Health Care Monitor
Special Report on Structural Provisions
Lippert v. Jeffreys

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Introduction

The purpose of this report is to bring to the attention of the Parties and the Court that the Monitor finds that IDOC will not achieve compliance with the several major structural components in the *Lippert v. Jeffreys* Consent Decree[1] before its deadline without urgent action by IDOC executive leadership, the State Legislature, and Governor. Consistent with provision V. J. of the Consent Decree the Monitor requests that Defendants meet and confer within the next 30 days about the steps to be taken and timeframe to achieve compliance. The Monitor strongly recommends that participants at the meeting have the decision making authority of the Executive Director, State Legislature, and Governor.

Structural Elements in the Consent Decree

The Consent Decree anticipated the need to establish the structural support[2] necessary to deliver adequate health care and prevent unnecessary harm. Structural supports include staffing, credentialing, policies, medical records, data systems, physical facilities, equipment, and organizational design. Of these, five had specific deadlines in the Consent Decree for early completion:

- Staffing
- Credentialing
- Comprehensive policies
- Electronic medical record
- Data production

At the six-year mark in the Consent Decree, IDOC has not achieved any of these provisions, significantly hindering compliance and improvements in care.[3] Although without deadlines for early completion, adequate physical facilities are essential to ensuring access to appropriate primary, secondary, and tertiary care and an effective organizational structure is necessary to lead and manage changes in health care that are specified in the Consent Decree.

Staffing

A staffing analysis was due within 120 days of the Monitor's appointment but was not submitted until two years later.[4] The analysis addressed only nursing tasks and estimated a need for 287 additional positions, 70% of which were nursing staff. With the exception of nursing, IDOC has produced no evidence of any analysis of the need for physicians or other types of health care positions. Regardless of whether IDOC has analyzed their staffing needs appropriately, IDOC does not, in the estimation of their own supervisors, currently have enough staff to implement the

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[1] Compliance with the Consent Decree was expected to be accomplished within 10 years of its approval on 5/9/2019 or on 5/9/2029.

[2] II.A, II B.2, II.B.3 of the Consent Decree

[3] Completion means that the desired effect of change is evident in processes or outcomes. The Monitor acknowledges some forward progress has been made in some of these areas, but it has not been sufficient to achieve compliance with the Consent Decree and significant barriers remain unaddressed by Defendants.

[4] Submitted to the Parties 8/17/21.

Consent Decree. Results from the Performance and Outcome measures, facility Quality Improvement meeting minutes, and mortality reviews support their opinion.

Even this limited goal of hiring an additional 287 personnel has not been met. Despite State funding for these positions the total number of budgeted positions decreased the last five and a half years from 974 to 914.

Credentialing

The Consent Decree requires that all physicians have completed a primary care residency. Over six years this remains incomplete and has worsened. Twenty three physicians in 2020 had appropriate credentials. In the Monitor's last report, IDOC had only approximately 16 credentialed physicians.[5] Since March of 2020, 49 physicians have resigned from IDOC[6]. Recruitment and retention remain major obstacles and are affected by difficult working conditions: professional isolation, remote physical locations of prisons, inability to timely obtain consultant and hospital reports, delays in ordered care, limited communication tools, outdated facilities and equipment, disorganized records, and restricted access to specialty care. These conditions discourage qualified candidates. The Defendants need to address these issues to attract or retain staff. Salaries may have to increase to retain qualified physicians to work in these conditions.

Policies

The Consent Decree required IDOC to establish a set of comprehensive policies within 18 months or by December 2020. Six years later, this remains incomplete. While IDOC issued 88 policies to facility staff over a year ago none have been effectively implemented.[7] In the Monitor's opinion this is because of staffing shortages, insufficient supervision in the chain of command, and inadequate facilities and equipment.

Despite development and dissemination of the new medical policies IDOC has retained a substantial number of older Administrative Directives related to medical care. At times, Administrative Directives conflict with the more recent medical policy. Compliance audit findings reference the Administrative Directives rather than the more recent medical policies, creating a direct barrier to implementation of the policies as directed by the Consent Decree.[8] The Monitor recommends consolidating Administrative Directives related to medical care into one which aligns with OHS's medical policy. This needs to be accomplished to eliminate future conflicts and confusion as the medical policies are updated.

[5] IDOC paid for the equivalent of 16.9 physician positions but there were 33 working physicians, four without appropriate credentials. It was not possible given the data provided to determine how many of the 16.*9* FTE working hours were from appropriately credentialed physicians but, we estimate 16.
[6] IDOC does not calculate turnover rate and used significant agency physicians.
[7] February 2024
[8] II.B.8

The Monitor finds the existing set of medical policies not yet comprehensive as required by the Consent Decree. At least two dozen additional subject areas have been identified that IDOC will need to develop into policy before the set can be considered comprehensive. IDOC needs to clear a path for the development and *effective implementation* of medical policy. The Monitor believes that change in the organizational structure of IDOC is necessary to implement medical policy. [9]

Electronic Medical Record

A signed contract for an electronic health record was expected within 120 days of the effective date of the Consent Decree[10] but a contract was signed four and a half years late. [11] Full implementation of the electronic record was expected by September of 2022. Implementation has not occurred as scheduled. IDOC set a November 2025 deadline for implementation, but this is now delayed. A pilot at three facilities is now scheduled to begin in November 2025 with implementation not yet scheduled. Based on the latest progress reports provided to the Monitor, wiring and device acquisition are incomplete.[12] IDOC has not planned for device, equipment, and wiring needs for expanded telemedicine or for needs based on requirements of new policy. Funding for these additional needs has not yet been secured.

Data Systems

IDOC has not complied with requirements to produce data sufficient for monitoring compliance.[13] The Parties and Monitor failed to agree upon the data and information necessary to measure compliance with the Consent Decree in advance of the first report. Now six years later there is still no agreement on required data elements. Of five V.G. reports submitted by Defendants, three contained no data, and two contained unusable material. IDOC has also not been able to fully comply with providing the Monitor with all data necessary to measure compliance for his reports.

IDOC lacks trained data personnel and maintains no functional data system. Nurses and clinicians manually collect fragmented information, often in inconsistent formats. This is wasteful use of human resources. Without a structure to produce meaningful data IDOC has no information on which to base decisions, manage the health care program or monitor its compliance with the Consent Decree.

IDOC needs to provide the data infrastructure (staffing, equipment, software, connectivity, and storage) to ensure that IDOC meets the data requirements of the Consent Decree. The Monitor has repeatedly recommended hiring qualified data managers who can design and implement reliable

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[9] See the last section of this report for the Monitor's recommendation and rationale for change in the organizational structure.
[10] II.B.4
[11] IDOC initially had a contract established with a vendor for an electronic health record statewide but terminated the agreement in 2020. The contract with the current vendor was not executed until April 2024.
[12] IDOC determined that the initial device count was based on individual worker desires rather that an evaluation of facility need based on facility needs. A device count based on functional needs is being planned.
[13] V.G.

data systems that includes extracting data and making it useable. IDOC has recently presented their plan for obtaining and storing raw data from the electronic record. No clear plan or funding has been provided for obtaining, maintaining, and producing useable data from this data source. This is not compliant with provision V.G. of the Consent Decree.

Facilities and Equipment

IDOC is required in the Consent Decree to have "adequate facilities". [14] Adequate facilities are the responsibility of the Executive Director to propose and the state legislature and Governor to fund. At year six of the Consent Decree IDOC has not surveyed medical or dental facilities[15], capital equipment, or specialized housing needs for elderly, disabled, and cognitively impaired populations despite recommendations from the Monitor dating back to 2020 and its own statement of intent in 2021.[16]

The evaluation of IDOC facilities conducted by CGL[17] did not include consideration of medical space and equipment nor the needs of the elderly, disabled, high risk medical, or those with cognitive disorders who need specialized medical housing and programming. The CGL report did not consider the age or prevalence of medical conditions among the population of incarcerated persons in the assessment of the physical plant needs of IDOC facilities.

The CGL report did document an increase in medical space was one of six major system needs. However none of the IDOC's 14 strategic goals are to improve medical care or medical space and equipment. This is despite IDOC agreeing to make these changes in the *Lippert v. Jeffreys* Consent Decree in 2019.

The CGL report also recommended construction of a 200 bed geriatric unit comprised of four 50-bed pods. However the report provided no data to support a geriatric unit of specifically 200 beds. A prevalence study for mild cognitive impairment and dementia in the Texas prison system, the largest prison system in the United States, found that 35% of persons 55 years of age or older had screening criteria for mild cognitive impairment and 9% had screening criteria for dementia.[18] As of the latest population data set dated 6/30/25, IDOC had 4,470 individuals 55 years of age or older. If 35% have mild cognitive impairment (1564) and 9% (402) have dementia, the number of persons with dementia alone would far exceed a 200-bed geriatric unit. The use of pods to house this population is ill informed and not consistent with prevailing practices for the care of elderly cognitively impaired persons.

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[14] II.B.2 and II.B.3

[15] IDOC hired Introba to complete template designs for six medical facilities as will be described below. The Monitor was also informed that the IDOC Agency Dental Chief was evaluating space and equipment on 9/10/25 at the NRC facility but the purpose or conclusion of this evaluation has not been provided to the Monitor.

[16] Lippert Implementation Plan dated 12/30/2021.

[17] CGL Facility Master Plan, Illinois Department of Corrections, Final Report, May 2023

[18] Jacques Baillargeon, Lannette Linthicum, Owen Murray et al; The Prevalence of Cognitive Impairment and Dementia in Incarcerated Older Adults, The Journal of Gerontology, Series B: Psychological Sciences and Social Sciences, 2023, **78**(12), 2141-2146

In 2023 the Illinois Capital Development Board had Introba, a design and engineering firm develop plans for medical office space at six IDOC facilities. At only two of the six facility design sessions was there any participation by a member of the medical program. The Monitor found the Introba design for medical office space problematic and unrealistic given the needs of the population served. The Monitor understands that no further action on the Introba study was funded.

Neither the CGL evaluation nor the Introba design project included any meaningful participation by the medical staff of the Office of Health Services or consultants with medical expertise. Neither were these plans informed by any assessment of the needs of the population in IDOC for medical care.

Achieving adequate facilities and capital equipment, as required by II.B.2 and II.B.3 will not be accomplished in the remaining four years of the Consent Decree because of the time it takes to plan and fund capital projects. Defendants should act now to initiate an assessment of the medical needs of the population and complete a capital improvement plan for facilities and equipment with an approved budget within the time remaining.

Organizational Structure

Although a specific organizational structure is not explicitly mandated in the Consent Decree it does state that Defendants shall ensure the availability of necessary services, supports and other resources.[19] It is apparent that much of the lack for forward progress on compliance with the Consent Decree is because of the current organizational structure for health care within IDOC.

The Chief of Health Services position[20] is described as having programmatic responsibility for formulation and implementation of statewide policy for health services. However, the position has no direct line of operational supervision over the HCUAs for the implementation of policy. HCUAs report to Wardens[21], who are without the expertise to provide medical oversight. They also do not have responsibility for implementation of medical policy as part of their role. Regional Coordinators provide "clinical supervision" of the HCUA, but clinical supervision is not defined in their job descriptions. The Regionals do not have line authority for the HCUAs and describe their role as consultative only. As a result, HCUAs are not held accountable to implement the changes that are necessary to improve the quality and timeliness of health care services provided at the facility.

IDOC utilizes a number of different vendors and other agencies to deliver health care.[22] On average 65% of the medical staff at facilities are employed by a vendor. Supervision of vendor staff is also

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[19] II.A

[20] Medical Administrator IV, Chief of Health Services position description.

[21] Administrative Directive 01.02.111 Facility Leadership and Direction 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". Wardens authorize the posting of all State medical positions at the facility, authorize use of all space for clinical care, and supervise the health care unit administrator typically through the Assistant Warden of Programs.

[22] For example the medical vendor has subcontracts to provide pharmacy, dialysis, radiology services. UIC provides HIV, hepatitis C, diabetes specialty care, lab and pharmacy services.

inconsistent and at some facilities these staff are unsupervised. This fragmented structure further undermines policy implementation and accountability.

The Executive Director must ensure that there is a clear line of responsibility and accountability for changes that must be made in the delivery of health care at IDOC facilities to achieve compliance with the Consent Decree. The Monitor has consistently recommended direct supervision of Health Care Unit Administrators (HCUAs) by the Office of Health Services (OHS).

Summary of Deficiencies

After six years, IDOC remains noncompliant with the following major structural provisions in the Consent Decree:

- Inadequate staffing analysis (IV.A & B) and inadequate staffing (II.B.2 and II.B.3)
- Sufficient physicians with credentials (II.B.2 and III.A.2)
- Incomplete and unimplemented policies (II.B.8)
- Delays in implementation of the electronic medical record (II.B.4)
- Lack of reliable and actionable data and reports (V.G)
- No assessment of the adequacy of facilities or equipment to meet the medical needs of the population (II.B.2 & 3)
- Ineffective organizational structure without accountability for the accessibility and quality of health care available in Illinois prisons (II.A)

Consistent with provision V. J. of the Consent Decree the Monitor requests that Defendants meet and confer within the next 30 days about the steps to be taken and timeframe to address the deficiencies listed above.
