State of Ohio Chapter

ODRC Agency Professional Committee Meeting

Monday, May 20, 2020

SEIU 1199
Geoff Davies, Administrative Organizer, 1199
African Grant, CPS, Trumbull Correctional Institution
Sandra Gladding, Psychology Assistant 2, Northeastern Reintegration Center
Rachel Whitten, CPC, Madison Correctional Institution
Matthew McLeary, RN, Mansfield Correctional Institution
Linda Wright, RN, Allen Oakwood Correctional Institution
Robert Mauro, CPS, Southeastern Correctional Institution
Jo Ward, MH RN, Correctional Reception Center

ODRC
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

Summary

Union question and comments in **bold**
State responses and comments in regular

Jennifer Clayton gives an overview on testing quarantine and isolation

Looking at the agenda items you've submitted I want to address overall the testing quarantine and isolation and PPE that we are going by.

Testing plan has evolved. Lit and science is evolving. Based on Lessons learned through mass testing: it's not a concise positive and negative result. There are positives, positive recovered, Negative, and negative negatives. We've had to implement nontraditional housing to establish cohorts. MCI and PCI still spread even with cohorting. No pinpoint of why, even with Social distancing (SD) and PPE and preventative measures. Chief medical teams across the state were included to help guide with DRC crisis.

When we did the shuffling, the virus seemed to spread. We applied all the principles, but we saw massive positives.

We did daily calls with gov and chief med officer of DRC and OSU, Chief Med off of Medicaid, some with Dr Acton, and Dr Hurst of ODH. Any time we do anything we vet the plan through all these. Our PPE grids were developed and vetted through ODH.

Return to work guidance also comes from ODH. We are looking to the experts.
There are not adequate supplies of PPE state or national. State though has funneled it. Whole state operating under critical shortage guidelines. We get a steady supply, but there's anecdotally where it's not applied properly.

OSU etc. only using N95 for aerosolized. ICU with have N95, but everyone else has a punch card to get a weekly surgical mask. We have more than that of course. They have N95 available for aerosolized. Science is tied to spread by droplet transmission. Its not airborne most of the time, when its airborne is when its aerosolized or is actively symptomatic. Not necessarily airborne only or only those who are actively symptomatic. When PCI was actively heightened, they were encouraged to use N95. Unless all inmates are symptomatic and we are following all of the 204, everyone should be donning a surgical mask. I.e. When seeing inmates, consider moving from a small area to a space where you can create social distance. Make sure all wearing masks. Staff and inmates.

Move aerosolized, coughing etc. into isolation unit, where N95 are worn.

(Testing)- In the dorm environment. Example maybe 3 test positive, The goal is to start tracing contacts. But by the time the threat is identified, the tracing identifies that the three testing positive have come inContact with likely the entire dorm as people are constantly up moving around (bathroom, dayroom, showers, laundry normal everyday activities of daily living). Contact tracing indicates there are likely more positive that will appear as a result of inadvertent spreading. If we remove actively sick inmates, they should be donning an N95 and PPE. Now clinical testing has been vetted and we are testing intake, release and random internal testing. Some are being tested twice purposefully and accidently. We've ran antibody testing also. Some have antibodies. Some don't. Reliability of antibody testing is spotty. We are working with OSU for testing, however we will be trying to get to LabCorp in the future. Due to the number of tests we've completed already, essentially, we are borderline mass testing. We are still placing people in quarantine and working institutions. We are not quite doing large scale testing as most institutions don't have the same vulnerabilities as PCI, FMC, and MCI.

<u>POSITIVE INMATE IN UNITS, AND PPE FOR STAFF</u>

CDC guidelines from April 15 say and recent warden update at Lorain says *it is presumed that there are other positive asymptomatic cases in other housing units.* Kelly Storm, DRC behavioral health director has said that you are treating all inmates as if they were positive for Covid 19. We know that the virus can spread asymptomatically. So, knowing this, why is the state not taking more precautions with staff? If we think everyone has it then shouldn't everyone have an N95 etc.? How far is PPE availability driving the strategy?
If we used it ideally, we would not be able to sustain supply. It's all controlled through the state EOC. They've done a great job. I've asked myself many times what if I just used it and asked for more. If we all did that we would run out of PPE. We can't make N95s. We're in this for the long haul. We have to

sustain for months maybe years. If one institution uses PPE as they wanted, then you would want the same at your facility. So, we have to stick to wants been vetted by the experts. If we exceed the [PPE] grids we'll struggle.

Does each institution have enough to provide all staff dealing with Covid suspected or positive inmates?
We are able to support the PPE for the grids. They're the same as OSU and Nursing homes.

The PPE grid states that suspected or confirmed inmates in isolation staff get full PPE inc N95. What is the difference in the units? Why not treated the same?
Because they're not aerosolizing. They're asymptomatic. The closeness and contact in terms of what is recommended. Now perfect world yes, we would have full PPE with N95 but the reality is it's not necessary if they're asymptomatic and you're not within six feet.

How are we guaranteeing that those inmates are not within six feet – when they're on rec, etc.
If they're symptomatic then N95. If not symptomatic and interacting them they wear a face mask, as well as the staff. We can sustain that. It's not a hope – it's the science. Now if they're coughing, they need mask and you need N95.

Will the inmates in the units only be symptomatic?
Yes, no symptomatic inmates in the units. We have surveillance.

Tamra Hairston, FMC – How many contacts with symptomatic did you have at PCI (to Kevin Runyon)
I was actively engaging with inmates in Frazier unit and each housing unit on the compound. Directing inmates to wear masks, answering questions and as a red badge you know…, people are going to stop you and ask questions. I did my best to answer what I could and understand the situation there. So I was in contact with multiple inmates on a regular basis, with and without Covid.

<u>TESTING</u>

Will staff know who is positive and who is not?
Yes, staff can know who's positive. Covid is public health reportable. But it's not going to be you'll know specifically who, just in general.

Why is DRC not mass testing inmates? Isn't it important to know who is positive and who isn't? Or is that not important?
We have to assume positive. If we tested everyone today, it's just a snapshot in time. We go to symptomatic vs asymptomatic. There's nothing to treat. So, we're cohorting. At Marion and PCI we did over a thousand bed moves and it didn't work. We're now trying to slow spread, give six feet. Mass testing didn't solve our problem, we didn't have success from that.
Testing plan, quarantine and isolation. In institutions with dorms – Belmont, or any others – you get a guy who tests positive in a dorm. Maybe three. Dr Eddy and his team are looking at their movements. By the time we've done that the spread is the whole dorm. Then you hear that they're leaving them in there. But contact tracing tells you. We could mov them around like at Marion or we could take out the actively symptomatic and put them in the infirmary and then separate that dorm. If not symptomatic then surgical mask them and you.

Sometimes problem also is symptomatic people don't always report or we don't dive deep enough into them.
Plan now – Dr Eddy has discretion. Testing intake, release, and internally. We are doing some antibody testing but its not reliable.
Appointments also. Then putting them into quarantine – finding space is a problem for that. There is not a lack of testing, it's just we're not mass testing.

So, you're freezing people in place and pulling out the symptomatic. I get you can only work with the tools you've got with the availability of PPE. So, if we're pulling out symptomatic when they turn that way, what is the estimate of infection and positive as a result? What's the best/worst case scenario?
We're learning as we go. Pulling the data in as we can. We have modelers looking at how you place people and looking at the rates. Problem is we were one for the first system in the country to have this problem. Other systems are learning from us. They're going through the same things. Texas is doing the same thing we are now.

At FMC OSU stopped giving results for the staff testing.
Kevin – Shouldn't be the case I'll find out about that.

Listening to director this week, last week and before it seems we're doing what is convenient not the best. We follow CDC or then we say we'll follow OSU. We'll do what's convenient not what's best.
I'd disagree with that. We're measuring everything. How things fit into an operational factor. If it was just pure infection control, we'd do a lot different. E.g. we'd have ten feet. With TB we pluck them out, test everyone around them and then test again. We don't have that with this.
I've seen 10 feet recommendation, not six. Six is convenient.
Operationally we are looking at how this affects all aspects of safety and security. But we are taking into account of what we can do based on ODH and the Governors teams to do the best practice. It's not about convenience. We are trying to do what's right. There is no perfect science at this time. Especially now that the state is opened up and we have to be putting ourselves in the best positions to avoid issues

Symptoms. CRC has been screening for symptoms, but only the basic three, temp, cough, contact. But there's such a wide range, how do we know when they're positive or say they're not lying?
Education. Institution has to do their best, so they know its for the good of everybody.
Right but when we got HIV hit there were several layers of protection. First was abstinent. Then latex. It feels like we're being given the lam version because we don't have the N95s. Hopefully what we've got is good enough to protect them. We don't know enough about this disease to know just procedural mask or cloth mask is enough protection.
Right, and N95 availability.

What's being done at Belmont? Approach.
First 3 at Belmont. We cohorted and stopped all movement for the dorms. And pulled out the inmates who were symptomatic. No more mass movements. Contact tracing happened. reduced bed moves. And implemented isolation. We are cohorting. We took lessons learned from PCI, FMC and MCI to do our best there at BeCI.
We've been doing that for weeks at ManCI. Why aren't others
Cohorting and not doing that mass movement like at PCI and Marion. Where do you put all the guys? We can only provide what we have. This goes for all staff you know. Make sure when you have that stand off distance, require that these inmates put their masks on and take a step back. I did that at PCI

and other places I've been. Although N95 is available, its limited and requires fit testing. We went to universal guidelines for staff. We included PPE for staff. We are pioneering the prison field. We are doing everything we can and getting it right and doing it well. We pull in ODH (Ohio Dept of Health) we talk to OSU (Wexner Medical center) and all pivotal points of contact, experts in epidemiology, and such regarding how should we proceed. The guidance given is not without input from the field experts. One main issue is that people may become complacent. We have to be sure that we are not becoming complacent. The leadership has to come from the top down. RNs you all are bots on the ground. Front line in enforcing standards and addressing the minor things and major. Combat Complacency. We have to work together In this. We have to create buy in for all staff and these inmates. They've got to be wearing the masks. Taking every precaution, washing hands, sanitizing. Tragically, not doing these things can cause lives. In all transparency, we are trying to make sure we are sharing all of our information as far as how many staff are testing positive. Higher ups and my office are doing their best to keep the numbers on the webpage up to date with accuracies.
Beth Hogan- we send out stats for all tested. Positive tests and recovered results are on the web and sent to the unions organizer.

When can staff get tested again after we get tested first time?
ICM is setting up hospitals to go get tested. You don't need a doctor's order; you just call them. Tell them who and where you are.

CASE MANAGERS & MENTAL HEALTH

MH and Case manager are here all hours all week, except RN etc. Case managers are doing all the things for the other classification, MH getting signatures. Those positions re getting really burned out. There are things we can do from home. What's going on with that? We're burning out.
We know what we have to do in order to succeed as a team. We want to make sure we are thanking those of you who are on the front lines of this. We recognize and appreciate those who are working in the institution. We are doing our best. But we don't have an answer for how we can help with that right now.
Kelly Storm – Recovery services and reducing staff, BH is essential. Linkage is essential. Personal and professional fatigue is a real issue.

Do we have the ability to give BH or CM one or two days at home as relief?
Not MH no.
Beth- On case Management, I don't think so, will get answer.

APA are at home. Surely, they're more important to be out and about?
Several institutions have submitted step down plans which would bring back librarians etc. Parole Officers are working from home.

Every institution seems to be doing something different to mitigate exposure to Case Managers, some are proactive some do very little. Is there a state issued requirement on the institutions?
Case managers – I've sent you everything I have for the statewide requirements.
There is nothing specific to case managers

A month ago, the Union requested a grade increase for Cas Mangers in light of not only the historical inequality and the duties added over time but now because all these other duties have be added. It was referred to OCB. What is the status of that?
It been merged with the previous request – the job audit review.
Why has it been merged? This is a specific request related to Covid.
You'd have to check with OCB.

When this all started, they put us on 13 hour days, we were okay. Two weeks later they took it back. Said it had to be approved by Central office, but then they said central took it away.
We received complaints due to the lack of notice contractually. They wanted to have had more time to notify.
Not from 1199. Can central office overrule institutions when it comes to these kinds of changes?
Yes
In what circumstances would you overrule?
I can't say.
So, it's basically down to each institution. Can it be put back in place (13.5hr days)? Modified late nights?
Beth- We can ask.

TRANSFERS

Inmates are being tested before they leave reception and go to other institutions. However, the results take more than a day and they are at the new institution by the time its known. Is this correct? If so, why not hold them until result back? Also, we are consistently over the fifty limit at CRC
Transfers for emergencies and such and will be going to OSP. Inmates are being tested before they go. If there's not test or result then they're not getting off the bus. We would definitely hear about that.
Well it's happening.
Let us know specifics. And we have to take parole inmates back. We're taking up to fifty from the county jails. They're being quarantined. We had to reopen reception because of the courts
Hairston – those released?
Kevin- they quarantined 14 days before release and tested. Not released if positive.

CRC: Lorain to CRC which would take us over fifty come in with Lorain numbers to make it looks like they're not here.
If it's over fifty, we'll look into that.
Kevin – new intakes should be cohorted and not transferred without their results.
We have been told it is happening. They're grouping them in six at a time and getting kicked back and forth
No – they should be kept together and not released transferred until tested. Please let me know who it is and when. When inmate goes somewhere with no result he'll be held on the bus.
Jo I will find out and track it down.

Mental Health – when unit is in quarantine, should we be seeing inmates them in our offices?
If symptomatic then N95 masks. Work with local institutions. Still doing in person meetings. Use the space you have or move to a bigger space. And would have the PPE that's in line with the recommendations.
If seeing symptomatic who are in isolation you would use N95. Not just quarantined or asymptomatic.

At CRC how can we continue to see crisis patience, RTU inmates who are actively in crisis and Covid positive? What about if you are not fit tested for N95? Can we have these staff who are responding to crisis symptomatic and asymptomatic inmates, can we get them fit tested? How do we get access to additional PPE if its weekend or second shift? Also, crisis is being used as an overflow infirmary unit.

KS- We will discuss ways to create private space in the units to see inmates in RTU for assessments and provide services. We will only need N95 when they are symptomatic. We will look at getting those staff that need it and are identified, fit tested, as well as all nurses are fit tested. We will try and be proactive about getting supplies in place were you all can access that.

KEVIN- We can put process in place to put PPE in easily accessible places as a precautionary in case of an event. ie weekends, 2nd and 3rd shift. We will work toward creating a document and process in places.

Can it be more than a document? Someone needs to call down there. We've been trying for weeks.

We will be putting out a plan of action to strengthen and tighten up the access of PPE and process it will not just be a phone call it will be that plus documentation that must be followed.

Next APC will be June 23. If there are any items, you want added to the agenda please submit by June 15th. Delegates to attend should also confirm by June 15th