SEIU District 1199 WV/KY/OH
Department of Correction and Rehabilitation

Agency Professional Committee Meeting
February 15, 2022

Co-Chairs:
Geoff H. Davies, Coordinator, SEIU District 1199
Don Overstreet, DRC, Bureau of Labor Relations

For the Union:
Sandra Gladding, Executive Board (PA2, NERC)
James Snowden, Executive Board Member (Nurse 1, GCI)
Athena Diven, Executive Board Member (CPS, MCI)
Rob Mauro, Delegate (CPS, SCI)
Shelby Bowers, Delegate, (CPS, CCI)
Trudy Holsinger, Delegate, (CPS, ManCI)
Shelly Portis, Delegate, (Psychiatric/DD Nurse, DCI)
Libby Hoyda, Delegate (Psychiatric/DD Nurse, NERC)
Mish Pachtler, Delegate (Psychiatric/DD Nurse, GCI)
Craig Wachauf, Delegate, (CPS, MACI)
Linda Wright, Delegate (Nurse 1, AOCI)
African Grant, Delegate (CPS, TCI)

For DRC:
Beth Hogon, Labor Chief
Jennifer Clayton, Dep. Director Holistic Services
Kevin Runyon, Medical Operations Director
Kelly Storm, Behavioral Health Director
Lynna McDonald UMC OSC
Arron Moore Unit Management North Region Administrator
Roberta Banks, Chief Bureau Personnel
Timothy Buchannan, Internal Reentry Something
Shawn Carr, Quality Ops Director
Norm Evans, LRO, WCI

Housekeeping

1. **Previous meeting Minutes**
   Mgt: if those are yours then okay. We don't have a process to agreeing.

Old Business

1. **MH to medical:**

Update from December 2020 APC that management was going to instruct and ensure proper orientation and a checklist for any MH working in medical.

Can we get agreement:

If being pulled/mandated then:

1. It's a last resort – there's no-one left to mandate, per contract
2. Offer the orientation and training, up to nurse to do it, but must meet a minimum standard – per policy
3. Specific prioritized duties
4. Timeframes – when should it be offered?
    - when known ASAP, to follow up

- Define irregular hybrid schedule.
    Mgt. Variable as needed.

Mgt: We have people at OSC looking at that. How much needed specific to that nurse. What nurse would be necessary. Feasibility. It not a forty hour block of instructing though, nor bare minimum. We'd like some recommendations.
Union: Respectfully that is your job. Also, we want a minimum.
Management: We don't want them alone with nothing. We do want to do the right thing. Its on the list for a strategy meeting next week, it'll be on there and assign in the meantime with Sean Carr education team.
Union: Until you come up with something formal we will advise our members that if ask for training and orientation from supervisors and it will be provided during down times and coordinating at the institution. If you have staff uncomfortable then they need to approach their manager to coordinate something now. That manager will then coordinate that.

Update: A grievance has since been filed by a Mental Health Nurse on this issue and also challenging the right of management to be able to pull at all. Updates to come.

2. Recruitment and Retention Supplement

A. December 2021 AP Jennifer Clayton JC: "there's a pending review and it goes to the director who we meet with this week. Some request and also general concerns on staffing"

B. OSP Social Worker R&R – update following g December APC
AV: we don't have this info, its Jenny and Kelly. Except for what Kevin has said that's no-one left.
DO: a lot will be addressed with the director coming up.

Union' main question is: does DRC care about retention, if not why? Reason for the question is that many institutions classification got the R&R but there are others who have been running short and doing more work because of it for years who got nothing.

Management: its both R&R. if its not 50% or not for a month it wouldn't be considered. We're not having issues recruiting or recruiting. Its rate not positions over time. It could be ten vacancies at any one time but if not vacant over a period of time its not considered.

Union: So what level then is fine? We have members who are consistently always doing more work for a positions or various positions open at any one time. So what is the level that's acceptable?

MH Delegate at DCI: why was ours denied? We have several entities we can go to, but we are short in one way or another and have been short for up to seven years. We asked for retention because our duties have triple and we've had only two nurses for five years. Our caseload has always been high.

Management: we review the sustained vacancy rates and the missions and those were applied systematically. We applied to MH and medical to prevent people moving and shorting where they were. So we have it to MH at some places to support overall nursing. At DCI we gave to BHP and SW2 for recruitment. Doesn't mean all classifications. The purpose for denying is because you are staffed with nursing for quire some time. We're working to get the rest filled which would balance out the extra work that MHN are doing from others.

3. Nursing Reductions – update from December 2021 APC

December 2021 APC Union, Union requested all current positions by institution filled and unfilled *and where reduced and why*. Requested management revisit the formula: if the population is down but OT and mandation is still high are we using the right formula or factors to determine how many nurses we need?

Mgt Kevin Runyon*: we'll look at those numbers and get back with you.*
BH: can we get the TOs from different points in time. Within a week.

Mgt KR: if we're going to reinstate we would look at encounters, caseloads, number of inmates etc. As they increase we would look. Now how do we do the scheduling where there a education.
Or we'd given facilities help because of something which then changed.
Union: If we are being mandated there should not be a reduction at all.
Mgt KR: We d o a review yearly obligated to do it. November traditionally but we do it continually
Lisa Ragland: review with changes to covid and everything, are you including transfers from one to another institution? And increasing positions there?
Mgt KR: yeah, it's not permanent. Some of those mass movements were related to denaturing some units because frozen quarantines etc. but yes we do look at that.
Union LR: so, we get dinged in audits for services not performed from prior institution
Mgt KR: when we look at the audit the person who's going to bust your chops is me. We can justify it based on whatever. And I can explain to ACA folks, and Jane and Annette and Sue. We look at that

Union: Are you being mandated because of vacancies or call offs? If position isn't filled. Have those mandation gone down then?
KR: I can't say, its covid and absences.
JS: we should get to overstaffed. If we could have filled that position when she went out, we could have more, if then not needed move the position.
Union: the position you took from us was our relief so now we're at minimum. Any time we have an absence we're in the red.
KR: I'll pull those numbers. I'll look at some of the operational stuff too.

Union: We feel the goal is just to incrementally reduce the number of nurses to create a new normal. Give us guarantees that it's not your goal.
Union RM: have we filled interim to then hire?
Mgt: No, contract. We can hire them to permanent positions. And we do hire them.

4. OSP MH Staffing Update

Kelly Storm, Dec 2021: *Maria King, regional admin, and Chris MHA there have put together a staffing proposal in reviewing. We me with OSP and Trumbull about the split position there. One of my plans is to go there and see how to increase access. What hinders the team is not just staffing but also access points and sharing space with other disciplines. Have met with warden for modification and plan to go back Q1 of 2022. Evaluating resources for PCNs*

Mgt KS: I did get there and did a through walkaround. Also asked MHA to pick up some clinical works. He's supposed to submit a plan on how he can do that. But honestly to me it was the environmental barriers that would allow increased access. Also competing for space because only so much room.
Union GD: you mean how long it takes to do anything because of security.
Mgt KS: What are the next steps: changed days for the split positions.
More next steps: I want MH to put the plan to pick up clinical, walk through with someone from construction to increase access, and then continuing to monito caseload numbers. Staffing is fine now but there is a process for looking at acuity and the service needs.

Union: Increased staffing for OSP MH. If not, then:

a. Why do they think its fine right now?
b. What is the threshold for not fine?

5. Thorough review of redundant processes – update

Mgt: Yes, that will be in the strategic review next week. Also ask again from your staff.

6. Case Managers Plan - update Our Plan

Mgt: Met with ORAS. Last meeting is February 22. There is a committee meeting with 1199 members on it. We'll take those members views and incorporate them.
1199 committee involved: African Grant, Michelle Curry will send to you.
No change in Unit schedule. Key things, nope.
Mauro: other from our members is there any talk?
Mgt: Until we present the plan I'd rather not comment.

<u>New Business</u>

1. **Increase in wages as an attempt for retention**
   What has to happen and what is DRC role in this

Mgt: Process in contract for PDQ. General wage increases and competitiveness is pure OCB, we have Outside of bargaining I'm not aware of any position increasing without OCB. OCB can tell you about process.

2. **Receiving R&R at institutions with R&R when picking up**,
   e.g. at MH picking up at Madison RTU Madison

Management: the R&R is for them at that facility. They don't carry it anywhere else either.
Union: Why not carrying?
Management: it's for them at their institution.
GD: Right that's the 'how', but not the reason 'why'
Management: Not sure what else to tell you
Union: sounds like it's because it is what it is

3. New use of force continuum - Members have been told a new one is being formulated?

a. It was emailed to staff and posted for review on January 25th. Draft policy. People asked to comment. It ended February 8th. It's being reviewed. New policy not yet posted.

4. Mental Health

A. We request information or an audit to compare caseloads now to five years ago
B. Doing HIT work – institutions without HIT at all

Union: *It's the tasks – how often we have to see them, what kind of documentation. Before you could do it all in one session, now its three separate sessions with 3 separate notes. Exponential increases. I'm doing more for each. We need more time and to do this smarter rather than seeing multiple times with multiples amounts of work.* B - HIT – where are they needed? Why don't we have them. See above. Why don't we have secretaries.

Management response: Our caseload across DRC is around 9500-10200, it's been consistent, even though total inmates are falling and. The inmates have gone down but its now mentally ill. Its stable, but the acuity is going up. Our population is putting a lot of burden on a lot of areas.

Union: when you have someone relatively stable you have to meet separately for treatment, for MHL, separately for counselling, etc. I could two things in one meeting that I can't do now.

Management: may be misreading the policy, we allow it in one contact. You can count it treatment and MHL contact as one, but we can't have someone seen only once it goes against standards in the community but there is potential to consolidate what you're doing.

Contact with individuals – our acuity is increasing. We're running 16 deep on residential care units. We are looking at it but we need to safeguard our sicker population. We will continue to see that. If people have idea, we're open to them

Union: Has the general increase in needs and acuity led to any discussion on increasing staffing?
Mgt: If we would add beds or change a mission/increase, then yes would look at staffing picture. We have residential and group home and dementia beds at AOCI. If I was going to expand that or look at another program in an institution, then would increase staffing levels. We do annual staffing review too.
GD: so a specific change needs to happen for staffing, also an annual review. When was last review? When is the next?
Management: We've done it in August traditionally. But we do it continually

Management response on HITs

We have had vacancies for quite some time. We've just had DAS agree with Ingenesis to evaluate our rates because underpaying. We have meeting tomorrow about those rates. Hopefully be more competitive. Where they are short, I've authorized OT. Also offered to unit secretaries to cover. Medical has allowed using medical HITs and OT for them.
Union: we had done an internship program? Also, any opportunity for a preceptor program to look for new people. Yes, there is a paid internship opportunity, and other programs so yes we do. If you're interested in being placed with one let? Define irregular hybrid schedule.
Mgt. Variable as needed.
Preceptors? we are definitely looking at that.

C. Not given time to do eLearning or training/CEU to do from home or work

BH: it is something we did in the past. Are we still allowing? Yes. Certain classifications we will confirm and send to you.

5. Vacation planning – see MOU from 2019 on simultaneous requests

Need consistent practice across all institutions, update
Union will send the MOU from 2019 to DRC for review and if still agreement.

6. RNs being mandated for LPNs

- We're mandated all over for LPNs, it is creating problems for us. What are you doing about it?
- Why aren't all LPNs working weekends? Mandate them from the shift, not us.

Our ask: We've been told by management that you cannot mandate an LPN except to an abutting shift. RNs are getting mandated to LPN positions when there aren't any or even when there are. Why are we mandated or pre-mandated but they are not? We want consistency when and how an RN is mandated in place of an LPN. If it should be LPNs make it LPNs, not an RN. We have enough to do.

Management response: There is language in the OCSEA policy about *correction officers* only being mandated to abutting shift. Does not apply to LPNs. We do not have any language on that.

Mgt KR: when we first had LPNs they weren't supposed to put on weekends. Over time there has been loss of focus on that and we've moved LPNs on weekends to give better weekends for RNs which has meant now there's no relief for LPNs. So, we either mandate RNs or we shift them back to the week. We're reviewing that right now. There are only so many LPNs. We do not have the ability to relieve them. They're then to lighten the load during the busy times.
Union: So then why are LPNs not mandated in the same way RNs are all over the place? The burden is being put on RNs.
Mgt: If you don't have enough LPNs you're going to have to hold over. What are your options if you don't have an LPN coming in so you'll mandate RNs. So, you'll have weekends where there are no RNs. We have more RNs, less LPNs. They were there to lessen the burden in the week.
Union: we have LPNs on the weekend but, when we get mandated for LPN spot we get pre mandated for it. When they take off and there's no one to work why is it RNs pre-mandated then? LPN have a mandation roster, they should get pre mandated just like we do.
Snowden: my AHCHA says Kevin said we can't pre mandate LPNs per Kevin Runyon. So, can you?
Management: I'm getting different stuff. Let us circle the wagons and get you a straight answer.

Update: in a separate meeting it was confirmed that there is no language that prevents LPNs being mandated. There is language in the OCSEA contract that restricts mandating COs to the abutting shift, but nothing about LPNs.

Next Meeting:
Second Tuesday every other month: April 12, June 14 for next two months