State of Ohio Chapter

ODRC Agency Professional Committee Meeting

August 26, 2020

Present for the Union:
Geoff Davies, Administrative Organizer
Robert Maurot, CPS, SCI
Jo Ward, MH RN, CRC
African Grant, CPS, TCI
Linda Wright, RN, AOCI
Monica Ford, CPS, LeCI
Ashley Osborne, RN, PCI
Sandy Gladding, BHP2, NERC
James Snowden, RN, GCI
Athena Diven, CPS, MCI (Executive Board Member)
Rachel Whitten, CPS, MaCI
Sherri Perry, RN, NERC
Ashley Orsbone, RN, PCI

Present for Management
Beth Hogon, Labor Chief
Don Overstreet, Bureau of Labor Relations
Jennifer Clayton, Dep. Director Holistic Services
Kevin Runyon, Medical Operations Director
Kelly Storm, Behavioral Health Director
Allison Vaughn, Labor Relations Administrator 1
Mike Davis,
Tracy Almanson-Murphy
Janet Crawford
Aaron Mohr
Shawn Carr
Lanaya McDonald
Roberta Banks
Timothy Buchanan
Emily Paine
Kevin Stockdale, Dep. Director/Chief Fiscal Officer

1. Working from home potential

With the limited supply of maximum PPE for members (N95s for those in quarantine unites for example) we request the State does everything possible to explore every option open to them to limit exposure to Covid for both the employees and the inmates. What study has been done for a working from home option for each classification within DRC? Even on a limited basis.

Case Managers more benefit from a flexible or alternative schedule rather than WFH. Contract allows to ask but it is often denied due to the Ohio Plan. What can be done to ensure that at all institutions case managers can have the flexibility to limit their exposure. If they're covering the core hours.
All those who can to work from home on a very limited basis, or flexible schedules. Where those who are not being allowed why can't they? An ODH review has shown no change or an improvement in productivity. The Governor has said that if you can work from home you should. Question is why is it not possible? For each area. What are the criteria for being able to WFH?

For example, Case Managers and MH below:

<u>Case managers</u>
Potential to work at home one or two days a week depending on the institution's security level, or to have more flexible or alternative schedules depending on the institutional need.

<u>Mental health</u>
Have different days of the week where there would be one person there to facilitate and set up the calls. Zoning the staff by the days. We're doing it now for treatment plans – we have a team in charge of housing unit, sets it up and do it on teams. We're teleworking from the office.
We would be able to do paperwork, case presentations, group prep. work, update logs, answer kites, complete evaluations (SSI), OH standards, contact other agencies PRN, set up MH referrals/appointments in the community for releases, secure housing for releases etc.
Even if we just limit one day of being exposed that can make a difference.

Discussion:
Overstreet: staff who provide direct care, not going to able to do that if not in the institution.
Buchannan (Unit Management): the incident commander, either local (Warden) or DRC Inc Com who would have the final say. I don't know that we would want to cut more out of the institutions than we already have. Also, alternative works schedule – cuts into staff availability.
Importance of case managers – face to face contact. Not best for institution. Reduced contact

Storm (Behavioral Health): I understand it, but importance to be in institution for population. Understand there is work they believe could be done at home. Continuing to strive for contacts, more important than ever that we're there as much as we can and as safe as we can. Do support alternative schedules, will work will all local mgrs. on it. For those identified – we document directly after, need to be there doing rounds, document straight after.

GCI Delegate: our Chief Med Officer does telemed visits within the institution. She's in an office with a screen. Why can't she do that from home? There are probably others in the same situation, not talking about RNs. But there's a good possibility that they're not working from home just because they don't want them to.

Union organizer: If we can show it would you look at it?

Storm: No.

NERC Delegate: When I'm at work in my office I'm not doing therapy for 40 hours. There is a lot I do. There is enough MH staff that they are available to meet the needs of the inmates, its doable. We go on vacations and things don't fall apart. Flu season is coming up.

Overstreet: of course, we'll consider it if you can show its doable. If you submit a proposal.
Storm: I would but again, with the impact BH has in the facilities. I'd consider e.g. 4x10s.
Hogon: We can't have a statewide criterion for when its considered. It needs to be dealt with at the local level, by the warden at each institution.
SCI Delegate: We did, and the warden said that Central Office said no.
Hogon: There is some oversight. If there's a good reason the warden should take it to Columbus. Disapproval reason can be shared.

Buchannan: We are still operating under Incident Command Structure. A lot of things have to happen. We're trying to start against spread. Opportunity was given to not do late nights. When we get to the new normal where do case manager fit in that? We're looking at partners going virtual, and where do case managers fit.

SCI Delegate: we're talking about alternative schedules. We can give them schedules, so they don't have to be here four or five days a week. We ask but they fight them tooth and nail. Same for pyschs.

Lebanon Delegate: We have gone to our warden, we have asked, but at Lebanon it was 4 tens or nothing. Something needs to be put out to them to say they do have the ability to adjust schedules.

CRC Delegate: At CRC they had the case mangers transitional work Schule with no problem, but after mgmt. shuffle that was taken away, same at Ross.

Overstreet: every warden takes these proposals seriously.

2. PPE use and supply

<u>Face Shields</u>
We request that face shields be provided for all those who want them (to worn with the mask). Any huge obstacle to this?

Response:
Runyon: Yes, we're looking at that, especially at outbreak institutions. Statewide. All staff, regardless of position. We're looking at feasibility, production. Where we have pushed them out though few have wanted them.

<u>N95 Masks for all</u>
We formally request that all staff be issued N95 masks for use when requested

<u>N95 cleaning at Battelle – poor return rates</u>
Union input: NERC, PCI, some aren't trusting the cleaning, they want a new mask every time. It's not labeled properly, who wore it they don't know who to return it back to. We don't trust how it's being cleaned and it's never been explained fully. It is not understood how they are cleaning them – individually or batch - some masks are returned without a bag, so nurses don't know who have handled it and prefer to throw it away and claim a new one. PCI – use a surgical rather than N95, you can visibly see the mask is soiled.

- AOCI – we're providing n95 to officers for non-medical. Are they handing them in for cleaning? Officers aren't writing the info on the inside, they're just asking for the mask each time
- Is there a requirement on the makeup? Is it sweat or is it makeup? How do they know?
- Are there instructions on the mask?
- Does the manufacturer support cleaning?

Discussion:
Runyon: We're just following CDC etc. There's a lot of things that wouldn't usually happen. We can look.
Roberta Banks: as far as I know yes for the N95 but for the KN95
Runyon: education piece on makeup – been a problem across the healthcare. Process to label – should be the nurse, there should be a posted sign on that. There needs to be a QA on that.

We can share the sterilization cleaning process info to staff so they can trust it. It's the accepted standard across the board. If there are problems understanding how it works it's our job to educate. Coming back soiled – we'd need report specifically.
Delegate: What kind of makeup is it? Certain types? Is it full face, lipstick etc.? Also non-medical staff are taking them also, they're not being taught on how to label and return etc.
Runyon: regardless of who gets it, they need the education process. We will work on that plan today.
NERC Delegate: here our staff concerned with the Battelle process. They're supposed to take it off, seal it in a bag, put in another bag and seal. When we get it back its not in a double bag or bag at all. How do we know that they follow their procedure?
Runyon: if you have them returned wrong whatever let us know so we can address. Also, there is the ability to store it in a paper bag. Preferably use the Battelle system. We're not happy wasting one mask.

CRC Delegate: What is the manufacturer recommendation on re-using and aren't we digging out of the shortage?
Runyon: No, still critical levels nationwide. We don't have the ability to get more. Once we're out of the shortage we'd love to go back. But the acceptable process of the Battelle is acceptable issued by FDA and CDC. That's what we're working under.
CRC Delegate: Can't we make them?
Runyon: To the specification needed for medical is more than we have the ability to do. It would cost more than any profit. We don't have the capability. We're making everything else.
We're at the mercy of the manufacture and then the state EOC who control the supply. We've requested more than a million masks and can't get them. I've sat through all those meetings, to try and get more. It's not our choice.

Kevin Stockdale, finance: we did look at that and nitrile mask. Main barriers are buying the machinery (which is not available) and second not enough medical grade fabric. Final is FDA not granted new manufacturers to make masks as certified. They don't want it to be the wild west.
Nitrile glove also same, lead time to make is 18 months. Also 3-4 million dollars.

Case managers denied N95 when doing temp checks but nurse required to when doing it

No when doing for non-positive inmates its procedural mask and goggles/shield. If the Nurse has one its because they were issued it that day, but generally no.

Nitrile Gloves
CRC, GCI, have received nitrile gloves marked "Not for Medical Use" we don't know what they're for and whether to use them.
Emily Payne (procurement): We're treating them as latex.
CRC Delegate: We are supposed to be using the nitrile mill because of the fentanyl.
Runyon: We use the nitrile because not sure when to use i.e. shakedowns. But in infirmary we have flexibility. We've been using nitrile because nitrile was more versatile, means you diont have to stop to think of which glove to use.
Delegate: Are these non-medical now replacing nitrile? So now have to make the decision on what to wear? And need education.
Runyon: Not sure, will have to come up with that plan. We have to look at how to best deploy those.
CRC Delegate: Nobody has told us anything has changed.
GCI Delegate: A real issue is we're being sent boxes of gloves in Chinese with a label that says not for medical use and no communication. What is the limitation to those gloves?

Payne: Nitrile gloves are going to hospitals because we're not considered first responders. The label was placed on them in customs based on nitrile number. We don't order, DAS sends them.
CRC Delegate: Doesn't make sense – latex gloves aren't marked 'not for medical use'. Why does the sticker say not for medical use?
Runyon: Let's get a better picture of what and where they are. We'll get something out as quickly as possible.

3. Transfers and Positives and Testing
Madison mass testing revealed 130+ cases. Asymptomatic previously. When will we accept it is everywhere and when will state be able to provide minimum provision of N95 to all employees? *Is there any discussion of mass testing again?*

No positive cases at NERC from 8+ weeks but getting transfers from ORW. Will there be moratorium on transfers from **red to modified** or less than red institutions? Despite whatever level an institution is at (most are currently still at a level Red....and NOT supposed to transfer inmates in or out), most are resuming full operations.

Discussion:
Runyon: Before they move internally, they need to be tested. If negative they can move. If positive they can't. If they refuse to test they're 21 days isolation on arrival.

NERC Delegate: when the inmates come in and they teste negative, who's to say the officers didn't infect them? They're not quarantined wherever they go.
Runyon: we can only screen so much, as we look at more testing we'll know.

GCI Delegate: I hear it but its not happening as advertised. We had a guy from CRC or FMC he had 3 positive tests and still came here. Told to let him go 14 days and not test him again.
KR: the first test positive is worthless. Its 10-14 days of symptoms. Testing only shows if he has virus dead or alive. This is strictly CDC recs.
GCI Delegate: Why transfer a test positive who's not through 10-14 days?
Runyon: that goes against our policy. We need that reported through incident report.

Runyon: movement is based on recommendation of tested and then moved. If some goes from one to another, they've tested negative or recovered. Any time we accept positive from a jail its coordinated with them

NERC Delegate: if test positive, isolated, no symptoms – we don't test again?
No, per CDC it's not worthwhile. If 10 days of asymptomatic the threat of passing the virus on.
After that 10 day point the ability to pass is diminished to pass. CDC.

AOCI Delegate: inmate in RTU, if inmate is on crisis they can be sent right away even if positive.
Runyon: Yes, but they should be in isolation once they arrive.
Storm: originally, we were transferring then testing, but now working with HCA to confirm symptoms prior to sending. If emergency move though we would notify receiving institution.

Delegate: 10 days after positive, does that apply to staff?
Runyon: That's HR, don't know their guidance. We have a written plan for that.

Janet Crawford, HR: yes, ten days, as long as not symptomatic for last 72 hours.

Mixing Transferred Inmates Within General Population
At CRC inmates who transfer in are mixing with other inmates in chow and rec. Same at AOCI according to news reports.

Runyon: everyone that comes in are put into a cohort that they don't go outside of. 14 day isolation for blue holds.
CRC Delegate: they go to chow hall from RTU unit, from D1, back and forth D1 and D3. The positive guy recently came from jail, positive in June. Refused test, and didn't get one here, declared on hunger strike. While there on hunger strike.

Runyon: Its controlled movement. If they know this a dorm that being exposed, if they move to the chow hall, they're supposed to be cohorts and clean chow hall in between. Its controlled movement within their cohort.
CRC Delegate: If the dorm leaves and go to chow from a unit with a positive, how is that separate?
Runyon: They shouldn't be mixing cohorts.
CRC Delegate: So, they go to chow together, they're mixing with staff and inmates they're at chow.
Runyon: We're not moving symptomatic inmates. Its controlled movement within the cohorts. We can't lock them all in the cell.
CRC Delegate: thanks for the honest answer finally.
Runyon: I'll always give honest answers.

204s and Communication to members
Why aren't 204s going to members direct, or to delegates also? Can't LRO forward them?
Locally: the expectation is yes, but keep in mind 204s aren't something you want to be pushing around. They're not for wide distribution. But the operational changes from the should be put out by management – duties, function, operational, that should be communicated in writing to the employees.

4. ORW - OB nurse position

When the OB transferred from FMC to ORW. ORW has OB clinic on Tuesdays, FMC had a designated nurse to do OB job. Why wasn't the Nurse position transferred and what is criteria needed to provide it?
Kevin – there wasn't one that I know of. When we did the move we deemed didn't need an additional potion There might have been an person who worked with the OB folks as an duty assignment.
We did do an assessment to see the need and there wasn't at that time.
I was at ORW Friday looking at staffing. We're adding 4 medical assistants to help. But no, the staffing. Medical assistants not in OB but in other areas like assessments, anywhere they can be plugged to relieve. They are contract employees.

5. CRC MH Recruitment and Retention – status request

Storm: We are meeting with R&R committee tomorrow, 8/26, also for Marion medical. Results directly after.

6. Diversity Competency training – not discussed

7. Covid leave

At our last APC we requested to know if Covid leave would be extended. Management response was "If any extension or new tranche it would be after that point [Dec 31st]." Requesting update.

How will this work when we have the usual seasonal sicknesses? Sinus, flu etc. general sickness spread by your school-aged children. If we have that we stay home and tested and cleared by doctor. Any little regular thing that wouldn't have previously will keep you home. If members have to use their own leave its then an incentive to not screen properly/accurately and come in because they know it's not serious.

Banks (HR): right now, we do give the 40 hours Covid leave. We will consider an additional 40 hours on a case by case if someone is hospitalized.
Delegate: If we tested and are off but cleared and cleared and it happens again?
Banks: No.
GCI Delegate: Contact tracing. If I have to use Covid leave for testing and I'm fine. I come back week later it happens again. Where is line on the obligation to use my time being drawn?
Overstreet: It's a fair point, we haven't had to deal with it too often. There is a consideration of a review of Covid leave.
SCI Delegate: if you're wearing your mask etc. then they're not putting you off. If you're doing everything correctly.
Runyon: Right, we've had to put them off if they've not kept mask on and close proximity for 10-15 minute. Protect your leave by protecting yourself.

8. Any other items
CRC Delegate: CRC MH staffing is still low; the agency nurses though are relieving the pressure. So, thank you.

Agreement to coordinate dates for next meeting in October.

PCI Delegate after the meeting indicated their microphone did not work and submitted a question by email. It has been forwarded to Hogon, Overstreet and Runyon for a response:

"Our infirmary went from 18 available beds to 26+ available beds in the infirmary during COVID. Occasionally that would be 26+ patients to 1 RN. At one point we did have agency working here to assist us with the staffing shortage and the increased workload. However, most of the agency nurses are gone and we are back down to 1 RN in the infirmary. Sometimes the infirmary can be very overwhelming and unsafe for the workload to be on 1 nurse. It is not good nursing practice for 1 RN to be responsible for up to 26 patients, even 18 patients is extremely difficult. The infirmary RN passes medications, does all patient care, IV's, infirmary shift assessments, safety checks and quarantine assessments on all patients, also while working with an ALP and taking any orders from the ALP such as medication changes, admissions and discharges.

Also even though we are in the "RED" at PCI and it is a modified "RED", why are we no longer getting assistance from agency nurses? It is no known secret that PCI has had its issues with staffing shortages, especially medical before COVID and now even more so because some staff members have left or agency members have left."