**Ohio Department of Rehabilitation and Correction**

**Agency Professional Committee**

**June 27, 2023**

**Union Attending:**

**Management:**

Housekeeping: check in on Case Managers Variance separate meeting – managers being told to come up with July schedule.

Housekeeping: next meetings: 8/15, 10/24, 12/14 or 1/9

1. **Nurses Good Day Mandation (excused mandation)**
* Need clear parameters of how and when excused and threshold.
	+ Goal: some let off but not others. HCA decides, can be inconsistent. Child in a final, too bad, but another gets waived. Not a great grievance issue. Lot of favoritism.
		- Used to be DWSS to determine, not HCA.
		- Guidelines or just number of waivers each month.
		- Out of state trip, paid for tickets etc., clear circumstance of prior commitment.
		- Set # waiver per timeframe for nurse to use.

DO: there is no one size fits. Case-by-case. If it is your good day and you have prior commitments that’s not unreasonable. We hope it will be considered. Most have done a good job of it. Looking for a restriction.

David Conley: AHCA and DW do try to work around it. If have tickets etc. those are the circumstances.

DO: if it does come back and is unreasonable then reach out to Kevin if needed. Great opportunity to be locally addressed. And contract negotiations aren’t far off. Can also do local agreements.

GD: we’re not looking for restrictions but guidelines to follow.

Alison Vaughn: When I had institutions many would have local agreements, CBA requires each institution establish own requirements. Can’t give guidelines generally, has to be the institutions.

* Pilot non-mandation for medical
	+ Where is the institution with most?
		- Lucasville
			* Second shift weekend is always the vacancy so it would hit first on second on the weekend.
		- AOCI

Linda: can start having the convo with nurses. Some said yes,

Agreement in principle to come along? We will have to follow up. Don to discuss will David Kevin and those management to see if it could work.

1. **Nurse Practitioners** picking up Nurse OT and DRC’s new intent to deny requests based on license and liability. You would mandate a nurse instead of allowing a CNP to work it?
* Is a NP held to NP standard if working as a nurse 1? Their scope would change according to the role. Where does it say they must work to a nurse practitioner scope as a Nurse 1?
* Nurse1 picks up as LPN? Same deal? Who carries liability?
* Contract does not limit. You’re denying current openings currently.

Goal: identify reason, to eliminate or resolve, and if not grieve.

David: NP picking up as RN. Role as RN is assessments etc. When NP does assessments and find has a skin infection, do they prescribe? Which they can.

Right, where is the regulation or rule? It my license and I can make that determination to expose myself to potential risk.

It would have to get back.

David: There have been some problems.

DO: we’ll table with Kevin and Jennifer and get back. Generate email response. 2-3 weeks.

1. **Contract CNP**

Holding spots that should be filled by state CNP. There are TWO contract CNP's at AOCI and a state nurse who has her CNP wants to bid on the position. LRO at AOCI: OSC has not given permission for us to fill the NP position. Why? Is this everywhere? – will be grieved.

Goal: brief discussion then move.

1. **Step Hiring**

Now posting positions with pay ranges. Great, but it’s a problem for current employees who get leapfrogged comparable to their experience. Retention and moral issues.

Recognition it’s not fair. Can we advance nurses to match when it does happen?

Since September 2022:

21 Nurses

2 SW1

1 BHP1

1 BHP2

1 Psych/DD

1 Psychologist

When you hire somebody on more than an existing nurse with the same or more experience you negatively affect morale and create more reasons to leave.

**Goal**: Is there recognition of this and what can/will you do about it?

Roberta: We do recognize the concern. But also, the tools we have to hire experienced staff are different. With leapfrogging we will take that into consideration. We will try to the best of our ability not to leapfrog other staff.

DO: timing is everything too. Its different now than it was before. Your point is duly noted.

1. **2024 budget:** DRC requested extra funding in the budget round. It looks likely to be less than what was asked for (7% vs 15%). Will that be used for recruitment and retention initiatives, if so what?

**Directors testimony to the finance committee in March:**

*To support our workforce, we have engaged in a multitude of recruitment and retention (R&R) efforts. This included a pay increase for correction officers and R&R supplements for targeted health care positions.* ***But money alone will not fully address workforce issues and our strategic plan in this area involves things that are not monetary.***

*…*

*As the Governor stated in his address, treatment for mental illness must be a focal point for our state. It is closely related to substance abuse and can be a major contributor to recidivism. 23% of the DRC’s incarcerated population is on the mental health caseload. In this budget, we have requested funds to repurpose already existing facilities to meet these needs. Using a Treatment Mall approach, the new mental health housing areas will allow an individual to get multiple levels of mental health services to address chronic and acute needs, without having to go to another facility. It will be staffed by a multi-disciplinary team of security and medical professionals who will be able to provide holistic services to individuals at almost all acuity levels.*

* The director’s plans and goals do not focus on filling positions to implement these goals. Does the director think allowing cell phones will attract licensed professionals to come work in prisons?
* *Where will this staff come from? The vacancy rates for Nurse 1 has not improved. Data provided for MH yesterday, have not been able to fully analyze, what have you learned?*
* *Raise for Corrections officers showed significant improvement in hiring in some areas, reducing vacancies by 20 percentage point London 10 at Toledo and PCI*
* *What do we need to do to get raise/step addition for RNs, mental health social workers/counselors.*

**Goal**: what is your plan? You told us at R&R that a lot of this is negotiations. Officers got theirs through negotiation. What will you do for our 26% vacancy rates for nurse and for MH? How are you going to meet the directors goals f inmates cant get services now?

Roberta: I really have no information on the budget and how it will shake out and what we’ll have available. We hope to have some for R&R across the board, not just nursing. You shared your frustration. If we have money left in the budget great if not we’ll have to look at different funding.

I cant tell you the strategic plan. We cant until we know what we have. Our intent and goals will be predicated on the budget and what is approved. Make no mistake we have the same concerns. We need the staff.

Gary: Last APC we said there’s 18% vacancy for COs and 26% for Nurse 1s. They’ve been getting the Teamwork incentive since covid and we’ve not even though we are significantly less staffed. We’re shorter than them but we’re being told take it and deal with it. You do that with the budget you have.

RB: we did do the bonus in November. For Teamwork incentive it was under review, not sure where it is. We’re sympathetic and empathetic.

DO: its not been approved. We can follow back up on but its not been approved as of now.

GS: other non-monetary things – what are they, we cant go to different shifts because we don’t have the staff.

DC: Bet has submitted the R&R for Nurses, will be addressed. If approved, it would be a bit more competitive.

GS: if you lose one nurse that’s an extra mandate per week when you’re small group.

DP: doesn’t include the Psych or MH? Bonus was just

1. **Mental Health Waiting Lists** requested June 7, not yet provided.
2. **Mental health – outpatient treatment teams**

Treatment teams-why are they done for everyone with everyone needing to be present? It’s not that way in the community. In a hospital setting it makes sense. If I am seeing a psychiatrist and a therapist, they do not have a treatment team meeting about me with each other and the nurse and any support group I may be attending. Many of the inmates who come to the treatment team I have never met and never will. Also an incredible waste of resources. Clinicians are capable of discussing, consulting, sharing – whatever form of communication you wish to call it – among themselves. We are able to know when there is a need to schedule the team for more complex cases.

**Goal:**

* Treatment team to be done by clinician individually unless as a team as indicated by the clinician. Request based not automatic.
* Reception treatment plans only done with complex and 7 days suicide watch follow up.

Sandy: you’re paying us to be clinicians. In the community if you’re seeing a therapist and support groups etc they are not all getting together on you. Liaisons should be able to create the treatment plans without having to meet with a team. We don’t know some of the inmates coming through, nor would the social worker. We’re wasting hours listening to other peoples treatment plans. As a clinician I know when to call it for a complex case. Not meant to exclude cirsi or suicide or RTU (which is diff), but general population and we know what they need. We did it during covid.

Maria: understood I can take that back.

We are looking at opening RTU in other sites to accommodate the waiting lists. High priority.

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Goal: brief discussion then move.

David: concern with new grads is they don’t have experience without collaborating physician on site. We don’t have enough doctors on site. NP have to have a provider/collaborator. We’re trying to recruit like crazy. Doing the best we can.

GD: what about other NPs to transfer, you’re blocking them. If an NP has a collaborator. If they have a physician collaborator, then that could happen.

David: special Allen oakwood is we don’t have a doctor.

Linda: we have three NPs. On is state, two is contract. We have no doctor, we use on call or Eddy or Granson. Doesn’t that mean our state nurse is working under them right now?

David: yes, not specially, but they are under a provider in the state. We have a doctor with NPs under him out of Belmont. We have plenty NPs but not enough doctors.

LW: Doctor signs off on EKGs, our NP is using Eddy and Granson?

DC: yes, because no CMO. Eddy, Granson and Pepper doing it for multiple institutions.

LW: Why wouldn’t another NP work under that same doctor?

DC: simply, every doctor can have five under them, they’re at capacity.

LW: Does the doc have to be state employee? If new NP would she have to be working under state MD or can it be any MD?

DC: in practice it would be ODRC doctor. Or contract doctor. Has to be ODRC in some form. Couldn’t be any old doctor.

Darrel: shouldn’t an existing NP be able to bump out a contractor?

DO: its management right to fill it or not.

1. **Belmont Medical Staffing follow up – Losing second shift position.**

We were told that our inmate population is down, does this mean 200 inmates = 1 RN?

If our population goes back up, then we get that nurse back?

Being down 200 doesn't change any of our workloads.

KR: it was cut based on chronic care, acuity etc. said earlier.

TJ: can we see a report? It doesn’t t feel that way.

TJ: like fusion orders not whole thing. We take in 30-60 intakes and release as much. A lot we do that don’t translate into the reports. Second shift today. At 4pm 72 insulin dependents, and 17 more at camp. That nurse has to do them, then seg.

KR: that’s why I’ll look at it. Where and how utilized. I can look at that.

David: Kevin is still looking at it. I was at Belmont recently. We’re going to pilot Belmont to be a self scheduling institution with the RNs. It can be factored in.

1. **InGenesis Contract**

This is still an issue at SOCF.

SOCF - status? Still short. Mandation twice weekly. We can’t get the contractors. We want them, we’re short, other institutions getting Tier 3 pay. Local management cannot change it.

KR: they need to know the wage before they come. I’ll call them tomorrow.

David: Kevin has not shared it, but we’re looking at the R&R.

1. **Staff assaults**

What is the general update? Success/failure and lessons? Some specific places where decreased rates and increased.

* *Delegates to take concerns to each institution FPC when needed.*
* *Sweitzer to take them to ask best practices for where they’ve significantly decreased. Geoff to send.*

Ragland:

1. **Case Managers Plan**
2. Our Plan - Since July 10, 30 policies have been signed off/approved by the Director. Is the policy concerning Incarcerated Persons clothing issue more of a priority to the director than the work-life balance of Case Managers?

Variance came out of the OMA Policy.

a. Variance on hours. Need thorough explainer.

MCI warden wants July schedule done by Thursday. Violation of contract. Getting this done, what about Our pLan?

Lyneal – they can still come in at 7, doesn’t change.

Late Night will specially end at6pm

Roation late nghts – policy ha snever stated it is institution its unit staff. If they’ve deviated from the policy I don’t know what to say about that.

4 hours is the Case Mangers choice

1. Staffing review

“Staffing requirements should be determined on more than inmate population figures and should include review of staffing needs for health care, academic, vocational, library, recreation, and religious programs and services. Workload ratios should reflect such factors as goals, legal requirements, character and needs of the inmates supervised, and other duties required of staff. Workloads should be sufficiently low to provide access to staff and effective services.

Protocols: Written policy and procedure. Staffing plan.

Process Indicators: Staff interviews. Documentation of periodic review.”

* RB, April 11, GCI: I believe they have 10 case manager positions, 7 are filled. GCI’s case manager density is 7.2 and with the current population, GCI should have 6.5 case managers. Based on this analysis, the current vacancy will not be filled at this time.
* RB, June 5, NERC: NERC has 4 filled case manager positions. NERC’s case manager density is 2.7 and with the current population, there should be 1.9 case managers. Based on this analysis, the position will not be filled at this time.
* Now PCI

Question: NERC and GCI rationale is based on numbers, but policy says it should be based on more than that. Grafton has multiple partnerships and more work than your numbers suggest, and NERC would now have two unit managers, two case managers and four sergeants. How are the programs going to get completed with only two people to do them, especially when most require two facilitators?

And majority thereof?

1:250.

251-500 – 2

501-750 – 3

751-1000 – 4

Its predicated on the ratio. They do an analysis. Its case by case.

Lyneal: if they think they cant meet the need the Uma and Warden go through regional and it’ll be approved or not. Some have some have not.

UMA and Warden would ask for review/concerns. The warden can request to fill. It goes through the vetting.

NERC: 482 count currently would be two. But

They’re not going to have much room for much else.

Lyneal, yes but you run what you can according to the staffing you have.

I don’t expect you to run 6 groups.

2 Unit Managers? Roberta question.