of unsanitary conditions in housing units (lack of soap, towels, sharing towels, and lack of sanitation) that require specialized cleaning.
[878] In the past, IDOC has had outbreaks of norovirus, histoplasmosis, and scabies. See Danville Prison Outbreak Not Caused by Virus, Maybe Fungus reported 9/13/13 by PBS found at https://will.illinois.edu/news/story/danville-prison-outbreak-not-caused-by-virus-maybe-fungus. Stateville Prison Laid Low by Flu-Like Virus; Patch 12/28/12 as found at: https://patch.com/illinois/joliet/stateville-inmates-laid-low-by-norovirus-oubreak. Illinois prison has outbreak of rash; Corrections1 11/17/13 as found at: https://www.corrections1.com/correctional-healthcare/articles/ill-prison-has-outbreak-of-rash-4H2kBWKkevpNYR08/

Relationship with Illinois Department of Public Health (IDPH) and Infectious Disease Consultation

The Monitor's 8th Report states that IDOC had completed a written agreement with IDPH that formalized the public health relationship between IDPH and OHS/IDOC and that monthly meetings were taking place.[879] However this agreement has never been shared with the Monitor.[880] According to the Agency Infection Control Coordinator regular monthly meetings with IDPH had stopped for some period of time. IDOC plans to reinitiate joint meetings with IDPH on a quarterly basis in January 2026 to include the new vendor and a regular agenda.[881] The Monitor recommends meeting minutes be kept as well.

The Monitor requested any written guidance IDOC had received from IDPH regarding infection control since March 2024 and received copies of 16 documents for folders of information.[882] These consisted mainly of emails between IDPH and IDOC Agency Infection Control Coordinator with IDPH's suggestions to participate in webinars, and provision of guidelines, health advisories, and other materials believed to be of interest to IDOC. The three communications received in 2025 all involved participation in web-based training or seminars. These documents do not reflect an ongoing consultation with infection control issues within IDOC.

There was one communication regarding an individual who had Candida aureus.[883] This is a fungal disease that can quickly colonize multiple people and is especially problematic for correctional environments because of congregate living quarters and the need for isolation of those with advanced disease. It is not clear if this person was ever in an IDOC facility as there was discussion about transferring the patient from a hospital to a nursing home. This is one example of IDOC consulting with IDPH, which was appropriate. If this patient were admitted to an IDOC facility ongoing consultation with an infectious disease physician for clinical care would have been necessary. This example points to the ongoing need for a clinical consultative service in infection control. Because the Monitor has not seen the agreement between IDOC and IDPH, it is unclear if it includes clinical consultation.

There are no other documents about consultations with IDPH including our recommendation that IDPH be consulted on the lab and diagnostic testing recommended at intake facilities.[884] The Monitor has suggested that IDPH could assist with development of an infection control plan including what should be in the plan, could help with process issues such how to improve vaccinations, provide advice on development of a training curriculum for infection control nurses, and how to develop an appropriate surveillance system.[885] IDPH could also provide assistance in developing an infection control manual. There was no evidence of regular communication, meetings or any other regular contact with IDPH is occurring.

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[879] Health Care Monitor 8th Report, Lippert v. Jeffreys, November 13, 2024, page 234.
[880] The Monitor requested meeting minutes or a program description of IDPH's relationship with IDOC. See Monitor's 9th report documentation request dated 5/10/25. Nothing was received from IDOC in response. Since no formal agreement was ever produced it leads the Monitor to believe that such an agreement never was completed contrary to the information provided by IDOC at the OHS – Monitor monthly call on 9/21/23.
[881] Meeting with IDOC regarding infection control on 11/13/25.
[882] Material provided by IDOC on 8/15/25 in response to the Monitor's documentation request item 149.
[883] Email from Mike Bierman IDPH to Dr. Bowman and Joseph Ssenfuma dated 8/9/24 provided by IDOC in response to the Monitor's documentation request item 149.
[884] Health Care Monitor 9th Report, Lippert v. Jeffreys, November 13, 2024, page 141.
[885] Ibid, page 234.

Infection Control Nurses and Program Support Staff

The Monitor requested two documents on facility infection control staffing.

- Nursing personnel at each facility who are assigned the duties of Infection Control listing their names, licensure (RN, LPN), and percentage of time assigned to these duties (document request 148).
- Provide documentation of training provided to facility infection control nurses beginning February 2025. Documentation should include topics discussed, who was in attendance, and any measures of post-training competency (document request 152).

Aside from the Agency Infection Control Coordinator, there are no budgeted infection control positions in IDOC. IDOC provided no data or information in response to the Monitor's request on nursing personnel assigned the duties of infection control nurses or the percent time assigned to infection control duties.[886] The Monitor's 8th Report documented that only three facilities had assigned 100% of a position's responsibilities to infection control.[887] The Monitor recommended in the 8th Report that facilities take steps to ensure that dedicated infection control nurses have adequate time to fulfill their responsibilities.[888] The extensive duties outlined in the Facility Infection Control Policy (G.03.01) indicate that a full-time infection control nurse is necessary in all but the smallest facilities. Because there are no dedicated staff there is no corresponding position description. Instead, nursing staff are tasked with infection control duties along with their other clinical responsibilities and the duties assigned vary by facility.

IDOC also provided no data that any training had been provided to nurses assigned infection control duties (document request152 above). This appears unchanged from the previous report. The Monitor's 8th Report, noted the absence of a standardized training curriculum for facility nurses. Staff responsible for infection control duties received only on-the-job training, with no formal curriculum or clinical oversight. Without properly trained nurses, the effectiveness of the program would be inadequate. The Monitor recommended that an effective, ongoing infection control training program be developed for all infection control nurses, with documentation of annual training sessions.[889] The Agency Infection Control Coordinator told the Monitor that the new vendor intended to assign two regional infection control nurses who will help in training for facility staff.[890] However, the Monitor has no evidence of vendor staffing to date and no evidence of training.

IDOC does not make any data personnel available to assist in development and maintenance of a surveillance system. The lack of this services is evident in the Infection Control Report and Monitoring section below. Data staff must be available to make an infection control surveillance system functional.

Safety and Sanitation Rounds

Policy G.03.01 Facility Infection Control requires the Infection Control Nurse to participate in monthly Safety and Sanitation rounds, during which they must monitor and track eight specified infection control

[886] IDOC Response to Lippert Monitor 9th Report Documentation Request, dated 8/15/2025, item 148.
[887] Health Care Monitor 8th Report, Lippert v. Jeffreys, November 13, 2024, pages 236 – 238. These included Western, IRCC, and Stateville. Given Stateville's closure there would be the need for one less infection control nurse.
[888] Health Care Monitor 8th Report, Lippert v. Jeffreys, November 13, 2024, page 242.
[889] Health Care Monitor 8th Report, Lippert v. Jeffreys, November 13, 2024, pages 238 and 242.
[890] Meeting with IDOC regarding infection control on 11/13/25.

matters. Review of the safety and sanitation inspection records and meeting minutes reveals that requirements of policy G.03.01 are not accomplished.[891] Expansion of the safety and sanitation inspections is discussed in the Safety and Sanitation section earlier in this report.

Immunization Program

IDOC's Implementation Plan tracker, tasks 27 to identify a mechanism to track the volume of vaccines offered, administered and refused per facility and 28 to include the number of candidates eligible for those vaccines are both documented as complete. Evidence of completion is a link to a group of documents that the Monitor cannot currently access.[892]

Performance and outcome measures include data on influenza, pneumococcal, and Shingrix vaccines. There has been a small improvement in influenza vaccination. See the discussion on Vaccinations earlier in this report. Other vaccinations are not tracked despite the Implementation Plan tracker documenting that ALL adult immunizations are tracked.[893] Policy G.03.01 Facility Infection Control procedure I.T. states:

> "The Agency Infection Control Coordinator develops nurse protocols for vaccination. The facility Infection Control Coordinator is to train and oversee the nurses who perform this function; this is done in consultation with the IDPH consultant. The HCUA and Director of Nursing are to arrange which nurses will perform this function."

The is no evidence yet that this procedure is implemented.

Policy G.01.01 Infection Control Program, procedure IV. requires facility infection control coordinators to maintain documentation of hepatitis A and B vaccination status for those who are at potential risk of exposure to fecal pathogens and blood-borne infections. This includes custody workers and porters. Also, the policy on facility infection control states that duties of the "dedicated Infection Control Nurse" include "vaccination and training procedures for individual in custody workers who expect to have blood-borne pathogen exposure in their work".[894] The Monitor agrees with these policy statements as they protect the health of both the incarcerated population and the staff. However, there is no evidence that these policy requirements have been implemented.

IDOC provided no data or information in response to the Monitor's request for documentation of training provided to porters and other incarcerated individuals assigned to assist in infirmaries and other high-risk areas. The Department stated this training was being developed with the hope to start it in October 2025.[895] There is no evidence to ensure that these individuals are educated or vaccinated.

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[891] Material provided by IDOC on 8/15/25 in response to the Monitor's documentation requests 55 and 92.
[892] IDOC has declined to give continued access to the Implementation Plan Project Manager's tracking spreadsheet. The reason to discontinue access was that IDOC is in litigation regarding the Implementation Plan.
[893] Implementation Plan task 28 to track adult immunization and RHM/cancer screening acceptance rates is documented as completed on the IDOC Implementation Plan tracker.
[894] G.03.01, procedure I.BB.
[895] IDOC Response to Lippert Monitor 9th Report Document Request 158 dated 8/15/2025. This training should cover proper methods and barriers to prevent the transmission of infections.

Monitoring of Negative Pressure Respiratory Isolation Units

The Consent Decree specifically calls out the requirement to monitor negative pressure units (III.J.2.). IDOC policy establishes requirements to monitor negative pressure rooms.[896] (Policy G.10.01Transmission-Based Precautions outlines the specific requirements for monitoring negative pressure rooms. Health care staff are responsible for ensuring that each isolation room maintains adequate negative pressure, verified through the tissue test. When a patient occupies a room under respiratory isolation, staff must perform a tissue test daily. When the room is not in use for respiratory isolation, staff must conduct the test at least weekly. Staff must document all testing activities in a log that records the results of each tissue test.

The previous monitoring report identified deficiencies in testing methodology, specifically noting noncompliance with the mandated tissue test procedure. Instead of using the required tissue paper method to verify negative pressure, staff relied solely on pressure gauge readings without appropriate verification.[897]

Policy G.10.01. Transmission Based Precautions, procedure V. describes the method used to monitor negative pressure rooms. Twenty-two of 29 facilities provided documentation of their review of negative pressure rooms.[898] Review of these documents indicates persistent documentation failures further compounded by systemic reporting deficiencies. Examination of facility logs revealed the absence of a standardized tool for recording monitoring activities. Documentation of both pressure gauge checks and tissue paper tests remains inconsistent across facilities. This is evidence that Policy G.10.01 has not been implemented.

Tuberculosis (TB) Screening Program

The Centers for Disease Control and Prevention (CDC) recommends symptom screening upon entry to a facility and isolation if symptoms are positive until TB can be ruled out. They recommend screening with Interferon Gamma Release Assay (IGRA) or a Mantoux skin test of all incoming inmates. If a patient has a positive IGRA or Mantoux skin test, CDC recommends timely chest radiography and prophylaxis. CDC recommends follow up annual screening of all inmates with a negative IGRA or Mantoux skin test.

IDOC has no specific policy or procedure on tuberculosis screening for inmates. Three policies give some information on tuberculosis screening.[899] Policy B.01.01 requires annual screening for tuberculosis, assigning a "designated member of the nursing staff" to conduct TB screening, but gives no procedure for how this is to be accomplished, and does not require any tracking of the test. The policy requires that patients with latent TB will receive prophylaxis if not already provided. E.05.01 requires orders to be obtained for QuantiFERON testing. The policy requires that nurses "Identify patients who may have transmissible disease and require isolation" but this is insufficient direction for symptom screening for active disease. Policy G.03.01 requires the "dedicated Infection Control nurse"[900] to ensure that all new

[896] G.01.01 Procedure item I.P.5. and G.03.01 Facility Infection Control Procedure item I.Q.E..
[897] Health Care Monitor 8th Report, Lippert v. Jeffreys, November 13, 2024, page 241.
[898] Material provided by IDOC on 8/15/25 in response to the Monitor's documentation request item 156.
[899] B.01.01 Preventive Services and Period Health Assessment; E.05.01 Intersystem Receiving Screening; and G.03.01 Facility Infection Control.
[900] Only three facility infection control nurses were dedicated based on data from the 8th Report. Data for this report was not provided.

patients in reception centers are screened for tuberculosis; ensure timely chest X-rays are completed and prophylaxis is initiated for those identified through screening; and perform annual tuberculosis interviews for changes in TB status with prophylaxis and treatment as indicated. *None of these policies includes a procedure for how screening is to be accomplished. None require tracking of the results of screening.* The Monitor has recommended development of an infection control manual which policies can reference.

Three policies mention employee TB screening.[901] Policy G.03.01 requires the facility Infection Control Nurse to perform new employee TB testing. G.05.01 requires new employees to receive initial symptom screening, and a Mantoux skin test. A primary care physician is required to document follow up of positive tests results. Details on when annual screening is accomplished and the process for screening are not provided in the procedure.

These policies are not specific enough, particularly for screening individuals in custody. How screening is to occur and what symptom screening consists of is not described. No information about tracking results of screening tests is provided and apparently not performed. A policy and procedure specific to tuberculosis screening should be developed or a procedure for tuberculosis management and tuberculosis screening developed for the infection control manual and referenced in policy. How surveillance data for tuberculosis screening is obtained and analyzed needs to be described in policy.

The Monitor's previous findings noted that the IDOC implemented IGRA testing for tuberculosis screening exclusively within its four Reception and Classification Centers (R&C). The Monitor has recommended replacing the Tuberculin Skin Test (TST) with IGRA blood testing for all individuals in custody throughout the IDOC system.[902] Currently, the IGRA testing has not been expanded beyond the R&C Centers. The Monitor requested a report on any progress made to expand IGRA testing beyond the reception centers and a copy of the specific budget request[903]

IDOC provided six documents providing cost data comparing IGRA testing and unit cost of Tubersol used in Mantoux skin testing. The cost of the test alone showed a significant difference between Tubersol (skin testing $1.48 per test- two visits needed) versus IGRA (blood test $39.52 per test- one blood test needed). However, when labor costs were included, the costs per individual test were $41.37 per IGRA test vs. $58.83 per Mantoux skin test.[904] IDOC recently informed the Monitor that they do not intend to expand IGRA testing and will continue with Mantoux skin testing.[905] The Monitor believes that given staffing shortages IGRA testing should be pursued especially because the American Thoracic Society, Infectious Diseases Society of America, Centers for Disease Control Joint Clinical Practice Guidelines recommend using TB blood tests (IGRA).[906]

Recommendations:

[901] G.03.01 Facility Infection Control and Health Maintenance; G.05.01 Employee TB Testing; and Administrative Directive (AD) 03.02.101 New Employees (effective 6/11/24).
[902] Health Care Monitor 8th Report, Lippert v. Jeffreys, November 13, 2024, pages 240-241, 242.
[903] Monitor's 8th report document request dated 5/10/25, item 159.
[904] Documents provided by IDOC on 8/15/2025 to the Monitor in response to document request 159.
[905] Email from Katelin Buell to Catherine Knox 11/21/25. No reasons were given for this decision.
[905] ATS/CDC/IDSA Clinical Practice Guidelines: Diagnosis of Tuberculosis in Adults and Children, published 12/8/2016 as found at https://www.idsociety.org/practice-guideline/diagnosis-of-tb-in-adults-and-children/

1. Continue the development and implementation of a comprehensive, statewide Infection Control Program.
2. Ensure that the Agency Infectious Diseases Coordinator maintains certification in infection prevention and control through the Certification Board of Infection Control and Epidemiology.
3. Initiate quarterly statewide infection control meetings of infection control personnel. Establish a standard agenda to ensure all aspects of the Infection Control Program are assessed and discussed on a rotating basis.
4. Establish the Agency Infection Control Committee to provide oversight and guidance to the Infection Control Program. Establish a standard agenda to ensure all aspects of the Infection Control Program are reviewed on a rotating basis.
5. Continue to maintain the IDOC relationship with the Illinois Department of Public Health for consultation and advice on preventive and public health issues. Capture meeting minutes and track action items.
6. Hire or contract with an infectious disease physician consultant or academic program to provide access to outpatient consultation on patients with complicated infections.
7. Take steps to ensure that facility infection control nurses are allotted sufficient time to be able to manage the infection control duties outlined in Policy G.03.01. Assign a full-time RN in all correctional centers except for the small facilities.
8. Develop an effective and ongoing infection control training process for all infection control nurses and document annual updated training sessions. Establish a process to track training completion.
9. Complete the collaborative development of an Infection Control Manual (with assistance of SIU) and the Infection Control PowerPoint presentation (with assistance of IDPH) that will serve as a reference guide and training tool for infection control staff and other clinicians.
10. Standardize the monitoring of negative pressure units to include tissue test results. Ensure these results are reported to the monthly facility CQI committee meetings.
11. Replace tuberculosis skin testing (TST) with IGRA blood testing for all individuals-in-custody (IIC) in the IDOC.
12. Require that all custody workers/porters at risk for fecal-borne and blood-borne infections be vaccinated for Hepatitis A and Hepatitis B or have documented proof of immunity. Establish a process to identify them and a tracking process to monitor compliance.
13. Track and report on the Infection Control Program's compliance with infection control-related elements of the Consent Decree and items in the Implementation Plan.
14. Develop workflows sufficient to ensure surveillance data for the infection control program is automatically captured and reported.

Hepatitis C Treatment Program

IDOC policy is aligned with USPSTF,[907] CDC,[908] and the Infectious Disease Society of America[909]recommendations for universal hepatitis C infection screening. The Monitor reviewed a

[907] USPSTF recommends screening for hepatitis C virus in adults aged 18 to 79 years. B recommendation as found at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening
[908] CDC recommends universal hepatitis C screening for all adults 18 and older and all pregnant women during each pregnancy; as found at https://www.cdc.gov/hepatitis-c/hcp/diagnosis-testing/index.html.
[909] Hepatitis C Guidance 2023 Update: American Association for the Study of Liver Diseases- Infectious Diseases Society of America Recommendations for Testing, Managing, and Treating Hepatitis C Virus Infection as found at https://www.idsociety.org/globalassets/idsa/practice-guidelines/hcv/ciad319.pdf

sample of 49 reception records for this report. Menard did not include laboratory test results but the remaining 39 records from Graham, Logan, and NRC all included a hepatitis C test. However, this is an insufficient sample to determine the effectiveness of intake screening for hepatitis C but confirms that hepatitis screening is typically conducted.

Current standard of care for hepatitis C patients include universal treatment for all patients with hepatitis C.[910] Current standards of care in evaluation of persons with hepatitis C include establishing liver fibrosis levels and cirrhosis to inform prognosis, planning for further treatment, and determines need for ongoing evaluation which would include surveillance for hepatocellular carcinoma.[911]

The Monitor requested the following documents to monitor hepatitis C.

- A hepatitis C treatment list with the number of individuals separated by facility with hepatitis C, the number undergoing treatment, the number awaiting treatment, the number who completed treatment, the number treated, and the number of annual visits via telemedicine to the UIC liver clinic.
- A list of hepatitis C individuals listing name, identification number, date of birth, fibrosis score and whether they were treated at UIC.

IDOC provided documents for both requests. The first document IDOC provided was a summary of the number of individuals in IDOC with hepatitis C not a list of hepatitis C patients as requested. IDOC provided the data on 8/15/25 and did not provide the date range for this data; its title was Statewide HCV Tracking 2025. The dates of diagnosis, referral, and completion of treatment are unknown. Based on the data, the Monitor can only say that IDOC is referring patients to UIC, and about half of the patients in IDOC with hepatitis C at the time of this data remain to be treated. Because IDOC did not include the dates applicable to this data it was less useful. The IDOC data was as follows.

1. The number of individuals currently infected with hepatitis C (658);
2. The number of individuals currently receiving treatment (31);
3. The number of individuals who have completed treatment (213);
4. The number of individuals who have been referred to UIC (59);
5. The number of individuals with hepatitis C who have refused treatment (47);
6. The number of individuals with contraindications to treatment (9); and
7. The number of individuals who are pending treatment (299).

IDOC provided a second document which was a list of all patients treated at UIC for hepatitis C between approximately January of 2024 to end of June 2025.The list from UIC and the data from IDOC were apparently not comparable dates. The UIC data does show that from 1/10/25 to 7/18/25 102 patients started treatment for hepatitis C or approximately 15 per month.

IDOC provided data that is insufficient to determine if IDOC is complying with current standard of care for treatment of hepatitis C.

The Monitor strongly recommends IDOC to use the electronic record to obtain the following data

[910] Ibid.

[911] UpToDate section on Patient evaluation and selection for antiviral therapy for chronic hepatitis C virus infection. See also Hepatitis C Guidance 2023 Update: American Association for the Study of Liver Diseases- Infectious Diseases Society of America Recommendations for Testing, Managing and Treating Hepatitis C Virus Infection cited above.

elements.

1. Date of entry into IDOC by individual inmates;
2. The numbers of persons coming into IDOC monthly;
3. Date of released from IDOC by individual person;
4. Name and IDOC number of those screened for hepatitis C monthly with date of testing;
5. Name and IDOC number of all individuals who test positive or negative for hepatitis C.
6. Name and IDOC number of all individual who have a fibrosis test, test name, the date of test and test result;
7. Name and IDOC number of all individuals with hepatitis C referred to UIC for treatment with date of referral;
8. Name and IDOC number of all individuals persons who complete hepatitis C treatment with date of completion;
9. Name and IDOC number of those with F3/F4 or cirrhosis diagnoses;
10. Name and IDOC number of individuals with Hep C with date(s) of ultrasound, MRI, or CT of abdomen.

These data elements should all be present in the electronic medical record and allow for automatic data acquisition that can be used to verify compliance.

Data that should be on the IDOC dashboard includes:

- Percent of incoming inmates screened for hepatitis C monthly;
- Number of incoming inmates positive for hepatitis C per month; and
- Number of individuals with hepatitis C who complete treatment per month:

The Monitor has not seen evidence of a protocol or practice of obtaining ultrasound screening for hepatocellular carcinoma of persons with advanced fibrosis or cirrhosis including those with hepatitis C. Based on record reviews, it does not appear that cirrhosis is a condition that is followed in chronic care. This is discussed in the earlier section on Preventive Health Care section. Treatment of cirrhosis and advanced fibrosis as medical conditions warranting individual chronic care follow up is needed.

As noted previously, the definition of contraindications to HCV treatment used by IDOC are not in alignment with current standards of care.[912] It is unclear what definition of "contraindication" to treatment is being used in the material. The Monitor's recommendation in the last report was to consult with the UIC HCV specialist and develop a definition of the contraindications to hepatitis C treatment. It is unclear if that was done.

Summary:

- IDOC policy requires hepatitis C screening but the numbers and percent screened is not known and IDOC does not audit its performance.
- The data provided by IDOC for hepatitis C treatment has no dates and is difficult to interpret. UIC data show approximately 15 persons a month have treatment for hepatitis C initiated.
- UIC tracks the numbers treated but a comparative number with respect to the hepatitis C population within IDOC is unknown.
- IDOC will have an electronic medical record. They need to obtain hepatitis C data using their

[912] Health Care Monitor 8th Report, Lippert v. Jeffreys, November 13, 2024, page 244.

electronic record to verify their status more effectively with respect to diagnosis and treatment of hepatitis C.

- The electronic record will have data on fibrosis testing and should have problem lists that identify cirrhosis to make surveillance for hepatocellular carcinoma effective.

Recommendations:

1. IDOC needs to track and report liver ultrasound screening for hepatocellular cancer (HCC) in individuals with treated or untreated HCV advanced liver fibrosis. The current national recommendation is to perform liver US every six months on all patients (HCV and other liver conditions) with advanced liver fibrosis.
2. IDOC should begin to track the number of new admissions to the four Reception and Classification Centers that are identified having active HCV infections.
3. The data requests listed above should be gathered and reported electronically in the new electronic medical record (EMR).
4. Display hepatitis C data on a statewide dashboard as recommended above.

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:

To evaluate the Consent Decree provisions listed above, the Monitor requested the following documents:

1. A list of allocated/budgeted medical and dental positions (also noting FTE) with vacancies for each position at each facility to include IDOC and Wexford positions. These should be separated by position type. Aggregate positions statewide should be included.
2. A list of SIU and OHS allocated or budgeted staff by position type, noting primary area of responsibility, with vacancies.
3. The number of hours worked by staff employed by any staffing agency or locum tenens at each facility by job title since March 2025 to include dental hygienists, and dentists.
4. Facility Reconciliation of Hours worksheets since January 2025.
5. Spreadsheet listing all dentists with name and assigned facilities.
6. Provide, by facility, the number of requests for dental care, the number of examinations, the number of emergent procedures completed, the number of routine procedures completed, the number of dental cleanings, the number of prosthetics, the number of extractions, the number of restorations, the average wait times, longest wait times, and the backlogs for prosthetics, extractions, restorations, and dental cleanings[913]

As discussed in the Staffing section of this report, IDOC provided staffing data that was nonresponsive to

[913] Monitor's documentation request 9th report, dated 5/10/25, items 8, 9, 14, 16, 34, 165.

the request for budgeted, filled, and vacant staffing that is comparable to IDOC's Court-filed Staffing Analysis staffing numbers. The State staffing list was inaccurate for medical positions but not for State dental positions. Vendor staffing, however, did not include vacant and filled FTE positions and vendor hours worked did not include agency, or overtime hours. As a result, comparison to the Staffing Analysis was not possible.

Dentists

The number of FTE State and vendor dentists budgeted is 34.45 but IDOC did not provide the number of filled positions for the vendor. The Court-filed Staffing Analysis included 36.15 dentists,[914] which is 1.7 more dentists than are now budgeted. When the Staffing Analysis was filed with the Court there were 27.4 dentists positions filled compared to 15.88 positions working now,[915] a 42% reduction from the time the Staffing Analysis was filed with the Court. If agency and overtime are included, the 15.88 hours worked is a 50% vacancy rate. The staffing situation for dentists is worse now than when the Staffing Analysis was filed. The vendor uses agency staff to fill dental positions and the data provided by IDOC cannot be used to make a comparison with the 2021 Staffing Analysis. The vendor relies on a subcontractor (Jet Dental) and overtime coverage to supplement dental staffing; however, the manner in which IDOC reports this data does not permit a valid comparison with the 2021 Staffing Analysis.

The vacancy table submitted by the Department (redacted) identifies systemwide dentist staffing shortages during the review period.[916] Because the table does not include a date of assessment, the timing of the vacancy snapshot cannot be verified. Nonetheless, the data reflect 13 unfilled dentist positions, demonstrating persistent staffing gaps that undermine the Department's ability to provide timely and adequate access to dental care.

Facility Name	Dentist
Big Muddy	Vacant
Centralia	Vacant
Danville	Dentist #1
Decatur	Dentist #2
Dixon	Dentist #3
East Moline	Vacant
Graham	Vacant
Hill	Dentist #4
Illinois River	Vacant
Jacksonville	Dentist #5
JITC	Vacant
JTC	Dentist #6, Dentist #7
Kewanee	Vacant
Lawrence	Vacant
Lincoln	Vacant

[914] This included 1.8 recommended new positions which has since been eliminated.
[915] This is the average working dentists from January to June of 2025 as found in the Wexford folder in document request #8. The 1.68 average Chief Dentists were not included.
[916] Names of dentists were redacted and assigned numbers.

Logan	Dentist #2, Dentist #8
Menard	Vacant
Murphysboro	Dentist #9
NRC	Dentist #10, Dentist #11
Pinckneyville	Dentist #9
Pontiac	Dentist #6, Dentist #12
Robinson	Vacant
Shawnee	Dentist #13
Sheridan	Dentist #14, Dentist #15
Southwestern	Dentist #16
Taylorville	Dentist #17
Vandalia	Vacant
Vienna	Vacant
Western IL	Dentist #18

A total of 18 individual dentists, supplemented by Jet Dental mobile services, provided some level of coverage across the system during the review period. However, the aggregate hours reported fall well below what would be expected of a fully staffed vendor workforce. A recommended inmate-to-dentist ratio is 1000 to 1.[917, 918]

Overall staffing patterns reflect a system operating with an insufficient and overstretched dental workforce. This concern is particularly evident at Dixon Correctional Center, a facility with an operational capacity of approximately 1,975 individuals (see table below), where the reported coverage is inconsistent with what would reasonably be expected for a facility of this size, which would typically require staffing equivalent to at least two full-time dentists (2.0 FTE) to meet routine and ongoing oral health care needs.

[917] Makrides, N.S., et. al., Dental Services in Correctional Settings, in M. Puisis, Ed. *Clinical Practice in Correctional Medicine,* 2nd ed., Elsevier/Mosby, 2006557-563.
[918] Douds, A. S., Ahlin, E. M., Fiori, N. S., & Barrish, N. J. (2020). Why prison dental care matters: Legal, policy, and practical concerns. *Annals of Health Law, 29*, 101–129.Available at: https://lawecommons.luc.edu/annals/vol29/iss2/3

Vendor Dentist Hours Worked Compared to Budgeted Contract Hours -Dixon			
Metric	Jan/Feb 2025	Mar/Apr 2025	May/June 2025
Total Dentist Hours Worked (two-month period)	181	219.75	309.75
Expected hours worked for 2 budgeted dentists for 2-month period	624*	688**	656***
Shortfall	443	468.25	346.25
Percent of Staffing Need Met	29%	32%	47%
* In January and February of 2025, there were 39 work days (New Year's Day and Martin Luther King Day were State holidays). 39 days x 8 hours =312 x 2 dentists = 624 hours			
** In March and April there were no State holidays but 43 workdays x 8 hours =344 x 2 dentists = 688 hours			
*** In May and June there were 41 workdays (Memorial Day and Juneteenth were State holidays) x 8 hours= 328 hours x 2 dentists = 656 hours			
Data from Wexford folder in document request #8			

At Dixon, the Total Dentist Hours Worked—representing the actual amount of clinical care available to patients—demonstrate substantial limitations in coverage. During January–February, only 181 hours of dentist time were recorded, increasing modestly to 219.75 hours in March–April, and rising to 309.75 hours in May–June. When converted to clinical workdays using the Department's standard 7.5-hour day, this equates to 24.13, 29.30, and 41.30 workdays, respectively. Even in the final reporting period, these levels remain well below what would be required to support routine, urgent, and preventive dental services for a facility of Dixon's size and population.

The IDOC was unable to provide any information responsive to the Monitor request for backlog data.[919] The absence of these data prevents any meaningful evaluation of whether staffing levels are adequate to meet clinical demand or to evaluate the Department's progress toward the Decree's access-to-care requirements.

Given these deficits, it is essential that the Department and its new vendor, Centurion, address the persistent shortages in dentist staffing and take immediate steps to stabilize clinical capacity across all facilities. Moving forward**, Centurion must focus on filling all outstanding dentist vacancies, while IDOC must independently conduct a comprehensive statewide staffing analysis to determine the dentist hours required at each facility based on population size, clinical demand, and documented backlog.** Without these data, and without an IDOC-driven staffing model aligned to system needs, there is no assurance that timely and adequate dental care can be delivered.

Jet Dental Mobile Unit

To help offset staffing shortages, the Vendor utilized a mobile dental unit operated by Jet Dental under its

[919] IDOC Response to Lippert Monitor 9th Report Document Request, item 165, dated 8/15/25 to include the number of prosthetics, extractions, and restorations completed; the average and longest wait times for these procedures; and the associated backlogs for prosthetics, extractions, restorations, and dental cleanings.

contract with Wexford. According to the documentation provided[920], Jet Dental delivered onsite services at four facilities, Danville, Dixon, Illinois River, and Logan, during the January–June 2025 reporting period. The use of a mobile unit has the potential to supplement limited onsite capacity, particularly in facilities with persistent vacancies or high clinical demand.

However, the dataset submitted[921] to the Monitor contained irregularities that undermine its reliability. Multiple entries (Logan) reflected **future service dates** well beyond the reporting period. Although the Monitor received the dataset[922] in August 2025, the file included service entries for **October and November 2025** at Logan Correctional Center, dates that had not yet occurred.

Given ongoing staffing shortages and the vendor transition underway, accurate and reliable reporting of mobile dental unit activities is essential. IDOC must ensure that future datasets adhere to basic standards of completeness, internal consistency, and chronological accuracy so that the Monitor can evaluate the effectiveness of this supplemental service.

Hygienists

IDOC has not conducted a workflow analysis to determine how many hygienists are needed. IDOC's population is approximately 29,000 individuals with 22 hygienists. These facilities have uneven distribution of hygienists. Three facilities have no budgeted hygienists.[923] IDOC provided the number of vacant hygiene positions but did not make clear if the hours worked included overtime or agency staff.

This number of hygienists is unable to obtain compliance with dental prophylaxis being conducted annually and hygiene as necessary to satisfy dental standards of cleaning prior to procedures. Hygiene staffing levels are insufficient to meet annual dental prophylaxis requirements as outlined in dental policy E.04.01.[924]

An analysis of the bi-monthly Lippert Medical Positions data[925] reveals that the vendor averaged a vacancy percentage of 19.7 % with approximately 3.5 FTEs being vacant for the 6-month reporting period. The table below highlights Wexford's staffing of the hygiene positions across IDOC. The table below is based on hours worked. A vacancy rate cannot be calculated because the hours worked did not include agency and overtime hours.

[920] Jet Dental Service from October 1, 2024 to April 1, 2025 a document provided by IDOC on 8/15/25 in response to the Monitor's document request, item 14.
[921] Ibid.
[922] Ibid.
[923] Vienna, Western, and NRC.
[924] E.04.01 Oral Health Services effective 2/2024 procedure II.E. "Routine dental prophylaxis will be conducted annually".
[925] Three files in Wexford folder provided by IDOC on 8/15/25 in response to the Monitor's document request 8.

Vendor Hygienist Budgeted Hours vs Hours Worked with Percent Unfilled Hours				
Month	Budgeted FTEs	Hours Worked in FTEs	Hours Not Filled in FTEs	Percent Unfilled Hours
Jan-Feb	19.55	14.01	5.54	28.3%
Mar-April	19.55	16.99	2.56	13.1%
May-June	19.25	15.62	3.41	17.7%
Average	19.45	15.54	3.83	19.7%
Data from Wexford folder in document request #8				

Without a staffing report, production data, or backlog information, the impact of hygiene vacancies on service delivery cannot be determined. Several facilities, notably Vienna and NRC, show no documented evidence that dental hygiene care was provided during the review period. It is unclear whether these facilities shared an FTE or whether dentists assumed responsibility for hygiene procedures.

Dental Assistants

The table below presents Wexford's dental assistant staffing for the January–June 2025 reporting period.[926]

Vendor Dental Assistant Budgeted Hours vs Hours Worked with Percent Unfilled Hours				
Month	Budgeted FTEs	Hours Worked in FTEs	Hours Not Filled in FTEs	Percent Unfilled Hours
Jan-Feb	36.2	24.12	12.08	33.4%
Mar-April	36.2	27.93	8.27	22.9%
May-June	35.9	25.48	19.42	29.0%
Average	36.1	25.84	10.26	28.4%
Data from Wexford folder in document request #8				

It is unclear if the dental assistant staffing are a result of the substantial number of unfilled dentist positions. Once the vendor fills these vacancies, each dentist will require a budgeted dental assistant position to meet programmatic expectations, maintain clinic efficiency, and ensure that treatment can be delivered safely and effectively.

Summary

The transition from Wexford to Centurion has restricted access to key operational reports, limiting the Monitor's ability to assess current system performance. When coupled with the failure to provide comparative data for budgeted, filled and vacant dental positions, absence of service delivery metrics, such as production, backlog volumes, and wait-time data, this information gap makes it impossible to fully evaluate how staffing levels have affected clinical operations or contributed to delays in treatment. The Monitor's recommendations from the Eighth Report therefore remain unchanged, with continued

[926] Ibid.

emphasis on the need for a comprehensive workload analysis of all dental positions to ensure that care is delivered efficiently, consistently, and without excessive delays.
With respect to backlog data, the Monitor believes that the Department must maintain ownership and oversight of these metrics. A review of the Med Database[927]reveals that the platform has the potential to track a variety of items necessary to monitor dental care if appropriate data expertise is assigned to manage it. Development of a functional system will be critical for monitoring patient access, identifying emerging delays, allocating staffing resources, and evaluating the performance of any dental vendor. The Monitor continues to recommend utilizing the electronic record system to obtain data for most data monitoring. Forward progress in this area is essential to understanding and managing IDOC's dental program across the enterprise.

RECOMMENDATIONS:

1. A statewide workload analysis needs to be accomplished to address discrepancies in dental care staffing across the state. A workload analysis should ensure equitable distribution of dental hygienists and dentists based on facility needs and population size.
2. Staff ratios (e.g., inmate-to-dental ratio) should be established after completing a workload analysis. This ratio should be designed to ensure compliance with the Consent Decree and the overall needs of the population.
3. All facilities should have a budgeted hygienist position. A workload (staffing) analysis should be used to redistribute hygiene support based on population size and facility need.
4. Expeditiously recruit and hire dentists to fill all current and ongoing dentist vacancies.
5. Conduct a thorough analysis to identify the root causes of attrition and vacancies among dental personnel.
6. Continue to provide emergency and essential dental services during this staffing shortage.
7. Obtain data expertise to ensure that data captured by the electronic record will be able to provide the necessary data to verify dental compliance. If IDOC decides to utilize the Med Database, IDOC should obtain expert data support assistance.

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 requested the following documents specifically to review for compliance with the items from

[927] This is currently a data collection system used by 19 facilities to collect a variety of data on sick call, specialty care, and dental care. Only 19 facilities participate. It is not governed by policy, and there is variability in data entered. The draft version sent to the Monitor has incompletely entered data; incorrect dates and some data entered which appears to be inappropriate. Despite these early problems, this type of data collection is a positive development. The Monitor strongly recommends using the electronic record for data capture and obtaining personnel with expertise in data management and presentation to avoid the data collection issues that IDOC has had in the past.

the Consent Decree listed above.

1. Provide five dental charts from five sites (Graham, Logan, Vienna, Hill, and Pontiac) for patients who had a dental extraction(s) in the month of March or April 2025. [928]
2. Provide six dental records of patients that had urgent care (sick call) appointment at Dixon, Graham, Sheridan, Lawrence, Vienna, and Logan.[929]

Use of SOAP Format

The Consent Decree requires that all urgent care notes be documented in SOAP format. A total of 36 urgent care records were requested for review. The Monitor limited the review to care provided between January and July 2025. Several records were excluded because they fell outside this time frame, and others were omitted because the associated requests pertained to routine care, such as cleanings, fillings, or inquiries about the status of ongoing treatment, rather than urgent conditions. One facility, Sheridan, did not submit any records.

Eighteen records met the inclusion criteria and were reviewed. Thirteen (72%) appropriately utilized the SOAP format. Although most urgent care notes followed the required structure, it was evident that some clinicians did not consistently or accurately document information within the appropriate SOAP sections. Moreover, the presence of a template, whether paper-based or digital, does not on its own ensure proper or meaningful documentation. An example of a clinical note (extraction) from Logan is provided for review.

SUBJECTIVE:
ext #1
OBJECTIVE:
pan one pa
ASSESSMENT:
ext 1
PLAN:
ext 1
EDUCATION:
post op instr given tylenol 500 given and amox 500
CO-PAY:
☐ $5.00 Co-pay

[928] Monitor's documentation request 9th report dated 5/10/25, item 162 to include medical problem list, dental notes, documents, consents, and requests for care for 6 months prior through two weeks after the extraction and the most recent dental x-ray report(s). These records should have health histories or indicate that the provider reviewed a health history before extracting a tooth.

[929] Monitor's documentation request 9th report dated 5/10/2025, item 171. Three or more years of record to include a copy of the request for care, the clinic's response, and any grievances filed in the last three years. Records will also include any consents for dental care. A total of 36 dental records were requested. All urgent care records should use the SOAP format. The purpose of requesting records from the past three years is to verify that each patient's medical history was completed, updated, and reviewed (as would be done at the Biennial Exam).

This SOAP note records treatment in only a minimal fashion and does not demonstrate clinical reasoning or patient input. It reflects a checklist approach rather than a comprehensive clinical narrative. A review of the dental progress notes indicates that the documentation does not follow the standard SOAP format.

- The Subjective section should include the patient's reported symptoms, complaints, or chief concern prompting the visit.
- The Objective section should document the clinician's findings, including observations of the oral tissues, radiographic interpretation, and any visible pathology. However, these critical elements were missing or incomplete in several records reviewed.
- The Assessment should synthesize the subjective and objective information to establish a clear diagnosis or clinical impression that justifies the treatment rendered.
- The Plan section, while listing an extraction, failed to include procedural details such as the type of anesthesia administered, extraction technique, intraoperative complications, or confirmation of hemostasis.

Comprehensive documentation in each section is necessary to meet accepted clinical standards.

This type of documentation deficiency was observed in both electronic and handwritten notes. Continued monitoring by IDOC and the vendor should emphasize not only the consistent use of the SOAP format but also accurate and complete application so that the record reflects the clinician's diagnostic reasoning, procedural actions, and the patient's presentation.

The most recent revision of the Oral Health Policy, E.04.01, clarifies the appropriate use of the SOAP format for urgent care notes. However, publication of a policy alone does not ensure compliance.

It is recommended that the Chief of Oral Health Services collaborate with the new vendor to ensure that all newly hired dental staff receive structured orientation and ongoing guidance on SOAP documentation standards. In addition, IDOC and the vendor should routinely monitor the quality of SOAP entries and incorporate periodic reviews of progress notes into the Continuous Quality Improvement (CQI) program. This approach will help ensure consistent compliance, improve documentation accuracy, and promote accountability across all facilities.

SOAP Format Use in Non-Urgent Care

Of the 30 records provided in response to the Monitor's request for records of patients who were seen urgently[930], nine were used to document encounters unrelated to urgent care. The Monitor observed the SOAP (Subjective, Objective, Assessment, Plan) format being applied to hygiene appointments, routine clinical encounters, and treatment planning.

While the SOAP format is widely used in medicine and dentistry as a structured method for documenting patient encounters, its application within IDOC has been inconsistent and, in many cases, inappropriate. The Monitor frequently observed hygienists using SOAP notes to document routine cleaning visits and dentists using them to document comprehensive examinations and treatment plans. In these instances, the SOAP note was used in place of the required documentation formats that capture essential elements of a Comprehensive or Biennial Examination. To ensure accuracy and consistency, SOAP should be reserved

[930] Records provided by IDOC on 8/15/25 in response to the Monitor's documentation request 171.

for documenting urgent or problem-focused encounters, not as a substitute for comprehensive examinations, hygiene appointments, or treatment planning.

Documented Health History

For this portion of the review, the Monitor requested extraction records, as all providers are expected to review a patient's health history prior to performing an extraction. In addition to the dental health history, the Monitor also requested the Problem List to determine whether the dental record was consistent with the patient's reported medical conditions.[931]

An initial limitation identified in this review was that the Monitor did not specifically request inclusion of dental Form 0422. This omission created a challenge, as the medical history is typically documented on Form 0422. By limiting the production request to dental records from the previous six months, the Monitor inadvertently reduced the ability to fully assess the completeness of medical history documentation. As a result, the Monitor could evaluate medical history only in those cases where a DOC 0422 form happened to be included in the submitted records.[932]

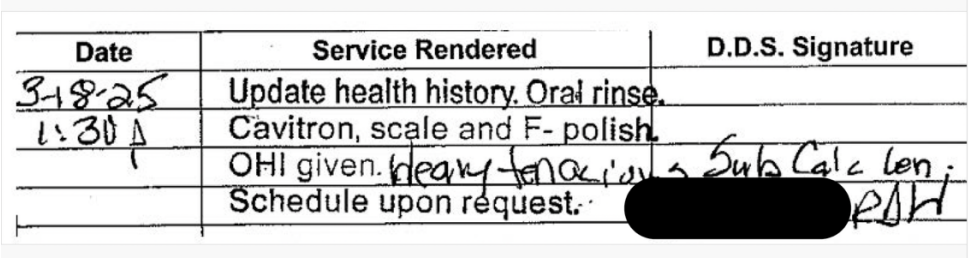
Nineteen extraction records containing DOC 0422 forms were reviewed. Of these, ten (52%) included current health histories. Six records lacked a completed medical history section on the 0422 form, and three records contained outdated information, including one last updated in 2004, and one additional record dated 2002 was only partially completed, rendering it unreliable for clinical decision-making.

Among the ten records with current health histories, only four documented that the dentist reviewed the patient's medical history prior to performing the extraction. This inconsistency raises concern regarding compliance with standard preoperative protocols and the adequacy of provider review to ensure patient safety.

The request for corresponding Problem Lists provided the Monitor with additional context for cases in which the dental section lacked a recorded health history. Notably, three patients from Hill Correctional Center had documented hypertension (noted on the problem list).[933] The medical history section of the dental Form 0422 was blank. Yet, extractions were performed without evidence that a medical history was reviewed or that a blood pressure reading was taken prior to the procedure. This represents a serious lapse in clinical practice and exposes patients to significant risk, including hypertensive crisis, stroke, myocardial infarction, or cardiac arrest.

While reviewing records for comprehensive dental care, the Monitor identified several hygiene progress notes from Hill Correctional Center that raise concern regarding documentation accuracy.[934] The standardized stamp used in these entries indicates that the patient's health history was updated ("Update health history"). However, review of the dental records did not show any updated histories. The example below illustrates one such entry.

[931] Monitor's documentation request 9th report dated 5/10/25, item 162.
[932] For the next report the request will be revised to include all 0422 forms.
[933] Dental patients 1-3 (Hill Correctional Center).
[934] Note these observations were made from a completely different set of records looking at Comprehensive Care.



Date	Service Rendered	D.D.S. Signature
3-18-25	Update health history. Oral rinse.	
1:30	Cavitron, scale and F- polish.	
	OHI given. Heavy [illegible] Sub Calc Gen.	
	Schedule upon request. [redacted]	RDH

In three separate records containing this standardized stamp, none of the health history sections were updated; in fact, each medical history section was entirely blank.[935] The use of a standardized documentation stamp is acceptable only if the clinician performs and documents all procedures indicated on the stamp. However, when stamps are used without verifying that each required element has been completed, the record becomes misleading and clinically unreliable.

The quality and completeness of health histories collected by IDOC dental staff are of concern. A thorough medical and dental history is foundational to safe and effective treatment planning, yet current documentation practices remain inconsistent and incomplete.

As previously noted in Monitor's 8th Report:

> "The current health history section on the IDOC dental form is inadequate and fails to collect sufficient information. The Monitor recommends that the Chief of Oral Services consider utilizing a more comprehensive health history from established sources such as the Federal Bureau of Prisons, Department of Defense, Veterans Administration, or a standard oral surgery office. These organizations have developed thorough and effective health history forms that could serve as a valuable template for creating a more robust and informative questionnaire."[936]

The Monitor reiterates that the existing health history form is insufficient and should be redesigned to meet professional standards. A revised form should include a complete review of systems, documentation of current medications, allergies, and relevant medical conditions. It should require provider verification of a review and record updates at each encounter.

Continued monitoring of this issue is warranted. Oversight should be conducted by the Chief of Oral Health Services and incorporated into facility-level Continuous Quality Improvement (CQI) studies to ensure that health histories are consistently updated, reviewed, and accurately documented.

Documentation of Dental Problems and Plan Care

The Consent decree requires dental personnel to document in the dental record whenever they identify a patient's dental issue and provide proper dental care and treatment (III.K.12.). To assess compliance with this requirement, the Monitor requested that all urgent care records include a copy of the written request for treatment.[937] From these requests, the Monitor verified that the patient's concern was received, triaged, documented, and appropriately addressed.

[935] Dental patients 4-6 (Hill Correctional Center).
[936] Health Care Monitor 8th Report, Lippert v. Jeffreys, November 13, 2024, page 251.
[937] Monitor's documentation request 9th report, dated 5/10/25, item 171.

Seventeen of the 18 dental records reviewed contained the corresponding health requests, allowing partial tracking of the care process from initial submission through triage and treatment. However, documentation was often incomplete, making it difficult to determine whether the sequence of care met the expectations of the Consent Decree.

According to IDOC Policy E.06.0 [938], health care requests must be triaged within 24 hours of receipt in the health services department by a nurse or the appropriate clinical discipline. The individual responsible for triage is required to assess each request for urgent needs and sign the health request. The signature must include the individual's professional title or degree suffix to identify the credential of the person performing the triage. Personnel designated to conduct triage include the following:

- Medical complaints: Licensed Practical Nurses (LPN/LVN), Registered Nurses (RN), midlevel providers, or physicians
- Dental complaints: Dentists, dental hygienists, Licensed Practical Nurses, or Registered Nurses

As reflected in the table below, multiple deficiencies were identified. The elapsed time between submission of the request and the documented review exceeded 24 hours in several cases.[939] None of the requests included a professional credential accompanying the reviewer's signature, and five requests lacked any signature from the staff member responsible for reviewing the request.

Additionally, three facilities did record or stamp the date of SCR review, limiting the ability to determine if triage was provided within an appropriate timeframe.[940]

Patient ID	Date of Request (Inmate) Urgent Care	Nature of Sick Call Request (Patient Concern)	Date Request Reviewed	Days Triage	Evaluated by Clinic or Health Care professional	Care Addressed in (Days)	Was Care Timely
#28	2/22/25	Tooth Ache Request Extractions "Emergency" No triage date only date the Patient was seen	No Triage Date	Out of Compliance	3/14/25	20days	Patient appears to have pain meds issued.
#29	4/6/25	Tooth Ache Filling came out and cracked tooth "very painful"	No Triage Date	Out of Compliance	4/22/25	16days	Cannot Determine. Illegible Notes.
#30	5/11/25	Wisdon tooth chipped Cutting into face both sides Need to be seen "ASAP"	5/19/25	8 days	6/11/25	31days	Pain Meds on 6/11/25. Unclear if patient was given meds for pain rior to appointment
#31	5/14/25	"My tooth is broken extremely (sic) nerve pain"	5/19/25	5 days	6/4/25	21days	Pain Meds on 6/04/25. Unclear if patient was given meds for pain rior to appointment
#32	6/4/25	Pt Complains of wisdom tooth that should have been extracted 1 yr ago. Needs care "ASAP"	6/10/25	6 Days	6/20/25	16days	Referred to Oral Surgery. Unclear if pain meds were provided.
#33`	4/17/25	Please help me ASAP" . . ."This tooth hurts so bad"	No Triage Date "Scheduled"	Out of Compliance	5/10/25	23days	Patient had painful teeth which DDS addressed
#34	5/16/25	I have a bad toothache in the back of my mouth	5/16/25	1 day	5/29/25	13days	No Record except for consent of extraction.

In some instances, the triaging provider documents in the dental record that the request was received, reviewed, signed (with credentials), and scheduled appropriately. The Monitor notes that this practice reflects the intent of the Consent Decree and represents a sound documentation process that should be standardized across all facilities.

In most instances, appropriate care was provided; however, the timeliness of care for patients presenting with toothaches and infections remains a concern. When patients report severe pain or signs of infection, evaluation and treatment should be prompt. While a dentist may not always be immediately available to assess the patient, timely clinical intervention is still required. Care does not necessarily need to result in

[938] Non-Emergency Health Requests and Services.
[939] Dental patients 28-33.
[940] Dental patients 28, 29, and 33.

definitive treatment (i.e., a dental procedure) at the initial encounter; however, patients should receive appropriate interim management, such as analgesics and/or antibiotics, when clinically indicated.

The agency has additional work to do in this area, particularly in defining and standardizing a process to ensure that all requests are reviewed, documented correctly in the dental record, and accompanied by the corresponding written request as part of the permanent record. This issue should be incorporated into Continuous Quality Improvement (CQI) reviews to promote consistent and accurate documentation practices across all facilities.

Summary

The Monitor's review identified partial but inconsistent compliance with key documentation requirements outlined in the Consent Decree. Under **III.K.1**, all urgent and emergency dental care must be documented using the SOAP format; however, only 72% of reviewed urgent care notes adhered appropriately to this structure, and many lacked essential clinical detail needed to demonstrate diagnostic reasoning or support the treatment provided. During a meeting with the Chief of Oral Health Services on December 5, 2025, the Monitor's dental consultant was informed that a training video on SOAP documentation had been developed and was shown via screen share. This type of structured guidance represents a proactive step toward improving the quality and consistency of SOAP notes.

Compliance with **III.K.11**, requiring a documented dental health history for each prisoner, also remains inconsistent. Only about half of reviewed records contained current health histories, and several forms were outdated or incomplete. This poses safety concerns, particularly when care, such as extractions, is delivered without evidence that the provider reviewed the patient's medical status. Finally, under **III.K.12**, dental personnel are required to document identified dental problems and the care provided. While some records demonstrated appropriate documentation of the triage and treatment process, others lacked dates, review notes, or verification of timely follow-up, making it difficult to assess whether care was delivered within expected timeframes. Continued training, clearer guidance, and routine CQI monitoring will be necessary to support full compliance with these provisions across all facilities.

RECOMMENDATIONS:

1. Ensure all dental providers use the SOAP (Subjective, Objective, Assessment, Plan) format exclusively for documenting urgent and emergency dental care, as required by the Consent Decree. The Chief of Oral Health Services, in collaboration with the vendor, should conduct structured training for all new and existing dental staff to promote consistent and accurate use of SOAP documentation. Records of training completion as well as documentation of proficiency in SOAP charting should be maintained. Regular audits should be conducted to verify compliance and identify deficiencies for targeted retraining.
2. The Chief of Oral Health Services and vendor clinical leadership should counsel and retrain providers who consistently fail to use the SOAP format appropriately or who document incompletely. Repeat noncompliance should be addressed through performance management and follow-up review within the CQI process.
3. Reinforce the requirement that all dentists and hygienists review, verify, and update patient health histories prior to treatment. Documentation of this review must appear in the clinical note or on the designated form (DOC 0422). Facility-level audits and CQI studies should track compliance with this requirement to ensure patient safety and adherence to policy.

4. Ensure that all requests for urgent dental care are dated, triaged, and included in the patient's permanent record. Providers should document both the date of receipt and the date of triage to establish timeliness of response. Expectations for these practices should be contained in and consistent with E.06.01 Non-Emergency Health Requests. IDOC and the vendor should develop a uniform process across facilities for recording, tracking, and auditing the flow of urgent care requests. This process should be incorporated into facility-level CQI reviews.
5. The Chief of Oral Health Services should develop or update a written policy specifying documentation requirements for all dental encounters, including the placement of clinical notes, consents, and radiographs in the dental record. The forthcoming electronic health record should incorporate standardized templates for these elements to ensure consistency across facilities and facilitate compliance monitoring.
6. Develop and implement a more complete health history form based on established models from the Federal Bureau of Prisons, Department of Defense, Veterans Administration, or comparable correctional and public health systems. The form should include a full review of systems, documentation of medications, allergies, and relevant medical conditions, and should require provider verification at each encounter.

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:
The Monitor requested the following documents specifically to review for compliance with the items from the Consent Decree listed above.

1. Provide five dental charts from five sites (Graham, Logan, Vienna, Hill, and Pontiac) for patients who had a dental extraction(s) in the month of March or April 2025.[941]
2. Annual clinical performance reviews of physicians, nurse practitioners, physician assistants, dentists, dental hygienists, and dental assistants since July 2024.[942]

Diagnostic X-rays Made Before Extraction

[941] Monitor's documentation request 9th report dated 5/10/25, item 162 to include medical problem list, dental notes, documents, consents, and requests for care for 6 months prior through two weeks after the extraction and the most recent dental x-ray report(s).
[942] Monitor's documentation request 9th report dated 5/10/25, item 40. IDOC provided performance reviews, called "peer reviews" by Wexford for its dentists, dental hygienists, and dental assistants for 2024, which were finalized in summer 2025.

For this portion of the review, the Monitor requested dental extraction records, as all providers are expected to obtain a radiograph before performing an extraction. Twenty-seven records were submitted, of which 22 were reviewed.[943]

Of the 22 records, four (18%) documented that an X-ray was taken, and six (27%) indicated that a preoperative X-ray was reviewed prior to extraction. Obtaining an X-ray and reviewing it prior to extraction are separate functions. While several records documented that an X-ray was reviewed, the documentation did not indicate when the X-ray that was reviewed was taken, making it impossible to determine whether a true preoperative assessment occurred. For example, two entries noted that X-rays were reviewed but did not specify that an X-ray was made, raising the possibility that providers referenced older radiographs**. This is an area of concern that should be closely monitored by the new vendor and the Chief of Oral Health Services to ensure compliance with diagnostic standards and Consent Decree.**

Because site visits were not conducted during this reporting period, the Monitor was unable to directly assess the diagnostic quality of radiographic images across facilities. It should be emphasized that when evaluating compliance with radiographic requirements, all images must be diagnostic, clearly displaying the entire tooth, including all root structures and adjacent anatomical landmarks, and free from cone cuts, artifacts, or distortions.

Diagnosis and Reason for Extraction Documented

Of the 22 records, nine (41%) included a diagnosis or stated reason for extraction. In some cases, the reason for extraction appeared on the consent form; however, this information should also be explicitly recorded in the clinical note. The Monitor observed that providers frequently listed the prognosis as "non-restorable," but this description alone does not explain the underlying cause. For instance, it is unclear whether the tooth was deemed non-restorable due to a fractured root, extensive caries, or severe periodontal disease. Clear documentation of the etiology is essential to substantiate the clinical rationale for extraction.

This is an area of concern that should be closely monitored by the new vendor and the Chief of Oral Health Services to ensure compliance with diagnostic standards and the Consent Decree.

Consent Obtained

Of the 22 records reviewed, 21 (95%) documented that patient consent had been obtained. In ten records (45%), consent was noted in the clinical progress notes; in eleven (50%), a signed consent form was present, but the clinical note did not document consent. While the Monitor credited both scenarios as compliant, the Chief of Oral Health Services and the vendor should require both: (1) a signed consent form and (2) a corresponding entry in the clinical record. As noted in the Monitor's 7th and 8th Reports, paper forms can become separated from the dental record, resulting in an incomplete history of care.[944]

Performance Reviews conducted by the Lead Dentist for Wexford included an analysis of ten records per provider. One component of the review focused specifically on patient consent. Of the eighteen records

[943] Four records from Pontiac were not reviewed because of illegible entries. One record from Logan was not used as no extraction was recorded.

[944] Health Care Monitor 7th Report, Lippert v. Jeffreys, December 27, 2023, pages 202-203; Health Care Monitor 8th Report, Lippert v. Jeffreys November 13, 2024, pages 253-254.

analyzed, fifteen dentists (83%) demonstrated 100% compliance in obtaining signed consents, while the remaining three dentists demonstrated compliance rates of 90%, 75%, and 66%, respectively.[945]

Minor documentation errors were noted but did not represent systemic patterns of noncompliance. In two cases, the dentist extracted teeth which were different from those authorized in the consent form.[946] In one case, a tooth was extracted on March 14, 2025, but the consent form was dated March 15, 2025.[947] Overall, dentists and their staff demonstrated a high level of compliance in obtaining and documenting patient consent.

No extraction records were received for individuals who lacked decision-making capacity, requiring the Department to follow the Illinois Health Care Surrogate Act.

Summary

The Monitor's review identified inconsistent compliance with the Consent Decree requirements governing diagnostic imaging, documentation of clinical rationale, and informed consent for dental extractions. Under **III.K.10.a**, diagnostic radiographs must be taken before every extraction; however, only a minority of records contained documentation confirming that an X-ray was obtained, and in many cases it was unclear whether the reviewed radiograph was current or clinically appropriate for preoperative assessment. This lack of clarity, and the limited documentation of when radiographs were made, prevented verification that diagnostic imaging was consistently performed prior to extraction as required.

Compliance with **III.K.10.b**, which requires that the diagnosis and reason for extraction be fully documented, was also inconsistent. Fewer than half of the reviewed records included a clear diagnosis or stated reason for extraction. Notations such as "non-restorable" were common but did not explain the underlying clinical etiology, limiting the ability to determine whether the extraction was appropriately justified.

Documentation of consent, required under **III.K.10.c**, was the most consistent of the three areas reviewed. Ninety-five percent of extraction records demonstrated that patient consent had been obtained, either through a signed form or a notation in the clinical record. However, the lack of dual documentation, both a signed form and a corresponding entry in the progress notes, remains a vulnerability, as paper forms may be separated from the record. Provider performance reviews conducted by the Lead Dentist demonstrated generally strong compliance with consent procedures, although some isolated documentation errors were noted.

These findings indicate partial compliance overall, with the strongest performance in obtaining patient consent and the greatest deficiencies in documenting diagnostic radiographs and the clinical rationale for extraction. Continued oversight by the Chief of Oral Health Services and the new vendor, including clearer guidance, improved documentation standards, and targeted monitoring, will be necessary to achieve full compliance with the Decree's requirements.

RECOMMENDATIONS:

[945] Material provided by IDOC on 8/15/2025 in response to the Monitor's documentation request item 40.
[946] Dental patients #7 and 8.
[947] Dental patient #9.

1. The Chief of Oral Health Services and the new vendor should ensure that all extractions are preceded by a diagnostic radiograph that meets clinical standards for image quality and completeness. Continuous Quality Improvement should monitor this practice to ensure provider compliance. This is the same recommendation as the 8th report.
2. Ensure that there is documentation that X-rays are taken, reviewed, and considered in the extraction procedure. Dentists must document in their clinical notes that they have made and reviewed a current X-ray. Continuous Quality Improvement should monitor this practice to ensure provider compliance. This is the same recommendation as the 8th report.
3. Providers must clearly record the clinical diagnosis and etiology prompting extraction (e.g., advanced caries, root fracture, periodontal disease, or failed endodontic treatment). The Chief of Oral Health Services and the new vendor should ensure training is provided emphasizing documentation of the diagnostic rationale, not simply note that a tooth is "non-restorable." Facility CQI committees should review a sample of extraction records quarterly to assess compliance with this requirement and develop targeted corrective measures when deficiencies are found.
4. The Chief of Oral Health Services and the vendor should require that all extractions include dual documentation:
    - A signed consent form; and
    - A written entry in the clinical record confirming that consent was obtained.

    Consent documentation compliance should be included in CQI audits. For those dentists who demonstrate less than 90% compliance, the Chief of Oral Health Programs should work with the new vendor's Lead Dentist to ensure compliance 100% for all procedures requiring consent. The dentists who are at risk are identified in the Performance Reviews conducted by the previous vendor.

Dental Support (Equipment and Policies)

Addresses items II.B.8, III.K.4-5; III.K.13

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, within eighteen (18) months of the Preliminary Approval Date. 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.*

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:

The Monitor requested the following documents specifically to review for compliance with the items from the Consent Decree listed above.

1. **Facility logs or standardized spore testing reports since September 1, 2024, verifying that medical and dental equipment is properly sterilized reported in the facility's monthly QI minutes.**[948]
2. List of all dental equipment with the date of the most recent calibration and/or inspection by an authorized dental equipment vendor. The list should identify any defective equipment that requires repair or replacement, along with the date the repair or replacement was completed.[949]
3. Provide copies of the Dental Unit Overview forms submitted by each facility quarterly since January 2025.[950]

Dental Policies

The Department submitted twelve dental policies for the Monitor's review. Eleven of these policies addressed various aspects of dental infection control, and one pertained to oral health services. Each policy was reviewed by the Monitor and returned with comments and recommendations for revision.[951] An Administrative Directive[952] containing additional policy instruction was also promulgated and disseminated on June 1, 2025; however, it was not provided to the Monitor for review or comment.

Several issues warrant additional emphasis to ensure alignment with the Consent Decree requirements III.K5. and III.K.10.

1. A. Section III.K.5 requires IDOC to have dental radiology hygiene policies that include the use of lead aprons with thyroid collars and the posting of radiological hazard signage in all areas where X-rays are taken. G.18.10 Dental Radiology focuses primarily on infection control procedures. As written, it does not fulfill the intent of III.K.5, which is radiology hygiene. A radiology hygiene policy should establish standards that protect patients and staff from unnecessary radiation exposure by outlining the proper use of lead aprons and thyroid collars, adherence to the As Low As Reasonably Achievable (ALARA) principle, operator qualifications, equipment calibration, and safe operating procedures. It should also require posting of appropriate radiological hazard signage, maintaining inspection logs, and ensuring compliance with ANSI, OSHA, and state regulatory guidelines across all areas where X-rays are performed.

   B. There is also no policy addressing radiological hazard signage, which is required for compliance. Signage must be posted at every entrance to X-ray areas, clearly visible at eye level, and compliant with ANSI Z535 and OSHA radiation safety standards. Recommended wording includes "Caution, X-ray Area" and "Radiation Hazard, Authorized Personnel Only." Beyond signage and PPE, the current policy fails to incorporate essential radiation safety principles. To be compliant, IDOC must explicitly incorporate the ALARA principle, restrict operation of radiographic equipment to licensed or credentialed staff, and ensure radiology

[948] Monitor's documentation request 9th report, dated 5/10/2025, item 157.
[949] Ibid, item 157.
[950] Ibid, item 157.
[951] The Monitor returned comments and suggested revisions to IDOC on E.04.01 Oral Health Services on 7/11/2025 and on G.18.01 – G.18.11 on 9/23/25.
[952] AD 04.03.102 Dental Care for Individuals in Custody.

technique charts are posted near each X-ray unit. Unauthorized staff must not remain in the operatory during exposure unless wearing appropriate protective equipment.

C. With regard to calibration and equipment maintenance requirements, the Department must specify the timing and frequency of vendor inspections, and documentation should include verification of exposure accuracy, collimator alignment, leakage testing, and timer accuracy. These records must be retained for a minimum of three years, or in accordance with IDOC record-retention standards.

D. Since IDOC facilities operate both dental and medical X-ray units, the absence of a unified radiation safety policy presents a systemwide deficiency. A general radiology hygiene and safety policy is warranted to establish baseline standards applicable to all radiographic modalities, including dental, medical, orthopedic, and trauma care. Such a policy would not replace dental-specific procedures but would provide foundational requirements for radiation safety, protective equipment, signage, operator qualifications, and equipment calibration across all clinical environments where radiographic services are provided.

2. Section III.K.10 of the Consent Decree specifies that "in instances where a prisoner lacks decision-making capacity, the Department will follow the Illinois Health Care Surrogate Act." Because this requirement pertains to dental care and was articulated within the dental section of the Decree, the Monitor recommends that it be incorporated into dental policy E.04.01Oral Health Services.

Thyroid Collars

For this section, the Monitor reviewed the *Dental Unit Overview* as reported by IDOC facilities to SIU.[953] Twenty of the 29 (69%) facilities submitted a review. One facility, Vandalia Correctional Center, provided a 2024 version of the document. Nineteen facilities (95%) reported having thyroid collars available for patient care, while Vandalia Correctional Center reported that a thyroid collar was not available.

While the survey data suggest that thyroid collars are generally available, the intent of the requirement is to ensure that a policy is in place mandating their use during all radiographic procedures. Proper radiology hygiene requires that a protective apron **with an integrated thyroid collar** be routinely used to minimize patient exposure. Availability alone does not guarantee compliance. For this reason, audits should include **direct observation of radiographic practices** to verify that protective equipment is being used correctly and consistently. The Monitor further recommends that the annual Equipment List review be expanded to include verification and evaluation of the integrity of aprons and thyroid collars to ensure they remain functional and safe for clinical use.

The Monitor's Dental Consultant has discussed continued use of thyroid shielding with the Chief of Oral Health Services. Notwithstanding those discussions, the Monitor's position remains that the Department should continue the use of thyroid shielding at this time.

[953] Documents provided by IDOC on 8/15/25 in response to the Monitor's documentation request item 164.

The Monitor's 7th Report, noted guidance from the American Academy of Oral and Maxillofacial Radiology does not recommend routine use of thyroid shielding, and that this position has been supported by the American Dental Association.[954] As a result, some state jurisdictions have eliminated the requirement for thyroid collars. Illinois, however, is not among those states. The report further states, "discussions regarding thyroid collars will depend on the State Dental Board's adoption of these recommendations." The ADA's guidance does not supersede Illinois law. The Illinois Administrative Code (Title 32, Part 360 – Use of X-Rays in the Healing Arts) continues to require the use of protective shielding, including lead-equivalent protective aprons or barriers, during diagnostic radiographic procedures. These regulatory requirements remain in effect and have not been amended to eliminate patient shielding.

Moreover, several prerequisite conditions must be addressed before any change in practice could be responsibly considered. IDOC's dental radiology equipment is aging and does not consistently reflect modern digital X-ray technology. Prior to discontinuing thyroid shielding, IDOC should obtain an independent evaluation—such as an inspection by the Illinois Emergency Management Agency (IEMA)—to confirm that equipment emissions fall below thresholds that would support such a change. This reinforces the Monitor's prior recommendation that a qualified consultant evaluate all medical and dental spaces and equipment. Older radiographic systems are generally associated with higher exposure risk than newer digital systems and, where identified, should be prioritized for replacement.

Radiological Hazard Signs

Radiological hazard signs are verified by the Monitor team during on-site visits; however because the current review cycle did not include site visits, this component of the Decree (III.K.5) was not assessed. Given that radiological hazard signage is an explicit requirement of the Decree, the Monitor recommends that the Chief of Oral Health Services develop and implement a standardized audit tool or survey instrument that verifies signage presence, condition, and visibility to document whether all areas where X-rays are taken are clearly marked with standard radiation hazard placards. Signage should be positioned so that it is clearly visible to all individuals upon entry to the area, consistent with radiology safety standards. The audit results should be reported through the CQI process or other regular compliance reporting mechanisms. See also comments above on Dental Policies related to the need for policies to address radiological signage

Radiological hazard signage should comply with ANSI Z535.2 visibility and color standards and the federal requirements outlined in 10 CFR §20.1902 and 29 CFR §1910.1096. Signs must display the radiation trefoil symbol in magenta, purple, or black on a yellow background, accompanied by wording such as "CAUTION — X-RAY AREA" or "CAUTION — RADIATION AREA."

The statewide status of radiological hazard signage remains undetermined. Moving forward, the Monitor will request documentation from the Department confirming that all radiographic areas are clearly identified in accordance with Decree requirements and applicable safety standards.

Dental Equipment

[954] Health Care Monitor 7th Report, Lippert v. Jeffreys, December 27, 2023, page 204.

The Monitor's last report advised the Department to develop a standardized equipment list for all IDOC facilities.[955] The intent was to identify dental equipment requiring annual inspection—including, at a minimum, vacuum machines, dental compressors, dental chairs, sterilizers, and X-ray processors.

For the current review cycle, the Department compiled surveys and submitted a spreadsheet that reflects the equipment identified in the Monitor's recommendation.[956] The submission also expanded the list to include handpieces and Cavitron units at each facility. This represents measurable progress toward standardizing equipment data collection and is more comprehensive than the documents submitted for earlier reports, as well as the Dental Unit Overviews, which are limited in scope and did not include information from all facilities.

Although the spreadsheet format shows improvement, it continues to lack critical information, specifically, the dates of inspection by an authorized dental equipment vendor. Without documented inspection timelines, the Monitor cannot determine whether annual inspections are being conducted as required, or whether identified deficiencies have been addressed in a timely manner. To ensure safety, reliability, and regulatory compliance, all inspections must be conducted by qualified health technicians or authorized dental equipment vendors. A professional evaluation is essential not only to verify that equipment is functioning properly and meets required safety standards, but also to confirm that it remains suitable for safe patient care and appropriate use by staff.

A review of the June 2025 Dental Equipment spreadsheet shows numerous equipment deficits across multiple IDOC facilities; however, the spreadsheet does not include dates indicating when these issues were identified or when corrective action was taken. When cross-referenced with the Dental Unit Overview documents, it appears that several of these problems may be long-standing. Without this information, the Monitor cannot determine how long clinics have been operating with compromised equipment or whether the Department has already attempted to address these deficiencies. Several facilities report non-functional dental chairs, deficits in slow-speed handpieces, and X-ray processors or X-ray units that are either inoperable or outdated. Some facilities continue to rely on hand-dipped radiograph processing, an obsolete technique that was replaced more than two decades ago by automatic digital or film processing. Additional facilities report problems with compressors, vacuum systems, and operatory delivery units.

These equipment deficits significantly affect the ability of dental providers to deliver timely, safe, and comprehensive care. The absence of documented timelines for the identification of equipment failures and the submission or resolution of repair requests prevents accurate assessment of progress and delays system-level planning. To ensure continuity of operations, the Department should maintain dated logs of all equipment failures, repair requests, and ASR submissions so that priority repairs can be tracked and resourced appropriately, particularly when year-end funds are available.

Below is a collation of equipment failures listed on the dental equipment spreadsheet that are considered by the Monitor to be high-risk because failure directly impacts the ability to diagnose or treat patients. However, the Monitor also recognizes that the Department's recent implementation of a standardized, system-generated equipment inventory and tracking list represents a meaningful improvement and should

[955] Health Care Monitor 8th Report, Lippert v. Jeffreys November 13, 2024, page 259.
[956] June 2025 Dental Equipment List - Updated provided by IDOC dated 8/15/25 in response to the Monitor's documentation request item 163.

assist in more timely identification, prioritization, and resolution of equipment deficiencies moving forward.[957]

1. Dental Chairs
   Big Muddy, Centralia, Danville, Hill, Illinois River, Jacksonville, Lawrence, Lincoln, Menard, Pontiac, Shawnee, Sheridan and Western
   - Chairs are reported as broken, inoperable, leaking, or structurally compromised.
   - Directly limits the number of patients who can be treated per day.
2. X-ray Equipment
   East Moline, Graham, NRC
   - Includes nonoperational X-ray processors, malfunctioning digital units, and failing panoramic machines.
   - Prevents proper diagnosis.
3. Compressor / Vacuum Failures
   Jacksonville (compressor and vacuum system)
   - Suction and air supply failures halt restorative, surgical, and hygiene procedures.
4. Handpiece Repairs
   - The "Handpieces" entry appeared as a column in the Equipment List spreadsheet, affecting several facilities. These findings were corroborated with Dental Unit Overview forms, which identified problems with handpieces and related operational concerns
   - These issues limit the provision of restorative care, prosthetic adjustments, and hygiene polishing.

Dental Space

The Department's list of dental equipment [958]represents a constructive first step toward standardizing and consolidating key information on dental equipment across IDOC facilities. This year's submission, identifying the number of operatories and dental chairs at each site, helps establish an initial baseline for assessing clinical capacity.

The data, however, reveal a significant concern: five facilities report having only a single operatory.[959] In clinics with both a dentist and a dental hygienist assigned, a one-operatory layout restricts care to a single provider at a time. This forces one provider to remain idle, reduces clinical productivity, and contributes to delays in delivering routine, urgent, and preventive services.

Beyond staffing inefficiencies, single-operatory clinics introduce operational vulnerabilities. When only one chair is available, any equipment failure, scheduling conflict, or clinical emergency immediately halts all dental services. This limited capacity represents a structural barrier to providing adequate, safe, and continuous care for the incarcerated populations at these facilities.

The Monitor commends the Department for taking steps to address operatory and space limitations at NRC and Jacksonville, recognizing that retrofitting or redesigning clinical areas can be complex.

[957] Flagged from the June 2025 Dental Equipment spreadsheet submitted by IDOC in response to the Monitor's document request item 163.
[958] Ibid.
[959] Jacksonville, NRC, Taylorsville, Vienna, and Lincoln.

Nevertheless, the issue extends beyond these individual sites and warrants a systemwide assessment of operatory capacity. This is in line with the Monitor's recommendation for a consultant to evaluation medical and dental space.

To improve access to timely dental care for the remaining identified clinics, the Department should consider a range of options, including renovating existing dental clinics, identifying additional space within or adjacent to Health Services, or augmenting capacity through mobile dentistry units. These approaches would increase clinical throughput, reduce wait times, and enhance the overall reliability of dental operations across IDOC.

Spore Testing

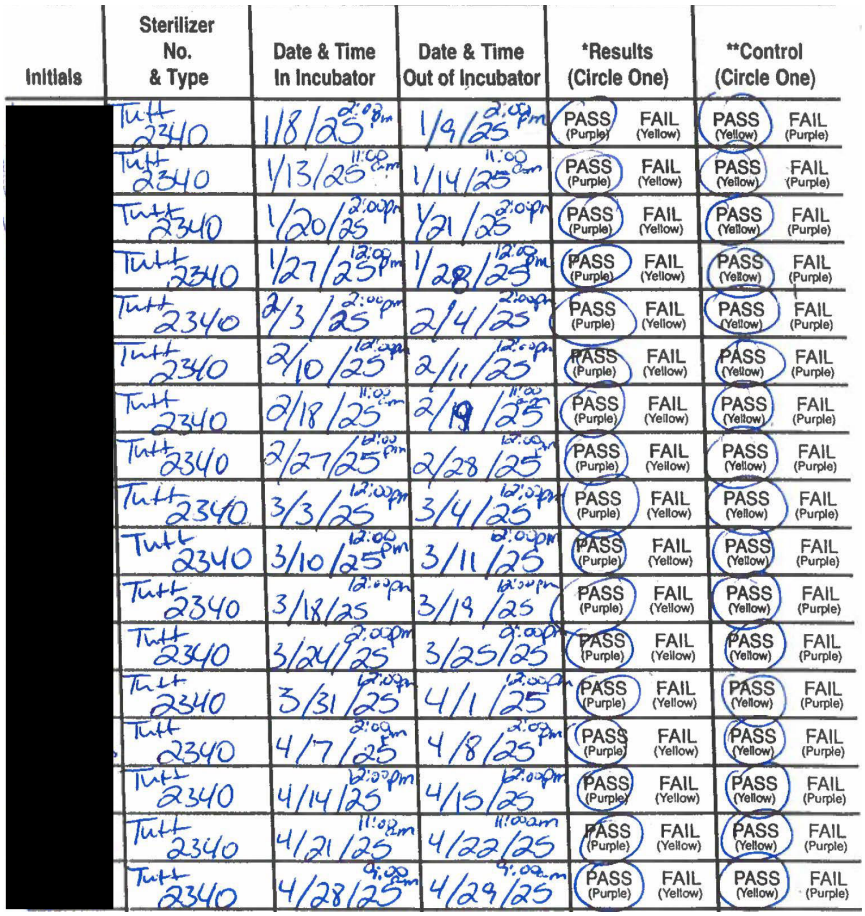
For this reporting period, the Department provided the Monitor with both the **Dental Unit Overviews** and the **actual spore-testing records** (including in-house testing logs and reports from external vendors).[960] The Monitor relied primarily on the actual test logs and reports, as they are considered more accurate and reliable sources of information. In one instance, a Dental Unit Overview (SIU survey) reported that spore testing was conducted *monthly*, while the corresponding test logs showed that ***weekly* tests were actually being performed.**[961]

Of the **27 IDOC facilities** that currently operate dental clinics, **20** (74%) submitted spore-testing documentation. The following facilities **did not provide spore-testing logs** for this review period: **Centralia, Decatur, Joliet Treatment Center, Sheridan, Taylorville, Vienna, and Vandalia**.[962] Spore test recording practices vary significantly across facilities. Most facilities used the manufacturer's **standardized logbook**, which includes essential fields such as:

- Date of test
- Date and time placed and removed from the incubator
- Documentation that a control was run
- Test disposition (PASS/FAIL)

The following example from **Shawnee** reflects an **appropriate format** for documenting spore tests:

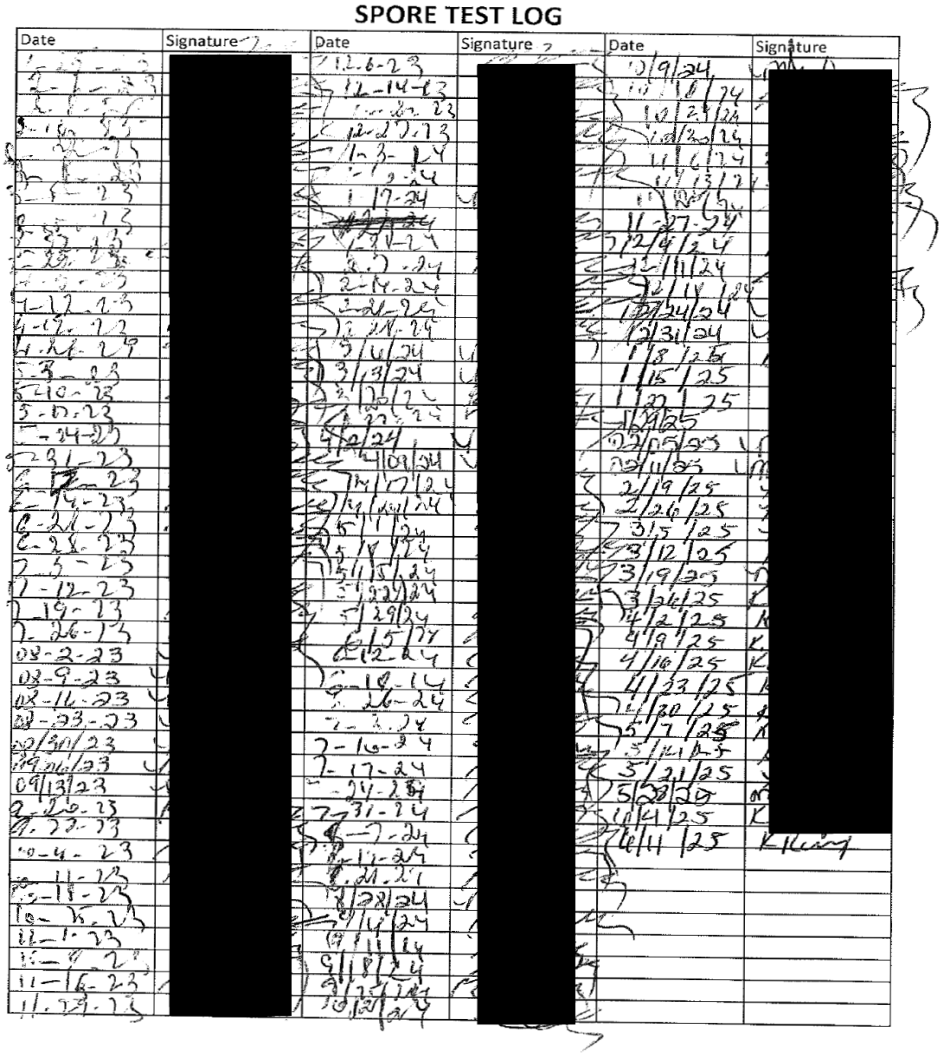
[960] Documents provided by IDOC dated 8/15/25 in response to the Monitor's documentation request item 157 and 163.
[961] Graham Correctional Facility.
[962] Decatur provided CQI Minutes indicating autoclave tests were performed weekly.



Initials	Sterilizer No. & Type	Date & Time In Incubator	Date & Time Out of Incubator	*Results (Circle One)	**Control (Circle One)
[redacted]	Tutt 2340	1/8/25 2:00pm	1/9/25 2:00pm	PASS (Purple) FAIL (Yellow)	PASS (Yellow) FAIL (Purple)
	Tutt 2340	1/13/25 11:00am	1/14/25 11:00am	PASS (Purple) FAIL (Yellow)	PASS (Yellow) FAIL (Purple)
	Tutt 2340	1/20/25 2:00pm	1/21/25 2:00pm	PASS (Purple) FAIL (Yellow)	PASS (Yellow) FAIL (Purple)
	Tutt 2340	1/27/25 12:00pm	1/28/25 12:00pm	PASS (Purple) FAIL (Yellow)	PASS (Yellow) FAIL (Purple)
	Tutt 2340	2/3/25 2:00pm	2/4/25 2:00pm	PASS (Purple) FAIL (Yellow)	PASS (Yellow) FAIL (Purple)
	Tutt 2340	2/10/25 12:00pm	2/11/25 12:00pm	PASS (Purple) FAIL (Yellow)	PASS (Yellow) FAIL (Purple)
	Tutt 2340	2/18/25 11:00am	2/19/25 11:00am	PASS (Purple) FAIL (Yellow)	PASS (Yellow) FAIL (Purple)
	Tutt 2340	2/27/25 12:00pm	2/28/25 12:00pm	PASS (Purple) FAIL (Yellow)	PASS (Yellow) FAIL (Purple)
	Tutt 2340	3/3/25 12:00pm	3/4/25 12:00pm	PASS (Purple) FAIL (Yellow)	PASS (Yellow) FAIL (Purple)
	Tutt 2340	3/10/25 12:00pm	3/11/25 12:00pm	PASS (Purple) FAIL (Yellow)	PASS (Yellow) FAIL (Purple)
	Tutt 2340	3/18/25 12:00pm	3/19/25 12:00pm	PASS (Purple) FAIL (Yellow)	PASS (Yellow) FAIL (Purple)
	Tutt 2340	3/24/25 2:00pm	3/25/25 2:00pm	PASS (Purple) FAIL (Yellow)	PASS (Yellow) FAIL (Purple)
	Tutt 2340	3/31/25 12:00pm	4/1/25 12:00pm	PASS (Purple) FAIL (Yellow)	PASS (Yellow) FAIL (Purple)
	Tutt 2340	4/7/25 2:00pm	4/8/25 2:00pm	PASS (Purple) FAIL (Yellow)	PASS (Yellow) FAIL (Purple)
	Tutt 2340	4/14/25 12:00pm	4/15/25 12:00pm	PASS (Purple) FAIL (Yellow)	PASS (Yellow) FAIL (Purple)
	Tutt 2340	4/21/25 11:00am	4/22/25 11:00am	PASS (Purple) FAIL (Yellow)	PASS (Yellow) FAIL (Purple)
	Tutt 2340	4/28/25 9:00am	4/29/25 9:00am	PASS (Purple) FAIL (Yellow)	PASS (Yellow) FAIL (Purple)

In contrast, other facilities submitted documentation that lacked essential information. The following excerpt from **Illinois River** represents an **inadequate method of recording**, as it does **not include test**

results or control indicators.



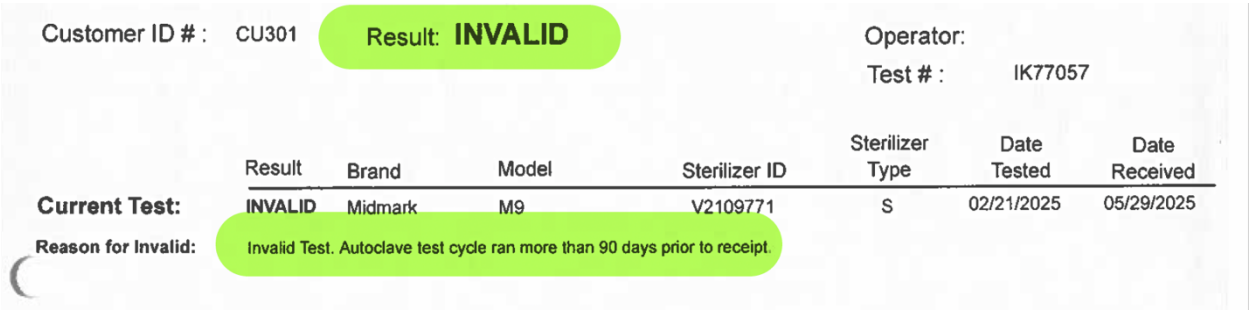
In the Monitor's **8th Report,** the following minimum documentation for spore test reporting were listed and include:

- the date of the test;
- an indication that a control was run;
- the test's disposition (positive/negative; and
- an explanation for any deviation from weekly testing.[963]

[963] Health Care Monitor 8th Report, Lippert v. Jeffreys November 13, 2024, page 259.

A significant concern observed by the Monitor involves the timeliness of submitting spore test vials/ampules for analysis. During the review of spore-testing documentation, it was noted that at Logan, a spore test was conducted, yet the testing company did not receive the ampule until 23 days later. There were also two additional entries in which subsequent tests were performed two weeks after the prior test, indicating extended intervals in monitoring.

At Logan, two spore tests conducted in February on a Midmark sterilizer were deemed invalid because the vials were not received by the vendor laboratory until more than 90 days after the test cycle was run (see below).



Customer ID # : CU301 Result: **INVALID** Operator:

Test # : IK77057

	Result	Brand	Model	Sterilizer ID	Sterilizer Type	Date Tested	Date Received
Current Test:	**INVALID**	Midmark	M9	V2109771	S	02/21/2025	05/29/2025

Reason for Invalid: Invalid Test. Autoclave test cycle ran more than 90 days prior to receipt.

The circumstances surrounding these invalid results remain unclear. It is not known whether the facility failed to submit the vials in a timely manner, whether there was a delay in the facility's mailroom, or whether the delay occurred within the postal system. The record also indicates that other spore tests were conducted during the same period, yet only the two vials in question were received more than 90 days after processing and subsequently classified as invalid. This inconsistency raises concerns about the facility's internal procedures for handling, documenting, and submitting spore-test vials. When a result is failed or deemed invalid, an explanation should be documented and included with the test record to demonstrate awareness of the issue and the actions taken in response.

Such delays are concerning. If sterilizer loads were run during the interim—and the test ultimately failed—there would be no timely mechanism to identify a compromised sterilization process. A similar scenario occurred at Graham, where a test result was received two weeks after the vial was processed. This issue was subsequently addressed when the facility initiated in-house testing in April, which helped improve turnaround times and reliability.

Without a complete submission of spore-testing data from all facilities, the Monitor cannot determine whether weekly spore testing is occurring at every site as required. Although the available data suggest that weekly testing is generally being performed, gaps in documentation and the absence of data from multiple facilities prevent the Monitor from making a definitive determination of compliance.

Spore testing is an essential clinical safeguard and directly supports several provisions of the Consent Decree. Consistent biological monitoring provides measurable assurance that sterilization is effective, protects patient safety, and aligns with the Decree's intent to establish a comprehensive, standardized, and safe health care system across all IDOC facilities.

Summary

DOC has made progress in this area since the last Monitor's Report. Two developments warrant particular recognition: the submission of the Dental Equipment list and the provision of spore-testing logs. The Dental Equipment list represents a meaningful step toward establishing a systemwide method for tracking essential dental equipment and begins to build a foundation for ongoing data collection and operational oversight. However, the submission did not indicate who conducted the survey or when it was completed. Including this information is necessary to demonstrate compliance with the requirement for annual inspections and to verify the reliability and timeliness of the data.

The submission of spore-testing records was likewise beneficial. In contrast to prior cycles that relied primarily on summarized CQI reports, the Monitor was able to review month-by-month facility-level logs, which offered greater insight into actual practices and the consistency of testing across sites. Continued improvement will require full participation from all facilities to ensure complete and accurate systemwide monitoring.

RECOMMENDATIONS:

1. IDOC must 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 submitted, the work order, the purchase order approved, and the date equipment is repaired or replaced.
2. Standardize the list of equipment requiring annual inspections. All facilities must contract with qualified vendors for comprehensive annual equipment surveys. Inspection dates and the name of the entity and person conducting the annual inspection should be added to the Dental Equipment list.
3. Clinics with only one operatory cannot support both a dentist and a hygienist simultaneously. IDOC should explore:
    - Renovating clinical areas.
    - Identifying adjacent space in Health Services.
    - Deploying mobile dental units for capacity augmentation.
    - Alternate provider clinic schedules so that dentists work on different days or staggered hours (short-term solution).
4. Hire a consultant to perform a survey of medical and dental areas to evaluate space and capital equipment to ensure safe and adequate dental space and equipment.
5. Ensure that all dental autoclaves undergo spore testing per the Centers for Disease Control and Prevention (CDC) guidelines, at least weekly.
6. Establish precise documentation requirements for spore testing reports, including the testing date, whether controls were run, and the test results (positive/negative). Explanations should accompany any deviations from weekly testing.
7. 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.
8. Establish a dedicated radiology hygiene policy that focuses specifically on radiation safety and exposure prevention. Such a policy should establish clear standards to protect both patients and staff from unnecessary radiation exposure by outlining:
    - Proper use of lead aprons and thyroid collars.
    - Adherence to the ALARA (As Low As Reasonably Achievable) principle.

- Operator qualifications and required training.
- Equipment calibration and performance verification.
- Safe operating procedures for radiographic equipment.

In addition, the policy should require the posting of appropriate radiological hazard signage, maintenance of inspection logs, and adherence to ANSI, OSHA, and state regulatory guidelines across all areas where X-rays are performed. Because the facilities operate both medical and dental radiographic units, IDOC should implement a unified policy to establish baseline standards for all radiographic modalities.

9. Conduct routine audits to verify that radiological hazard signage and thyroid collars are posted, intact, and routinely inspected at every facility. Findings should be documented and reported as part of the CQI review or added to the SIU Dental Unit Overview.

Dental Access

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.K.2. *Each facility's orientation manual shall include instructions regarding how prisoners can access dental care at that facility*
II.B.6.h. *IDOC agrees to implement changes in the following areas: Dental care access and preventative dental care.*

OVERALL COMPLIANCE RATING: Partial Compliance

FINDINGS:
To evaluate the Consent Decree provisions listed above, the Monitor requested the following documents:

1. A list of allocated/budgeted medical and dental positions (also noting FTE) with vacancies for each position at each facility to include IDOC and Wexford positions. These should be separated by position type.[964]
2. Provide by facility, the number of requests for dental care, the number of examinations, the number of emergent procedures completed, the number of routine procedures completed, the number of dental cleanings, the number of prosthetics, the number of extractions, the number of restorations, the average wait times, longest wait times, and the backlogs for prosthetics, extractions, restorations, and dental cleanings.[965]
3. Any log (preferably electronic) that tracks and monitors facility and statewide biannual dental cleanings provided by hygienists. The percentage of eligible individuals who have been offered, refused, or received biannual dental cleanings should be provided prior to each court report of the Monitor .
4. Copies of the orientation manuals for Hill, Lincoln, Decatur, Dixon, Centralia, Pinckneyville, and NRC.[966]

[964] Monitor's documentation request 9th report, dated 5/10/2025, item 8.
[965] Ibid, item 165.
[966] Ibid, items 166 and 167.

5. List of all dental equipment with the date of the most recent calibration and/or inspection by an authorized dental equipment vendor. The list should identify any defective equipment that requires repair or replacement, along with the date the repair or replacement was completed.[967]

Access to care is a multifaceted issue influenced by several interrelated factors. These include adequate staffing levels, sufficient and properly equipped clinical space, the availability and maintenance of essential dental equipment, and clear communication with the incarcerated population regarding procedures for requesting and receiving dental care. Each of these components must function effectively to ensure timely and equitable access to oral health services across IDOC facilities.

Staffing

The Monitor was provided a table indicating **13 facilities with dentist vacancies** during the reporting period. The Schedule E FTE data, in the reconciliation reports, show that the dental program operated with significant and persistent staffing shortages.[968] Across the system, an average of **31.36 dentist FTEs** were allocated for the three reporting periods (January–June 2025), yet only **15.88 FTEs** were working. This resulted in **15.46 unfilled dentist FTEs**, an overall vacancy rate of **49.3%**. For Chief Dentists, **3.0 FTEs** were authorized but only **1.32 FTEs** were working, yielding **1.68 unfilled Chief Dentist FTEs** and an average vacancy rate of **56.1%**. See below.

Budgeted Vendor Hours with Hours Worked and Unfilled Hours for Dentists								
	Chief Dentist				**Dentists**			
	Budgeted hours	Hours Worked	Budgeted Hours Unfilled	Percent Unfilled Hours	Budgeted Hours	Hours Worked	Budgeted Hours Unfilled	Percent Unfilled Hours
Jan-Feb	3	1.27	**1.73**	57.6%	31.45	13.98	**17.47**	55.5%
Mar-April	3	1.4	**1.5**	53.2%	31.45	16.21	**15.24**	48.4%
May-June	3	1.28	**1.72**	57.5%	31.15	17.47	**13.68**	43.9%
Average	3	1.32	**1.68**	56.1%	31.36	15.88	**15.46**	49.4%
Data does not account for agency staff or overtime and therefore cannot be used to compare to Staffing Analysis numbers								
Data from Wexford folder in document request #8								

Because both categories represent **clinical provider positions**, it is appropriate to examine them collectively. When combined, the dental program had:

Clinical Dentist Staffing (Chief Dentists + Dentists, Combined)				
Category	Allocated FTEs	Worked FTEs	Unfilled FTEs	Vacancy %
Combined Average for Jan–Jun 2025	34.36	17.2	17.16	49.90%

[967] Ibid, item 163.
[968] Documents provided by IDOC on 8/15/25 in response to the Monitor's documentation request, item 8.

This means that **approximately half of all clinical dentist positions were vacant** during the review period. These deficits significantly limit the system's capacity to provide routine, urgent, and preventive dental services.

The Monitor cannot determine from the reported hours whether the worked FTEs reflect permanent employees, part-time practitioners, locum tenens coverage (Jet Mobile Dental Unit), or shared personnel, making it impossible to evaluate the stability of the clinical workforce or to compare to the Staffing Analysis benchmark.

A comparable Schedule E summary for hygienists or dental assistants was not provided. However, reconciliation data indicate approximately a **20% vacancy rate for hygienists** and a **28.4% vacancy rate for dental assistants**, further impairing the program's ability to meet clinical demand. A more detailed discussion of these staffing challenges appears in the Dental Staffing section of this report.

N**o backlog data** were provided by the vendor or IDOC. Backlog information is essential for determining how staffing shortages affect access to care, wait times, and system performance. As stated in the last report, "IDOC should standardize backlog reporting and establish clear definitions for each backlog category."[969]

The database, currently under continued development, has the potential to capture backlog data and provide the Department with a systemwide monitoring tool. However, until IDOC consistently reports backlog metrics, the Monitor cannot fully evaluate the adequacy of dental staffing or its impact on timely treatment.

Given that there is over a 50% dental vacancy rate, the Chief Oral Health should develop a procedure for sending patients with acute dental conditions to a local dentist for care. The Monitor advises that the Chief Dentist consult with the Monitor's Dental consultant for advice.

Productivity

Only limited information was received that could be used to review the productivity of dental hygiene care and no comprehensive data for dentists, examinations, extractions, restorations, or prosthetics was provided.[970]

As with backlog reporting, it is anticipated that once operational, the Department's Med Database will allow IDOC to track this information consistently and accurately. Reliable productivity metrics are essential for assessing staffing adequacy, monitoring access to care, and determining whether the dental program is meeting the requirements of the Consent Decree.

Clinic Infrastructure and Operatory Capacity

The Monitor's review of the Department's operatory and chair inventory identified five facilities operating with only a single operatory. This configuration limits simultaneous use by a dentist and dental hygienist and can contribute to reduced productivity and delays in routine, urgent, and preventive care. Although the Department has begun to address space limitations at NRC and Jacksonville, the issue is broader. It highlights the need for a systemwide evaluation of operatory capacity and clinic design.

[969] Health Care Monitor 8th Report Lippert v. Jeffreys, November 13, 2024, page 260.
[970] Documents provided by IDOC dated 8/15/25 in response to the Monitor's documentation request 166.

Options such as renovating existing spaces, identifying additional operatory locations within Health Services, or supplementing capacity through mobile dental units may help improve access and operational reliability. A more detailed discussion of clinic infrastructure and its implications for service delivery appears in the Dental Support section of this report.

Orientation Manual

The Monitor reviewed orientation manuals that were requested from seven facilities, along with documentation confirming that compliance information had been distributed to all IDOC facilities.[971] Two facilities, Hill and Centralia, did not include a dental section or specific instructions regarding access to care. The manuals from Decatur and Dixon contained poorly defined and inadequate references to dental services, while Lincoln and Pinckneyville provided partial instructions. In contrast, one facility, NRC, submitted an exemplary manual that incorporated all required elements under the Consent Decree and aligned fully with the Implementation Plan.

The NRC orientation manual clearly outlines procedures for submitting requests for both routine and urgent dental care, including dental cleanings, oral hygiene education, and self-care practices. This well-developed dental access section appears to have been derived from an email issued by IDOC's Agency Medical Coordinator on August 7, 2025. The email specified the required content for the dental access section of orientation manuals and provided a standardized template developed by the Office of Health Services (OHS). It was disseminated to Clinical Services Supervisors, Health Care Unit Administrators (HCUAs), and Assistant Wardens of Programs (AWPs).

Given the timing of this communication, it is likely that facilities did not have sufficient time to revise their manuals before submission. If all facilities adopt the template and revise their manuals accordingly, it would satisfy the Monitor's expectations for compliance in this area. All facilities should have a standardized orientation manual with information on access to medical and dental care that is consistent with OHS policy.

RECOMMENDATIONS:

1. **Establish a standardized, systemwide backlog and productivity reporting system.** The Monitor strongly recommends utilizing data in the electronic to provide data with respect to determining compliance because the Monitor does not have confidence in the data integrity provided to date in paper and manual tracking. If IDOC should use Med Database, they should finalize the Med Database and require all facilities to report examinations, cleanings, emergent care, restorative procedures, extractions, prosthetics, and wait times in a uniform format. This reporting must occur monthly and be reviewed at the facility and statewide CQI levels. Each of the fields in the database need to be defined and instructions given as to what and how the information is to be recorded on the log. The information on the log needs to be verified for completeness and accuracy. However IDOC obtains data, the Monitor strongly recommends obtaining data expertise in data management.
2. **Conduct a systemwide operatory capacity assessment to determine whether current clinical space supports the required level of care.** This assessment should evaluate the number of operatories, chair functionality, equipment reliability, and workflow capacity to determine whether

[971] Documents provided by IDOC dated 8/15/25 in response to the Monitor's documentation request 168.

each site can support timely access to routine, urgent, and preventive care. Facilities with only one operatory should be prioritized for corrective action. This is consistent with the Monitor's recommendation to obtain a consultant to review medical and dental clinical space.

3. **Create facility-specific staffing plans that integrate FTE needs with clinical workload and operatory capacity.** Given that approximately 50% of dentist FTEs were unfilled during the review period, IDOC should assess how many hours are needed at each facility to meet population demand and ensure timely access to care. These plans should also incorporate hygiene and dental assistant vacancies and their impact on service delivery.
4. **Strengthen and standardize facility orientation manuals regarding access to dental care.** IDOC should ensure that all facilities adopt the OHS-approved template outlining procedures for requesting routine and urgent dental care, dental cleanings, oral hygiene education, and self-care. Manuals should be reviewed.

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:

The Monitor requested the following documents specifically to review for compliance with the items from the Consent Decree listed above.

1. Provide copies of health records for 20 new admissions to NRC and 10 new admissions for each of Menard, Logan, and Graham for the month of April 2025.[972]
2. Provide five dental charts from five sites (Graham, Logan, Vienna, Hill, and Pontiac) for patients who had a dental extraction(s) in the month of March or April 2025.[973]

According to E.04.01 Oral Health Services, dental examinations are expected to be performed within 7 calendar days of assignment to a Receiving Center and shall include:

1. A visual oral exam.
2. Dental x-rays such as panoramic views and bite wing.
3. Intra- and extra-oral soft tissue examination to assess; asymmetries, a lymph node exam, and a brief temporomandibular joint examination.
4. Medical and dental history.

[972] Monitor's documentation request 9th report, dated 5/10/2025, item 107. Records to be sent include the problem list, data base, intake screening forms (including vaccine history and any RHM screenings), medical history, physical examination, dental exam and instruction on oral hygiene, health assessments, and corresponding progress notes, orders, results of diagnostic testing, and any patient refusals for the first 45 days following the reception date.
[973] Monitor's documentation request 9th report, dated 5/10/2025, item 162. The records are to include medical problem list, dental notes, documents, consents, and requests for care for 6 months prior through two weeks after the extraction and the most recent dental x-ray report(s).

5. Dental conditions are documented on the problem list.
6. Education is provided on oral health and documented.
7. Patients who receive initial dental treatment plans and referrals for further evaluation will be completed in a timely manner based on acuity.
8. All dental examinations, findings and education on oral health shall be documented.

In addition to the existing policy, Administrative Directive 04.03.102 provides further guidance regarding intake screening examinations. However, this AD will not be used for the current review, as the requested records were from April 2025 and the AD was not released until June 2025.

Initial Dental Screening Examinations

A total of 49 records were submitted in response to the Monitor's request.[974] One partial record from Graham lacked dental clinical notes and was excluded, resulting in 48 records eligible for review. Thirty-two of the 48 records reviewed (67%) were completed within the required seven-day time frame. Three individuals (6%) did not receive a screening examination. Thirteen records (27%) documented screenings that occurred outside the seven-day requirement. Five screenings were completed 8–9 days after admission, while eight records (17%) reflected delays of 11 days or more, including screenings performed 25, 35, and even 36 days after admission.

NRC was the only facility to consistently perform initial screening examinations within the required time frame, although two individuals did not receive a screening at all. Graham completed two screenings outside the seven-day requirement. Menard and Logan showed the greatest deficiencies, with four and six delayed screenings, respectively. Logan also failed to complete one screening, resulting in seven out of 10 records (70%) being either missed or completed outside the required seven-day time frame.

Dental Radiographs

All facilities documented that panoramic films were obtained during the screening examination.[975] A concern raised by the Monitor in the last report involved the diagnostic quality of panoramic images produced at NRC.[976] Whether these films meet diagnostic standards will require either on-site review by the Monitor or duplication of the images for evaluation. Future site visits will focus on determining whether panoramic films produced at the Reception Centers are of adequate diagnostic quality.

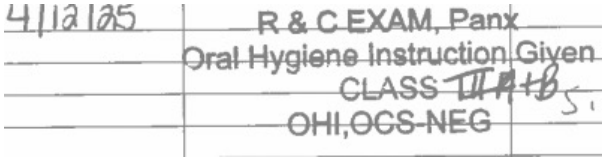
Intra- and Extra-Oral Soft Tissue Examination

The Decree requires that screening examinations include both intra-oral and extra-oral soft tissue assessments (III.K.3). These components are essential for the early detection of oral cancer as well as other soft tissue abnormalities. Facilities that documented completion of an Oral Cancer Screening were credited; however, it is important to emphasize that soft tissue examination encompasses more than cancer detection alone. Facilities must explicitly record that a comprehensive soft tissue examination was performed.

[974] Documents provided by IDOC dated 8/15/25 in response to the Monitor's documentation request 107.
[975] A panoramic dental X-ray provides a comprehensive view of the teeth, jawbones, sinuses, and surrounding structures in a single image, allowing clinicians to detect conditions that may not be visible with standard intraoral films.
[976] Health Care Monitor 8th Report Lippert v. Jeffreys, November 13, 2024, page 263.

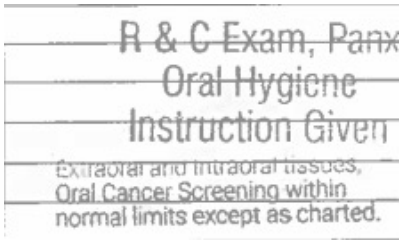
Of the 45 screening examinations reviewed, 18 records (39%) did not show documentation that an oral cancer screening, soft tissue assessment, or extra-oral examination was performed.[977] These omissions were all from NRC. The remaining 27 records (59%), originating from Graham, Menard, and Logan, documented that an oral cancer screening, soft tissue examination, or extra-oral assessment was performed.

The Monitor is concerned about the use of standardized stamps in the clinical record that prepopulate clinical findings. For example at Menard the 0422 forms (both sides), had the following stamp applied to every intake record. This practice is problematic because the stamp automatically indicates that the oral cancer screening was negative, regardless of whether the provider actually performed or confirmed the assessment.



Using a stamp in this manner is not acceptable for clinical documentation. A stamp should serve only as a template to guide the provider in documenting the elements **actually performed**, not as a pre-completed record of findings. Pre-populating clinical outcomes, such as a "negative" oral cancer screening, introduces significant risk of inaccurate documentation and undermines the reliability of the clinical record.

Similarly at Graham the 0422 forms (both sides), the following is stamped on every intake record which introduces a risk for inaccurate documentation. See below:



The use of stamps in this manner is problematic. If stamps are to be used, they must serve solely as prompts for the provider to circle or mark the items actually performed during the examination—not to prepopulate clinical findings. Even with a caveat such as "Oral cancer screening within normal limits except as charted," there remains a significant risk that providers may overlook or fail to verify clinical information. Below is an example of a rubber-stamp format that appropriately guides the provider to record only the elements of the examination that were completed. [978]

[977] Documents provided by IDOC dated 8/15/25 in response to the Monitor's documentation request 107. The three patients who did not have examinations were excluded from analysis lowering the denominator.
[978] This serves as an example. The Chief of Oral Services needs to determine what elements should be included in a standard stamp/form.

Dental Screening Examination		
Elements	Performed	Notes
Screening	Yes/No	
Health Hx	Yes/No	
PSR	Yes/No	
X-rays	Yes/No	
OHI	Yes/No	
Extra Oral Exam	Yes/No	
Intra Oral Exam	Yes/No	
Class (APHA)	Yes/No	
Provider Name Printed		
Provider Signature		Date

Medical Dental Histories Recorded at Screening Examination

Forty-four of the 46 dental records reviewed (96%) showed that a medical and dental history was recorded during the initial screening examination, indicating a high level of compliance. However, as noted in the Monitor's Seventh and Eighth Reports, the content of these histories remains inadequate and does not meet the standard expected for a comprehensive medical history.[979]

The Monitor reviewed problem lists to assess the accuracy of the medical histories obtained in the dental clinic. Several clinically significant conditions documented on those lists were not reflected in the corresponding dental health histories. These included non–insulin-dependent diabetes mellitus (NIDDM),[980] chronic kidney disease,[981] and infectious diseases,[982] as well as four patients with documented hypertension.[983] These conditions are directly relevant to dental treatment planning, medication selection, and risk management. Standard medical history forms typically include specific questions regarding systemic diseases and medication use; therefore, the omission of this information indicates that the current history-taking process is insufficient and does not reliably capture medically relevant conditions.

A more robust and standardized medical and dental history form should be developed to ensure that significant health conditions, particularly chronic diseases and drug allergies, are consistently captured and integrated into dental treatment planning.

Oral Health Instruction

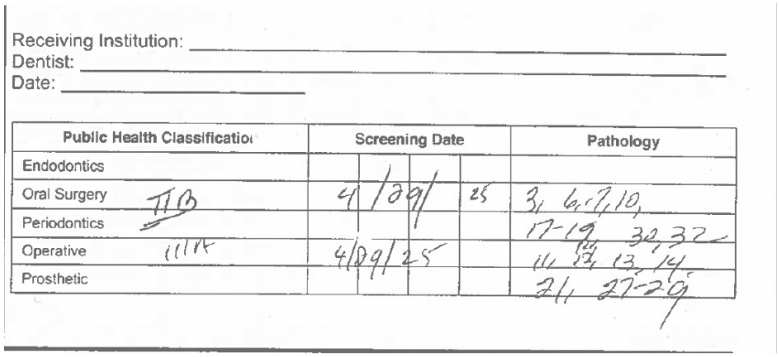
Oral Health Instruction (OHI) was provided in all but two initial screening examinations (95%). The two records lacking documentation of OHI originated from Logan.[984] Given that some facilities distribute written instructional materials, it is recommended that the provision of these handouts be documented in the clinical notes on the 0422 to ensure consistent and complete recordkeeping.

[979] Health Care Monitor 7th Report, Lippert v. Jeffreys, December 27, 2023, page 213; Health Care Monitor 8th Report, Lippert v. Jeffreys November 13, 2024, page 264.
[980] Dental patients 2, 10, and 11.
[981] Dental patient 11.
[982] Dental patients 1 and 12.
[983] Dental patients 1, 2, 3, and 10.
[984] Dental patients 13 and 14.

Documentation of Treatment Needs

Establishing a standardized, comprehensive format for recording treatment needs is essential to improving the quality and consistency of dental care across IDOC intake facilities. Currently, treatment needs are recorded in different formats by the facilities using paper records. See examples below:

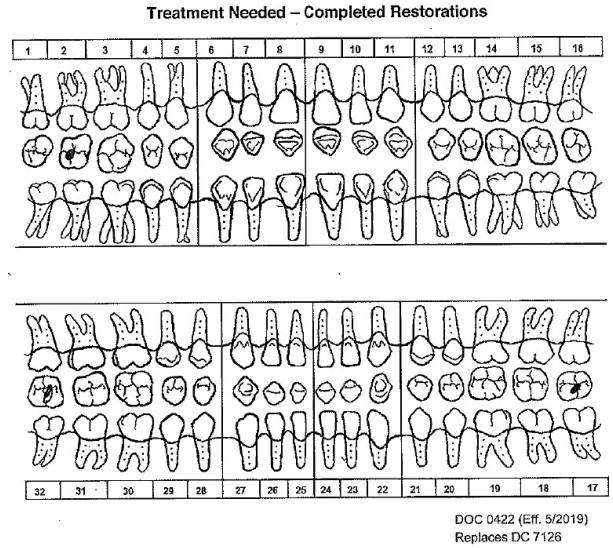
Dentists at Graham chart teeth requiring care and then record treatment needs within the Public Health Classification section of dental form 0422. This approach identifies the teeth requiring care and assigns an American Public Health Association (APHA) classification. While this provides a useful summary of needs, it does not represent a true treatment plan, as it lacks sequencing, prioritization, and any periodontal or hygiene assessment.



Receiving Institution: _____
Dentist: _____
Date: _____

Public Health Classificatio	Screening Date	Pathology
Endodontics		
Oral Surgery TIB	4/29/25	3, 6-7, 10,
Periodontics		17-19 30, 32
Operative (1)(14	4/29/25	11, 12, 13, 14
Prosthetic		21, 27-29

At NRC dentists chart treatment needs, but do not complete the Public Health Classification section of the 0422, and do not provide an APHA classification. The absence of a standardized framework results in inconsistent documentation and makes it difficult to compare needs or assess acuity across patients.



Treatment Needed – Completed Restorations

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

DOC 0422 (Eff. 5/2019)
Replaces DC 7126

Dental Treatment Plans

IDOC E.04.01 Oral Health Services states that:

> Patients who receive initial dental treatment plans and referrals for further evaluation will be completed in a timely manner based on acuity.[985]

[985] E.04.01 Oral Health Services, Procedure, I. F.

Patients do not receive a treatment plan. Instead, what is commonly documented is a list of treatment needs without any indication of sequencing, prioritization, or comprehensive planning. An adequate treatment plan should reflect the order in which care should be provided, taking into account urgency, complexity, periodontal status, and restorative needs.

Because all dentists are required to complete a comprehensive dental examination within 30 days of admission, which must culminate in a formal, phased treatment plan, it is unclear why the Initial Dental Screening and Dental Examination section contains language suggesting that treatment plans originate at screening. This inconsistency contributes to confusion among providers and has resulted in wide variation in practice across facilities.

Periodontal screening examinations
Screening for periodontal disease was absent from the records reviewed. However, the Monitor notes that Periodontal Screening and Recording (PSR) will be a required component of all future screening examinations per Administrative Directive (AD) 04.03.102, made effective in June 2025. Incorporating PSR into the intake screening process is essential, as it provides critical information for assessing periodontal health and informing appropriate treatment planning.

American Public Health Association (APHA) Classifications
The APHA dental classification system is a legacy document that is no longer supported by the American Public Health Association but is referenced in the recently published AD 04.03.102.[986] However, neither the E.04.01 Oral Health Services nor the AD specifies when or how this classification system is to be used. Historically, some dentists have applied the APHA classification during intake, resulting in inconsistent use across facilities. If the Department intends for the APHA system to be utilized, the policy should clearly state when and for what purpose it applies, and if so, ensure consistent implementation. The Monitor has no preference regarding its adoption but recommends uniformity in application should the Department choose to retain it. If IDOC chooses to retain use of this document, its use should be described in policy.

Summary
With the transition to a new vendor, the Department has a valuable opportunity to standardize the initial dental screening and examination process across facilities. This goal is both reasonable and achievable, particularly since only four facilities conduct intake screenings. Consistent documentation, using the same data elements and format, will strengthen accuracy, comparability, and continuity of care. The recent inclusion of periodontal screening reminder (PSR) requirements in AD 04.03.102 reflects meaningful progress toward a more uniform and clinically accurate intake screening process.

RECOMMENDATIONS:

1. IDOC should ensure that the required elements of the dental intake screening examination are consistently completed. The Department, in coordination with the vendor and local CQI teams, should monitor, report, and document the key components of the screening process during monthly CQI meetings. Systematic collection and analysis of these data will allow the Department to evaluate performance, identify gaps in compliance, and implement targeted corrective actions.

[986] The Monitor's dental consultant contacted the American Public Health Association (APHA) regarding this classification system; however, APHA staff were unable to locate the instrument or provide information on why it is no longer recommended or used by its constituents.

2. Ensure that panoramic X-rays are consistently documented as being made during the initial dental examinations at Reception Centers.
3. In accordance with the most recent revisions to Administrative Directive 04.03.102, the Department should implement the required standardized periodontal assessment protocol, Periodontal Screening and Recording (PSR), as a routine component of all dental intake screening examinations. Facilities should ensure that PSR findings are consistently documented in the dental record for every individual screened. Full implementation of this requirement will promote uniformity across facilities and support a comprehensive evaluation of periodontal health and treatment needs.
4. The Department should ensure that all dental professionals perform and document a comprehensive intraoral soft tissue examination and extraoral examination as part of the intake screening process. Consistent with Administrative Directive E.04.01, the extraoral assessment should include evaluation of the temporomandibular joint (TMJ), identification of facial or mandibular asymmetries, and any other relevant clinical findings. Clear and consistent documentation of these elements is essential. Documentation of an oral cancer screening alone does not fulfill this requirement. While an oral cancer screening is subsumed within the broader soft tissue examination, it is not consistent with the Consent Decree, which requires evaluation and documentation of all intraoral and extraoral soft tissue findings.
5. The Department should determine whether the APHA dental classification system will continue to be used as part of the intake screening process. If the system is to be retained, the E.04.01 and AD 04.03.102 should clearly specify when and how the APHA classification is to be applied. In that case, IDOC should ensure that all dental professionals complete the Public Health Classification section on form DOC 0422 and assign an appropriate priority category to every patient, including those who are asymptomatic (Category VI). The Department should provide training to dental staff to support consistent and accurate use of the classification system.
6. Review and upgrade, or replace imaging equipment at NRC and other facilities to ensure that panoramic films are diagnostic and meet the standard of care. In cases where films are substandard, corrective actions should be taken promptly.
7. Ensure oral hygiene instructions are available in multiple languages, including Spanish, to accommodate the diverse patient population.
8. Eliminate use of stamps that pre-populate the patient's dental record with clinical findings.

Dental Hygiene

Addresses III.K.7; II.B.6.h; III.K.8
III.K.7. *Dental hygiene care and oral health instructions shall be provided as part of the treatment process.*
II.B.6.h. *IDOC agrees to implement changes in the following areas: Dental care access and preventative dental care*
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 evaluate the Consent Decree provisions listed above, the Monitor requested the following documents:

1. Any log (preferably electronic) that tracks and monitors facility and statewide biannual dental cleanings provided by hygienists.[987] The percentage of eligible individuals who have been offered, refused, or received biannual dental cleanings should be provided prior to each court report of the Monitor.
2. Provide the logs of dental cleanings for the last 12 months from Logan, IRCC, Lawrence, Pontiac, and Robinson with dental hygienist staffing.[988]
3. Evidence of inclusion of dental services and care in quality improvement activity.[989]
4. Provide five dental records patients of patients who have received routine care (dental fillings, root canals, and partial dentures) at Pinckneyville, Shawnee, Hill, Robinson, and Vienna.[990]

The Monitor's Dental Consultant also reviewed the Med Database.[991]

Biennial Dental Cleanings

According to IDOC a review of IDOC Oral Health Services' dental examinations and dental cleanings is accomplished by having the SIU team pull 20 random charts to determine whether dental examinations are occurring and whether dental cleanings are being performed every two years.[992]

The Consent Decree requires that dental cleanings be provided at least once every two years. IDOC has initiated a performance measure on dental hygiene. This measure reviews about five to six records per facility to assess whether dental hygiene was accomplished. The quality of the services was not evaluated. Also not evaluated was whether hygiene was done preparatory to a procedure. When the electronic record is implemented, the Monitor recommends that this measure should be conducted through the electronic record for 100% of patients.

Hygiene was considered completed for 67% for the 4th quarter of the 2025 fiscal year but this score includes refusals. Sixty-four percent actually received hygiene services. This reflects measurable progress toward compliance. During this rating period, six facilities reached 100% compliance[993], and three facilities achieved 90% compliance.[994] These audits survey a small sample of records (5-6 per facility) which is the reason the Monitor recommends 100% survey using the electronic record.

However, several facilities reported compliance rates below 50%:

[987] Monitor's documentation request 9th report, dated 5/10/2025, item 166.
[988] Monitor's documentation request 9th report, dated 5/10/2025, item 169. The information provided should include daily schedules that include the patient's name and ID #, the date the appointment was requested, date of appointment, date of cleaning or refusal, rescheduled date if appointment was cancelled, and date of follow-up cleaning. A copy of the dental tab for the 19 facilities can be found within the "Monitor Databases" folder within this production.
[989] Monitor's documentation request 9th report, dated 5/10/2025, item 59.
[990] Monitor's documentation request 9th report, dated 5/10/2025, item 172 to include the patient's request for care, the dental clinic's correspondence, any consents for care and any dental grievance filed in the last five years.
[991] Documentation provided by IDOC dated 8/15/25 in response to the Monitor's document request items 166 and 169.
[992] Documents provided by IDOC dated 8/15/25 in response to the Monitor's documentation request 59. Previously the sample consisted of 10 random charts per facility. This was increased to 20 random charts effective July 1, 2025.
[993] Centralia, Jacksonville, Kewanee, Robinson, Sheridan, and Southwestern.
[994] Hill, Decatur, Vandalia.

Facilities with < 50% Compliance	
Facility	**Compliance Rate**
East Moline	50%
JTC	30%
Pinckneyville	30%
Western	20%
Danville	20%
Dixon	10%
Pontiac	0%

The 10% score for Dixon was based on a refusal. None of the 10 sampled charts included dental hygiene. These data indicate that targeted interventions are needed. A focused effort by the vendor and the Chief of Oral Health Services should be directed toward increasing compliance at these lower-performing facilities.

The full 2025 fiscal year data[995] is shown below.

Dental Hygiene Fiscal Year 2025								
	July-Sept 2024 1st QRT 2025		Oct-Dec 2024 , 2nd QRT 2025		Jan-Mar 2024, 3rd QRT 2025		April-June 2024, 4th QRT 2025	
Charts sampled	276		278		280		279	
Hygiene completed	152	55%	154	55%	150	54%	179	64%
Documented Refusals	9	3%	6	2%	12	4%	8	3%
Excluded	115	42%	118	43%	118	42%	92	33%
Score		**58%**		**58%**		**58%**		**67%**

The Monitor has the following comments:

- The excluded category is not defined. It is a large part of the sampled population. If the excluded population is not included in the sample, the sample size is considerably smaller than 10 charts per facility, making the data less valuable.
- The number of refusals is small, indicating patients accept and likely need these services.
- A longer time period of observation is necessary to determine if changes in scores are just random variation or show a trend.

Biennial Dental Cleanings and Oral Hygiene Instruction

To assess compliance with the requirement that dental cleanings be performed at least once every two years and instruction in oral hygiene consistently provided and appropriately documented records were requested for a five year period from five facilities.[996] Many of the dental records submitted from Vienna

[995] This is from Statewide data in each of the four quarters of data in document request 59.
[996] Monitor's documentation request 9th report, dated 5/10/2025, item 172.

were incomplete, and only one record was provided from Robinson.[997].As a result, 14 records were eligible for full review of the criteria related to routine hygiene care and Oral Hygiene Instruction (OHI) and the results were:

- 71% (10 out 14 records) demonstrated compliance with the requirement to provide dental cleanings at least every two years.
- 92% (13 out of 14 records) demonstrated compliance with the provision for oral hygiene instruction.

Prevention

OHI was provided in nearly all instances in conjunction with dental hygiene appointments, indicating that instruction is predominantly delivered during cleaning encounters. Review of intake examinations further showed that approximately 90% of new admissions received OHI, reflecting consistent delivery of this requirement at intake.

IDOC provided a spreadsheet[998] with data on dental services for review. Although still in development, the spreadsheet has been deployed across 19 IDOC facilities. For this section of the report, the Monitor reviewed two specific data fields: last cleaning date and scheduled cleaning date.

The Med Database differs from the results of performance and outcomes measures for dental services. For example, the dental hygiene performance and outcome results for Pontiac for the 4th fiscal quarter (April to June of 2025) was 0%. The Med Database column for the date of last cleaning included 164 persons who were seen for hygiene for the same period as the SIU measure. This is for a quarter so the Med Database would pro-rate 656 people as seen for hygiene in a year but there are only 471 people incarcerated in Pontiac. IDOC needs to clarify the methodology for data entered and have an explanation of the data before drawing conclusions. But a 10-chart sample over a quarter showing zero percent hygiene compared to a log that shows 164 persons received dental hygiene in the same quarter warrants more investigation and explanation before drawing any conclusions.

While the Med Database represents forward progress by the Department data-entry issues were identified. For example, in the Pontiac database, 14 edentulous patients, individuals who wear dentures, are documented as having received dental cleanings. It is unclear whether these individuals were merely scheduled, assessed as edentulous, and erroneously recorded as having completed a cleaning despite no prophylaxis being performed. In contrast, some facilities, such as East Moline, correctly identify edentulous patients and assign "N/A" (Not Applicable) in the last-cleaning field. Improving consistency in how hygiene encounters and non-encounters are coded will enhance the reliability and interpretability of the dataset. As it currently exists, the Monitor cannot utilize the Med Database to verify compliance due to data integrity, but IDOC should proceed in the most effective way it can to obtain accurate data.

Summary

[997] To conduct a more robust and meaningful review, the Monitor will request additional records in the next reporting cycle and emphasizes the need for facilities to provide complete and accurate documentation as specified in the data request.

[998] This data is also discussed in the Data and Sick Call sections of the report. This spreadsheet is only used by 19 facilities. It has three worksheets: one each for specialty care, sick call and dental. It contains entries that lack data integrity and are not always accurate. Errors are identified in data entry that do not give confidence in the data entered. The concept of the process is good, but IDOC needs to utilize individuals with training and expertise in data management to ensure standardization and data integrity.

Progress continues toward compliance with III.K.7 and III.K.8.

The Monitor continues to recommend use of the electronic record to verify compliance toward multiple provisions of the Consent Decree. The introduction of the Med Database represents a step forward in tracking and understanding dental care encounters across the system. But much remains to be done to ensure its data integrity. Its effectiveness, however, depends on accurate, timely, and consistent data entry at each facility. Further refinement of the database, supported by a standardized dental data-entry instruction guide, would promote uniformity in documentation practices and strengthen the overall reliability of reported data.

IDOC has informed the Med Database has already undergone its first revision and that the Department is requiring all individuals responsible for entering dental data to receive training, including video-based instruction produced at the SIU studios and guidance on the use of Excel spreadsheets. This training, if implemented effectively, has the potential to improve data integrity and support more accurate systemwide monitoring.[999] Given the development and implementation of the electronic record and the data expertise that IDOC would require to improve the Med Database, the Monitor continues to recommend obtaining data expertise to conduct queries of the electronic record to obtain data on all scheduled appointments.

Persistent concerns remain regarding the sequencing of care. As documented in the Monitor's Eighth Report and the Dental Comprehensive Examination section of this report, multiple instances were noted in which hygiene services occurred **after** restorative or prosthetic treatment. Proper sequencing requires hygiene care to **precede** restorative/prosthetic therapy, and all extractions and restorations must be completed **before** fabricating any prosthesis. A healthy periodontium is foundational to both restorative and prosthetic success. The workflow used for implementation of the electronic record should have addressed this issue. If that was not done, staff assigned to manage the electronic record should conduct a workflow of dental processes to ensure that the electronic record can be used to appropriately sequence a desired workflow.

RECOMMENDATIONS:

1. **Strengthen efforts to achieve biennial dental cleanings across all facilities, prioritizing** sites currently performing below the statewide average. Increased attention to routine preventive care will help reduce disease burden and lessen the demand for urgent or complex procedures.
2. 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.
3. **The Monitor strongly recommends use of the electronic record to capture and present data for purposes of compliance with the Consent Decree.** If the Med Database is used, IDOC must hire expert data personnel to standardized data definitions and data entry across all facilities. Establishing uniform data-entry protocols will improve the reliability of systemwide reporting and support accurate monitoring of dental program performance.
4. IDOC must ensure that all facilities submit complete, accurate, and fully responsive records when documentation is requested by the Monitor. This includes providing all charts, logs, and supporting materials specified in data requests and supplying additional records when initial submissions are incomplete or insufficient, as occurred with Vienna and Robinson.

[999] Meeting with the Chief or Oral Health Services, 12/5/25.

Comprehensive Dental Care
Addresses item III.K.6

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.*

OVERALL COMPLIANCE RATING: Non-Compliance

FINDINGS:

The Monitor requested the following documents specifically to review for compliance with the items from the Consent Decree listed above.[1000]

1. Provide three dental records (2024-2025) of patients who have received partial or full dentures from Southwestern, Danville, Pontiac, Shawnee, and IRCC.
2. Provide five dental records patients of patients who have received routine care (dental fillings, root canals, and partial dentures) at Pinckneyville, Shawnee, Hill, Robinson, and Vienna.[1001]

Criteria for Comprehensive Examination Review
For this section of the report, the Monitor reviewed Comprehensive Examinations, those conducted within 30 days of admission or as part of the Biennial Examination cycle, to determine whether they were completed in accordance with E.04.01 Oral Health Services, effective 2/2024d whether an appropriate treatment plan had been established.[1002] Policy E.04.01 Oral Health Services sets forth the following requirements for the comprehensive dental examination and treatment plan. It states:

> "Continued treatment initiated by the reception center, if applicable;
> 1. Medical and Dental History review;
> 2. A review of current medications;
> 3. Reviewing the results of all diagnostic tests;
> 4. Visual observation of the teeth and gums;
> 5. Review of panoramic X-rays and bite wing for diagnostic purposes;
> 6. Oral Cancer Screening;
> 7. Periodontal Disease/ Gum exam and evaluation;
> 8. Missing teeth and Tooth decay examination;
> 9. Existing restoration examination;
> 10. Evaluation of tooth and bite alignment;
> 11. Complete temporomandibular Joint (TMJ) Examination;
> 12. Dental health education; and
> 13. Oral/dental hygiene instruction."[1003]

[1000] Monitor's documentation request 9th report, dated 5/10/2025, item 170.
[1001] Monitor's documentation request 9th report, dated 5/10/2025, item 172 to include the patient's request for care, the dental clinic's correspondence, any consents for care and any dental grievance filed in the last five years.
[1002] Only Comprehensive Examinations and Biennial Examinations completed after the policy's publish date were reviewed. These records provide insight into whether providers are aware of providing services consistent with updated policy requirements.
[1003] Procedure II.B of E.04.01 Oral Health Services.

Documentation on the patient's dental record is to include:

1. Complete mouth charting and categorization of treatment needs;
2. A summary of oral hygiene education and instructions provided;
3. Development of a treatment plan.
4. Dental conditions are updated on a problem list
5. Declination of care to include defining the consequences of the refusal.

Dental examinations and treatment plans are to be completed within 30 days of an individual's admission to their home site. The examination is to be supported by X-rays, and if necessary additional diagnostic periodontal classification 1-4, measurements, and mobility, in addition to information obtained from the intake screening.

This policy language aligns with the standards of both the American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCHC). The Monitor supports conducting a comprehensive examination within 30 days of admission, as this ensures that a complete assessment and treatment plan are established early. Without such an examination, a transfer to a facility lacking an on-site dentist could result in unnecessary delays in care.

A total of 40 dental records were requested for review, including 25 comprehensive care records and 15 prosthetic care records.[1004] Of records received 28 records were determined to be eligible for review. Many of the submitted records were illegible, incomplete, missing required forms (Form 0422), or did not extend far enough back in time to provide an adequate longitudinal view of care. These deficiencies limited the scope of the review and necessitated working with the available documentation. As a result, the number of records reviewed varies across subsections of this part of the report.

Comprehensive Examinations Conducted Within 30 days

The Monitor reviewed comprehensive examinations completed after the individual in custody was transferred to a designated home facility. Three records were of individuals admitted in 2025.[1005] One record was excluded due to the facility's failure to provide a complete dental record.[1006] None of the records from this small sample of three received at IDOC from January – July 2025 revealed that a comprehensive exam was completed within 30 days.

Six records involved admissions that occurred in 2024, with comprehensive examinations completed after the Oral Health Services policy became effective in February 2024. Two records were excluded from review due to the facility's failure to provide complete dental records.[1007] Four records remained available for analysis. Of these, three patients did not receive an examination within 30 days of admission.[1008] The remaining record documented that a "referral exam" was completed within 30 days; however, the documentation did not demonstrate that a comprehensive examination had been performed.[1009]

[1004] Monitor's documentation request 9th report, dated 5/10/2025, item 170 and 172.
[1005] Dental patients #15, #16, and #17.
[1006] Dental patient #15 (Vienna).
[1007] Dental patients #18 and #19.
[1008] Dental patients #21, #22, and #23.
[1009] Dental patient #20.

None of the intake or comprehensive examinations documented a periodontal evaluation.[1010] This represents a significant deficiency in the Oral Health Program. When records do not demonstrate that a periodontal screening was performed, using a periodontal probe, either at intake or during the 30-day comprehensive examination, the examination cannot be considered complete.

A review of the Fusion workflow indicates that the new Electronic Health Record is designed to prompt both the intake dentist and the receiving facility dentist to record periodontal findings (probe depths); however, this functionality remains a future enhancement. At present, no standardized template exists to capture periodontal assessment data, and providers are not consistently assessing or documenting patients' periodontal status at intake or during the comprehensive examination. This gap results in incomplete examinations and undermines compliance with policy requirements and accepted standards of care.

Biennial Examinations

Biennial examinations occur every two years after the initial 30-day comprehensive examination.[1011] These examinations are comprehensive in scope as they are used to formulate treatment plans for ongoing care.

The results of the performance and outcome measures indicate that on a small sample of records, statewide, 58% of approximately five to six records per facility completed a biennial examinations during the fiscal year 2025.[1012] Review of fourth-quarter data shows that six facilities achieved greater than 90% completion of a visit, while twelve facilities reported compliance rates below 50%.[1013] The facilities listed below demonstrate poor completion rates with the biennial examination requirement for the Oral Health Program.

SIU Performance Data	
Graham	50%
Shawnee	50%
Taylorville	50%
NRC	50%
Joliet	40%
Menard	40%
Big Muddy	30%
Logan	30%
Danville	20%
Dixon	10%
Western	10%
Pontiac	0%

[1010] Excluding patients needing dentures.
[1011] E.04.01 Oral Health Services, Procedure III. G and H.
[1012] Documents provided by IDOC dated 8/15/25 in response to the Monitor's documentation request 59.
[1013] Pontiac reported 0% compliance for both biennial hygiene services and biennial oral examinations. It is unclear whether any data collection or survey activity was conducted at Pontiac during the review period.

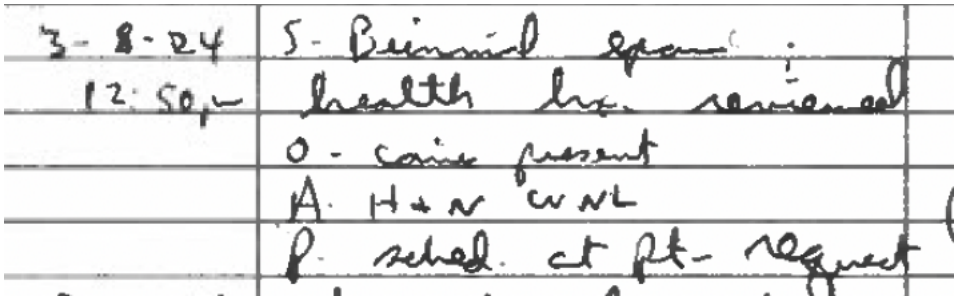
Because the sample size is small, a couple of records makes a significant difference in the score. It is for this reason that the Monitor strongly recommends use of the electronic record to capture 100% of patient data.

Patient records reviewed for this portion of the report had admission dates prior to August 2023. A total of 23 records were eligible for review to assess whether biennial examinations were completed. Seventeen of the 23 records (74%) did not demonstrate completion of required biennial examinations.[1014] Of the records reviewed, no formal periodontal assessments were documented, indicating that a periodontal probe was not used to assess attachment loss or assign a periodontal classification, resulting in 0% compliance with this requirement. In addition to the absence of periodontal examinations, most records reflected only partial assessments. Twenty-one of the 22 (91%) records lacked updated health histories, and 19 out of 23 (82%) records did not document the acquisition of new radiographs. In several instances, examinations relied on outdated X-rays rather than current diagnostic imaging. Additionally, no examinations included an evaluation of the temporomandibular joint or an assessment of occlusal relationships, and no records contained a summary of oral hygiene education or instructions provided.

There is no standardized method for conducting examinations across facilities. Some dentists record findings in general clinical notes, others use SOAP note entries, and some document partial findings on the IDOC Dental Form 0422. However, SOAP notes are designed for documenting single episodes of care or focused encounters and are not appropriate for developing or recording a comprehensive examination or treatment plan. In every instance reviewed, documentation was incomplete because dentists failed to record all elements required for a comprehensive or biennial examination.

The absence of a thorough and standardized examination directly affects the quality of treatment planning. When critical diagnostic information is omitted, the resulting treatment plan lacks clinical rationale, sequencing, and prioritization. Consequently, care becomes reactive rather than preventive or restorative in scope. A poorly conducted examination will inevitably produce an inadequate treatment plan, undermining both continuity of care and the effectiveness of the policy.

Below are two examples of documentation of biennial examinations, one entered as a SOAP note and the other as a clinical note.

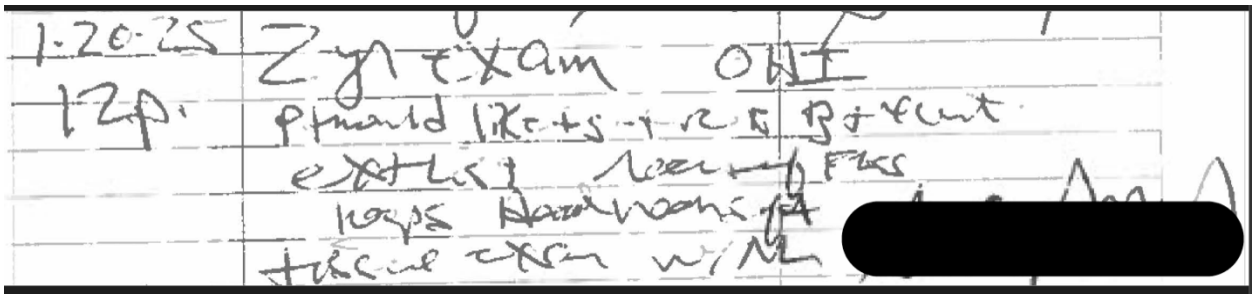


The SOAP note for the comprehensive examination is minimal, lacking documentation that X-rays were taken or reviewed.[1015] There is no record of an intraoral soft tissue examination or a periodontal

[1014] Monitor's documentation request 9th report, dated 5/10/2025, item 170 and 172.
[1015] Dental patient 24.

assessment. It is unclear what, if any, diagnostic findings were identified or recorded. Furthermore, there is no corresponding 0422 form as it is blank.

The following entry is made as a clinical note.[1016]



Although the clinical note is difficult to read, what can be discerned indicates that the dentist placed the patient on the extraction list and documented a review of floss loops, along with a head and neck and soft tissue examination described as within normal limits. However, there is no documentation of an X-ray review, a medical or dental history review or update, a temporomandibular joint (TMJ) examination, an occlusal evaluation, a summary of oral health information provided or a periodontal assessment.

Both examples lacked multiple required elements of an examination. These deficiencies demonstrate a pattern of incomplete documentation and underscore the lack of a consistent, thorough examination process. Additionally, no approved glossary of abbreviations exists, making record review difficult. Providers often use individualized and nonstandard abbreviations in their clinical notes.

It is strongly recommended that the Chief of Oral Health Programs collaborate with the vendor to ensure that all elements outlined in policy are fully incorporated into the examination process. This can be accomplished through the use of standardized, fillable PDF forms that can be accessed electronically or, alternatively, through the development of a standardized clinical stamp to promote consistency in documentation. Using the existing Oral Health Services policy as a framework, a standardized template can be created to guide providers in properly documenting examinations. The following example illustrates how a checklist can be converted into a standardized form to ensure policy compliance and promote uniformity across facilities.

[1016] Dental patient #25.

IDOC Comprehensive Dental Examination Checklist

Patient Name: _____ ID#: _____
Facility: _____ Date: _____
Exam Type: Biennial Comprehensive
Examiner: _____ Signature: _____

#	Examination Element	Completed	Comments / Findings
1	Continued treatment initiated by reception center (if applicable)	Yes No	
2	Review of medical and dental history — new diagnoses must be recorded.	Yes No	
3	Review of current medications — new medications must be updated in record.	Yes No	
4	Review of all diagnostic test results (labs, imaging, etc.)	Yes No	
5	Visual observation of teeth and gingiva	Yes No	
6	Review of panoramic and/or bitewing X-rays*	Yes No	
7	Oral cancer screening (EO/IO soft tissue exam)	Yes No	
8	Periodontal Examination and Evaluation — Oral Hygiene: Good Fair Poor	Yes No	
9	Assessment of missing teeth and caries — must be recorded on new 0422.	Yes No	
10	Evaluation of existing restorations — must be recorded on new 0422.	Yes No	
11	Evaluation of occlusion and tooth alignment	Yes No	
12	TMJ (temporomandibular joint) examination	Yes No	
13	Dental health education provided	Yes No	
14	Oral hygiene instruction provided	Yes No	

**Panoramic films valid for 5 years; Bite Wings and periapical films (if indicated) must be updated every 2 years.*

PSR (Periodontal Screening and Recording) — Record PSR codes or probing depths for each sextant. A PSR score of 3 or 4 requires full-mouth periodontal probing.

UR	UA	UL
LL	LA	LR

Summary

Treatment Plan Generated: Yes No Date Entered in Record: _____
Follow-up Required: Yes No If Yes, specify: _____

Treatment Plans

Similar to comprehensive examinations, treatment planning lacks standardization across facilities. Treatment plans were documented in multiple formats, including SOAP notes, standard clinical notes, clinical notes incorporating stamps, and entries on Dental Form 0422. This variability reflects the absence of a uniform approach to treatment planning.

Policy requires that treatment plan appointments include the documentation of vital signs—at a minimum, blood pressure and pulse—at the time the treatment plan is developed and at each dental visit thereafter.[1017] However, this information was consistently absent from the clinical notes reviewed. The Oral Health Program must adopt a standardized method for developing treatment plans that ensures all required elements, as defined in policy, are consistently documented.

Of the 27 dental records reviewed, 10 were generated from biennial examinations. In many of these cases, the documentation did not constitute a true treatment plan but rather a list of identified treatment needs without prioritization or sequencing of care. Examples of this deficiency are discussed further in the subsection titled Comprehensive Care. The remaining 17 treatment plans were typically developed following a dental hygiene visit, after referral to a dentist, or as a result of a sick-call appointment initiated

[1017] E.04.01 Oral Health Services Procedure III. E.

through a limited examination. These encounters often produced treatment plans that were incomplete, fragmented, and lacking continuity, organization, and a logical sequence of care. As a result, treatment delivery appeared ad hoc rather than guided by a structured and comprehensive plan.

Comprehensive Care

Delivery of care varies widely across facilities, ranging from well-organized, plan-driven treatment to episodic care initiated by through sick call requests. As previously noted, many patients receive abbreviated treatment plans developed during sick call encounters, resulting in fragmented and poorly sequenced care.

In one example, a patient at Graham Correctional Center requested care for a partial denture through the sick call process.[1018] The patient was first seen on February 24, 2024, when impressions were taken. He received a dental cleaning on March 1, 2024, and was scheduled again on March 3, 2024, for a try-in appointment. A partial denture was delivered on March 24, 2024. Hygiene care should always precede prosthetic impressions. Several months later, during subsequent sick call appointments, it was discovered that the patient had fractured and grossly decayed teeth, conditions that should have been addressed before prosthetic treatment was initiated. This sequence reflects a lack of comprehensive treatment planning and case management.

In another case, a patient at Danville Correctional Center presented to the clinic on November 26, 2024, for a sick call appointment.[1019] The dentist documented multiple decayed teeth (#2, #3, #5, #12, #13, #30, and #31) identified as restorable, and two teeth (#15 and #17) were deemed non-restorable. The dentist recommended extractions and a hygiene appointment, and the patient was appointed for dental cleaning. However, the next appointment on January 31, 2025, was used to take impressions, and the partial denture was delivered on March 7, 2025. In this instance, care was again provided out of sequence. Hygiene appointments should precede restorative or prosthetic therapy, and all extractions and restorations must be completed before prosthetic fabrication begins.

In a third example, a patient at Southwestern Correctional Center, who did not have a treatment plan, was seen by a dentist on April 21, 2025.[1020] The dentist determined that the patient should receive a full upper denture and a lower partial, and impressions were taken that same day. A wax try-in was completed on May 2, 2025. On May 15, 2025, the patient was seen by the dental hygienist for a cleaning, during which the hygienist informed the patient that his periodontal disease was so advanced that he would need to sign a consent acknowledging the risk of tooth loss during routine scaling. Despite this, on May 30, 2025, the dentist delivered a full denture and a partial denture that included teeth identified as mobile.

This case reflects care provided entirely out of sequence. Impressions should never be made on teeth that have not been cleaned or are periodontally unstable. If teeth are so mobile that consent is required due to the risk of extraction during routine cleaning, clinical judgment should dictate that the affected teeth be extracted and a full denture fabricated instead.

The management of routine dental care within IDOC reflects a systemic lack of coordinated sequencing. After patients are evaluated, whether during an examination, sick call, or hygiene appointment, they are

[1018] Dental patient #27.
[1019] Dental patient #26.
[1020] Dental patient #23.

placed on multiple waiting lists: one for hygiene, one for restorative care, one for extractions, and one for prosthetics. These lists are not organized in a logical or sequential order. As a result, patients may appear on any list without regard to the appropriate order of care. For example, a patient might receive prosthetic treatment before necessary hygiene or restorative work has been completed. Ideally, patients should move through care in a structured sequence: hygiene first, followed by extractions, then restorative procedures, and finally prosthetic care. Instead, the current system functions more like a "first-come, first-served" process, resulting in disorganized and inefficient care delivery.

While the implementation of the electronic health record (EHR) may help address some of these problems, the oral health program continues to exhibit a fragmented approach to comprehensive care and treatment planning. This fragmentation affects both the prioritization and the delivery of care.

Summary
In the Monitor's Eighth Report, the following was noted:

> "…Despite introducing a new dental policy, there seems to be a lack of consistency in how examinations and treatment plans are formulated across the system. It is unclear whether dentists have received proper communication or guidance regarding the requirements for conducting examinations and structuring treatment plans. The Monitor recommends developing annual and new-hire orientation training for dental staff to standardize the process of examinations and treatment planning throughout the enterprise."[1021]

It is readily apparent that the policy is not being consistently followed or adequately monitored for compliance. In the absence of clear instruction and oversight, each dentist attempts to meet expectations in their own manner and format, none of which fully align with policy requirements. Effective training must be implemented through a coordinated effort between the vendor and the Chief of Oral Health Services for IDOC.

The absence of documented periodontal examinations, specifically evidence of periodontal probing, is a significant concern. No records reviewed demonstrated that periodontal assessments were performed at intake screenings or during comprehensive examinations, whether conducted at 30 days or as part of the biennial examination cycle. Periodontal evaluation is a routine component of community-based dental examinations and an essential element of a complete assessment. Until the Oral Health Services Program demonstrates consistent performance and documentation of periodontal examinations within the required timeframes, compliance with this requirement cannot be confirmed.

Documenting that a biennial (two-year) examination was performed without completing the basic required elements does not constitute a valid examination. There should be evidence that hard and soft tissues are examined. A new dental form 0422 should be generated, capturing the details of the examination (to include periodontal probing). Incomplete examinations undermine the integrity of clinical documentation, compromise treatment planning, and prevent IDOC from demonstrating compliance with established standards of care.

[1021] Health Care Monitor 8th Report, Lippert v. Jeffreys November 13, 2024, page 271.

The Electronic Medical Records (EMR)) workflow submitted by IDOC has the potential to address several of the deficiencies identified by standardizing intake screenings, comprehensive examinations, and treatment planning. However, this functionality represents a future enhancement and has not yet been implemented. IDOC needs to retain software expertise in modification of workflows within the EMR to make adjustments to existing workflows to be aligned with requirements for compliance with the Consent Decree. The dental program should map out workflows of current processes including staging of examinations and present these to personnel who can modify screens as indicated. As such, it does not remedy the current inconsistencies in clinical practice or documentation. Until these workflows are operational and supported by clear guidance, training, and oversight, the variability and deficiencies observed during this review are likely to persist.

RECOMMENDATIONS:

1 Ensure that all comprehensive examinations include the required elements: periodontal assessment, soft tissue examination, hard tissue examination, bitewing X-rays, and full-mouth or panoramic films. Develop a protocol to guarantee intentional comprehensive examinations are performed on all patients receiving dental care.
2 Mandate the use of periodontal probes to assess attachment loss and make periodontal classifications. Implement soft tissue examinations as a standard part of all comprehensive and biennial examinations to ensure 100% compliance with the Decree.
3 Require that all treatment plans are formulated based on comprehensive examinations, including periodontal and soft tissue assessments.
4 Ensure that intraoral radiographs are consistently made part of the treatment planning process. Standardize the use of recent panoramic films in patient records and avoid reliance on outdated films.
5 Incorporate oral hygiene as a regular component of treatment plans for all applicable patients.
6 **Establish a protocol requiring that hygiene appointments occur prior to definitive dental treatments,** including restorations and prosthetics.
7 Create a uniform method for documenting treatment plans, such as a standardized format or template, to be used by all providers. Consider implementing a stamp outlining the care flow for comprehensive and biennial examinations, ensuring all necessary elements are included.
8 Introduce annual and new hire orientation training for dental staff, focusing on the importance of comprehensive examinations, consistent documentation, and treatment planning. Provide ongoing education to address gaps in provider training, particularly in areas related to periodontal assessments and radiographic procedures.
9 Perform workflows for dental processes and assess whether the electronic record facilitates expected workflows and adjust accordingly.

Attachment A
Health Care Monitor
9th Report
Lippert v. Jeffreys
Mortality Reviews

January 21, 2026

The Monitor reviewed 15 deaths. Care is unchanged and does not consistently adhere to OHS policy or standards of clinical care. Care at facilities without physicians is especially poor.

We limit this report to patients with asthma. Most asthma deaths are preventable[1] so we evaluated whether the mortality reviews identified and corrected deficiencies and provided instruction on preventing subsequent asthma deaths. We also evaluated quality of care as it pertains to nurse evaluations, chronic care management, medication management, and specialty referral.

The Monitor values the mortality review process managed by SIU, Office of Correctional Medicine that has been in place since 2022. These reviews are thorough and have identified myriad opportunities to improve the care of patients in the IDOC. The Monitor has identified some areas of disagreement with the findings of the Mortality Review Committee. These are discussed in the interest of improving the mortality review effort and providing feedback on areas for further inquiry or consideration by the reviewers. Again, the Monitor considers the mortality reviews a very valuable contribution to changing the quality of care provided patients in the IDOC.

Background for Asthma Care

Asthma is typically diagnosed using spirometry or pulmonary function testing to determine *reversible* airflow changes after use of bronchodilators. In IDOC, peak expiratory flow rates (PEFR) are typically obtained instead for persons with asthma. This is an easy office test with an inexpensive hand-held device. The test is useful as a monitoring technique for asthma but should be correlated initially and periodically with spirometry especially when medication is changed.[2]

In IDOC patients with chronic obstructive pulmonary disease (COPD) are monitored in chronic clinic as if they have asthma. Parameters for management of care used by IDOC for patients with COPD and asthma are the same when the focus of treatment for these two diseases differ. However, COPD is also typically diagnosed with spirometry to determine if *irreversible* airflow obstruction exists.[3]

For patients who come into prison with a diagnosis of asthma or COPD, their prior medical records including spirometry or pulmonary function testing should be obtained. For both asthma[4] and

[1] Global Initiative for Asthma 2025 update. See page 14 in introduction where it states, "Most of these deaths occur in low and middle-income countries, and most of them are preventable".
[2] UpToDate Peak expiratory flow monitoring in asthma.
[3] Global Initiative for Chronic Obstructive Lung Disease, 2024 Report available at https://goldcopd.org/2024-gold-report/
[4] UpToDate Pulmonary function testing in asthma.

COPD[5] periodic spirometry is recommended. Patients with asthma and COPD in IDOC rarely have documented spirometry or pulmonary function testing.

Monitoring changes in lung function is the essential responsibility of primary care providers in managing asthma patients. This involves monitoring asthma severity and the degree of control and modifying medications to obtain best control. This involves taking a symptom history and monitoring medication use.

The severity of asthma is described as mild, moderate, or severe based on the medications needed to control symptoms. Mild intermittent asthma requires only rescue medication, used when symptomatic. Control of mild persistent asthma requires a low dose inhaled corticosteroid in addition to, as needed, rescue medication. Moderate asthma requires rescue medication and controller medications including medium dose inhaled glucocorticoids or low dose glucocorticoids and additional controller medications. Current recommendations are to use a long-acting beta agonist with a steroid in a combined inhaler. Severe asthma requires high dose inhaled glucocorticoids with additional controller medications and possibly oral corticosteroids.

The degree of control is based on a symptom history including:

- Frequency of daytime asthma symptoms;
- Frequency of nocturnal awakenings from asthma;
- Use of a rescue inhaler more than twice a week;[6] and
- Ability to conduct normal activities without limitation.

The patient is well controlled if none of these symptoms are present; partly controlled if one or two of these is present and uncontrolled if three to four of these are present.

Other issues that should be considered in asthma evaluations include:

- Monitoring comorbid conditions (chronic nasal allergic rhinitis; upper respiratory conditions, GERD, etc.) that may exacerbate asthma control;
- Monitoring the number of unscheduled medical care interventions for asthma;
- Measurement of peak expiratory flow rate[7] as compared to personal best[8] or expected PEFR for age, weight, and height.

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[5] Global Initiative for Chronic Obstructive Lung Disease, 2024 Report available at https://goldcopd.org/2024-gold-report/

[6] Rescue inhalers consist of short acting beta agonist medication in an inhaler form. These medications provide quick relief of the asthma as opposed to controller medications that focus on long term action to control the asthma. A controller medication is added when rescue medications are needed more than several times a week.

[7] Peak expiratory flow rate is the amount of forced expiration that can be obtained in one second using a specific hand-held device that measures Liters/minute. This can be done at home or in a physician's office and is a simple method to track status.

[8] The personal best PEFR is used as the baseline benchmark for the patient and subsequent PEFR tests are measured against the patient's personal best. A personal-best PEFR is obtained when the patient has no symptoms or wheezing, feels no restrictions to activities of daily living, and gives a best effort. IDOC does not capture personal best PEFRs to use as a baseline to measure change in asthma status and control.

In addition to symptom history and medication use, providers must also ask whether the patient is able to eliminate exposure to allergens and control conditions that may exacerbate asthma. Once the provider has determined the current disease status and degree of control of the patient the therapeutic plan is modified accordingly, including medications.

Patient 1

The first patient[9] was a 50-year-old man with a problem list documenting asthma. He also had allergic rhinitis, prostate cancer, hyperlipidemia, fatty liver, gastroesophageal reflux disease (GERD), obesity, and low white count from an undetermined etiology. None of these other diseases were on the problem list and were not followed in chronic clinic. This is inconsistent with IDOC policy on chronic illness.[10]

Monitoring Changes in Lung Function

This patient's first asthma clinic was 8/2/22. Deficiencies noted with this visit included:

- No symptoms history was documented.
- The best peak expiratory flow rate (PEFR) (370/420/300 was 81% with an expected PEFR of 516). Without symptom monitoring it is more difficult to interpret the PEFR tests with respect to an assessment and plan.
- Providers prescribed Alvesco (a steroid inhaler) once a day, however this drug is recommended to be used twice a day. The rationale for this lower dose was not documented. The patient remained on this dosing schedule for the entire two-year period of record review.
- The patient was given an assessment of mild persistent asthma. It is unclear how the provider came to this conclusion given that symptoms were not assessed.
- Even though the patient was described as having mild persistent asthma, he was treated with medications that are typically used for moderate asthma (Step 3 option).
- There was no history whether the patient received his medications, but the medication administration record (MAR) showed that the patient had not received Alvesco for over two months (at the prescribed dose, the inhaler would be expected to last two months).
- There was no documented evaluation of the patient's understanding or training the patient on inhaler use.
- The follow up chronic clinic was not ordered.

This care is not consistent with standard of care.

The next chronic clinic for asthma wasn't until 6/13/23 almost a year later. Deficiencies with this chronic clinic included:

- The timing and frequency of visits was not consistent with existing chronic care policy.[11]

[9] This is patient #3 in our Mortality Review patient identifier list.

[10] The policy was sent to facilities in February of 2024. This particular death was in June of 2024 so there was minimal time for correction. Nevertheless, the practice of not evaluating all chronic conditions in chronic clinic is inadequate care.

[11] At this time the policy was Administrative Directive 04.03.105 Chronic Illnesses which required chronic care for asthma every six months in January and July. The Monitor does not agree with the Administrative Directive and recommended that all chronic diseases be followed in the same clinic and be as frequent as needed based on the least well controlled disease.

- There was no history except a statement "no new problems" which was inaccurate because since the last visit, the patient experienced the following:
    - URI with coughing 10/21/22.
    - On 11/15/22 the patient had symptoms of URI with productive cough, congestion and runny nose, *and wheezing*. A PEFR was not taken. His symptoms were consistent with exacerbation of asthma. The nurse referred to a provider but the patient was not seen. There was no follow up. All symptomatic asthma should be followed up by a provider shortly after the episode of exacerbation.
    - On 12/2/22 the patient was referred to an ENT specialist for dysphagia but wasn't seen until 6/1/23, or six months later (a very untimely consultation for dysphagia). The ENT specialist diagnosed allergic rhinitis and reflux disease, both of which are triggers for asthma and he recommended an inhaled nasal steroid and to consider omeprazole if the abdominal symptoms worsened. The provider was unaware of these recommendations and did not order the recommended medication. It was a major failure to not address allergic rhinosinusitis and GERD because these are comorbid conditions.
- The highest PEFR of 325/400/420 was 81% (expected PEFR of 516). It was not possible to determine a strategy for treatment because a symptom inventory was not taken.
- The provider continued step 3 treatment for mild persistent asthma without a symptom history. This was not in line with current standards.
- The patient had not received any of his asthma medications in months, but this was unrecognized.
- The blood pressure was very high (172/86) but was not addressed.
- The assessment was mild persistent asthma in good control without any history being taken. Such an assessment cannot be made without symptom history.
- There was no documented evaluation of the patient's understanding or any education on inhaler use.
- A follow up clinic was not ordered.

This care is not consistent with standard of care.

The next chronic clinic for asthma was 9/26/23. Deficiencies with this encounter included:

- The provider took no history of symptoms experienced since the last clinic.
- The provider did not acknowledge the three asthma related events since the last clinic. These included:
    - On 7/30/23, a nurse saw the patient using a shortness of breath protocol. The nurse documented that the patient was on Alvesco and Albuterol but the patient was also on montelukast. The nurse wrote that the patient was taking rescue medication (Albuterol) 4-5 times a day. The patient complained of sneezing and had wheezing and PEFRs of 300/400/350 (78% of predicted). The nurse appropriately consulted a physician *who ordered to increase the Alvesco to twice a day but for only five days.* There was no written prescription or MAR verification that the medication was ordered or that the patient received the increased dose. The patient remained on once daily Alvesco. The patient had exacerbation of asthma and stepwise increased dose of medication was indicated. The temporary five-day order for inhaled corticosteroid was insufficient and not standard of care.

  - On 8/3/23, a nurse saw the patient for upper respiratory infection. The nurse did not mention the asthma exacerbation four days ago. The patient had nasal congestion and a dry cough. Cough can be an asthma symptom but the nurse did not interpret the cough as related to asthma. The nurse errored in writing "no" to the protocol question, "Asthma complicating a URI". The nurse should have consulted a provider. These symptoms were likely related to the asthma exacerbation on 7/30/23. The nurse should have obtained PEFRs.
  - On 9/4/23 a nurse evaluated the patient using an abdominal pain protocol. In response to the protocol question, "Any chest pain, SOB, back pain, weakness", the nurse wrote "SOB, hx of asthma". If the patient had asthma and shortness of breath the nurse should have obtained PEFR, listened to the lungs, and taken further history of asthma. It appeared that the patient still had uncontrolled asthma.
- The PEFRs had decreased slightly to 340/330/360 (using best PEFR = 69% of predicted) but the patient had no wheezing. Patient effort was not documented. The provider documented the status as moderate persistent asthma (which was worse than the prior visit) which appeared accurate. However, the patient was already on therapy for moderate asthma and had at least one exacerbation of asthma since the last visit which was about 7 weeks earlier. The MARs indicate that the patient had not been receiving his medications as prescribed over the past several months. This should have been corrected but was unrecognized. Typically, a worsening of asthma calls for increased medication, but this was not done. Additionally, the patient wasn't receiving medication as prescribed. None of this was discussed in the progress note.
- The provider did not discuss whether the patient was taking or getting his medication or review proper inhaler use. There were interruptions in receiving Alvesco and montelukast since the last visit in June.
- The provider did not ask the patient about allergy or GERD symptoms even though these are triggers for asthma.
- A follow up clinic date was not scheduled.

This care was not consistent with standard of care.

The next chronic clinic was on 12/18/23. Deficiencies at this encounter included:

- The provider did not take a symptom history.
- The provider did not ask whether the patient was receiving medication as ordered. Nor did the provider ask about how frequently rescue medication was used. The MAR indicates that the patient did receive medication but the frequency of use was not documented.
- The patient's blood pressure was elevated (150/86) but not acknowledged as high.
- The PEFRs (200/225/200) were 43% of predicted and the patient had wheezing in all lobes and had slightly labored breathing. The patient was having an asthma exacerbation with decreasing PEFR demonstrated over the past year, and a half as shown in the table below. The provider ordered additional rescue medication by nebulization for two weeks with a follow up in a week. This is not consistent with standard of care. The provider should have increased the controller medication and initiated burst steroid therapy.[12]

[12] Based on UpToDate algorithm in section Acute exacerbations of asthma in adults: Home and office management.

Peak Expiratory Flow Rate Changes		
Date	**PEFRs**	**Percent of Predicted**
8/2/22	370/420/300	81%
6/13/23	325/400/420	81%
9/26/23	340/330/350	69%
12/18/23	200/225/200	44%

- The provider documented "reiterating the importance of KOP inhalers" but did not provide the patient instruction on proper inhaler use.
- The provider did not ask about allergy or GERD symptoms.
- While the provider appropriately ordered a follow up visit, the patient's asthma condition was not addressed at the follow up visit.

This care was not consistent with standard of care. The patient had asthma exacerbation and was not appropriately treated. This placed the patient at risk.

The last chronic clinic visit was on 5/2/24. The form documented that the clinic was only for high blood lipids. This was five months since the last clinic and the patient had severe asthma. Deficiencies with this visit included:

- Policy distributed in February 2024 required that "all chronic care problems shall be documented and seen together".[13] This was not done. The patient had a severe asthma exacerbation 5 months earlier and had not yet been seen for this in follow up. The provider should have evaluated the asthma at this chronic clinic.
- The provider did not address significant asthma issues since the last chronic clinic including:
    - On 4/21/24 a nurse documented that the patient signed up for sick call because his rescue inhaler was empty. The nurse wrote that the yard officer said the inmate refused to come to sick call. Nevertheless, if the patient was out of medication, the nurse should have attempted to provide it the same day[14].
    - A nurse saw the inmate on 4/23/24 and gave the patient an inhaler but did not evaluate the patient.
- The provider did not take a history of asthma, allergic rhinitis, or GERD symptoms.
- The patient had a severe asthma exacerbation in December, had not been seen in follow up for the asthma, had run out of rescue medication, but the provider did not follow up on his asthma. The provider did not ask about medications but the MAR shows since January that the patient was not receiving medication appropriately.
- Lungs were described as having "crackles". The provider should have obtained PEFRs.

[13] Policy F.02.01 Chronic Care Procedure XI.

[14] The inhaler should have been provided the same day because if a patient has need of the inhaler he very possibly has symptoms and prompt treatment was indicated.

This care was not consistent with standard of care.

On 6/19/24, at 4:20 pm the patient was having trouble breathing. On arrival of an LPN the patient was described as was not responsive, sitting against the wall and not responding to verbal commands. The nurse documented a pulse of 33. Narcan was given. At 4:23 pm an ambulance was called. At 4:25 pm no pulse was detected and CPR was initiated. An AED was not used (unclear if it was available). Another dose of Narcan was given at 4:27. At 4:29 911 was called and the patient was transferred from his cell to E house on a stretcher. Unclear if CPR continued during transport. The AED wasn't applied until 4:29; no shock advised. Rhythm not documented. At 4:40 EMTs arrived and patient left in an ambulance. The patient died in a hospital.

On 6/20/24, an autopsy was done and the coroner determined that the cause of death was asthma contributed to by hypertensive cardiovascular disease and heat exposure.

Minimizing Exposure to Asthma Triggers

Asthma triggers are environmental or internal exposures or events that can initiate an exacerbation of asthma or make asthma worse. Some of the many exposures and events include allergens and allergic rhinitis, exposures to environmental agents that exacerbate asthma[15], gastroesophageal reflux disease (GERD), respiratory infections, and hot and humid environmental conditions. This patient experienced these triggers. Yet, there was no evident documentation of a discussion with the patient about asthma triggers.

Allergic rhinitis and GERD

The patient was sent to an ear-nose-and-throat (ENT) specialist to evaluate dysphagia. Six months later the ENT saw the patient (which was not a timely consultation) and gave diagnoses of allergic rhinitis and GERD. The consultation wasn't reviewed until six weeks later when a provider ordered the two medications recommended by the consultant but did not enter the diagnoses into the problem list. Both prescriptions expired and were not renewed. The conditions were not followed in chronic clinic. Providers prescribed antihistamine pills continuously but the indication for these was not provided.

The Stateville facility, where he was housed, is known to be infested with cockroaches, mice and other vermin that can contribute to allergies that worsen asthma control.[16] The source of this patient's allergies were never investigated and the allergic rhinitis as a potential contributor to asthma was not discussed with the patient.

There was no evidence that IDOC providers recognize allergic rhinitis or GERD as asthma triggers. They did not monitor allergic rhinitis or GERD in the patient's chronic asthma clinic visits.

Upper respiratory infection

[15] In this patient's case these included feces from vermin and cockroaches which is discussed below.
[16] Dobbey v. Weilding, 1:13-cv-01068, U.S. District Cout, Northern District of Illinois; Stateville Safety and Sanitation Reports March 2022 – March 2024.

The patient had an upper respiratory infection on 10/21/22, followed by another episode on 11/15/22 with wheezing indicating that the upper respiratory infection was worsening his asthma. The nurse seeing the patient contacted a provider and advised adding the patient to the provider's list the next day. The next day there is documentation that the patient was added to the list but was not able to be seen. The patient's medication wasn't adjusted nor was the patient followed up.

On 7/30/23 a nurse saw the patient for shortness of breath and wheezing. The nurse called a provider and obtained a prescription for five days of an additional dose of his steroid inhaler. There was no follow up, no provider evaluation, and no indication provided for the medication change. Four days later, a nurse saw the patient again using an upper respiratory infection protocol but did not associate the symptoms with asthma. No referral or change in therapy occurred. This was not appropriate provider monitoring.

Heat and humidity exposure

Exposure to heat and humidity exposure as a trigger for asthma occurred around the time of the patient's death and contributed to his death.

On 6/14/24, the Will County Emergency Management Agency officially urged precautions in advance of expected high temperatures for the following week.[17] Temperatures do affect the elderly and at-risk individuals for heat related complications. In 2016, IDPH issued an advisory bulletin to Illinois Long Term Care Facilities and other interested parties.[18] This advisory bulletin gives appropriate information that is pertinent to IDOC when temperatures are in the 80s or above which occurred at the Stateville facility from 6/17/24 to 6/19/24. These recommendations include monitoring residents for signs and symptoms of heat related stress; procedures for relocation of residents to air-conditioned or cooler areas of a facility; monitoring temperature and humidity in housing units; maintenance recommendations; recommendations to identify persons with circulatory or respiratory problems, which this patient had; recommendations for those receiving certain medications including anticholinergics or antihistamines and those with high-risk medical conditions (e.g. asthma[19]) to be monitored closely during high temperature periods.

The medical record made no mention of the heat and did not document any effort to evaluate the patient for a heat related problem. However, a news report[20] documented that a nurse at Stateville told an emergency responder that an individual was unresponsive and in and out of consciousness. The nurse stated that "It's a possible overdose, probably possible heat stroke". The dispatcher asked how long the individual had been outside if there's a chance he had a heat stroke. The nurse replied, "No, he's been in his cell, but it's like 100 and something degrees in here," the nurse replied.

Though the outside temperature was high it did not constitute a heat warning. Nevertheless, Stateville housing units are not air conditioned and indoor air is a concern. 77 IL Admin Code §

[17] https://willcounty.gov/will-county-ema-urges-precautions-ahead-of-high-temperatures.
[18] Found at https://dph.illinois.gov/content/dam/soi/en/web/idph/files/publications/hot-weather-advisory-061616.pdf
[19] See the American Lung Association web page titled "Too Hot? How to NOT Trigger Your Asthma" as found at https://www.lung.org/blog/asthma-heat-triggers
[20] Heat Stress 'Significant Contributing Condition' in Death of [redacted], Who Died While Incarcerated at IDOC's Stateville | Chicago News | WTTW September 13, 2024, by Blair Paddock and Brandis Friedman.

330.3170 states that in nursing homes air-conditioning systems shall be capable of maintaining an ambient air temperature of between 75 degrees Fahrenheit and 80 degrees Fahrenheit, pursuant to the requirements of Section 330.770(j). While Stateville is not a nursing home, this patient was 50 years old and did have a medical condition that could be exacerbated by heat exposure. The Illinois regulation is an appropriate benchmark for indoor heat in the prisons.

On 6/30/25, the Agency Medical Director sent out the annual memorandum on Prevention of Heat Related Illnesses. There is no administrative directive or policy on this issue. This memorandum emphasizes the need to maintain indoor temperatures below 85 degrees Fahrenheit. It also directs that when the heat index is 85 degrees and above multiple measures are to occur including:

- Pass ice twice a day,
- Monitor persons behind solid doors,
- Ensure water and ice are made available,
- Open food hatches of solid doors,
- Increase shower frequency,
- Ensure cold water taps work,
- Ensure ventilation systems are functioning,
- Inspect all individuals in custody and note any heat related issues,
- Medical staff are to identify individuals who may be susceptible to heat related illness and move them as recommended,
- Curtail hard labor and make water available during working hours,
- Temperatures within cells and on wings/gallery are to be documented on shift reports.

IDPH guidelines for indoor air quality recommend indoor temperatures for healthy working-age males in winter be between 68-75 degrees with relative humidity between 30-60 percent and in summer between 73-79 degrees and humidity between 30-60 percent.[21] The IDOC recommended indoor maximum recommended temperature of 85 degrees is higher than recommended for the working- age population. The memorandum does not specify how monitoring of temperatures or susceptible individuals is to occur nor does it specify how medical staff are to identify individuals susceptible to heat related issues. There was no evidence that anyone was monitoring the temperatures inside Stateville.

The autopsy of this individual concluded that asthma, hypertensive cardiovascular disease and heat stress were significant contributing conditions of his death. This implies that the heat was excessive in the housing unit.

Medication Management

Medication management is one of the cornerstones of asthma management. The standard of care is to adjust medication stepwise to symptoms and functional status. This patient was on the same three medications (a rescue inhaler and two controller medications) for the entire period of record review despite deteriorating functional status based on PEFR. There was no evidence of symptom histories being taken at any chronic clinic. Status and degree of control were not accurately

[21] IDPH Guidelines for Indoor Air Quality as found at https://dph.illinois.gov/topics-services/environmental-health-protection/toxicology/indoor-air-quality-healthy-homes/idph-guidelines-indoor-air-quality.html.

determined because no symptom history was obtained. Nor was medication prescribed in accordance with recommended stepwise treatment for exacerbations and deterioration of status.

The patient did not receive ordered medications. The IDOC medication management process is dysfunctional, and the Monitor has recommended that since 2021 a process analysis be completed.[22] This case confirms the Monitor's concerns.

Providers prescribed Alvesco, a steroid inhaler, as one puff daily. The FDA recommends that this drug be used twice a day. The use of once-a-day inhalation was never explained. The record review was from 6/15/22 to 6/19/24 or 735 days. The patient, therefore, should have used 735 inhalations. Each inhaler contains 60 inhalations. The expected number of inhalers that should have been received over 735 days is 12.25 but the patient only received eight inhalers or about 65% of doses needed. The patient was on daily montelukast medication and received this KOP. He should have received 735 doses but received 493[23] pills or only 67% of expected doses. The patient received only about two thirds of the controller medication prescribed. This included the time-period before his death.

The albuterol is difficult to assess because it is used "as needed" so the precise number of times that the patient needed the medication cannot be obtained. Approximate need can be determined if a history of symptoms is taken and the symptom number is extrapolated from the history taken at chronic clinics. Alternatively, each inhaler has a dose meter that shows how many doses remain. If the inhaler is checked at clinics, the number of doses used can be determined. This is not done as a typical practice in IDOC and was not done for this patient. The patient received eight inhalers over the two years. Rescue medication was prescribed at a dose of one to two inhalations four times a day or up to a maximum of eight inhalations a day. Given the 735 days this would be 5,880 inhalations if a maximum dose was used by the patient. Each inhaler has 200 inhalations, and the patient was provided with eight inhalers that contained 1600 inhalations. Without an accurate history of symptoms and medication use, it isn't possible to determine whether the patient received sufficient rescue medication or whether the patient didn't need or request the medication. It was clear, however, that the medications with regular dosing frequencies were given only approximately two thirds of the time so the patient was undermedicated. The medical record and the MAR do show that in April the patient ran out of inhaler and one was given to him on 4/24/24 but there was no evaluation of the patient.

Over the course of care the patient did not uniformly have access to prescribed medications by a significant margin (one third of the time).

Patient Education

There is no evidence of patient education, including for the following:

[22] Health Care Monitor 3rd Report, Lippert v. Jeffreys, February 15, 2021, page 120; Health Care Monitor 4th Report, Lippert v. Jeffreys, September 16, 2021, pages 160, 163; Health Care Monitor 5th Report, Lippert v. Jeffreys, June 22, 2022, pages 140-141; Health Care Monitor 6th Report, Lippert v. Jeffreys, March 13, 2023, pages 141, 147; Health Care Monitor 7th Report, Lippert v. Jeffreys, December 22, 2023, pages 166-167, 173; Health Care Monitor 8th Report, Lippert v. Jeffreys, November 8, 2024, pages 216-217, 225.

[23] In some months the patient received two KOP doses; in other months one or no doses. In one month (March of 2024) the patient received two doses one of the typical 30 pills and the other dose was 13 pills. This accounts for the total odd number of pills received.

- Proper inhaler technique,
- How the personal-best PEFR is used to manage their medication use,
- Discussion of asthma triggers including exposure to allergens, how to manage the patient's rhinitis, and how the patient's obesity and GERD rhinitis may affect his asthma, and
- Education on how to manage and use the prescribed medications.

Mortality Review

The Monitor disagrees with or has a comment about several findings in the IDOC mortality review.

- The mortality review states that the patient was seen at appropriate intervals in chronic disease clinic. The Monitor disagrees.
    - This finding is based on the Administrative Directive stating that patients with asthma are to be seen every six months. The new policy F.02.01 (effective Feb 2024) is that the patient is to be seen as frequently as warranted by the patient's least well controlled disease.[24] The Mortality Review findings should be consistent with policy in effect at the time of patient encounters.
    - Regardless of the policy the patient had exacerbations of asthma on 11/15/22 and 7/30/23. Especially for the 7/30/23 exacerbation, an early follow up in chronic illness clinic should have been ordered, regardless of policy. The patient wasn't seen for two months after the exacerbation.
- The review asks whether the patient's activities of daily living were impaired by disease or disability and is answered "no". Based on the Monitor's review the providers never asked whether activity of daily living was impaired, so it is unclear how this was determined. The patient had several episodes of shortness of breath and asthma exacerbation, so the asthma was impairing his activity of daily living.
- The mortality review states "yes" that the patient was in the proper setting at the correctional facility for the level of care needed. The Monitor would disagree. He had asthma and was housed in a cell whose temperature exceeded that which would be considered safe. He should have been moved to a housing unit with a cooler temperature.
- The mortality review states in the Miscellaneous Medical History Notes
    - That the patient "was seen routinely for his chronic medical conditions". While the task of seeing the patient every six months was mostly accomplished, the quality of these visits was inadequate. The patient also should have been evaluated soon after exacerbations of his asthma but was not. After 12/18/23 there should have been another chronic clinic visit but there was none. Being seen "routinely for his chronic medical conditions" should include consideration of the quality of those visits and the context of his disease status.
    - This section also states that he "was also seen in Asthma Clinic for pulmonary function tests". This is unclear. Pulmonary function testing only consisted of peak expiratory flow rate testing and that testing was not always documented as evaluated. This individual never had spirometry or pulmonary function testing completed. Peak expiratory flow testing was done but the results were not appropriately analyzed and considered in therapy. This individual was never more than 81% of predicted and at one visit was less than 50% predicted without any changes in therapy.

[24] This patient was not seen.

- The review documents that the autopsy was done and that the autopsy diagnosis was bronchial asthma, r/t hypertensive cardiovascular disease and heat stress. The issue of heat stress was not addressed in the mortality review but was important as a cause of death. The patient's housing should have been considered.
- S7 Nurse SBA Review states there was several delays in receiving medications. This is understated considerably. This patient received only about 67% of the asthma medication ordered and this wasn't mentioned. The Monitor would recommend assessing the degree to which patients receive ordered medication.
- The Monitor would have appreciated the clinical pharmacist's comment on the Alvesco dosing. The FDA package insert recommends this medication twice a day dosing whereas the providers prescribed it as once a day. The Monitor would have found the pharmacist's opinion useful. Also, the pharmacist's opinion would have been appreciated regarding the panel of medications used by providers as it appeared stepwise treatment was not provided.

Summary

This was a preventable death.

- Asthma care did not follow current standard of care guidelines.
- Providers did not:
    - Obtain history of symptoms or medication use from the patient during chronic clinic episodes;
    - Obtain spirometry or pulmonary function testing in their asthma care;
    - Evaluate peak expiratory flow tests especially when they were significantly abnormal. PEFRs were not considered in therapy planning;
    - Question whether the patient received or took his prescribed medication and did not know that the patient was not receiving medication as ordered;
    - Provide information to the patient on how to use his medication;
    - Act appropriately when the symptomatic patient had PEFR less than 50% of predicted; and
    - Prescribed the same dosages of asthma medication over two years when the patient's asthma deteriorated over that time-period.
- The medication system was such that the patient received only approximately 67% of prescribed asthma medications. The patient did not have access to necessary medications.
- The prison system did not provide the patient access to housing that was environmentally safe for his health. Exposure to excessive heat which contributed to his death.
- The medical care was deficient by not providing access to reasonable asthma care.

Patient 2

This was a 40-year-old man with asthma on admission to IDOC. [25]

He entered NRC on 3/4/22 and transferred to Danville on 3/18/22. He was released and re-incarcerated within approximately 6 months. The chart provided for this death begins in September of 2022. The problem list documented only asthma.

[25] This is patient #4 in the mortality review list.

Monitoring Changes in Lung Function

The patient had three chronic clinic visits for asthma. The first chronic clinic was 1/19/23. Deficiencies included:

- The only history was that the patient did better in winter and that he took albuterol every other day. An inadequate symptom history was obtained.
- There was a nurse interim visit for his asthma.
  - At 7 pm, a LPN saw the patient on 9/18/22 on a "Code 3" for shortness of breath. The nurse called a provider who ordered IM and oral steroids but did not document review of this episode. There were multiple deficiencies in this encounter to include:
  - An RN should have evaluated the patient.[26]
  - The PEFRs were 250/250/250 and the expected PEFR was 539 so he was at 46% of expected PEFR, which is a severe exacerbation. The patient was unable to say a complete sentence, was using accessory muscles to breathe, had audible wheezing, and had oxygen saturation of 91%. The patient should have been given immediate beta agonist therapy, in addition to the steroid therapy that was ordered (parenteral steroids and a 7-day course of prednisone). A strong argument could be made that the patient should have been sent to an emergency room. Since a physician was not immediately available, at a minimum, the patient should have been admitted to the infirmary so he could be monitored. This care placed the patient at risk. A 2-week follow up was ordered.
  - The oral prednisone was not provided until four days (9/22/22) after the event. This was not timely implementation of the order.
  - At the 2-week follow up the provider documented that the patient had exacerbations every 2-3 months. PEFR was not obtained, nor were current symptoms obtained. Medication use was not assessed. The only recommendation was for the patient to call for an emergency when he has an exacerbation. Controller medication was not increased. Of note, the blood pressure was 153/97 and had been 142/83 during the exacerbation. These were unrecognized.
- Albuterol, Alvesco, Singulair, and Nasacort were listed medications but there was no evidence on the MAR that the patient had received any asthma medication for the three months prior to the clinic visit on 1/19/23 (except for the single tapering prednisone dose). The patient's lack of medication use went unnoticed by the provider.
- The patient was on a steroid nasal inhaler for presumed allergies, but the provider did not ask about control of the allergies nor was any examination completed.
- The provider documented PEFR testing as 450/450/450. The expected PEFR for a 40-year-old 69 inch male is 539 with a lower limit of normal of 385. This person was at 71% of predicted. A personal best had not been obtained to use as a benchmark. This is a low PEFR and the controller medication should have been increased.
- Spirometry should have been ordered because of the low oxygen saturation during the exacerbation and as a baseline as there apparently was no spirometry on record.

[26] Note the patient was seen earlier that day by an RN using the protocol for Cold/Upper respiratory infection. The nurse did not follow the protocol which directs a consult with a physician if the patient has an asthma diagnosis. The nurse also did not act on the patient's elevated blood pressure (142/106). The RN acted outside scope of practice in not following the protocol.

- The patient was assessed as having moderate persistent asthma in fair control. The Monitor agrees with the moderate persistent designation, but no symptom history was obtained except that albuterol was used every other day. The degree of control was documented as "fair". The basis for this conclusion is unclear. The PEFR at 71% of predicted was not assessed by the provider who should have considered raising the controller medications as the patient was on a step-3 regimen (low-dose inhaled glucocorticoid and anti-leukotriene daily) that was not controlling his asthma based on PEFR and recent exacerbation.

This visit was not consistent with standard of care for asthma.

The second asthma chronic clinic was on 7/3/23. Deficiencies with this encounter included:

- The only symptom history was "Doing OK. Using inhalers regularly; more in summer". This is an inadequate history.
- No PEFRs were obtained.
- The provider did not assess the patient's rhinitis which is an asthma comorbid risk.
- There was no examination.
- No data was obtained to support the assessment of moderate persistent asthma in fair control. This evaluation was inconsistent with an expected asthma evaluation based on standard of care. There was no change in medication and insufficient evaluation to determine if the current regimen was adequate.

The provider did not check whether the patient was receiving his medication and did not provide any education on use of the inhaler. This visit was not consistent with standard of care for asthma.

The third asthma clinic was on 1/4/24. Deficiencies included:

- No history was taken including of symptoms.
- Since the last chronic clinic visit the patient experienced three asthma related events.
    - On 7/25/23 a LPN saw the patient using a shortness of breath protocol. An RN should have evaluated the patient.
        - The nurse noted humidity and grass pollen as exacerbating his breathing.
        - The nurse did not question the patient about medication use. PEFRs of 450/450/475 (88% of predicted). The nurse noted no wheezing or accessory muscle use. The patient asked for a renewal of his albuterol. He had received albuterol on 6/16/23 and another on 7/10/23 according to the MAR. Because albuterol inhalers have 200 actuations, by 7/25/23 he would have used 400 actuations over 39 days or about 10 puffs a day if used continuously. This is significant excess use that was not recognized by the nurse. Asking about medication use and a check of the MAR are essential but not typically done. The likelihood of excess use should have been reported to a provider. However, the nurse took no action.
    - On 8/15/23 an LPN saw the patient using a shortness of breath protocol.[27]
        - The LPN noted asthma and noted sinus congestion and cough but did not take PEFRs or take any medication history so it was unclear how frequently

[27] The consent Decree does not support the use of LPNs to perform sick call but if necessary to have LPNs perform this duty only with appropriate supervision. III.A.10. LPNs are practicing outside their scope of practice when using the sick call protocols when making clinical decisions without supervision.

the patient was using rescue medication. The protocol requires consultation with a provider if asthma complicates an upper respiratory infection. This did not occur. Three hours later the LPN wrote that the doctor ordered naproxen for six months, but this appeared unrelated to the shortness of breath episode. The provider should have been provided symptoms, the PEFRs which were not done, and an asthma clinical assessment should have been made. The blood pressure was elevated at 155/70 but not addressed.

- On 8/25/23, a nurse evaluated the patient using an upper respiratory infection protocol. The patient couldn't hear out of his right ear. Childhood asthma was documented but it was unclear if the nurse believed it was an active condition; no asthma medications were documented. The blood pressure was 147/86 but not acknowledged as abnormal. No asthma symptoms were taken and PEFRs were not obtained. The nurse did not call a provider even though the protocol calls for referring to a provider if asthma complicates a URI. Since the nurse did not question the patient about asthma symptoms and did not obtain PEFRs, it is unclear how the nurse could determine that asthma was not complicating the upper respiratory complaint.

These three episodes were relevant but not discussed at the chronic disease clinic.

- The PEFRs were 470/510/500 which was 95% of predicted, which is good control. But the provider documented the patient as having mild persistent asthma. The patient was on three asthma medications (low-dose inhaled corticosteroid; a leukotriene inhibitor, and a rescue medication) which was a step-3 option for moderate asthma. He had good control of moderate persistent asthma. The provider's assessment appeared inaccurate.
- There was no evaluation of medication usage or instruction on use of his inhalers. For the last four months prior to the chronic clinic, there was no MARs for October or December and the patient did not receive montelukast in September and did not receive albuterol or Nasacort in December. The provider did not review the MARs.

The patient was released from prison sometime between January, 2024 and July, 2024. He was reincarcerated at NRC on 7/19/24 and reception screening was completed that day. Deficiencies of the reception screening included:

- The nurse documented that the patient was only on an "inhaler". Prior history of prednisone was not obtained. No other history of his asthma was taken. The nurse failed to ascertain that the patient had been taking three asthma drugs and Nasacort for allergic rhinitis just six months earlier prior to discharge.
- PEFR testing was not completed.
- The nurse did not identify that the patient had previously been diagnosed with allergic rhinitis.
- The patient was not issued a rescue inhaler for three days and received no further medication after 7/22/24.

The physical examination was completed on 7/19/24. Deficiencies included:

- There was no symptom history of his asthma.
- PEFR testing was not obtained.
- Spirometry was not ordered nor were prior spirometry results obtained.
- Medication history was not obtained.

- The provider prescribed as-needed albuterol only (six months earlier the patient had been on three asthma medications and a nasal steroid inhaler).
- The provider also failed to identify allergic rhinitis.
- The provider did not obtain sufficient clinical data to make an appropriate assessment of the status of the asthma. Appropriate step therapy could not be initiated.

On 8/26/24 the patient transferred to IRCC. Transfer screening was not completed. The medical record was received on 8/26/24 and an intake chart review was completed by a nurse on 9/11/13. The nurse noted no chronic medical problems and the patient was referred to (A) clinic but what that meant was unclear.

During his last two months of incarceration, the patient did not have a chronic clinic for management of asthma. On 9/17/24 the patient experienced a code 3 at 9:20 pm. CPR was started and the patient transferred to a hospital where he died in the emergency room. Asthma was documented as the cause of death.

Minimizing Exposure to Asthma Triggers

- The patient was on Nasacort for presumable allergic rhinitis, but the condition was never documented, was not on the problem list, and was not monitored at clinics.
- There was no effort to identify the source of the allergy.

Medication Management

- For the 11 months in 2023 when a current valid prescription for Alvesco was in place, the patient received medication 91% of the time. For montelukast the patient received medication 27% of the time.

When the patient was re-incarcerated in July 2024, the only new medication prescribed was Albuterol. However, the patient was only recently discharged (January of 2024) and the pharmacy continued to have active prescriptions from the prior incarceration. An August 2024 MAR was generated for the prescriptions of Alvesco, Nasacort, and montelukast from the prior incarceration. However, none of these medications were given and no one asked whether he should continue to receive the medication after reincarceration.

Patient Education

- The patient received no education on inhaler use.

Mortality Review

The Monitor has the disagreements with the following mortality review findings.

- The mortality review documented that the patient was seen at appropriate intervals for his chronic illness. After the release in January 2024, the patient was re-incarcerated in July of 2024. After this new incarceration, the patient was not seen in chronic illness clinic for over two months. This is not consistent with the timeframes or content for evaluation of a chronic condition contained in MPPM policy F.02.01. The content and quality of the intake evaluation for a patient with asthma was not considered during mortality review.
- The chronic illness evaluations and intake evaluations were not consistent with standard of care as described above.
- Section S4 Miscellaneous item K asks whether the patient's activities of daily living were impaired by disease or disability. This was answered no but there is no apparent

documentation that providers asked this question of the patient. Symptom history by providers did not ask about asthma symptoms so it is unclear if the patient did or did not have impairment of activities of daily living.

- The autopsy was not available when the mortality review took place. The autopsy showed that the patient died of acute asthma exacerbation. The failure to provide the patient with his usual medications for asthma and possible lack of access to rescue medication at the time of death is strong evidence that the death was preventable.
  - Providers did not:
    - Obtain history of symptoms or medication use from the patient during chronic clinic episodes;
    - Obtain a baseline spirometry or pulmonary function test;
    - Evaluate peak expiratory flow tests especially when they were significantly abnormal. Providers did not consider PEFRs in therapy planning;
    - Question whether the patient received or took his prescribed medication;
    - Provide information to the patient on how to use his medication;
    - Act appropriately when the symptomatic patient had PEFR less than 50% of predicted; and
    - Prescribed the same dosages of asthma medication over two years when the patient's asthma deteriorated over that time-period.
    - Know or document that the patient was not receiving ordered medication.
  - Upon reincarceration the medication system was such that the patient received only approximately 27% of one of his prescribed asthma medications.
  - The medication system was such that the patient did not have access to appropriate medications and this contributed to his death.
  - The formulary relies upon a 3rd option of level 3 asthma medication which was ineffective for this patient. Other more appropriate medications need to be available for prescribing providers.
  - The patient was re-incarcerated after approximately six months and the health care staff did not know what his prior medications were. The pharmacy recognized the patient's old prescriptions and printed them on a MAR but no one inquired as to why these were not prescribed upon return to prison. There was a failure to maintain medication continuity in the patient's treatment of asthma upon reincarceration.
  - The patient was under-medicated. The mortality review documents that the patient was using another patient's medication.

Patient 3

This was a 54-year-old man with a problem list documenting asthma as his only medical condition.[28]

Monitoring Changes in Lung Function

[28] This is mortality review patient #5 in the mortality review list.

- The patient appeared to be incarcerated on 2/27/24 at NRC. The patient was not seen for intake screening and was not provided a rescue inhaler upon arrival. The patient experienced an exacerbation on 3/1/2024 as a result of the failure to appropriately screen a new intake to the prison system.

Problems with the encounter with a nurse practitioner on that date included:

- No symptom history was taken except to note the patient had shortness of breath and congestion.
- PEFRs were not obtained.
- Medication history was not obtained.
- An optional step-3 therapy of nebulization with albuterol; Alvesco 160ug one puff daily and Singulair was ordered without an assessment of the status of the patient's asthma. Prednisone 40 mg for four days was also ordered. No follow up was ordered.

This is not standard of care for asthma.

On 3/20/24 the patient transferred to Vienna without having had intake screening or a chronic clinic visit. Deficiencies included:

- The transfer summary documents asthma and lists his medications (without dosages) but does not document the lack of intake screening.
  The nurse at Vienna who completed receiving screening noted the patient was to be scheduled for asthma chronic clinic. The nurse did not note that the patient had not been seen for the initial chronic care assessment while at NRC and did not schedule it to take place at Vienna.

On 4/14/24 a nurse evaluated the patient for shortness of breath. Medications were noted. Problems with this encounter included:

- The blood pressure was elevated (150/83) but not acknowledged or addressed.
- PEFRs were 150/175/150 (predicted PEFR 491- PEFR 36% of predicted) and the patient had wheezing throughout his lungs. The patient should have promptly seen a physician, received immediate short acting beta agonist, steroid medication and his controller medication should have been increased. Instead, an on-call physician ordered a one-time dose of parenteral steroid medication with instructions for follow up as needed. This is substandard care. If no physician was available, the patient should have been sent to an emergency room. For follow up, the patient should have been monitored on an infirmary so the patient should also have been transferred to a facility with an infirmary. The patient was not being monitored and this placed him at risk.

Three days later, on 4/17/24, a nurse saw the patient again for shortness of breath. Deficiencies with this encounter included:

- PEFRs were 275/300/375 so he was at 76% of predicted. He was using rescue medication three times a day and had wheezing in all lung fields. These findings demonstrate that the patient was still in exacerbation.
  - He should have seen or a provider consulted promptly. This did not happen. Instead, the nurse scheduled the patient for the next provider clinic.

A nurse practitioner conducted a chronic clinic on 4/18/24. Deficiencies with this encounter included:

- Symptom history was minimal. The practitioner documented shortness of breath and wheezing and noted that changes in weather was a trigger for exacerbations. The patient had asthma since childhood. The patient gave a 40-year history of smoking. The practitioner did not ask about daytime symptoms, frequency of rescue medication use, nighttime awakening, or activity limitation due to asthma. These are standard symptom questions.
- The PEFRs at this encounter were 150/150/160 and were 33% of predicted. The patient had wheezing and diminished lung sounds. Oxygen saturation was 94%. The assessment was severe persistent asthma in poor control. The only treatment was albuterol by nebulization three times a day for three months. At a minimum this patient should have been started on steroid medication and had his controller medications increased while under monitoring on an infirmary or he should have been sent to an emergency room for treatment. This is substandard asthma care. Over-use of rescue medication when increased controller medication is indicated is a common problem with asthma care in IDOC.
- Because the patient had a long history of smoking, pulmonary function testing or spirometry was indicated both because of the persistence of symptoms and to clarify diagnosis due to his smoking history.

On 4/24/24, a nurse documented doing a chart review and concluded that the patient was overusing or misusing his asthma medication. Deficiencies with the nurse's review included:

- The nurse did not take a PEFR or obtain a symptom history.
- The nurse documented that the patient would be on Alvesco twice a day under directly observed therapy (DOT) for six months, effectively doubling the patient's dose of this medication. There was no documentation by the nurse that the order came from a provider, though a provider did sign a prescription. From the documentation it appears the nurse was acting out of scope of license. There should have been more documentation of an evaluation by a provider than simply signing a prescription written by someone else.
- The nurse documented no data about how the conclusion was made that the patient was misusing medication. Instead, the patient may have been using the excess rescue medication to control his symptoms. The order allowed for 8 doses of albuterol per day during this time period. The MAR documented 178 doses left in the albuterol inhaler on 4/22 and on 4/24 there were 132 doses left. So, the patient used 46 inhalations over a two-day period when the order would have allowed 16. On 4/29 the patient had 113 doses and the next day he is recorded as having 97 doses or 16 doses used over a 24-hour period. The nurse's chart review should have resulted in a prompt provider evaluation to increase his controller medication, but this was not done. To conclude, that the patient was misusing medication was cynical, the patient's asthma was uncontrolled, and the nurse should have advocated with a provider to change the plan of care.

On 5/6/24 a provider saw the patient in chronic clinic. The provider documented shortness of breath, three weeks of non-productive cough, nighttime wheezing, and use of albuterol 3-4 times daily. The patient was able to talk in full sentences but had fine expiratory wheezing. The PEFRs were 235/215/300, which was 61% of predicted. The assessment was asthma exacerbation with atypical bronchitis and chronic allergic rhinitis. The provider started antibiotics (doxycycline) for 10 days and started a tapering prednisone regimen starting at 60 mg tapering over nine days. The Alvesco was increased to 320 mcg twice a day but for only 10 days then decreased to 160 mcg

twice a day for 90 days.[29] Short course increased dose of inhaled corticosteroids is not a typical recommended treatment. This patient needed longer term increase of controller medication.

A physician followed up with the patient on 5/13/24 which was toward the end of his tapering steroid dose. The patient was not wheezing. The physician told the patient to take the increased dose of Alvesco until the prednisone ended. Deficiencies included:

- There was no plan for what to do after the steroids ended.

On 5/16/24 a physician saw the patient again a day after his steroid medication ended. The physician assessed that the asthma exacerbation was resolved but there was no plan for increased controller medication. The patient returned to a lower dose of Alvesco (160 mcg twice a day), montelukast, and as needed albuterol. Deficiencies with this plan of care included:

- The provider should have continued a higher dose of controller medication. The preferred management is inhaled corticosteroid combined with a long-acting beta agonist, but a less preferred option continued to be used (medium dose inhaled steroid with montelukast) which had not previously worked well for the patient.

On 7/2/24 the patient placed a health request saying he was concerned about his breathing. A nurse didn't receive the request until 7/5/24 but the patient saw a physician in chronic clinic on 7/4/24. Deficiencies identified with the response to this request were:

- This was not a timely evaluation of a serious complaint.

On 7/4/24 a physician saw the patient in chronic clinic. Deficiencies with the chronic care encounter included:

- No symptom or medication history was taken noting only that the patient wanted a refill of montelukast and asked to have Alvesco KOP.
- The PEFRs were 300/350/350 (71% of predicted). The patient still was not in good control. The only change in medication was to increase the rescue medication to every 4-6 hours. The controller medications should have been increased, not the rescue medication.

On 9/24/24 at five am, a nurse responded to a code 3 emergency using a shortness of breath protocol. The PEFRs were 100/150/100 with tachycardia (100), oxygen saturation only 93-94% with wheezing in all lobes. The nurse documented that the patient was short of breath but could complete a full sentence and was not using accessory muscles to breathe. This patient was having a severe asthma exacerbation. An oxygen saturation of 93% was particularly concerning. Deficiencies with this response included:

- Based on protocol, the nurse should have contacted a provider if the patient did not improve on nebulization therapy. The nurse did administer albuterol by nebulization but did not document PEFR after the nebulization. Instead, the nurse recommended "as needed" follow up. This was a serious error.

The protocol requires that the patient be placed in the infirmary for 24-hour observation. The patient was discharged back to housing when the protocol directs otherwise. This facility does not

[29] If the record is reviewed, the reader should note that the chronic care note documents increasing Alvesco to 2 puffs BID but the prescription orders Alvesco 2 puffs twice a day for 10 days to decrease back to 1 puff twice a day for 3 months.

have an infirmary. The nurse should have contacted a provider for direction as it was not possible to follow the protocol because of not having access to infirmary level care.
An hour later, on 9/24/24 at six am, a different nurse evaluated the patient because he couldn't breathe. The respiratory rate, pulse, and blood pressure were all elevated (24, 112, and 158/76 respectively) and the oxygen saturation was 91% which was a red flag number. PEFRs were not taken. The patient's skin was described as clammy. The nurse called a doctor who ordered oxygen and intravenous steroid medication with observation. Deficiencies with this encounter include:

- An immediate beta agonist medication was not provided. This was an egregious error by the physician. The patient should have been sent to a hospital for management as the facility was unable to provide an appropriate level of care for the patient.

On 9/24/24 at 6:10 am, (10 minutes later) a nurse documented that the patient "still can't breathe" but was "able to speak small sentences without interruption or gasping for air". At 6:30 am the nurse documented that the patient felt better but the pulse was still 112. The nurse documented giving the patient a nebulization treatment. At 7:45 am a nurse practitioner evaluated the patient and wrote a very brief note. The patient had oxygen saturation of 96% off oxygen and at rest and PEFRs were 150/150/145 (31% of predicted) with audible wheezing. nurse practitioner ordered an increase of the steroid inhaler Alvesco 320 mcg, 1 puff [twice a day] x 12 months" and "Medrol dose pack 4 mg as directed". Deficiencies with the evaluation and plan of care by the nurse practitioner included:

- No symptom history or history of rescue medication use was taken.
- The patient was sent back to his housing unit with an ordered follow up in 2-3 days. Without an infirmary at this facility this patient should have been sent to a hospital until his condition was more stable.
- The provider order for Alvesco had an error in that it. Alvesco does not come in a 320 mcg dose inhaler. The order should have said 160 mcg, two puffs twice a day. The handwritten MARs from September and October were handwritten and repeat the error of Alvesco 320 mcg 1 puff twice a day. A printed MAR from the pharmacy MAR wasn't present until November when the error was corrected. It is likely that the patient was not taking appropriate medication. This is a significant medication management error. The instructions on the MAR were inaccurate for two months and the patient likely did not receive the correct dose of Alvesco.
- The prescription for Medrol should have been written with specific doses of prednisone over the six-day period instead of the packaged product name. There was no evidence that the patient received this medication.

On 9/30/24 at 2:45 am, a nurse evaluated the patient on an emergency basis for shortness of breath. The PEFRs were 100/100/150 (31% of predicted). The respiratory rate was 24 which is elevated. The patient had wheezing in both lungs. The nurse gave a nebulization treatment and the PEFR increased to 300 (61% of predicted). Deficiencies with this encounter were:

- The nurse documented that the patient was on prednisone and Alvesco 320 mcg BID but did not verify this with the MAR. If the nurse had reviewed the MAR the fact that the patient was not receiving the medication as ordered would have been identified and could have been corrected.

That same day at 11:33 am a nurse practitioner saw the patient and documented that that the patient was coughing with back pain and that the "Medrol dose pack didn't help". A second course of prednisone was ordered as well as a chest x-ray and follow up as needed. Deficiencies with this encounter included:

- The practitioner did not check the MAR and was not aware that the patient hadn't received the recently ordered steroid medication.
- The practitioner also did not recognize that the patient was not receiving an increased ordered dose of Alvesco. A higher dose of controller medication was indicated but not provided.
- The practitioner did not take a symptom history appropriate for asthma follow up .
- A pulmonary function testing should have been ordered instead of a chest x-ray and referral to a pulmonologist should have been considered.
- This patient should have been placed on an infirmary for follow up until stable. Vienna does not have the capacity to provide infirmary level care. Instead, he was in an observation cell without medical monitoring.
- The prednisone should have been given as directly observed therapy (DOT). The order on the MAR was handwritten and differed from the prescription written by the physician. The nurse documented issuing 30 tablets however this was an inaccurate number of tablets to fulfill the prescription.[30]
- The purpose of the chest x-ray was not indicated but presumably it was to rule out pneumonia. This x-ray, which should have been done immediately, wasn't completed for two weeks (10/15/24). The x-ray results are not documented in the record.

The following day on 10/1/24, a nurse practitioner documented that the patient could return to general population housing from an observation cell. Deficiencies with this encounter included:

- This patient should have been transferred to a facility with an infirmary.
- The patient had "mild expiratory wheezing" but did not have PEFRs checked.

On 11/10/24 at 2:15 pm, a nurse saw the patient using a shortness of breath protocol. The patient's pulse was 114, his respiratory rate was increased to 24, and oxygen saturation was at red-flag levels (86%) and the patient could barely speak. The medication history documented taking albuterol and Alvesco in the morning and evening.[31] The nurse called a physician. Deficiencies with this encounter included:

- Doses were not documented and should be provided. This patient was on the wrong dose of Alvesco because of a prescribing error that had yet to be discovered.
- The patient had no evidence of receiving montelukast from September through November, but this was unrecognized. The patient also had no evidence of receiving Alvesco in

[30] The physician wrote "prednisone 20 mg 3 tabs daily x 3 days, then 2 tabs daily x 3 days, then 1 tab daily x 3 days then 10 mg 1 tab [every] day x 3 days". But what the nurse transcribed to the MAR was different stating, "Prednisone 20 mg 3 tabs daily x 3 days, then 2 tabs daily x 3 days, then 1tab daily, then 10 mg q day x 3 days". The "1 tab daily" did not include the number of days and was confusing. If the patient was given 20 mg tablets for the first 9 days then 21 tablets should have been given with 3 additional 10 mg tablets for the last three days. If 10 mg tablets were given for all days, then 39 tablets should have been given.

[31] "8 hits" of albuterol was documented without specifying over what time period.

October. So, the patient wasn't receiving all of his controller medications for two months prior to this episode.

- The on-call physician made a significant error by not sending the patient to a hospital. An 86% oxygen saturation in a person with asthma should result in hospitalization. Instead, the nurse documented that the on-call physician ordered an intravenous line and to give solumedrol (a steroid) intravenously every eight hours for three days; 2 liters of oxygen; and nebulization treatments every six hours for three days. This order was not transcribed to a prescription and there is no evidence that the patient received the solumedrol or nebulization treatment.

On 11/10/24 at 2:40 pm, the nurse called the doctor back because the oxygen saturation was 85-88% and the patient was unable to get comfortable and had poor respirations and was standing bending over. The doctor ordered the patient to be sent to an emergency room.

The patient returned four hours later from the emergency room. The patient had wheezing in all lung fields. The oxygen saturation at the hospital was 98% and vital signs were normal. There was no evidence of active pulmonary disease on chest x-ray. The EKG showed left ventricular enlargement with possible ischemia. The patient was given nebulization treatments and improved, so he was released with a recommendation to give steroids and inhalers as needed. The ER commented that the patient's asthma was unstable and recommended referral to a pulmonologist. The patient returned to the facility at 6:30 pm and a nurse evaluated the patient. Deficiencies with the patient's care upon return to the facility included:

- The nurse called a physician who ordered to keep the patient in observation until seen by a provider in the morning or to call the physician. The patient was not seen the following morning by a provider, and the physician was not called. The patient wasn't seen by a provider for three days.
- The patient should have been transferred to a facility with an infirmary so his medical condition could be monitored appropriately.
- The on-call physician did not order steroids or adjust controller medications. At a minimum his controller medications should have been increased, and steroids appeared indicated.

Just after midnight on 11/11/24, the patient asked for a nebulization treatment. The nurse described the patient as slightly short of breath with an oxygen saturation of 92% which is low. After treatment the oxygen saturation increased to 96% and the patient felt better. Deficiencies with this encounter included:

- The nurse should have obtained PEFRs before and after administering a nebulization treatment.
- The oxygen saturation was low and the nurse should have consulted a provider but did not.

Later at 11:20 am on 11/11/24, the patient was wheezing and requested a nebulization treatment which was provided.

On 11/14/24, a nurse practitioner saw the patient. PEFRs were 320/300/340 (69% of predicted). The practitioner documented that the patient had a 40-year smoking history and was short of breath when lying down. Further inquiry about cardiac symptoms was not obtained. A CT scan of the

chest was ordered. This was reasonable given the 40-year history of smoking to rule out COPD. No history related to asthma symptoms was taken. Deficiencies with this encounter included:

- This was the first visit post-hospitalization, but no report was made available for the provider to review. The practitioner had to ask for the ER records. [32]
- The chest x-ray ordered 9/30/24 was still unavailable about 6 weeks later.
- The practitioner ordered albuterol nebulization treatment three times a day for two weeks. The practitioner should have increased controller medication but instead increased rescue medication.
- The practitioner did not give instruction to the patient on using his inhaler and did not notice the prior error in documenting Alvesco dosage and use. There is no documentation telling the patient that he should use two inhalations of Alvesco twice a day instead of one inhalation twice a day.

On 11/19/24, a nurse evaluated the patient using a shortness of breath protocol. The oxygen saturation was 93% which is slightly low and 95% after nebulization. The patient had wheezing in all lobes but the nurse did not obtain PEFRs. The nurse called a physician who ordered placement in observation and IV solumedrol every eight hours without any follow up. Deficiencies with this encounter included:

- The patient should have been transferred to an infirmary where he could be properly monitored.

Later on 11/19/24, a nurse practitioner documented referral to a pulmonologist as recommended by emergency room ten days earlier for pulmonary function testing.[33] Deficiencies with the provider's review included:

- Positive EKG findings suggestive of hypertrophy and ischemia were not noted. An echocardiogram should have been considered.
- The pulmonary function testing was appropriate. However, a pulmonology referral should also have been ordered, as recommended by the emergency room, as the patient's asthma was unstable.

On 11/20/24, a nurse practitioner saw the patient and documented that the patient felt much better and had clear lungs. Deficiencies with this encounter included:

- No history of symptoms or medication use was documented.
- The practitioner did not obtain PEFRs.
- The practitioner ordered another chest x-ray since the results of the x-ray ordered 9/30/24 were never provided.

On 11/21/24, a nurse practitioner saw the patient. Deficiencies with the provider encounter included:

- No history of symptoms or medication use was documented.

[32] The emergency room record has a fax date on it of 11/10/24 at 4:11 pm. The nurse practitioner signed and dated the report as reviewed on 11/15/24 but did not see the patient.

[33] The nurse practitioner notes on 11/19/24 that the referral was based upon review of the ER notes. However, the same nurse practitioner signed and dated the ER record four days earlier on 11/15/24.

- The oxygen saturation was somewhat low at 93% but was not acknowledged and PEFRs were not done.
- The practitioner discharged the patient from observation after an x-ray was done. The practitioner should have reviewed the x-ray prior to discharge. It was not clear what the purpose was for the second x-ray.[34]

On 11/27/24 a nurse documented the chest x-ray was rescheduled and finally completed 12/4/24. A 4 mm nodule was present. Deficiencies with this diagnostic procedure were:

- Two months to obtain an x-ray is unacceptable.
- The patient's name on the report is wrong.
- The report of the x-ray completed 12/4/24 was mostly illegible.

On 12/9/24, a nurse evaluated the patient using a shortness of breath protocol. The form was partly illegible. The patient was in general population. The patient had inspiratory and expiratory wheezing. PEFRs were 190/150/200 (41% of expected). The nurse documented that the patient was on Alvesco (dose not noted) and albuterol. The nurse contacted a provider who gave a verbal order for a DuoNeb treatment stat. Deficiencies with this encounter included:

- The nurse failed to appreciate that the patient was not receiving montelukast that was ordered.
- There was no evidence that medical staff had explained to the patient to use two inhalations of the Alvesco inhaler. The Alvesco was last given to the patient on 11/6/24 and if used correctly would have needed refill on 12/6/24.
- The MAR does not document receipt of the stat DuoNeb treatment.[35]
- This patient was still in asthma exacerbation and controller medication should have been increased and steroid medication considered; instead, providers relied on increasing rescue medication.

On 12/11/24 a nurse practitioner saw the patient. The examination noted inspiratory and expiratory wheezing indicating continued asthma exacerbation. The only assessment was follow up of shortness of breath. The provider ordered starting DuoNeb three times a day Deficiencies with this encounter included:

- No history of symptoms or medication use was documented.
- PEFRs were not taken.
- Controller medication was not increased.
- Despite the patient having active wheezing, the DuoNeb treatment did not start for two days (12/13/24).
- Physician oversight of this unstable patient's condition and plan of care was non-existent.

On 12/15/24, a nurse saw the patient using a shortness of breath protocol. The PEFRs were 300/325/300 and the patient was wheezing in all lung fields. The nurse called an on-call

[34] The original order on 9/30/24 for chest x-ray was to rule out pneumonia. A chest x-ray was done at the ER on 11/10/24 and was unremarkable.

[35] There is a progress note by a nurse 40 minutes later that the patient returned the supplies for the nebulizer treatment but no documentation the treatment was administered.

physician who ordered solumedrol 125 mg IM stat, to start a Medrol dose pack, and to follow up with a provider on 12/20/24. Deficiencies with this encounter included:

- The nurse wrote "see MAR" instead of documenting medications. The MAR documented that the patient had not received any medication except for a few nebulization treatments.
- The medication orders were not transcribed into an order for provider signature. The orders were also not transcribed to the MAR. There was no evidence the patient received the solumedrol or the Medrol dose pack.
- The patient had uncontrolled asthma and was not being treated.

On 12/20/24, a physician saw the patient in follow up of his shortness of breath. Documentation was that the patient had no recent attacks. The doctor did document no wheezing at that time and noted that the patient was finishing a Medrol dose pack. The plan was to continue Alvesco and Medrol dose pack. Deficiencies with this encounter included:

- A symptom history was not documented although the patient had continuous wheezing documented in the record at clinic visits for the past month.
- There was no evidence of a prescription for the Medrol dose pack nor was there evidence on the MAR that the patient received the medication. There also was no evidence on the MAR that the patient was receiving albuterol either.
- PEFRs were not obtained.
- The assessment was “mild persistent” asthma. No history was taken to verify a mild persistent status. Also, the patient had prescriptions for three asthma drugs which is inconsistent with a mild persistent status. This patient had uncontrolled wheezing for the entire month prior to this visit. The patient did not have mild persistent asthma.

On 12/24/24, a CT scan documented diffuse pulmonary emphysema. A follow up CT scan was recommended in a year. Deficiencies in the patient’s care at this point included:

- If prompt pulmonary function testing and referral to a pulmonologist had occurred this diagnosis should have been identified much earlier. This patient may or may not have had asthma concurrent with the emphysema.

On 12/28/24 at 7:55 am, a nurse evaluated the patient using a shortness of breath protocol. The patient was unable to sit and was interviewed standing. The nurse was unable to obtain blood pressure. The patient was unable to complete a full sentence without interruption. The patient was using accessory muscles and had retractions and appeared in respiratory distress. The respiratory rate was 28. PEFRs were unable to be obtained. The patient had wheezing which was audible without stethoscope. The nurse called a doctor on call who ordered Decadron IM and then solumedrol 125 mg IV; oxygen 10 liter by facemask, and an IV. The doctor ordered that the patient be placed in observation. Deficiencies with this response included:

- The provider’s decision to place the patient in observation and initiate treatment on site was unsafe and placed the patient at risk of harm. The patient should have been sent directly to a hospital.
- About 10 minutes later at 8:07 am the patient’s oxygen saturation dropped to 79% and the nurse asked the lieutenant to call an ambulance. At 8:10 am the patient stopped breathing and CPR was started. EMS arrived and assumed care, but the patient was eventually pronounced deceased by the EMS physician.

Minimizing Exposure to Asthma Triggers

The problem list documented chronic allergies but these were never discussed by providers with respect to his asthma. If these allergies acted as triggers for asthma exacerbation, it was unnoticed by providers. The patient was not questioned about allergies.

Medication Management

Medication management at this facility was very poor with multiple errors which included the following.

Steroid orders

1. The 5/6/24 order for tapering prednisone (which should be given urgently) was not provided until 5/9/24 or three days later.
2. There is no documentation on the MAR that the 9/24/24 order for solumedrol (a steroid) intravenously was given.
3. There is no documentation on the MAR that the 9/24/24 order for Medrol dose pack (a steroid medication) was given.
4. The MAR documents that 30 tablets of prednisone 9no dosage given) were provided to the patient KOP but the number of tablets provided is inconsistent (in any combination of 10 or 20 mg pills) with the requirements of the prescription given on 9/30/24. There also were no instructions documented as given to the patient.
5. A provider ordered Singulair, Albuterol, and Alvesco on 3/1/24 for three months. The original MAR documents correct start and expiration dates but these were handwritten. For April the handwritten MAR has inaccurate start and end dates.
6. The May 2024 MAR documents that the number of puffs left on the albuterol inhaler is to be recorded daily. There was no prescription and no order for these evident in the record.
7. There was an entry on a handwritten May 2024 MAR for albuterol for nebulization but there were no dates associated with the order.
8. A prescription for an albuterol inhaler was ordered 4/18/20 but not received by the patient until 4/20/24 which is a two-day delay.
9. A prescription for Alvesco written on 5/6/24 was not received by the patient until 5/8/24.
10. A nurse used a pharmacy label of a prescription for albuterol. The start date on a pharmacy label for albuterol was crossed out and a new start date of 7/4/24 inserted in handwriting. A similar change was made to the end date. This amounts to dispensing, and if completed by anyone other than a provider or pharmacist is unlawful.
11. On the August 2024 MAR, a prescription written for albuterol on 7/4/24 wasn't initiated until 7/6/24, a two-day delay.
12. On the August 2024 MAR, a prescription for Alvesco written 7/9/24 wasn't received by the patient until 7/11/24.
13. On 9/24/24, a provider ordered Alvesco inhaler be increased to 320 mcg with directions to take one puff twice a day. Alvesco does not come this dosage so a 160 mcg inhaler must be used with instruction to take two puffs twice a day. This was not done and nurses continued handwritten MARs for two months with instructions to take 320 mcg of one puff twice a day. If the patient used one puff, he remained on the same dose of medication. A pharmacy printed MAR with the correct directions wasn't available until November. There was no evidence that anyone gave the patient appropriate instructions on the inhaler use.

These errors were compounded by administration problems. Missing medication based on the MAR included:

1. Ordered steroid medication was not provided twice. Both orders were on 9/24/24. Steroids were also given inaccurately based on a 9/30/24 order.
2. There was no prescription for a year-long MAR entry for nebulized albuterol.
3. Montelukast expired on 5/30/24 and wasn't renewed until 7/4/24.
4. Montelukast was not documented as given from September to December of 2024.
5. The 160 mcg Alvesco inhaler has 60 inhalations, and the patient was on a twice a day schedule from April to September so an inhaler would last one month. The patient was not given an Alvesco inhaler in August.
6. In September 2024 the Alvesco prescription changed to 320 mcg twice a day. In order to accomplish this, an inhaler would have to be given every 30 days, but the patient was given no Alvesco in October and none in December. The patient was given significantly less controller medication (montelukast and Alvesco) than what was ordered.

For these reasons, the patient was significantly undermedicated.

In addition, the use of Alvesco and montelukast are not the preferred controller option in management of asthma. The preferred option of a long-acting beta agonist with steroid inhaler combination. This is not used within IDOC for unclear reasons. Also, over the 10 months of care, providers ordered six courses of steroid treatment.[36] This means that the patient was uncontrolled with severe asthma 60% of the months of care. This is complicated by the patient not receiving one of these courses and getting an inaccurate number of pills for another course. This patient was uncontrolled most of his incarceration and providers did not manage his medication by increasing controller medication. The one attempt to increase controller medication resulted in a prescription error that likely resulted in no change in medication. These errors likely contributed to his death.

Finally, the patient may have had a combination of asthma and COPD, but the autopsy diagnosis verified emphysema. The diagnosis of COPD was delayed due to the lack of timely spirometry or pulmonary function testing. This diagnosis should have helped in the planning treatment for this patient.

Patient Education

There was no documentation of education on inhaler use, avoidance of asthma triggers or on appropriate use of medication.

A provider ordered a 320 mcg dose of Alvesco when that order required two inhalations. Original instructions included only one puff per use and did not result in giving the appropriate amount of medication. This error was never corrected, and the patient was not given appropriate instruction.

The patient was given 30 tablets of an unknown dosage of prednisone with no instruction how to take the medication. The number of tablets did not correspond to the order of the provider. It appeared that an incorrect dose of medication was provided with no instructions on how to use the medication.

[36] The 9/24/24 orders for solumedrol and Medrol dose pack were to be given contiguously and are counted as one course.

Mortality Review

1. The Monitor disagrees with the mortality review conclusion that the patient was seen at appropriate intervals for his chronic illness.
    a. The chronic care policy F.02.01, states, "The frequency of Chronic Care appointments ordered is as warranted by the patient's least-well-controlled health conditions".[37] The patient had chronic clinic visits on 4/18/24; 5/6/24; and 7/4/24. The patient experienced "code 3" emergencies for asthma on 9/24/24, 9/30/24, and went to the hospital emergency room for asthma on 11/10/24. The patient should have had his asthma condition evaluated in chronic clinic promptly after each of these episodes.
2. There were a multitude of medication errors that contributed to the patient not receiving necessary medication. These were not identified in the mortality review but were an important contributor to his death. We suggest that the pharmacy review more closely documentation of medication administered and issued KOP to the patient. Each of these asthma patients did not receive all the medication ordered. Also, medication errors as well as delays in receipt of medication, or failure to administer medication contributed to poor management of this patient's condition.
3. In the section S4 Miscellaneous K., the review documents that the patient's activities of daily living were not impaired by disease or disability. The Monitor disagrees. This patient was described as wheezing and short of breath on numerous occasions which impaired his ability to function. There typically was no inquiry by providers about the patient's capacity to perform ADLs.

    In the section S4 Miscellaneous P, the mortality review documents that the patient was in the proper setting at the correctional facility for the level of care needed. The Monitor disagrees. This patient was at Vienna which does not have an infirmary. On multiple occasions the patient had acute exacerbations of asthma including an episode when a provider ordered parenteral solumedrol for three days. For some of the last months of his life, the patient should have been housed on an infirmary unit but instead was placed in an observation cell. The patient should have been transferred to a facility with an infirmary. Also, there were several occasions when the patient was experiencing an acute exacerbation of asthma without an onsite provider present and should have been sent to a hospital instead.

Summary

This was a preventable death.

- Providers did not:
    - Obtain history of symptoms or medication use from the patient during chronic clinic episodes or in follow up care for asthma;
    - Providers did not obtain a baseline pulmonary function test or spirometry despite difficulty in controlling the patient's asthma and even though he had risk of COPD (heavy smoker) and showed signs of COPD (repeated lower oxygen saturation);
    - Evaluate peak expiratory flow tests especially when they were significantly abnormal. Providers did not consider PEFRs in therapy planning;
    - Question whether the patient received or took his prescribed medication;

[37] F.02.01, Procedure section X. effective February 2024.

  - Provide information to the patient on how to use his medication;
  - Act appropriately when the patient was symptomatic and had PEFR less than 50% of predicted; and
  - Prescribed the same dosages of asthma medication for six months when the patient's condition deteriorated over that time-period.
  - Know or document that the patient was not receiving ordered medication.
  - Did not provide standard of care for this patient with asthma/COPD.
- The medication system was such that the patient endured multiple medication management errors that contributed to his death. He did not have access to appropriate medications.
- The system relied on a 3rd option of level 3 asthma medication which was ineffective. Prednisone and rescue medications were used in the absence of an appropriate step-up standard of care.
- The prison system did not provide the patient access to infirmary level care when it was clinically indicated.
- The medical care was deficient by not providing access to reasonable asthma care.

These three asthma deaths were all preventable. In all three cases, providers prescribed the same three asthma medications that are 3rd line options and not preferred. There were many management mistakes that are correctable. Problems with asthma care included the following.

- Providers did not use standard of care step-therapy in adjusting asthma medications.
- Providers failed to take necessary symptom or medication history recommended in usual asthma care.
- Providers failed to appropriately assess asthma status or adjust medications based on an appropriate asthma status and degree of control.
- Baseline and periodic pulmonary function testing or spirometry was not utilized for any of these three patients. These diagnostic tests are seldom performed in IDOC despite being standard of care in asthma and COPD care. This failure is partly responsible for not promptly identifying the one patient who predominantly had COPD.
- Providers did not appear to understand the differences between asthma and COPD or how to differentiate the treatment and management of either.
- Asthma triggers were not evaluated as part of asthma care. One patient had rhinitis and GERD which were not considered as part of his asthma care. Heat exposure was not considered as a risk for asthma exacerbation. Smoking was not considered in another patient as a risk for COPD.
- Medication failures including missed administration of doses, failing to recognize expiring medications, failing to review prior medication history to ensure continuity of medication care, late delivery of medication after prescription, pharmacy errors in not notifying prescribers of inaccurate prescriptions, administration errors, failing to maintain accurate documentation of administration of medication, and failure to administer critical medications (steroids) all contributed significantly to these deaths. The medication process needs revision.
- In two of the deaths, appropriate housing was not provided to the patients. In one, heat exhaustion was not considered during a summer heat spell and the patient was exposed to excessive heat. In another case, the patient had serious and multiple exacerbations of his asthma and was not appropriately monitored and was at a facility without an infirmary. He

should have been transferred. He also suffered exacerbations that warranted a higher level of care in a hospital but was not transferred.

- Nurses were inconsistently aware of asthma urgency and when to call a provider. Providers, especially on-call providers, were inconsistently aware of asthma urgency and the need for hospitalization. This placed patients at significant risk.

Recommendations

1. IDOC should engage in provider and nurse re-training on appropriate asthma and COPD care using contemporary guidelines. Training should include:
2. How to take asthma symptom history to determine level of asthma control.
3. How to take a typical symptom history for COPD.
4. How to use physical findings including PEFR with level of asthma control data to then use step care in adjusting medications.
5. How to assess asthma triggers in managing asthma care.
6. How to utilize pulmonary function testing and spirometry in asthma and COPD care.
7. How to differentiate asthma from COPD.
8. Differences in management of COPD and asthma.
9. When referral to a pulmonologist is indicated.
10. How to evaluate medication usage using the existing MAR system.
11. How nurses and providers should conduct and document an on-call telephone consultation from a remote facility nurse to an on-call provider. Suggest using SBAR[38].
12. When to refer a patient to a hospital for exacerbation.
13. When to admit to an infirmary in asthma management.
14. How a nurse should conduct a "shortness of breath" evaluation when asthma or COPD are considerations.
15. Red-flag findings for nurses to consult a higher level of professional in asthma or COPD care.
16. How to conduct a nebulization treatment including PEFR testing before and after and when to consult a provider.
17. Familiarization of nurses and providers for what medications are typically used in asthma care and what is typical recommended step care.
18. Mortality reviewers should:
    a. Pay more attention to the *quality of clinical care* in chronic disease management and outpatient primary care to identify opportunities to improve.
    b. Utilize the most recent policies as a basis for evaluating provision of care.
    c. Address whether patients receive their ordered medication.
    d. Identify process errors in the medication process.
    e. Familiarize themselves with infirmary care and what outpatient care means in a prison so that levels of care are separated into general population housing, infirmary care, and hospitalization. This entails understanding what types of care are available

[38] SBAR stands for Situation, Background, Assessment, Recommendations or Request. SBAR is a method of communication over a phone or otherwise between medical team members about the condition of the patient. It can be useful as a method for nurses at facilities to communicate with on call physicians. Typically, this communication is poorly documented and there have been significant errors including mortality when this communication is flawed. More information about SBAR can be found on the Agency for Healthcare Research and Quality at https://www.ahrq.gov/teamstepps-program/curriculum/communication/tools/sbar.html. IDOC should consider a policy and procedure on phone communication because it is an essential aspect of care in the prison system.

at each facility. At Vienna, there is no infirmary which affected one of the patients described in this review.