DEFENDANTS' IMPLEMENTATION PLAN
LIPPERT CONSENT DECREE

EXECUTIVE SUMMARY

The Illinois Department of Corrections ("IDOC" or "Department"), Office of Health Services ("OHS") and Governor Pritzker recognize the importance of compliance with the Consent Decree entered on May 9, 2019, in *Lippert v. Jeffreys, et al.*, no. 10-cv-04603 (Doc. no. 1238). Consistent with the Consent Decree, IDOC proposed an implementation plan. As provided for in Section IV.B of the Consent Decree, the Monitoring team proposed more detailed language. The District Court approved most of the Monitor's suggested edits/additions to the implementation plan over IDOC's objection. IDOC will execute this plan subject to any future court relief that it might obtain. This plan outlines a quality improvement approach to the delivery of medical and dental care. A philosophy of quality improvement will serve as a guide as we implement changes to our health care system. Finally, Defendants submit that this plan may require occasional amendments to accurately reflect future endeavors.

Defendants recognize the significant benefits associated with developing an enhanced leadership structure for OHS. Enhanced leadership includes additional OHS executive level staff, the development of audit teams, a quality improvement team, and increased data assistance. This affords OHS the ability to have more intensive oversight of health care staff, conduct more effective vendor monitoring and have the ability to dedicate staff to transforming the Department's quality improvement program.

Accordingly, this task will serve as a primary focus for the Department. Another initial focus of OHS is to institute the following structural components to its health care program:

- System-wide implementation of an Electronic Medical Record ("EMR");
- Development of a comprehensive set of health care policies and procedures that address all the provisions of the Consent Decree;
- Development of an audit function to ensure compliance with the Consent Decree;
- IDOC, through the Capital Development Board, will hire a consultant to determine whether adequate physical clinical space and equipment is available at all facilities; and develop an analysis of deficiencies and write a report with findings and recommendations to correct deficiencies and needs. This will include recommendations made by the consultant hired to determine needs of the aged, infirm and disabled. IDOC will use this report to take corrective actions to remedy the deficiencies and needs.
- Develop a quality improvement program to satisfy requirements of the Consent

Decree;

- Hire sufficient staff to implement this plan;
- Hire a qualified consultant to quantify the numbers of aged, infirm, and disabled, to determine gradations of need of the population, to identify appropriate housing and management options for this population and to produce a report of findings and recommendations;
- Organize the OHS to effectively implement this plan;
- Implement an infection control program sufficient to provide surveillance, prevention and control of communicable disease.

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

In addition, IDOC will evaluate the health care needs of the aging, infirm, and disabled populations housed in IDOC facilities. IDOC will seek assistance from the Illinois Department of Aging or a qualified consultant to develop a survey to quantify the numbers of these population groups within IDOC, and assess the health care and health-care-related housing needs of these populations. IDOC will develop options and recommendations to address the clinical care need gaps and clinical-care-related housing need gaps identified in the survey. IDOC will take appropriate actions to correct gaps in housing and clinical care needs of these populations.

A staffing analysis was conducted through the combined efforts of the OHS leadership team and the Health Care Unit Administrators ("HCUA") assigned to each facility. The positions presented in the staffing analysis represents IDOC's best estimate of the additional health care staff currently necessary to meet IDOC's identified mission and vision to provide "high quality medical care" to men and women in our custody. The analysis does not provide data as to what is minimally required by the Consent Decree or the U.S. Constitution. The staffing levels identified in the analysis are not meant to establish any minimum staffing level for any particular position at any particular facility, or at IDOC in general. The analysis should be viewed with the understanding that the needs of IDOC's health care system are dynamic and that modifications of the staffing analysis will be required to accommodate those changes. The staffing analysis proposes to add over 280 positions. However, this analysis was

conducted prior to implementing revised policies and practices, as well as an EMR. Without an assessment of the capacity of OHS to complete work as required by this Consent Decree, it also does not include many of the key recommendations of the Monitor. A full implementation of the updated policies and the EMR will likely impact the staffing needs. In order to address the evolving needs of the system, if IDOC determines it to be necessary, it may revise the staffing analysis as needed.

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

In the following sections, we give details of each of the components contained in this overview section.

OFFICE OF HEALTH SERVICES ("OHS")

The Chief of the Office of Health Services, a physician, will be the health authority of the medical program. By virtue of that authority, the Chief, OHS will have ultimate hiring and firing authority for all health care staff, make an annual proposal to the Executive Director for an annual health budget for the medical program, play a lead role (consistent with state procurement rules) in selection of medical vendors, and be responsible personally or through designees for administrative management of the health program. All Health Care Unit Administrators will report health care related information through a health care chain of command to this individual. OHS will incorporate health care leadership positions under an IDOC umbrella regardless of vendor arrangements. The Chief of OHS will be responsible for oversight and directing all aspects of health care operations. This individual will be the final health authority with respect to clinical decisions and clinical operations.

While the OHS staff has already expanded considerably, an outside vendor will be considered to augment OHS leadership staff in key areas that may be difficult for

IDOC to recruit. In addition to adding a full time Infectious Disease Coordinator, IDOC currently will establish an Infection Control program. Currently IDOC collaborates with the Illinois Department of Public Health ("IDPH"). This arrangement allows IDPH to provide consultation and guidance with respect to infection control policy on immunization, screening, and other public health matters. IDOC will formalize that relationship to ensure that IDOC has assigned consultation time with an infectious disease physician to help guide and develop their infection control program. If IDPH is unable to provide that service, a university program should be involved. If that is not possible, IDOC should hire an infectious disease physician for this purpose. Other additions to OHS staff will be discussed in the Quality Improvement section of this plan.

STRUCTURAL COMPONENTS

Implementation of the Electronic Medical Record ("EMR") at all sites is a critical component of the IDOC's compliance with the Consent Decree. With the implementation of a system-wide EMR, the OHS leadership team recognizes the benefit of creating a branch of OHS dedicated to health care information technology ("IT"). The addition of an IT Department to collect health care data will allow OHS to adhere to the Consent Decree. These individuals will have the expertise to modify EMR user interfaces, generate specific queries, and translate health care information into reports or to populate health system dashboards. This expertise will also allow IDOC to provide data for use in quality improvement programs and to verify compliance with the Consent Decree. The addition of an IT department dedicated solely to OHS is essential for monitoring the processes, encounters, and trends in IDOC's delivery of health care. This type of data management is crucial to appropriately tracking clinical progress and outcomes. The IT team will also assist the IDOC and the audit teams in developing and implementing a set of health care performance and outcome measurements. Additionally, the data team will assist IDOC in evaluating the electronic medication administration process to ensure that it functions in all facility settings and delivers sufficient data to verify aggregate and individual receipt of medication. The IT program will ensure that a call center is available to all staff on all shifts for problems with access to or use of the electronic record. The IT program will also ensure that new staff are appropriately trained in use of the EMR related to their work responsibilities before they begin their assignments.

OHS's Medical Coordinator has already initiated, in collaboration with one of the Monitor's consultants, a process to develop an enhanced set of policies and procedures. OHS will hire a project manager to expedite and facilitate this process if necessary. Several drafts are in progress. As drafts of these policies are completed, they will be circulated to the OHS leadership, IDOC officials, and the Monitor's staff for comments. Once a policy is completed, IDOC and any project manager it hires will ensure that training on the policy is provided to all sites. Going forward, these crucial documents will form the guidelines for practice and become the standard for measurement and accountability for performance.

As required by the Consent Decree, IDOC will survey all facilities to ensure there is adequate physical space and equipment for clinical care. This includes fixed and mobile equipment, dental equipment, and clinic space, including special medical housing for the infirm, disabled, and aged with dementia and memory deficits. This survey will be performed by the Illinois Department on Aging or qualified consultant done at every facility and will be memorialized in reports and provided to the Monitor.

QUALITY IMPROVEMENT

Quality improvement is a main component of the medical program in the IDOC. To that end, IDOC contracted with UIC's College of Nursing to advise on potential enrichments to our quality improvement program. Going forward, the Department will be working with SIU to build upon the recommendations outlined by UIC and assist the Department in creating a comprehensive quality improvement program.

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

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

- Develop screens in the electronic record to fully conform to IDOC clinical and data needs; and to fulfill requirements of the V.G. provision, needs of the audit

[1] Consent Decree § II.B.9.

team, and needs of the Monitor for his reports;

- Work to ensure that all necessary data elements are present in the medical record;

- Extract and compile data from the electronic record—in useable and acceptable format—for the audit team, Monitor (for verification of compliance and his reports), and for supporting quality improvement projects;

- Develop performance and outcome measures as required by the Consent Decree; and develop a dashboard of those measures utilizing data obtained from the electronic record to monthly show facility progress on these performance and outcome measures;

- Provide data to verify the degree of compliance with requirements of the Consent Decree;

- Assist OHS and quality teams on other data and project needs as needed.

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

AGED POPULATION

IDOC is committed to ensuring appropriate housing for the aged, infirm, and disabled populations including those with memory deficits, disabilities, and those in need of assistance with activities of daily living. Approximately 20% of inmates housed in IDOC are over 50 years of age. This population has considerably greater health needs and presents difficulties with respect to housing. However, there is uncertainty with respect to the scope of need for this population. For that reason, IDOC will hire a qualified consultant to develop a questionnaire based on the Illinois Department of Aging determination of need survey that is required of all persons entering a nursing home. This assessment of needs will result in a report with recommendations to form the basis for the development of action steps to provide appropriate resources, programming, and housing for the aged, infirm, and those with disabilities or those needing assistance with activities of daily living. The report would also provide guidance on the numbers of aged who have disabilities, memory deficits or other assistance needs that would provide data for a subsequent plan on how to best provide for these individuals. The analysis and development of the action plan will be performed in consultation with the Monitor.

STAFFING

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

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

Presently, IDOC is proposing to add a considerable number of positions. IDOC expects to fill vacancies to attain no more than a 15% vacancy rate for non-critical positions.[2]

STRENGTHENING ACADEMIC RELATIONSHIPS

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

RELATIONS WITH MONITOR

The Consent Decree requires the Monitor to provide input and assistance to IDOC and specifically states in Section IV.A:

[2] Critical positions are OHS non-clerical staff, HCUAs, Medical Directors, Directors of Nursing, Dentists, Dental Hygienists, Physical Therapists, and Project Management staff which should be filled as soon as possible.

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

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

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

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

CONCLUSION

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

Task No.	Task	Consent Decree Item Number	Goal	Monitor(s) assigned by Dr. Raba	Responsible Party Assigned by Dr. Bowman	Start	Proposed End Date	Percent Complete[3]	Completion Date
	STAFFING								
1	**Complete Initial Staffing Analysis.**	IV.A			OHS Leadership		Aug-21	100%	
1.a	IDOC will hire a qualified consultant to perform a workload analysis for ***all*** staffing needs. The workload analysis will form a baseline staffing need for all position types and the template or algorithm used in the analysis will be utilized to develop changes in staffing needs based on increases or decreases in inmate population or programmatic change.	IV.A, IV.A.2			OHS Leadership, Workload analysis consultant		Dec-23		
1.b	IDOC will ensure that the requirements of the workload analysis include analysis of all the Monitor's recommendations with respect to staffing. The workload analysis would provide a workload analysis methodology for staffing recommended by the Monitor.	IV.A, IV.A.2, V.E			Workload analysis consultant		Mar-24		
2	**Complete hiring of Executive OHS Leadership staff.** SIU will hire audit teams (1 coordinator, 2 physicians, 2 nurse practitioners, 4 RNs, 2 quality specialists, part-time dentist) 3 data team members, an executive director, a director of quality management, an administrative assistant, a quality improvement coordinator, 2 quality improvement specialists, 3 process analysts. IDOC will negotiate with SIU to hire project managers listed below.	IV.A, II.B.3, IV.A.2			IDOC Human Resources	Mar-20	May-23	100%	
2.a	IDOC will hire project managers for the following services: 1. Full-time Implementation Plan project manager 2. Full-time Electronic Medical Record project manager 3. Full-time Policies and Procedures project manager	IV.A, II.B.3, IV.A.2			OHS Leadership, IDOC Human Resources, SIU	Dec-21	Oct-23	33%	
2.b	OHS will meet routinely with IDOC Human resources, CMS, and the vendor to monitor time-to-hire and vacancies for health care positions and progress on hiring of health care staff. The group will set a time-to-hire goal and a vacancy goal to measure against.	IV.A, II.B.2, II.B.3, IV.A.2			OHS, IDOC Human Resources and Labor Team	Jun-21	To start July-23 with quarterly meetings		
2.c	OHS will meet routinely with vendor to review vacancies for health care positions and progress on hiring of health care contractual staff.	IV.A, II.B.2, II.B.3, IV.A.2			IDOC and Healthcare Vendor	Jan-17	Ongoing		
2.d	OHS will meet with IDOC human resources, the vendor, and CMS to identify and conduct corrective actions to facilitate the hiring of health care staff based on established goals. This group will establish and work to improve time-to-hire goals and establish workplans for corrective action for vacancy rates greater than 10% or any vacancies in critical positions (Medical Directors, HCUAs, Directors of Nursing, Dentists, project management staff, and OHS non-support staff). This group will track and report its progress over time as a performance and outcome measure as measured on a dashboard.	IV.A, II.B.2, II.B.3, IV.A.2			IDOC Human Resources, Central Management Services, vendor, OHS,	Mar-22	Until 15% vacancy rate attained		
3	Hire staff outlined in the Staffing Analysis as soon as possible with expedited hiring for key positions (Medical Directors, HCUAs, Directors of Nursing, Dentists, project management staff, and OHS non-support staff).	IV.A, II.B.2, II.B.3, IV.A.2			IDOC Human Resources		Ongoing		
3.a	SIU will post SIU positions.	IV.A, II.B.2, II.B.3, IV.A.2			SIU		Aug-22	100%	Jan-22
3.b	Vendor will post contracted positions.	IV.A, II.B.2, II.B.3, IV.A.2			Health Care Vendor		Ongoing		

[3] Percentages completed were supplied by Defendants and the Monitor has not yet verified compliance with these percentages.

Task No.	Task	Consent Decree Item Number	Goal	Monitor(s) assigned by Dr. Raba	Responsible Party Assigned by Dr. Bowman	Start	Proposed End Date	Percent Complete[3]	Completion Date
3.c	IDOC HR and facility HR will post IDOC positions.	IV.A, II.B.2, II.B.3, IV.A.2			IDOC Human Resources		Ongoing		
4	Revise existing policy so that Agency Medical Director or designee will approve position descriptions (which include qualifications) for facility healthcare specific positions including facility infection control coordinators, chronic care nurses, and quality improvement coordinators. The Agency Medical Director will ultimately be responsible for recommending the hiring and firing for all health care employees through designees.	IV.A, II.B.2, II.B.3, IV.A.2			IDOC OHS and Chief Compliance Officer, IDOC HR		July-23 for policy revision; ongoing for the remainder		
4.a	IDOC will develop an alternative source of obtaining physicians. IDOC will initiate negotiations with SIU, UIC or other parties (FQHCs, etc.) for arrangements to provide physician staff for any facility with vacant vendor Medical Director or physician for six months or more (without use of a "traveling medical director" or coverage doctor arrangement). IDOC will make contract modifications to the vendor contract so that these positions can be filled with alternate physicians and to allow the new physician to be the clinical authority at that facility.	II.B.2, II.B.3, III.A.2, IV.A.2			Agency Medical Director and Deputy Chief of Health Services and IDOC Human Resources		Nov-23		
5	**Create draft OHS organizational chart, including vendors, to demonstrate OHS reporting structure**. The organizational chart will show that the Agency Medical Director is ultimately responsible directly or through designees for the recommendation of the hiring and firing of all health employees including the HCUA. The organizational chart will clarify the reporting and supervisory relationship between the Office of Health Services leadership to the facility Health Care Unit Administrator.	II.B.3			IDOC OHS, Human Resources	Sep-21	Aug-23		
6	The organizational chart will illustrate the relationship between the Office of Health Services leadership and vendor staff and the relationship between the HCUA and vendor staff at each facility. The table of organization shall represent supervisory relationships.	II.B.3			IDOC OHS, Human Resources and Healthcare vendor		Aug-23		
	TRAINING OBJECTIVES								
7	**Develop written procedures for expectation of training to include:** 1. Procedural training (new policies, new procedural initiatives and new or modified processes); 2. Quality improvement and Safety training; 3. Clinical practice training and updates (e.g., provider training on asthma management, nurse training on vital sign assessment, medication administration, nurse training on use of a point of care device, etc.); 4. Electronic medical record training both initial and ongoing; 5. New employee training; 6. Training procedures shall include the format of training (in-person, video conference, onsite, quarterly meeting, etc.); copies of the new policy or procedure for all attendees; sign-off acknowledgement that training was received; in some cases verification of competence with the training (taking blood pressure, using a point of care device, etc.).	II.B.3, II.B.6.o, IV.A.2			OHS Quality Control Coordinator, Agency Medical Coordinator, Agency Director of Nursing, Deputy Chiefs, Agency Medical Director, SIU		Sept-23		
8	Have dedicated staff for infection control nurse, chronic care nurse, and quality improvement coordinators at each facility.	II.B.3			OHS, Agency Director of Nursing, Agency Medical Coordinator, SIU and Vendor		Jan-24		
8.a	Hire a training coordinator to track training, coordinate support for the training, and ensure staff training occurs for all relevant staff.	II.B.3, II.B.6.o, IV.A.2					Sep-23		

Task No.	Task	Consent Decree Item Number	Goal	Monitor(s) assigned by Dr. Raba	Responsible Party Assigned by Dr. Bowman	Start	Proposed End Date	Percent Complete[3]	Completion Date
	SECURE HEALTHCARE VENDOR						Dates for Tasks 9-16 are estimates		
9	Ensure RFP and contract is written to obtain sufficient staffing and be consistent with requirements of Consent Decree vis-a-vis its policies and procedures and include the possibility for using physicians from another source in the event the vendor cannot provide sufficient qualified physicians. Draft RFP to refer to appropriate agency consulting parties.	II.B.2, II.B.3, III.A.2, IV.A.2, V.G			IDOC OHS, IDOC Legal, IDOC Fiscal	Jul-21	Nov-22	100%	Nov-22
10	Send RFP to agency procurement department for review and approval.				IDOC OHS, IDOC Legal, IDOC Fiscal		Jan-23	100%	
11	• Submit BEP Goal Setting form to BEP Compliance Officer. • Submit Veteran's Business Program (VBP) Goal to Agency Compliance Officer. Send RFP to SPO for review and approval.				IDOC OHS, IDOC Legal, IDOC Fiscal		Aug-22	100%	Jan-21/Apr-23 (rev)
12	Post RFP.				IDOC OHS, IDOC Legal, IDOC Fiscal		Jan-23	100%	Jan-23
13	• Public Pre-Bid Conference Review Technical Bid. • Review and Score Diversity Commitment Submission. Send Technical Score to SPO for review and approval. Review and score Pricing. • Send Technical and Pricing Submission for award approval Protest Period of 14 days.				IDOC OHS, IDOC Legal, IDOC Fiscal		Aug-23	25%	
14	• Award RFP. • Negotiate contract specifics.				IDOC OHS, IDOC Legal, IDOC Fiscal		Oct-23		
15	Draft contract consistent with Consent Decree/sign contract.	II.B.2, II.B.3, II.B.6.r, II.B.7, III.A.2, III.A.4, III.M.1, IV.A.2, V.G, V.H			IDOC OHS, IDOC Legal, IDOC Fiscal		Dec-23		
16	**Monitor performance of medical vendor and take appropriate corrective action.** 1. Develop a standardized procedure for contract monitoring of staffing and clinical performance. 2. Use performance measures of vacancy rate, positions filled compared to contract staffing numbers, and number of days without key personnel (Medical Director, Director of Nursing, supervisory nurses) as a measurement of staffing performance. 3. Develop procedure to use annual facility audits in aggregate as measures of clinical performance of the vendor. 4. Develop a procedure for collating material from staffing and clinical performance to judge and score performance. 5. Develop standardized mechanism to notify vendor of results and to implement corrective action. 6. Develop a plan to track results of the corrective action.	II.B.2			Agency Medical Director, Deputy Chiefs, Fiscal		May-24		
	ELECTRONIC HEALTH RECORD (EHR) *****_specifications regarding full implementation will be provided after consulting the new EHR vendor_								
17	Complete facility wiring for EHR.	II.B.2, II.B.4			IDOC Telecom staff		Aug-21	100%	

Task No.	Task	Consent Decree Item Number	Goal	Monitor(s) assigned by Dr. Raba	Responsible Party Assigned by Dr. Bowman	Start	Proposed End Date	Percent Complete[3]	Completion Date
18	Arrange for assigned person in DoIT or hire consultant to annually meet with OHS and to review facilities to determine need for additional wiring, devices or equipment as new staff is onboarded, as equipment requires replacement, or when new programs require additional equipment or wiring. This will result in a brief summary of the review to OHS and director of DoIT.	II.B.2, II.B.3, II.B.4			IDOC Staff, DoIT or consultant		Annually		
19	• Post RFP for EHR. • Public Pre-Bid Conference. • Evaluate Bids received. • Select vendor for EHR.	II.B.4			IDOC OHS, IDOC Legal, IDOC Fiscal	Nov-21	Sept-23	50%	
20	Finalize implementation of Electronic Health Record.	II.B.4			IDOC OHS and IDOC Human Resources		Nov-25		
21	Hire or reassign a qualified dedicated full-time IT professional as project manager for the EHR implementation.	II.B.2, II.B.3, II.B.4			IDOC Telecom staff, OHS Chief		Oct-23		
22	**Determine necessary device count for future healthcare staff use of EHR.** IDOC OHS will identify point of care devices to integrate into EHR system such as glucometers, thermometers, automated blood pressure, pulse oximetry, ultrasound etc. as well as laptops, desktop computers, printers, scanners, and other devices necessary to effectively implement the EMR.	II.B.2, II.B.4, III.B.2			IDOC staff, OHS, DoIT		Feb-24		
23	**Ensure acquisition of devices for future healthcare staff to operate the EHR** 1. OHS and DoIT will develop a written procedure for requesting new devices in the event of new staff exceeding the existing device capacity; 2. reporting of defective or malfunctioning equipment so it can be replaced; 3. or requesting a meeting of DoIT with OHS designee(s) to request equipment needs for new initiatives which cost will be proposed through an expedited (for critical projects) or normal budget process (for routine projects).	II.B.2, II.B.4 III.B.2			EHR Project Manager Chief of Health Services, DoIT, CFO		Jun-24		
24	**Provide staff training on the use of the EHR. At least three months prior to "go live" develop a standardized plan that is then applied to each facility. Each facility may have barriers (no space to conduct the training, work schedules that conflict with training schedules, etc.). For that reason each facility will modify the standardized plan based on facility specifics. Employee-specific task training will be the standard (medication nurses receive training on the eMAR, providers receive training on chronic illness documentation, etc.) **training specifics will be outlined with the assistance of the selected EHR vendor in coordination with OHS leadership and the Department of Innovation and Technology (DoIT).*** Provide initial, end-user specific staff training to include: Medical, dental, and mental health providers, nurses, ancillary staff, facility administrative staff, OHS executive staff and Quality teams. The training plan shall include 1) where the training will occur, 2) ensuring that sufficient space and devices are obtained so that every trainee has a device to use and the space is conducive to a training session, 3) ensuring that prior to beginning training all staff have sufficient computer skills to utilize the operating system, 4) that sufficient time is allocated for training and that those who need more time to learn have an opportunity to do so, 5) that training groups are established (providers, medication nurses, schedulers, etc.) so that training is provided specific for the responsibilities of staff trained, 6) that there is a test requirement that ensures that the staff trained have acquired the skills necessary to effectively use the electronic record.	II.B.3, II.B.4, IV.A.2			EHR Project Manager, EHR Vendor, DoIT and OHS Leadership		Nov-24		
25	Hire 3 IT professionals to manage a help desk and to provide continuity training for new hires, new EHR features, upgrades, and revisions. IDOC may elect to contract out this service.	II.B.3, II.B.4, III.M, IV.A.2				Ongoing	Nov-24		

Task No.	Task	Consent Decree Item Number	Goal	Monitor(s) assigned by Dr. Raba	Responsible Party Assigned by Dr. Bowman	Start	Proposed End Date	Percent Complete[3]	Completion Date
26	Finalize and disseminate immunization and routine health maintenance (RHM) and cancer screening policies, procedures, and guidelines using the Center for Disease Control (CDC) adult immunization guidelines and United States Preventive Services Task Force (USPSTF).	II.B.1				Sep-22	Jul-23		
27	**Identify and finalize a mechanism to track immunizations and routine health maintenance (RHM) and cancer screening information until EHR is fully implemented.** The mechanism will track and report both the volume of specific vaccines offered, administered, and refused per facility and the percentage of eligible patients who have been offered, accepted, and refused specific vaccinations and routine health maintenance/cancer screenings. IDOC must implement an interval immunization and RHM/cancer screening tracking system prior to the full implementation of the EHR.	II.B.1, II.B.2, II.B.4, III.M.1.a.b.c.d			EHR Project Manager, Agency Medical Coordinator, Agency Director of Nursing, Deputy Chiefs	Jun-22	Dec-23		
28	**Track adult immunization and RHM/cancer screening acceptance rates** Develop and implement an interval immunization and RHM/cancer tracking solution using an electronic database (see #27.)Possible solutions for immunization tracking include open source relational database software, the Illinois Comprehensive Automated Immunization Registry I-CARE or similar database. 1. Complete immunization policy and procedures revision to include: a. Primary responsibility for the systemwide immunization program will be under the system's Infectious Disease Coordinator. b. Designated infection control nurses will coordinate the facility's immunization program and will have dotted line reporting to the system's Infectious Disease Coordinator. c. Modification that allows nurses, acting under protocol, to immunize patients. d. Annual health evaluation update of immunization and RHM/cancer screening status and offering of necessary immunizations and screenings at chronic care and specialty clinic visits, annual and biannual health visits, and regular vaccination/RHM/cancer screening events. e. Reception and classification centers will solicit and record immunization and RHM/cancer screening status and will offer and track required vaccinations and RHM/cancer screenings as part of the intake admission process. f. Immunization and RHM/cancer screening data will be reported regularly at the monthly facility QI meetings and at the systemwide Quality Council meetings. 2. Ensure that the implementation of the electronic health record includes requirements to track and automatically report immunization and RHM/cancer screening data. 3. Select a reputable database to assess immunization and RHM/cancer screening status at intake and update immunizations/RHM/cancer screenings prior to conclusion of the intake process. 4. Institute statewide training of nurses on safe immunization practices and updated immunization procedures and select RHM/cancer screenings.	II.B.1, II.B.2, III.M.1.a.b.c.d			EHR Project Manager and OHS staff, EHR Vendor, Infectious Disease Coordinator	Nov-22	Dec-23		

Task No.	Task	Consent Decree Item Number	Goal	Monitor(s) assigned by Dr. Raba	Responsible Party Assigned by Dr. Bowman	Start	Proposed End Date	Percent Complete[3]	Completion Date
29	**Develop a mechanism to notify providers of instances of medication non-adherence within the EHR.** 1. Establish policy and standardized procedures to support patient adherence with prescribed medications. a. Define which medications are to be monitored for non-adherence. b. Define the frequency for monitoring medication adherence. c. Determine how providers are notified. d. Define the expectations of providers when notified of non-adherence and steps to be considered to improve adherence including timeframes for action. e. Establish the factors to be addressed in documentation by providers of efforts to address adherence. f. Develop an audit tool or other tracking mechanism to account for the efforts and outcomes in addressing medication non-adherence. g. Inform staff of expectations and methods to address nonadherence and implement policy and procedure. h. Track implementation progress and compliance. 2. Establish the process within the EHR to accomplish notification and documentation of provider actions in response to notification of nonadherence. a. Determine how the EHR will distinguish medications that are to be monitored. b. Determine where the information to be monitored resides in the EHR (i.e. MAR). c. Identify the mechanism used to determine the frequency adherence is monitored and the means to identify when provider notification should take place. d. Determine how providers are notified of non-adherence (message, establish a task for chart review or patient appointment). e. Develop documentation template for providers to review nonadherence, meet with the patient to discuss, actions taken to address patient concerns, and education or counseling provided. f. Implement automated methods to monitor and report nonadherence. g. Monitor accuracy and timeliness of automated review and notification processes.	II.B.4, II.B.1, II.B.6.d	To support patient adherence with provider recommendations for medication treatment and constructively address the reasons patients are nonadherent.		1a-g: SIU Pharmacist to take the lead establishing clinical, procedural, and tracking requirements with assistance from OHS Deputy Chiefs, Agency DON & OHS Regionals. 2a-g: EHR Project manager, IDOC Department of Planning and Research, SIU Quality	Sep-22	Aug-24		
30	**Develop an infection control program which includes:** 1. Sufficient personnel within OHS who are appropriately qualified in communicable diseases and infection control to provide agency wide direction and to carry out these directions reliably at the facility level. (Agency Medical Director) August-23 2. Develop written guidelines on all operational aspects of infection control in facilities (i.e. education, exposure control, vaccination, monitoring and surveillance, prevention and treatment, outbreak investigation, policy enforcement). (Infectious Disease Coordinator) November-23 3. Establish surveillance report format to be used to analyze and report on infection control in CQI meetings at the facility and agency level. (Infectious Disease Coordinator) November-23 5. Work with data personnel to develop methodology to acquire data for surveillance reports manually to begin and eventually within the EHR (Infectious Disease Coordinator) November-23 6. Establish reporting methodology to document enforcement of each item in the Consent Decree relating to infection control (III.I.5; III.J.2-3) as well as any called out in written guidelines #2 above. (Infectious Disease Coordinator) November-23 7. Establish statewide infection control meetings of infection control personnel. (Infectious Disease Coordinator) August-23	II.B.5II.B.2-3, II.B.5, II.B.8, III.B.2, III.J.1-3, III.K.4; III.M.1			OHS Deputy Chiefs, Agency Medical Coordinator, Agency Director of Nursing, Infectious Disease Coordinator		Nov-23		

Task No.	Task	Consent Decree Item Number	Goal	Monitor(s) assigned by Dr. Raba	Responsible Party Assigned by Dr. Bowman	Start	Proposed End Date	Percent Complete[3]	Completion Date
31	**Ensure all traditional releases receive a Medical Discharge Summary** 1. Process mapping should be used to define the steps necessary to plan for continuity of care upon "traditional" release to the community. These steps include defining the clinician's review of patient needs in preparation for release, need for pre-arranged follow up care, handoff communication, provision of materials and supplies needed to continue care (medication, dressings, etc), availability of records, preventive care, and post release communication. 2. Review NCCHC E -10 Discharge Planning and ensure that the process includes identification of patients who need arrangements or referrals for follow up and assistance with application for health insurance. 3. Define responsible parties, timeframes and develop tools used to complete each step in discharge planning. 4. Develop and implement via policy and procedure that describes the steps of discharge planning, responsible parties, timeframes, and tools, including a standardized list of health care information to be provided to all discharges. Information will include: Diagnoses and active problem list, current medications, immunizations and screening, summary of recent medical care (clinic and specialist care), copies of pertinent diagnostic and laboratory reports, copies of pertinent specialty consultations, and instructions for follow-up and community health care resources. 5. Establish metrics and methods for reporting discharge planning encounters as a proportion of all discharges. 6. Establish tools to evaluate the process and outcomes of discharge planning and include in calendar of performance monitoring.	II.B.5, II.B.6.S, II.B.6.t			OHS Deputy Chiefs, Agency Medical Coordinator, Agency Director of Nursing, Process Analysts		Sept-23		
32	**Ensure appropriate discharge medication is provided at the time of discharge.** All discharges currently receive a 2 week supply of medication and a prescription for an additional 2 weeks of medication with one refill. HIV patients receive a 30 day supply of HIV medication upon discharge. 1. Survey each facility to determine: a. Who determines what medications are provided at the time of release? b. How discharge medications are obtained? c. Who prepares medications for discharge and how is the task completed? d. Does a clinician review and determine what medications the patient is to be provided in advance of the release? If so, when does this take place and how is it documented? 2. Establish and implement policy and procedure defining the process for clinician review of medications in advance of release, the process for procuring and packaging these medications, the methods used to provide them to the patient and how a two week refill is accomplished. 3. Establish methods to account for and document provision of discharge medication and compliance with written directives.	II.B.6.t			OHS Deputy Chiefs. Performance monitoring tool to be developed and implemented by SLC, Process Analysts		Jul-23		
33	**With the assistance of the audit teams and the Monitor, OHS will implement a preventable adverse event reporting system.** OHS with SIU will purchase third party adverse event reporting software currently in use in other health care settings or If IDOC decides not to purchase established off-the-shelf software, it will design its own electronic reporting system to capture any non-conformance to policy, procedure or perceived error or non-conformance. SIU will assist in the implementation of this system.	II.B.6.m, III.L.1	To utilize adverse event reporting system to improve quality of care		OHS Quality Control Coordinator, Deputy Chiefs, SIU, IDOC Chief Compliance Officer		Nov-23		

Task No.	Task	Consent Decree Item Number	Goal	Monitor(s) assigned by Dr. Raba	Responsible Party Assigned by Dr. Bowman	Start	Proposed End Date	Percent Complete[3]	Completion Date
34	**IDOC will assign a full time quality improvement staff or hire (at OHS level not at facility level) to manage adverse event reporting reports and manage the patient safety program.** This responsibility will include follow up on immediate remediation of adverse events, classification of all reports by type, organizing the reports systemically to show trends by facility, training staff at facilities on use of the system and on the procedure for making an adverse event report, and participating with the quality program in designing patient safety actions based on event reports.	II.B.6.m, III.L.1			Director of Quality Improvement and Agency Medical Director		Nov-23		
35	**With the assistance of the audit teams and the Monitor, develop and implement a procedure to analyze and use adverse event reporting to a) remediate the adverse event reported and b) subsequently analyze aggregate reports to prevent patient safety risks.** 1. Immediate remediation is tracked to ensure effective remediation occurred (e.g., if a patient experiences a fall in a shower because there is no grab bar, is a grab bar installed to prevent future falls). 1. A responsible person in the quality program (see item above) is hired/assigned to classify the adverse event and categorize all events system-wide and collate the data. 2. Data generated from the adverse event reporting system shall be used to shape safety improvement initiatives. 3. Data will be provided to OHS Quality Improvement and audit teams for review and the team will design corrective intervention for systemic preventable adverse reports or for facility specific reports when that facility had excessive reports of a similar type. 4. Following staff education, the intervention will be implemented. 5. Audit and data teams will monitor results and re-evaluate the success of the intervention at the conclusion of the designated study period. 6. Policy and or processes will be modified to embed the resulting process.	II.B.6.m, III.L.1	To utilize adverse event reporting system to improve quality of care		OHS Quality Control Coordinator, Deputy Chiefs, SIU, IDOC Chief Compliance Officer and Medical Compliance Administrator		Jan-24		
36	**With the assistance of the Monitor IDOC will establish patient safety program that incorporates information gleaned from critical events, adverse events, mortality review and audit results.** Safety initiatives will include, but are not limited to: infection prevention, injury prevention, and reduction of medication errors.	II.B.6, III.L.1	To utilize adverse event reporting system to improve quality of care		Agency Medical Director, Director of Quality Improvement, Quality Improvement Coordinator		Nov-23		
37	**Hire dietician(s)based on a workload analysis (based on requirements of the Consent Decree) or engage consultant services that will complete an analysis biennially of nutrition and timing of meals at all facilities for the population of inmates with chronic illness whose condition is affected by dietary conditions. The dietician will also provide individual consultation and counseling for individuals who have serious medical needs affected by diet and require such analysis.** OHS to consult SIU or other entity to develop process for dietary counseling.	II.B.6.i, IV.A, II.B.2, II.B.3, IV.A.2			Agency Medical Director, Dietician		Nov-23		
38	**Dietician will review prescribed medical diets and the overall nutritional content of the meals for non-medical diets.** OHS to consult SIU, or other entity, to develop process for dietary counseling.	II.B.6.j			OHS Quality Control Coordinator, Deputy Chiefs, SIU, IDOC Chief Compliance Officer and Medical Compliance Administrator		May-24		
39	**With the input of the Monitor,** the OHS QI Coordinator, Deputy Chief, SIU, Chief Compliance Officer audit team members, and data staff will develop performance and outcome measures that measure IDOC's compliance with the Consent Decree. The data manager will query the EHR and/or develop other data collection instruments to collect.	II.B.2, III.L.1			Deputy Chiefs, Director of Nursing, OHS Quality Control Coordinator, OHS Medical Coordinator		Sept-23		

Task No.	Task	Consent Decree Item Number	Goal	Monitor(s) assigned by Dr. Raba	Responsible Party Assigned by Dr. Bowman	Start	Proposed End Date	Percent Complete[3]	Completion Date
39.a	The data manager will develop a dashboard to display monthly and annual performance and outcome measures by facility and in statewide aggregate. This dashboard will be available, online, to all IDOC medical employees.	II.B.2, III.L.1			Data manager		Nov-23		
40	**OHS will develop comprehensive medical policies with the assistance of the Monitor to cover all aspects of a health care program.** Policies will reference existing, widely accepted, correctional health care accreditation standards such as those promulgated by the National Committee on Correctional Health (NCCHC) and the American Correctional Association (ACA). 1. Hire project manager or other person solely assigned to manage policy development, ongoing review, and maintenance. (Agency Medical Director) Initiate 2/23; ongoing 2. Establish an initial list of policies to be developed to address every provision in the Consent Decree as well as every NCCHC accreditation standard. (Project Manager) Completion 3/23 3. Establish, with the assistance of the Monitor, the essential elements and criteria that must be addressed in each policy on the list. (Project Manager and Agency Medical Director) Completion 4/23 4. Assign subject matter experts for each policy to be developed from amongst OHS leadership, regional staff, SIU, and vendor staff to draft the initial policy and to make revisions during the review process. (Initially Agency Medical Director or designee) Initiate 4/23 Completion 8/23 5. Establish a process, calendar, and timeframes for the IDOC and Monitor to review and comment on drafts through to finalization. Manage the development of draft policies through to finalization and provide monthly reporting to the Agency Medical Director, Chief Compliance Officer, and the Monitor on progress toward completion.(Project Manager)) Initiate 4/23 Completion 8/23 6. Establish the document format for every policy. The document format requirements need to include development of a standardized procedure for implementation at the facility level, as well as the elements to be included in tools to evaluate compliance with policy and procedure. (Project Manager) 3/23 7. Identify policy subjects that would benefit from process mapping and arrange facilitation of these with SIU. (Project Manager) 4/23 8. Evaluate whether additional resources are needed to implement each policy and procedure and secure the necessary equipment, supplies or personnel to do so. (Subject Matter Expert, Regional Coordinators). Initiate 6/23, Completion 9/23. 9. Establish a plan to provide standardized training and centralized reporting of training completion and subject knowledge in the set of comprehensive medical policies and procedures. Plan is to include the initial training of existing staff, orientation of new staff, annual evaluation of staff knowledge and compliance with P & P, and the method to inform staff of revisions to P & Ps. (Project Manager, Training Manager) Initiate 4/23, Implement 9/23, Completion 11/23 10. Establish a methodology for the Agency Medical Director to consider requests for exceptions to specific requirements in policy and procedure and to document any approved deviations. The Agency Medical Director will solicit input from the Monitor in making these determinations. (Agency Medical Director and Project Manager) Initiate 6/23; Completion 11/23 11. Establish the timeframes and expectations for implementation of policies at the facility level. (Project Manager, Agency Medical Director) Initiate 6/23, Completion 11/23. 12. Develop tools and methodology to measure conformance with each policy and procedure. (Audit Manager) Initiate 8/23, Completion 12/23	II.B.8	Establish a set of standardized operating procedures to provide ongoing clinical direction to staff for the operation of a health care program in the correctional setting.		Medical Compliance Administrator		Dec-23		

Task No.	Task	Consent Decree Item Number	Goal	Monitor(s) assigned by Dr. Raba	Responsible Party Assigned by Dr. Bowman	Start	Proposed End Date	Percent Complete[3]	Completion Date
	QUALITY IMPROVEMENT	III.L.1							
41	Fill IDOC Quality Improvement Coordinator position.	IV.A, II.B.2, II.B.3, IV.A.2			OHS and IDOC Human Resources		Jun-23	100%	May-23
42	**Develop Quality Improvement Partnership.** Develop a document that describes the detailed responsibilities of SIU with respect to the IDOC medical program including CQI. Update this document whenever those responsibilities change.	III.L.1	III.L.1		OHS Quality Improvement Coordinator, Agency Medical Coordinator, Deputy Chiefs, Agency Medical Director, SIU, IDOC Chief Compliance Officer	Sep-18	Ongoing		
43	**OHS and SIU, with the assistance of the Monitor will make changes to the existing quality improvement program to one that includes a principal goal of improving care in order to attain compliance with the requirements of the Consent Decree. The changes to the CQI program will be present in the CQI policy:** 1. IDOC will finalize Quality Improvement policy, and develop a training plan to be used for facility staff. 2. IDOC will develop a written plan for the statewide CQI program, as evidenced in policy and procedure, that will utilize the audit function as the principal driver of identifying systemic and other deficiencies whose correction will result in forward progress toward compliance with the Consent Decree. The audit reports, adverse medical event reports, performance and outcome measures, and opportunities for improvement identified in mortality review will also contribute to identification of deficiencies whose correction will contribute to forward progress towards compliance. See audit process below. See Task 7 above for training in CQI and patient safety.	II.B.9, III.L.1	To ensure that an adequate CQI program is established		IDOC Quality Improvement Coordinator		Nov-23		
43.a	**Develop an audit process** 1. IDOC will use Consent Decree requirements, contemporary clinical nursing standards and physician clinical care standards (e.g. as in UpToDate) and dental clinical care guidelines as a basis and, with the input and assistance of the Monitor, develop a medical and dental audit instrument. 2. IDOC will conduct an onsite, annual, comprehensive independent audit of each facility. The evaluation will cover all areas of the Consent Decree and include all aspects of clinical care. 3. Procedures for these audits will be developed with assistance of the Monitor to include development of a document list, data that will be evaluated, chart selection, interviews, touring with inspection, and a written report. 4. The audit team will train on audit methodology with Monitor on multiple site visits. 5. IDOC will ensure facilities cooperate and make staff available during audit visits. 6. Audit team will incorporate mortality reviews, performance and outcome dashboard results, adverse event reports, and any other audits into their annual evaluation. 7. A report will be delivered to the facility and system-wide quality committee and that committee will decide on corrective actions that the facility quality improvement program is to address. 8. The system-wide quality committee will develop a methodology to track corrective actions. 9. IDOC will develop a methodology for referral to peer review for egregious practice issues. 10. IDOC will aggregate audit findings into vendor oversight as represented in an annual report of findings.	II.B.9			OHS Quality Improvement Coordinator, Agency Medical Coordinator, Deputy Chiefs, Agency Medical Director, SIU, IDOC Chief Compliance Officer		Mar-24		

Task No.	Task	Consent Decree Item Number	Goal	Monitor(s) assigned by Dr. Raba	Responsible Party Assigned by Dr. Bowman	Start	Proposed End Date	Percent Complete[3]	Completion Date
43.b	**Establish a systems leadership council that meets quarterly whose responsibilities include:** 1. Direct CQI activities statewide; 2. Develop an annual quality improvement plan; 3. Meet quarterly and maintain minutes; 4. Review facility audits, performance and outcome measure dashboard, adverse event reports, mortality reviews, and other audits and evaluations and recommend corrective actions to individual facilities based on review of these audits; 5. Be responsible for attending an annual facility CQI meeting (this should be after the annual audit report) to summarize CQI findings with the facility and discuss corrective actions and approve facility annual CQI plan; 6. Standardize data for CQI reporting that facilities use; **7.** Statewide CQI team will assign quality specialists to mentor facility CQI coordinators on corrective action assignments.	II.B.3, II.B.9, III.L.1, III.M.2, IV.A.2					May-23	100%	
44	**IDOC will modify its CQI policy to change the current facility CQI programs to be more in line with Consent Decree requirements.** 1. See Task 4 above with respect to CQI coordinators. 2. Each facility CQI program will develop an annual CQI plan which is based on corrective actions related to its annual audit findings and findings on mortality reviews, summary adverse event reports, its summary of performance and outcome measures, and additional tasks deemed appropriate by the system leadership council. The annual plan will be approved by the Agency Medical Director and the System Leadership council. 3. Each facility CQI coordinator will have Institute for Healthcare Improvement (IHI) and/or six sigma training in addition to training provided by SIU. 4. The Quality Management Program will assign a statewide quality specialist to work with the facility CQI coordinator, HCUA, facility Medical Director and Director of Nursing in implementing corrective actions in their annual plan and for mentoring on quality efforts in general. 5. IDOC will continue the practice of maintaining monthly CQI meeting minutes which will be assigned to the CQI coordinator and will be in a standardized format statewide.	II.B.3, II.B.9, III.L.1, IV.A.2			Agency Medical Director, Deputy Chiefs, SIU, OHS Quality Improvement Coordinator		Sept-23		
45	Develop position descriptions for audit team members.	II.B.9, III.L.1			SIU		Nov-21	100%	Jul-21
46	Post position descriptions for audit team members.	II.B.9, III.L.1			SIU		Aug-22	100%	Aug-21
47	Hire Audit Team Members.	II.B.9, II.B.2, II.B.3, III.A.2, IV.A.2, III.L.1			Agency Medical Director		Aug-22	100%	
48	Audit teams will train with the Monitor and consultants in auditing three to four facilities.	II.B.3., II.B.9			Monitor and consultants and audit team		Mar-24		
49	Revise CMS 104 job description for Agency Quality Improvement Coordinator. This is also addressed in Task 4.	III.L.1 II.B.2, II.B.3, III.A.2, IV.A.2			Agency Medical Director		Aug-22	100%	Apr-22

Task No.	Task	Consent Decree Item Number	Goal	Monitor(s) assigned by Dr. Raba	Responsible Party Assigned by Dr. Bowman	Start	Proposed End Date	Percent Complete[3]	Completion Date
50	**Train facility quality improvement coordinators.** A training procedure with training curriculum will be developed and implemented for QI coordinators and facility leadership. The initial focus of training will include initiating and implementing corrective actions based on deficiencies identified by the audit program. Later training features can include methodologies to identify and report process deficiencies. Other training can follow incrementally. See Task 44 item 3 above. Training on patient safety will initially focus on how to report and remediate adverse events. Training will focus initially on falls, medication errors, polypharmacy, etc. The procedure and curriculum will be developed by OHS/SIU using information from healthcare quality improvement entities, correctional health accreditation organizations, or academic centers.	II.B.3, III.L.1, IV.A.2			OHS Quality Control Coordinator, Deputy Chiefs, Agency Director of Nursing, SIU		Dec-23		
51	Initiate process improvement projects by focusing on key problems related to Consent Decree: medication administration, sick call, improving access to specialty care, improving chronic care delivery. Process analysts will systematically map all steps and procedures of specified processes; analyze input, process, and output using root cause analysis; determine the desired output; make the process more efficient, with fewer errors, and in line with the movement towards compliance with the Consent Decree.	III.A.10, III.F.1-2, II.B.2, II.B.3, IV.A.1, IV.A.2	To improve medication delivery, sick call, chronic care, and reception center intake programs.		Qualified process analyst		Jan-24		
51.a	Hire or contract for two process analysts to perform necessary process analysis as described below.	II.B.2, II.B.3, III.A.2, IV.A.2, III.L.1, III.M.2			Agency Medical Director, IDOC Human Resources or SIU		Oct-23		
51.b	Develop procedure for initiating a new process improvement analysis and effort when audits, mortality reviews, adverse event reporting, or performance and outcome data show a serious systemic problem that is a barrier to compliance with the Consent Decree or is a significant patient safety risk.	III.L.1			Agency Medical Director, Process Analysts		Nov-23		
51.c	Revise policy and procedure for completed process analysis when a revised process differs from existing policy.	II.B.8			Policy project manager, process analyst		At completion of process analysis		
51.d	When a process analysis is completed, the process analyst and Medical Coordinator determine any staffing, equipment, or space needs are required beyond existing capacity. Additional needs are forwarded to Agency Medical Director who will discuss with Executive Director and Budget Director.	II.B.2, II.B.3, IV.A.1, IV.A.2			Process Analyst, Medical Coordinator, Agency Medical Director, IDOC Executive Director and Budget Director		At completion of process analysis		
52	**The process for specialty care should include:** 1. Analysis of use of telemedicine and e-consult to improve access to specialists. 2. Analysis of whether additional equipment (telemedicine) or contracts (with university programs) might improve access to specialty care. 3. Analysis of primary care physicians referral patterns for specialty care and utilization of consultant services. 4. Analysis of receipt and timeliness of consultant reports, and whether facility providers take appropriate action, if necessary, on those reports. **5.** Analysis of scheduling and tracking of specialty care to ensure whether scheduling is timely.						Mar-24		

Task No.	Task	Consent Decree Item Number	Goal	Monitor(s) assigned by Dr. Raba	Responsible Party Assigned by Dr. Bowman	Start	Proposed End Date	Percent Complete[3]	Completion Date
53	**The process improvement for sick call will address:** 1. Timely monitoring of access and identification of barriers to access sick call. Establish standardized process to review and account for addressing access issues. 2. Identify inefficiencies in the sick call process and reassign work, revise procedures, or obtain staffing necessary for timely responses to sick call requests. 3. Define and establish the resources necessary to promptly achieve a face-to-face encounter with a registered nurse. 4. Identify the methods and practices needed to fully address patient requests including how to document the patient's presenting complaint in their own words, and those with multiple requests. 5. Revise the use of nursing protocols to include limitations on their use with patients who require close clinician monitoring, elimination of the protocol for Non-Specific Discomfort and design a process for the periodic review and revision of treatment protocols based upon CQI, performance and audit data. 6. Establish a methodology to train registered nurses in the use of treatment protocols and practice clinical judgment with supervision until initial competency is established and the methods to determine the continuing competency of nurses assigned to sick call. 7. Establishing tools to monitor performance and quality of sick call. 8. The results of the process improvement project will be revised policy and procedure for sick call, clear definitions of the staffing and resource requirements needed to conduct sick call, training and supervision of nurses to ensure appropriate clinical assessment and decision making using the nursing protocols, limiting the use of protocols in patient populations requiring monitoring by clinicians, and audit methods to monitor and account for compliance with the Consent Decree, procedures and protocol.	II B.1, II.B.6.f, III.A.10, III.F.2			Agency Medical Director, OHS Director of Nursing, Process Analysts		Mar-24		

Task No.	Task	Consent Decree Item Number	Goal	Monitor(s) assigned by Dr. Raba	Responsible Party Assigned by Dr. Bowman	Start	Proposed End Date	Percent Complete[3]	Completion Date
54	**This process improvement for chronic care should address:** 1. Ensuring that chronic problems are accurately entered into the medical record problem list by providers. 2. Developing of a chronic care roster to track persons with chronic illness. 3. Seeing patients for all of their chronic illnesses in a single clinic and addressing all chronic conditions at every clinic. 4. Ensuring that adequate history is taken, and analysis of why adequate histories are not currently obtained. 5. Ensuring that there is an assessment and therapeutic plan for each problem. 6. Clinic scheduling will be based on the patient's degree of control. 7. Ensuring appropriate and timely referral to specialists when management exceeds the experience or knowledge of the provider and that follow up appointments with specialists are scheduled. 8. That immunizations are routinely tracked updated with use of a reliable immunization tracking mechanism (e.g. I-CARE). 9. That a therapeutic dental plan is made at the conclusion of the intake dental examination. 10. That dental x-rays are digitalized and organized in a picture archiving and communication system (PACS). 11. That laboratory tests are documented as reviewed and are ordered when indicated by the patient's condition or as directed by Disease Management Guidelines. 12. Ensure that clinical care follows national standards. 13. Make access to UpToDate available in all clinic examination rooms. 14. Ensure ability of providers to evaluate medication compliance and current medications at chronic care visits. 15. Make chronic clinic documentation more efficient and supportive of preventive measures (vaccinations, cancer screening, etc.) with implementation of the EHR. 16. Intake assessment to conclude with an initial assessment and therapeutic plan for all chronic illnesses.	II.B.1, II.B.6.c			OHS Quality Control Coordinator , Agency Medical Coordinator, Agency Director of Nursing, Deputy Chiefs, Agency Medical Director, SIU, Process Analysts		Mar-24		
55	**The process improvement for medication management will address:** 1. The use of two-part patient identification with the medication administration record. 2. The use of a pharmacy generated label to be placed on the MAR after the script has been profiled by the pharmacist and elimination of hand written orders transcribed onto the MAR. 3. Documenting on the medication administration record at the time medication is administered. 4. Administration of medication directly from pharmacy-dispensed, patient-specific unit dose containers. 5. Development of workflows for medications which are issued to patients to self-administer (KOP) and those administered to patients by a nurse (DOT) to be finalized in standardized statewide policy and procedure. 6. Elimination of medication discontinuity that occurs as a result of the non-formulary request and prescription renewal processes. 7. Pharmacy initiated consultation with providers regarding polypharmacy and prescribing patterns. 8. Expanded use of pharmacists to work with providers in managing chronic conditions, as is done now in the HIV clinic medication.	II.A, II.B.1, II.B.6.c			SIU Director of Pharmacy Standards & Operations, Deputy Chiefs, Agency Director of Nursing, Process Analysts		Feb-24		

Task No.	Task	Consent Decree Item Number	Goal	Monitor(s) assigned by Dr. Raba	Responsible Party Assigned by Dr. Bowman	Start	Proposed End Date	Percent Complete[3]	Completion Date
56	**OHS will ensure all routine health maintenance/cancer screenings and adult immunizations as respectively recommended by USPSTF (A and B recommendations) and CDC are being offered to all at risk patients including:** 1. Train healthcare staff on new immunizations and cancer screening policies. 2. Develop or implement an interval immunization and cancer screening tracking solution until EHR implementation as described above in Task 28. 3. Develop mechanism to audit compliance with immunization and cancer screening policies. 4. Evaluate facilities to determine readiness (equipment, supplies, and staff) to complete cancer screenings. 5. OHS will identify the health care staff personnel responsible for screenings. 6. OHS will identify barriers to obtaining appointments for offsite screening. 7. OHS will establish a method of documenting screenings and immunizations in the medical Record. 8. OHS will direct all facilities to report routine health maintenance/cancer screenings and adult immunizations data to monthly facility QI meetings and system Quality Council meetings as detailed above in Tasks 27 and 27.	II.B.1, II.B.2, III.J.1			Agency Medical Director, IDOC Infectious Disease Coordinator, OHS DON	Nov 2022	Mar-24		
57	**Replace tuberculosis skin testing (TST) with Interferon-Gamma Release Assays (IGRA) blood testing.** 1. IDOC replaced tuberculosis skin testing with updated IGRA blood testing at R & C facilities as of October 2021. 2. Establish written guidance for initial and subsequent screening for tuberculosis infection including the frequency, methods, timeframes, responsible parties, and reporting. 3. Establish a plan and implement finalized program which replaces TST with IGRA screening for tuberculosis infection statewide. 4. Use reporting metrics to monitor progress with implementation and to evaluate the effectiveness of the tuberculosis screening program.	II.B.3, III.C.1 & 3, III.E.1			Agency Infectious Disease Coordinator, Agency Medical Director, Agency Medical Coordinator, , Infectious Disease Coordinator		Dec-23		
58	**Increase access to HCV treatment.**				Agency Medical Director, IDOC Infectious Disease Coordinator				
58.a	Revise the Hepatitis C treatment protocol following consultation with the Monitor and the UIC Hepatitis C Telemedicine Clinic.	II.B.6.f and g, III.L.2				Mar-21	Mar-22	100%	Mar-2022
58.b	Disseminate, educate, and implement the revised Hepatitis C Treatment guidelines at all IDOC facilities.	II.B.1, II.B.6.f and g				Jun-21	Aug-23 for all facilities and thereafter ongoing	100%	
58.c	Standardize Hepatitis C Clinic monthly facility reporting tables to include a. total HC patients, b. # pts on treatment, c. # pts refused tx, d. # awaiting tx, e.# ineligible for tx. and report HC clinic data to facilities' monthly QI meetings.	II.B.2				Nov-22	Aug-23	100%	
58.d	Review and tabulate on a quarterly basis the UIC HCV telehealth's spread sheet of IDOC HC patients started on treatment. Based on this data identify facilities that are not expeditiously referring active HC patients for treatment.	II.B.1, II.B.2, II.B.6.f and g				Jan-22	Sept-23 and Ongoing	50%	

Task No.	Task	Consent Decree Item Number	Goal	Monitor(s) assigned by Dr. Raba	Responsible Party Assigned by Dr. Bowman	Start	Proposed End Date	Percent Complete[3]	Completion Date
59	Increase access to HCV treatment for individuals with F0 and F1 fibrosis levels.	II.B.6.g			Agency Medical Director, IDOC Infectious Disease Coordinator	Jun-22	Aug-23 for all facilities thereafter ongoing	100%	
60	**Hire Environmental Services Coordinator responsible for ensuring the adequacy and functionality of clinical space and sanitation to deliver adequate health care and ensure patient safety.** These responsibilities also include establishing policies, practices, and procedures to identify inmate illness or injury potentially related to environmental factors. The Environmental Services Coordinator develops oversight and reporting systems to identify deficiencies in clinical space and equipment as well as environmental conditions that need correction at the facility as well as identification of systemic issues that are directed to the patient safety and quality improvement committees for review and action.	II.B.2, II.B.3, II.B.6.k, II.B.6.p, III.B.1-2, III.C.2, III.F.1, III.I.5, III.J.2-3, III.K.4-5, III.K.13			Agency Medical Director, IDOC Human Relations		Feb-24		
61	**Develop a standardized safety and sanitation policy detailing procedures for cleaning and sanitizing medical areas and identifying a responsible party at each facility.** The policy will also outline necessary training, supplies and equipment to be used. Policy details will address security issues such as lockdowns and safeguarding areas containing medical supplies. *See Task 40 for additional steps to be taken in developing and implementing the safety and sanitation policy.*	II.A, III.I.5, III.K.4			Environmental Services Coordinator, Infection Control Coordinator		Jun-24		
62	**Develop safety and sanitation inspection tool that surveys all clinical spaces, equipment, supplies, etc.** 1. Test safety and sanitation inspection tool with Monitors at multiple sites to ensure adequacy of the tool. 2. Establish the frequency and calendar for a facility safety and sanitation inspections of all clinical spaces, equipment supplies, etc. 3. Identify who is responsible for performing safety and sanitation inspections and train them to produce reliable results. 4. Audit the reliability of safety and sanitation inspections.	III.J.3.; III.K.13			Environmental Services Coordinator		Aug-24		
63	**Implement periodic safety and sanitation inspections, using the validated inspection tool, to evaluate the presence, condition, and functionality of clinical space and equipment with a standardized process for reporting results.** 1. Establish a method to prioritize the repair or replacement of identified deficiencies that prevent disease or injury. 2. Report the results of safety and sanitation inspections to the responsible party at the facility for corrective action and follow up. 3. Track the progress of corrective action to the OHS Audit Committee. 4. Analyze results of safety and sanitation inspections to identify systemic issues concerning patient safety or that impede the delivery of timely, adequate health care. Report these results to the SLC via the patient safety or audit functions with necessary further action identified.	II.B.6.k, II.B.6.p, III.B.1-2, III.C.2, III.F.1, III.I.5, III.J.2-3, III.K.4-5; III.K.13			Environmental Services Coordinator; appropriate facility staff		Nov-24		
	ANALYSIS OF AGED AND INFIRM								

Task No.	Task	Consent Decree Item Number	Goal	Monitor(s) assigned by Dr. Raba	Responsible Party Assigned by Dr. Bowman	Start	Proposed End Date	Percent Complete[3]	Completion Date
64	**Identify and hire a qualified consultant to survey the medical needs for aged/infirm/disabled persons incarcerated in the IDOC.** 1. Determine the data that is appropriate to describing the needs of this population. 2. Define scope of review to include: a. determining the population of persons with dementia, memory impairment, aged and in need of supportive housing, severe medical infirmities and disabilities requiring specialized medical housing; b. describing and quantifying existing services, clinical care, and housing for this population and its appropriateness; c. providing recommendations and options for adequately addressing needs of this population. April-23 3. 3. Determine parties responsible for participation in the project and set dates and expectations for work product. May-23	II.A, II.B.1-3	Establish needs of aged/infirm/disabled population to ensure that necessary access to services is available system wide		Agency Medical Director or Deputy.		Dec-23		
65	**Identify existing IDOC levels of care with corresponding housing and programming arrangements for the aged, infirm and disabled**. 1. This includes review of existing medical classification system for housing the aged/infirm/disabled. 2. Identify a range of aged/infirm/disabled populations by functional status within each living arrangement. For example, general population, protected housing, infirmary, etc. The type of facility (minimum, medium, and maximum security) is to be identified. 3. Describe existing practices to prepare for early parole release of the aged/infirm/disabled and any expansions of such under the Joe Coleman Medical Disability Act. 4. Identify community resources available to aged/infirm/disabled incarcerated population, identifying Medicaid available resources and nursing home options for care at the end-stage of life.				Aged/Infirm/Disabled Consultant with Regional Nurses, IDOC custody Deputy and selected Wardens	Oct-22	Mar-24		
66	Assess medical needs of aged and infirm. 1. Convene a focus group of aged/infirm/disabled persons to identify issues with housing and programming unique to this population and their need for care. 2. Determine process to survey aged/infirm/disabled persons. Interviews using telemedicine may be an option. This may require sample sized population depending on numbers. 3. Survey to include level of care needed, cognitive survey Montreal Cognitive Assessment (MOCA or other similar survey instrument), clinical risk assessment, intensity of nursing care needed, functional capacity, proximity of facility to specialty services, need for specialty services. 4. Consultation with a survey research group may be indicated. 5. Perform record reviews of people surveyed. This may be a sample population of persons in various categories of nursing need and functional status. Record review is to determine medical needs, number and types of medications, need for specialty care, accommodations provided or needed, and need for nursing care.				Aged/Infirm/Disabled Consultant		Jul-24		
67	Convene a focus group of facility staff to better understand medical needs for the aged and infirm.				Aged /Infirm/Disabled Consultant		Jul-24		
68	Review selection of aged/infirm/disabled deaths over past year in order to make recommendations for improved medical care.				Aged/Infirm/Disabled Consultant, SIU		Jun-23	100%	

Task No.	Task	Consent Decree Item Number	Goal	Monitor(s) assigned by Dr. Raba	Responsible Party Assigned by Dr. Bowman	Start	Proposed End Date	Percent Complete[3]	Completion Date
69	Based on surveys and data reviewed, complete a report of the aged/infirm/disabled population to describe in various functional status cohorts the medical beds or special housing arrangements available for this population *as well as the need* for these based upon length of sentence, medical risks and conditions, nursing needs, functional capacity and disabilities, and need for specialty care of each group. Patterns of civilian care are to be used as a template to describe levels of care for a similar but incarcerated population. These are routine medical care, home nurse visit care, adult day care, elderly housing without assistance, assisted living, nursing home, skilled nursing home, and hospice. Develop housing and programming options for each group.				Aged/Infirm/Disabled Consultant		Oct-24		
70	Provide recommendations to address deficiencies identified in the study that impact the health and physical safety of the aged/infirm/disabled to include options for addressing deficiencies in housing these populations and support for each level of care. 1. Develop recommendations for modifications to housing and classification system for aged/infirm/disabled population to ensure match of housing to functional need. These recommendations may include identification of new or renovated housing for this population. 2. Provide housing recommendations to the Physical Plant Consultant to incorporate into the evaluation of space. 3. Identify and develop additional resources to address needs for equipment, training, specialty consultation in the care of the aged/infirm/disabled, and at the end-of-life (i.e. geriatrics, guardianship, dementia, medication management, rehabilitation, and activities of daily living). 4. Work with Re-Entry Services and Parole Board to develop process to identify eligible persons and make requests for early medical release. 5. Identify, develop, and implement a plan or policy and standardized procedures to address each recommendation. 6. Develop interim processes for housing until capital improvements occur. 7. Engage CDB in steps necessary to obtain approval and funding for necessary modifications. (IDOC Capital Projects) Initiate Jan-24, Complete Dec-25				Aged/Infirm/Disabled Consultant, Deputy Chief OHS with custody Deputy, Physical Plant Consultant (Subtask 6), IDOC Capital Projects, SIU		Dec-25		

Task No.	Task	Consent Decree Item Number	Goal	Monitor(s) assigned by Dr. Raba	Responsible Party Assigned by Dr. Bowman	Start	Proposed End Date	Percent Complete[3]	Completion Date
71	**Set forth guidelines and benchmarks related to infirmary care.** Additional implementation tasks that improve access to quality of care provided in infirmaries include: 1. Assess utilization of infirmary beds to include reasons for non-medical admissions, the prevalence, and reasons for lengths of stay longer than 7 days, reasons for readmissions to the infirmary in less than 30 days. 2. Solicit from facility HCUAs and Medical Directors information and data on backlogs for infirmary care to include procedures that must be completed in-cell, use of alternative placements such as Specialized Housing Unit or Residential Treatment Unit admissions that are delayed due to lack of beds, prolonged hospitalizations due to lack of infirmary capacity. This information could be solicited using focus groups with a skilled facilitator. 3. Define the purpose of infirmary care and the scope of services to be provided in statewide policy based upon the data collected on utilization in 2 & 3. 4. Determine the number of beds needed to provide the defined scope of service. 5. Establish the staffing and other resources needed to operate each infirmary according to the scope of service, number, and type of infirmary beds. 6. Define the responsibilities of staff assigned to provide infirmary care, including correctional officers. 7. Provide staff education to increase capacity to manage emerging areas of concern (aging, dementia, mobility impairment etc.). 8. Develop programmatic methods to manage infirmary services to include: a. Daily huddle or rounds by physician and nurse. b. Utilization review and approval. c. Treatment plans. d. Case management. e. Programming. 9. Establish procedures for infirmary care. 10. Develop reporting requirements and establish tools to monitor performance.	II.B.6.k, II.B.6.p, III.I.1-4			Physical Plant Consultant, Deputy Chiefs, Agency Director of Nursing and Regional Nurses		Feb-24		
72	**Develop a standardized emergency response bag with a list of contents.** 1. Work with fiscal to procure emergency response bag and contents for each facility. 2. Develop policy that ensures each facility has identical contents in their emergency response bag. 3. Educate staff on new emergency response bag policy. 4. With the assistance of the Monitor and the audit team, develop a process to ensure emergency response bags contain appropriate items and are securely stored.	III.B.2	To ensure that appropriate emergency equipment is available.				May-24		
73	Defendants, Monitor, and plaintiffs will meet to settle the meaning of data and information requirements for IDOC reports as stipulated in item V.G and develop a more effective methodology for transfer of information.	V.G			Agency Medical Director, Deputy Chiefs		Jul-23		
74	Develop mechanism to track, by name, physicians who lack required training as specified in Consent Decree III.A.2.	III.A.3-6			Agency Medical Director, Deputy Chiefs		Ongoing		
75	IDOC to establish an account with National Practitioner Data Bank.	III.A.2			Agency Medical Director, Deputy Chiefs		Dec-23		

Task No.	Task	Consent Decree Item Number	Goal	Monitor(s) assigned by Dr. Raba	Responsible Party Assigned by Dr. Bowman	Start	Proposed End Date	Percent Complete[3]	Completion Date
76	**Develop a mechanism to remove unqualified physicians. Recommendations for removal will be based on the following:** 1. Utilize mortality reviews of care or other methodologies (Task 77 part 2) of IDOC to identify egregious clinical errors that either cause harm or are likely to result in harm to the patient and are inconsistent with adequate medical care. 2. Confer with the Monitor to discuss problematic physicians. 3. Meet at regular intervals to discuss monitoring that has occurred. 4. Remove or take corrective actions on problematic physicians.	III.A.3-6			Agency Medical Director, Deputy Chiefs		Sept-23	50%	
76.a	**Develop a mechanism to remove other health care staff.** Utilize mortality reviews of care or other methodologies of IDOC to identify egregious clinical errors that either cause harm or are likely to result in harm to the patient and are inconsistent with adequate medical care.	II.B.6.r					Sept-23		
77	**Develop plan for no less than annual review of the clinical services provided by both credentialed and non-credentialed existing physicians and dentists.** 1. The plan for physician review as codified in policy and/or standard operating procedure should include the elements of care that would be annually reviewed, the process for identification and referral of staff to peer review, the establishment of a fair process and the standards used to evaluate professional care and clinical decision making, the qualifications physicians individuals must have to perform peer review, as well as the documentation of the evaluation, assessment, deliberation and decisions made in the review process. 2. The elements of care reviewed should include clinical services provided in sick call, onsite urgent/emergent care, chronic care clinics, infirmary admissions and progress notes, discharge and transfer care, timely and appropriate referrals to specialty care, continuity of care after offsite emergent, hospitalization, and specialty consultation care, intake healthcare services at reception centers including intake health assessments, review of diagnostic tests, mortality and morbidity reviews, annual performance reviews, health care patient grievances, corrective action plans, peer reviews for cause, etc. 3. Review of the physicians should be performed by independent contracted or consulting physicians such as SIU physicians with training in similar fields as the physicians being reviewed (i.e. primary care, specialty physician, dentist, etc.).	II.B.2, II.B.3, II.B.6.m, n, q, and r, III.K.9			Agency Medical Director, Deputy Chiefs, Medical vendor, Dental Director, SIU consultants	Nov-2022	Dec-23		
78	**Develop peer review process for providers.** 1. Develop policy and forms outlining provider review process. The annual peer review forms may contain administrative and process elements but should primarily focus on aspects of clinical care. 2. Train independent contracted or consultant staff on provider peer review process.	II.B.2-3, III.B.q, III.K.9			Agency Medical Director, Deputy Chiefs, Dental Chief, Vendor		Dec-23		
79	OHS to review physician/dentist annual assessments, peer reviews, adverse events, corrective action plans, and other evaluations and make appropriate recommendations for performance improvement, corrective action, and even termination.	II.B.6.q			Agency Medical Director, Deputy Chiefs, Dental Chief, Vendor		Aug-23		

80	**Develop and implement an effective mortality review process that is evidenced by an implemented policy.** The policy will include the following Monitor's recommendations: 1. Provide all death records to the Monitor as they occur. 2. All deaths should include an autopsy. 3. Provide a tracking log of all deaths at least quarterly. This log should include name, IDOC #, date of death, age, date of incarceration, facility at time of death, category of death, cause of death, whether the death was expected or unexpected, whether an autopsy was done and the date of the autopsy. The log should also include whether a mortality review has been completed. 4. A mortality review should be performed for each death by an audit team to include a physician and a nurse. 5. The mortality review needs to include at a minimum: a. Date of review b. Patient name c. IDOC number d. Date of death e. Age and date of birth f. Facility at the time of death g. Place of death (e.g. hospital, infirmary, etc.) h. Category of death (natural, homicide, suicide, etc.) i. Expected or unexpected death j. Cause of death k. Mental health diagnoses l. Medical diagnoses m. IDOC problem list n. Medications at facility at the time of death o. Case summary that includes both nursing and physician input that includes a summary of the care of the patient for their illnesses and care related to the cause of death or care that needs to be highlighted to identify opportunities for improvement. p. Autopsy diagnosis q. List all deficiencies (opportunities for improvement) identified in the mortality review and recommendations for corrective action of these deficiencies. r. Identified opportunities for improvement need to be evaluated by the OHS quality committee. That committee needs to assign responsibility for corrective action either to the facility quality committee or to an OHS responsible party. The OHS quality committee should monitor progress on resolution of the corrective action until it is completed. The facility quality improvement meeting minutes need to document their progress in resolving corrective action. 6. The quality improvement discussion regarding mortality review should be educational with a goal towards improving care. 7. Line staff employees should have an opportunity to provide anonymous information regarding events surrounding a death with an aim toward improving patient safety. A process for this should be established. 8. The quality improvement coordinator and audit teams should conduct follow up with facility quality programs to monitor actions taken to improve care based on information learned from mortality review. 9. IDOC will develop a procedure for referral of a nurse or provider to their respective peer review entity when a mortality review identifies an egregious clinical act by a provider or nurse. This procedure will be written. The group of providers performing peer review for an alteration of privileges will be leadership physicians (Chief and Deputy Chiefs).	III.M2, III.L.1	To ensure that an adequate mortality review process is in place		OHS Quality Control Coordinator, Deputy Chiefs, Audit Team, SIU	Sep-21	Aug-23	90%	
80.a	**A morbidity and mortality committee will meet monthly to evaluate deaths reviews and other**	III.M2, III.L.1			Agency Medical Director, OHS		Aug-23		

Task No.	Task	Consent Decree Item Number	Goal	Monitor(s) assigned by Dr. Raba	Responsible Party Assigned by Dr. Bowman	Start	Proposed End Date	Percent Complete[3]	Completion Date
	sentinel events. Actions taken to complete this task will include: 1. The Agency Medical Director will chair this group and designate other senior OHS leadership; members (physician, nurse, mid-level provider) of the independent audit team who reviewed the facility; others designated as needed by the Agency Medical Director. 2. The deficiencies or opportunities for improvement identified by reviewers will be evaluated by the mortality review committee who will also review the completed death reviews and any available morality reviews of the Monitor. The Mortality Review Committee will assign corrective actions to the facility; if systemic risk is identified the Agency Medical Director will decide on a course of action and decide whether a process analysis is needed (this decision should be recorded in the minutes); unsafe patient safety risks that endanger patients are immediately remediated; and egregious care by a provider or nurse will be referred to the appropriate peer review entity. 3. Corrective actions are monitored through completion by the Quality Management Program. The policy on Quality Improvement will define how corrective actions are monitored.				Quality Control Coordinator, Deputy Chiefs, Audit Team, SIU				
81	Hire a Chief of Dental Health Services.				IDOC Human Resources, Agency Medical Director		Feb-21	100%	Feb-21
82	Review and identify any language in the vendor's dental policies that impose a potential barrier or a restriction to any aspect of dental care.	II.B.6.h				Sep-22	Sep-23		
83	**With input from Monitor develop set of comprehensive standardized dental policies and procedures.** 1. Provide the drafts of these and other dental policies to the Monitor for input.	II.B.2, II.B.8, III.K.5			Chief of Dentistry, Agency Medical Director, QI Coordinator, SIU	Jul-22	Dec-23		
84	**Ensure all facilities have lead radiation aprons with thyroid collars for patient protection during X-Rays.** 1. Procure sufficient leaded aprons with thyroid collars so that each dental suite has a dedicated thyroid collar that is stored in the dental area. See Task 85 Below.	III.K.13			Chief of Dentistry, Agency Medical Director, QI Coordinator, SIU	Sep-22	Jul-23	100%	
85	**Create a standardized list of all medical equipment required in each dental operatory in the IDOC and develop an instrument for annual dental survey of dental equipment at every clinic.** 1. Contract with a professional evaluator (e.g. Henry Schein) of dental suite equipment to create a standardized list of dental equipment required in all dental operatories in the IDOC. 2. Develop an instrument to perform an initial and thereafter annual survey of presence, functionality, and calibration status (if required) of dental equipment in every IDOC dental suite. A record or log of the dates and findings of annual dental equipment surveys are to be maintained. 3. Dental operatory equipment that is missing, broken, or defective must be replaced. Work orders or fiscal requests must be tracked and regularly reported to the facility QI meeting until repairs are completed or new equipment is installed. 4. Each dental unit needs to track the last servicing or calibration and keep a record or log of servicing and calibrations which generally should be done at least annually. 5. Each facility's documentation of servicing, calibration, needed repairs and replacements, and the turnaround time of work and purchase orders are reported annually to the system's Quality Council. The annual independent audit would determine whether this survey of dental equipment was done and whether appropriate action was taken.	III.K.13			Chief of Dentistry, Agency Medical Director, QI Coordinator, SIU, Chief Compliance Officer	Sep-22	Aug-23		

Task No.	Task	Consent Decree Item Number	Goal	Monitor(s) assigned by Dr. Raba	Responsible Party Assigned by Dr. Bowman	Start	Proposed End Date	Percent Complete[3]	Completion Date
86	**Develop with QI audit team audit questions necessary to demonstrate compliance with items III.K.1-13. Consider and determine who is to perform dental audits.** 1. Audits of the dental provisions in the Consent Decree should be done by independent auditors with backgrounds and training in dental care (i.e dentists and dental hygienists) and should include comprehensive dental treatment plans and comprehensive exam, x-rays, oral cancer screening, and appropriate charting.	II.B.9	To ensure standardized information is available to inmates regarding access to dental care.		Chief of Dentistry, Agency Medical Director, QI Coordinator, SIU	Mar-22	Nov-23		
87	**Review and revise orientation manual for individuals in custody on access to dental care** 1. The orientation manual should include information on the dental services provided in the IDOC, directions on how to submit requests for routine and urgent dental care including dental cleanings, education on dental hygiene and dental self-care.	III.K.2	To ensure adequate dental quality of care.		Chief of Dentistry, Agency Medical Director, QI Coordinator, SIU	Sep-22	Nov-23		
88	**Develop a standardized protocol for patient treatment at the reception center to ensure:** 1. Panorex x-rays will be performed on all new admissions to the IDOC. 2. Intake screening dental examinations at the reception centers shall include intra- and extra-oral tissue examination. 3. Chronic and acute illnesses and dental conditions are listed on a problem list. 4. Problem lists are completed by providers. 5. Medical and dental history and physical exams are completed. 6. Patients receive initial medical and dental treatment plans and timely referrals for evaluation and development of comprehensive medical and dental treatment plans based on acuity.	III.C.1-4, III.K.3			Chief of Dentistry, Agency Medical Director, QI Coordinator, SIU		Nov-23		
89	Ensure IDOC implements a dental annual review policy for all dentists.	II.B.2, II.B.3, II.B.6.r, V.G	To ensure dentists are practicing in a safe and medically appropriate manner.		Chief of Dentistry, Agency Medical Director and Vendor		Mar-21	100%	
90	**Develop a dental review instrument and methodology including who is to perform the dental peer review.** 1. Contract with independent consulting dentists to perform annual dentist reviews. See Task 77.	III.K.9	To ensure dentists are practicing in a safe and medically appropriate manner.		Chief of Dentistry, Agency Medical Director, Agency Medical Coordinator	2020	Nov-23		
91	**Develop annual performance reviews for dental assistants and dental hygienists.** 1. Develop a standardized performance review tool for IDOC and vendor/contracted dental assistants that evaluates competency of dental assistants in performing their duties including cleaning and sterilization of dental equipment and disinfection of dental operatory surfaces. 2. Develop a standardized performance review tool for IDOC and vendor/contracted dental hygienists that evaluates competency of dental hygienists in performing their duties but primarily focuses on the clinical services delivered by the dental hygienist. 3. Collaborate with SIU Clinical Quality Group in the development of the performance review tools for both dental assistants and dental hygienists. 4. Performance reviews should be shared with and signed by the dental assistants and dental hygienists, reviewed by the Chief of Dentistry, deficiencies addressed with training and/or corrective actions, and results reported annually to the IDOC Quality Council.	III.K.9	To ensure dentists are practicing in a safe and medically appropriate manner.		Chief of Dentistry, Agency Medical Director, Agency Medical Coordinator, SIU	Nov-22	Sep-23		

Task No.	Task	Consent Decree Item Number	Goal	Monitor(s) assigned by Dr. Raba	Responsible Party Assigned by Dr. Bowman	Start	Proposed End Date	Percent Complete[3]	Completion Date
92	**Develop annual and new hire orientation training for dental staff. Training to include:** 1. Dental records with comprehensive examinations, X Rays, and treatment plans. 2. Dental records with legible notation if EHR are not available. Notes should be standardized using an acceptable dental documentation format or template to include patient medical history and dental examination. (initial and updated). 3. Consent form for extractions (Current X-Ray taken prior to extraction must be present). Dental treatment remarks/complaint form. 4. Dental specialist referral form. Medical services request form. Dental laboratory form if necessary. 5. Patient education and oral hygiene completion form. 6. Dental Policies and Procedures. 7. Infection Control guidelines. 8. Identify who will provide the training and how the training will be done (in-person, zoom presentation, etc), and where the documentation of training will be maintained. 9. An annual report covering training of dental staff will be provided to the IDOC Quality Council.	II.B.3, II.B.2	To ensure properly trained dental staff.		Chief of Dentistry, Agency Medical Director, Agency Medical Coordinator, Agency QI Coordinator, SIU, Infectious Disease Coordinator		Jan-24		
93	See previous tasks on adverse event reporting, audits, quality improvement, and outcomes and performance. It is presumed that dental is to be included in all areas of quality improvement.				Agency Medical Director, Deputy Chiefs, Agency Medical Coordinator, Agency Director of Nursing, Agency QI Coordinator	Mar-22	Nov-23		
94	**Make changes in urgent/emergent services to include:** 1. Standardize policies and procedure for provision of urgent/emergent services to include expectations for training, demonstrated competency and clinical proficiency in determining the urgent or emergent nature of the response needed, and documentation thereof. 2. Train staff to provide urgent/emergent services consistent with policy and procedure, validate staff competency in urgent/emergent care initially and annually thereafter. Track and report training completion and competency evaluation through the quality improvement process. 3. Standardize the clinical and operational review of onsite emergency response episodes as evidenced in policy and procedure. 4. Define criteria for acceptable documentation received from offsite services, as well as documentation of effort to obtain such documentation. 5. Tracking of all onsite and offsite urgent/ emergent services in separate log books. 6. Develop workload metrics necessary to ensure that patients are seen and their plan of care reviewed within 48 hours of return from off-site emergency services.	II.B.6.b, III.G.1, III.G.2, III.G.3, III.G.4			Agency Medical Director or Deputy Chief of Health Services/Agency Director of Nursing/Agency Medical Coordinator, Agency Training Coordinator		Nov-23		
	PHYSICAL PLANT	II.B.2	To provide adequate dental and medical facilities to provide adequate medical and dental care to inmates in IDOC.						
95	A qualified consultant will be retained to survey all clinical spaces. A qualified (in health facility design and operation) consultant will be retained to evaluate structural space and equipment relative to a useful life determination.	II.B.2, II.B.3, III.B.1-2, III.K.13, IV.A.2			Capital Development Board Agency Medical Director	May-22	Dec-23		

Task No.	Task	Consent Decree Item Number	Goal	Monitor(s) assigned by Dr. Raba	Responsible Party Assigned by Dr. Bowman	Start	Proposed End Date	Percent Complete[3]	Completion Date
96	Develop structural space and fixed equipment requirements for ***all*** clinical activities necessary to provide adequate medical and dental care. Clinical spaces include all health care units, dental units, intake areas, clinical examination rooms, support spaces necessary to carry out medical functions, infirmaries or other specialized housing for those with severe disabilities, are severely infirm, or have dementia or memory issues and are unable to care for themselves for each major facility. Benchmark requirements consist of space and equipment typically available in a contemporary health program.	II.B.2, II.B.3, III.B.1-2, III.K.13., IV.A.2			Physical Plant Consultant in consultation with Agency Medical Director and designees, Consultant for survey of aged, infirm and disabled and Monitor	May-22	Oct-23		
97	**Using the requirements in Task #96 as a benchmark, develop useful life analysis of physical status of existing medical and dental space and other medical, dental, support and housing (infirmaries and other housing spaces for infirm, disabled, or persons with dementia (including dental and medical support space) and living space for persons who need medically supervised housing (aged, infirm, and disabled).** This analysis would include any physical space or structure that impairs the delivery of care, access to care, or the safety of staff and/or the incarcerated population. The consultant will use the staffing analysis, to estimate current and future needs of staff who may work for IDOC. Use the recommendations of the survey of the aged, infirm and disabled to estimate housing and other needs of this population, The analysis will result in a report with recommendations on how to establish adequate medical and dental clinical and support space as well as adequate specialized infirmary or medical housing for the aged, infirm and disabled who need to live in a medically monitored unit. The recommendation will provide an opinion regarding deficient space and whether to rehabilitate existing space or build new space to provide adequate facilities. The analysis and recommendations will be given by facility.	II.B.2, II.B.3, III.B.1-2, III.K.13, IV.A.2			Physical Plant Consultant	May-22	Jan-25		
97.a	Develop an analysis of all existing fixed and mobile medical and dental equipment typically necessary to equip facilities for the types of services provided at each facility. The analysis will describe whether necessary fixed and mobile equipment is currently available and functional. The meaning of functional will include a useful-life perspective. The analysis will result in a report with recommendations on how to remedy any deficiencies identified. Equipment beyond useful life will be identified in the report.	II.B.2, II.B.3, III.B.1-2, III.K.13, IV.A.2			Physical Plant Consultant		Jan-25		
98	Based on recommendations in the consultant's report, develop a plan to address physical plant and equipment deficiencies identified.	II.B.2, II.B.3, III.B.1-2, III.K.13, IV.A.2			CDB, Fiscal and OHS	Oct-23	Can only be accomplished once deficiencies have been outlined		
99	Work with appropriate State partners to implement recommendations for sufficient medical and dental space and equipment for current and future healthcare operations and care for all inmates in need of medical care or medical supervision.	II.B.2, II.B.3, III.B.1-2, III.K.13, IV.A.2			CDB	Jul-24	Will be established once scope of work is completed		
99.a	Develop a timeline for completion of any rehabilitation or construction.	II.B.2, II.B.3, III.B.1-2, III.K.13, IV.A.2			CDB		Will be established once scope of work is completed		