DRC/1199
Agency Professional Committee Meeting
Agenda
September 26, 2023

Union Attending:

Charles O'Connor	Case Manager	SOCF
Athena Diven	Case Manager	MCI
Stephen Parson	Case Manager	MANCI
Erica Cruz	Case Manager	NERC
Gary Spradlin	Nurse 1	SOCF
Tamara Holmes	Nurse 1	FMC
Nicole Bowshier	Nurse 1	DCI
Lisa Ragland	Nurse 1	RCI
Jennifer Shantie	Nurse 1	LOCI
Daphna Dyer	Nurse 1	AOCI
Linda Wright	Psych/DD Nurse	AOCI
Angela Cooper	Psych/DD Nurse	MACI
Johnathan Hamm	Psych/DD Nurse	CCI
Sandra Gladding	Psych Assistant 2	NERC
Dejanairah Remmer	BHP 2	CRC

DRC Attending
Lyneal Wainwright, Internal Reentry Administrator
Alison Vaughn, Labor Relations Administrator
Rick Thomas, LRO2, FMC
Don Overstreet, LRO3, Bureau of Labor Relations
David Conley
Kevin Runyon, Medical Operations Director
Kelly Storm, Behavioral Health Director
Janet Crawford (Teams)
Beth Hogon, Chief, Bureau of Labor Relations (Teams)
Roberta Banks, Chief Bureau Personnel (Teams)

AGENDA

1. **Current filled/vacant per institution**
    a. Generating, Janet Crawford will provide spreadsheet.

2. **Union benefits and representation on job postings**
   See proposed changes to current posting.
   Don: we like them, we would acknowledge and take under advisement. Including this list anything else that will help.

Geoff: Union rights are valuable, thing that workers want.

3. **Rule 3 violators**

Our staff feel that Rule 3 (previously Rule 14) violations are not taken seriously and that there is a lack of consistency, follow through, and deterrence for violations. The deterrence that currently exists is not implemented consistently nor does it work. Does management recognize the issue as a problem and what is being done to remedy it?

- Current situation akin to sexual harassment being a condition of employment.
- Current tracking rule #3 – status
    - Tracking Rule 3 is still new. Too early. We believe that the penalty for the violations will bear out, but we still need the data. Everyone in our agency takes it seriously. High on our agenda. Not fluff. Big deal.
- Current sanctions and effectiveness
    - Sanctions are such we have to give it a chance to evaluate the data. Some inmates might not care about the sanctions.
    - The changes we're implementing takes time. Changing culture and mindset takes time.
- Isolating repeat offenders' proposal – AOCI model to consolidate violator in one area. LPH will be in 2H. GP population LPH. Repeat offenders who happen to be LPH will then be housed in the area. AOCI were just regular housing units. Can we also explore Telemid options.
    - DO: resources issue.
    - Face to face is preferred method, on community as well. Because none verbal communication.
    - Someone would be in the room with them anyway.
    - If Institutions would like to look at options, we can do that. Toledo for example.
    - GD: I'm saying persistent. Also having security there is different thing that being in the room with SW.
    - Kelly agreed we can look at those scenarios, HIPPA doesn't exist for those purposes in that scenario. If a need exists.
    - Kelly local issues can be dealt tight and work with them.
        - They need to be elevated.
    - LW: if it's a GP person who is a risk and they have a need to have a telemed and its approved there would be an area for them rather than in person to prevent the exposure. Most of the time the issues we have they're doing it deliberately, and management aren't taking them seriously. Not just LPH and MH guys, it happens when a nurse goes to seg with medications.
    - DO: why would you think mgt not be taken seriously?
        - Because thrown out because on a watch, or MH. RIB process isn't followed through.
        - Doing that's going to be at particular institution, doesn't mean mgt doesn't take it seriously.
        - LW: other institutions have the same issue but don't speak up.
        - DO: but if things are getting thrown out it can subvert the data.
    - Spradlin: we have chronic guys. If they have X number of Rule 3s say they go telemed?

- Kelly: can't say that, has to be case by case. Some acting out is part of their diagnosis. Someone has to manage the offender on the other side of the screen. But can do security reviews for individuals.
- DD: Allen we'll have inmates come over and if it's a male nurse then suddenly their shoulder pain goes away so they place another HSR until they get the nurse they want.
  a. Kelly: We have an obligation to see them.
  b. KR: the one we don't see will be the issue. Can't ignore it. But if we do the education piece. It's the prison game.
  c. GS: Pattern abuse of stalking charges?
  d. Cruz: needs tickets too for the paper trail. If culture creates slow morale like no point filing then nothing will be done. Vicious circle.
  e. LW: Tier 1 offenses, said Brian. So seen by Sargent and the conduct reports are "Refer to treatment team". Can these referrals go to RIB or must I be officer level?
  f. DO: I thought direct to RIB. Do Rule 3 firs offense go to RIB or to the hearing officer?
  g. Beth Hogan: Don't know, will check with Brian Wittrup and follow up.
  h. KR: is there anything we can do to support female staff. Employee Support program.
     LW: yes, but the culture doesn't support that. Want to leave the unit because you saw that? If it could be anonymous. Theres no number you can call, it put it on paper and everything is scrutinized and then talked about the next day in the breakroom. It's just the way it is. If people felt safe and anonymous and confidential.
  i. DO: that's what Employee Support does.
  j. Linda: could there be a free line for us that will link back for employee support to follow up with you.

- DOJ investigation at Mansfield - conclusions?
  i. Legal say ongoing so nothing to say.

4. Case Managers 4 hours programming

a. How it applies in each institution, realistic expectations.

Wish I could say it wouldn't be blanket but it is. CPS 40 % of job duties is programming. Reasons I hear about is things that have nothing to do with case management. Not changing programming, need to changes things that have nothing to do with your job. Prior to Covid we got stuck with funeral visits. So we need to look at that.
Lawyer visits too. Was handled through AA or sec, now its video so its case managers. We're looking at getting rid of that.
We have some case mangers tied up 3-4 hours doing legal.
RIB, sitting in on those. In most institutions now not doing them

Looking at getting rid of some things but not the program requirement

Told UMCs everything that is not a case manager duty go to local institution to discuss the issues that are not programming case programming an reentry.

A lot of case manager goals are on the wardens evals.

Athena:
CO: it's not the programming, it's the blanket. If you take away other job duties. But 4 hours of programming is total, its more than 4 with everything associated.
LW: 4 hours. 40 % of work week is 18 hours. So, it factored. We need to get rid of the things that are not programming.

Athena: not enough training for programs.
LW: We are working on hat. Vic Awareness, we don't control. Motivational, Roots to Success, have them all coming up.
Stephen Parsons: we don't have control over staffing of COs. Pod requires 2 officers. Half pop locked down. And I have been pulled to help feed, showers, etc. I can't control that. Also, Office hours. I met with 18 in my office, 16 questions related to GTL. I'm fielding nothing but GTL issues.
LW: you're supposed to have a rep, for them to go to. We have FAQs you can put up, or a sign. Is there anywhere still hanging it out?
CO: same across the state. Inmate comes to the case manager for everything, 9/10. I get 10-15 calls half being viapath /GTL issues.
LW: I will have Katie do an FAQ or email blast. That is another duty we have to look at.
SP: we have to do minimum amount of office hours which is taking a lot of time away.

Erica: on board with all that. We have accommodated attorneys, children service workers, zoom links for hearings. We only have 2 CMs at NERC. All these programs require 2 facilitators. I worry about maintaining four hours with just the two of us. We have UM and COs trained in it but they're being pulled.

Is there a minimum standard each day for office hours?
LW: its 2 hours a day. Also we changed the late night hours and now you're saying don't have the time.

Geoff: Lots you've said about that's a duty that needs to be stopped or taken away so why not hold this until those areas you're talking about are taken care of. Why issue it now?
LW: No. because we've already dealt with some if them. We still need to deal with legal or funeral visits. This is not new.
Lyneal: You still have the two week between programs.

DJ: Who are we supposed to reach out to about the tablets. They're manipulating the watch stuff. Id didn't get my tablet yet or not working.
Kelly: I'll let management know they need to refer to representative eon site about the tablets.

Outcome: it is what it is. Not changing. Katy will provide direction/FAQ on GTL issues.

Union next steps, every case manager follows up on the variance with comments and make it known.
Request each supervisors give direction of what to deprioritize that's not case management.
Request a list from Lyneal of those duties that have been identified as not Case Manager duties that are being changed/withdrawn.

UMC should be talking to case managers about priorities. So, if your UMA didn't give you then they should.
Won't make a list, because not me each institution is different. SOCF might be doing transport and escorts. Or going to chow or
Directions were for wardens and UMAs to get with CM for stuff not case management related and then go to warden and admin to see how can get these duties taken off. I make no progress let.

Lyneal, I will write the email though.

5. **Case Manager Academy - current CPS "refresher" requirements.**
   Current CMs refresher course requirements? Based on what? Cause to lead to the refresher? Evaluations, performance plans? We would like Academy if need to be part of a performance track or deficiencies rather than as a straight up tool that's perceived as punitive thing.

   Lyneal: the decision for the refresher is local level. Request Is not unreasonable though. Its only one or two people. Everyone else is new or NEOCC. I'm not saying you're going to get it. But I will go back and discuss because reasonable.

   Stephen P: we had some in ManCI so we did a local 8 hour retrain, prior to academy.
   Lyneal: I'm not going to tell the UMA how to do it at their level.

   CO: if you took 40 hours and did it by institution

6. **Staff requirement to teach at CTA – Mental Health (and others?)**
   Kelly: We use all institutions. May be once every six months, for those who have the skills an instruction. training. We don't force if don't have the staff levels. It's a great networking opp. Resume. If an institution feels they're the only one, then they get with Kim Roche.
   Can I say no? Skip me this time?
   Yes, with manager if someone else has training with advance notice.
   Can we just have a CTA person?
   No we want SME from the field current people with context.
   GD: no, I mean like someone hired.
   I'll ask Kim If someone I am being repeatedly takes with it they have opportunity to decline. I manager is forcing it we should address that institution.

DJ: people don't like to be forced; product is not the best. Some people like to teach, let them do it. CRC you're forced to teach in service. I'm not a teacher.
Kelly: Its good to get comfortable with the uncomfortable. …. But people have the right to decline. And if they don't have Skills Instruction training then won't.

Outcome: everyone has the right to decline, working with the manager and with notice.
GS: reason we can go to firearms training.
DO: its going to be up to your warden why etc.

7. CCI Psych Nurses R&R

a. R&R for Psych Nurses as part of MH with caseloads

Any Institution can submit for R&R which are reviewed. We would say if they feel the MH Nurse should be getting it then they should apply an doubt that in for the various reasons why.
GD: what factor send to be met.
KR: There are no vacancies. Vacancies are not an issue.
JH: CCI we have five vacancies in MH, we have different titles but we all counsel people and have caseloads. They're skipping retention.
So who's picking up the vacancies? Its divided across those there.
Kelly; we have 32-45 case load, up 15 from typical duties. Clinicians carry watches so they're absorbing that. The difficulty with recruiting is SW LICS we want to fill those and reduce those caseloads.
We got a psych assistant 2.

GD: if Psych nurses are taking some of that burden that others are getting then they should get the benefit of the R&R too.
KS: if they're no vacancies than any other factors need to go in the application. That app needs to come from the institution. Caseload vacancies get spread across different positions. But you look at duties and volumes as well.
GD: and if local management say no won't resubmit.
You have to start at the R&R. Temporary caseload isn't the permanent solution, its filling the vacancies.

8. LECI Mental Health R&R

a. Geographic imperative – WCI receives R&R, why not Lebanon?

Is in process. Was applied for being reviewed. We declined.
Geoff request the copy of the decline with reasons. Don agrees.

9. Belmont Sex Offender R&R

a. Only Classification in BECI MH not receiving, same recruitment issues.

No application received, Will need to be submitted at local level.
App to be made by local to Send to Nicole Erdos.

10. MAT Program and Nurse 1 responsibilities and liabilities

- Nature of the program, please provide specific responsibilities on Nurse 1
- What therapy/follow up is being provided
- Why are Nurse 1 administering?

Kevin: explanation. This is new to us. It's here to stay. Wil be part of our function. It's a federal ADA accommodation we need to make for individuals treatment on the street we need to continue. It's more and more in the institutions. And delivery sites. We're trying to modify the protocols to address the issues.
Identifying concerns like licensure concerns. Send those to us so we can explain or educate why they are not at risk with license.
It's not going away. Four places where CMS is doing it will be going away. We'll integrate. It's a national thing.

Identifying concerns

- Nicole, DCI. I am passing medication. Validated by DEA. It's painful. It's all watched, governed. Were
- Operational issues
- short staffed during. This is a whole new duty for us. It's the LPN and RN when LPN not there.
- Deliver medication (CMS) every Wednesday. The nurse is going up to get the medication. Time consuming. Not safe. Not secure. Schedule 2 and 3 narcotics. Getting it from some lady called Diamond not with right names on stickers.
- Box not secured. Not secured area. Counting on front counter. Complained and its moved to roll call. Still unsure, porters etc. Not closed locked doors. Individual counting.
- Expecting us to sign paperwork to take responsibility for stuff that might not be correct. Agrees to store handle in compliance with law. CMS no responsibility once accepted.
- Not the same nurse handing it out.
- Needs multiple officers for security. Cheeking. Not doing a MAR.
- CPO computerized training CPOE. ORW and DCI went. CTA said MAT medications will not be part of that. (Kelly: no, it will be, we'll train and absorb).
  - Where are we being trained in this?
    1. Kevin. Correct. That's not good. We can review all of that there. We will do it down there.
    2. NB: multiple orders don't meet expiration. Titrations not matching up.
    3. KS: Will schedule meeting at Dayton with all involved so we can address all these concerns.
- We don't even have a secure container to carry it in.
- NB: I've heard way more things from other delivery sites. PCI do it much differently. Very regimented and tight.
    1. Put your challenges in writing to get them addressed.
       (Nicole send to Geoff to forward to KR)
- GS: Will we be getting more staff to deal with this?
- Recovery Services have MAT coordinators, do DRC have similar positions
- MAT positions? Have a specific position?
    1. Kelly: we have to determine how to grow the program. We use the vendor for the four sites. Looking at how we can expand within that. We have new two year contract with CMS. Absorbing it won't be until end of that. Trying to manage growing number at delivery sites. It's a everyday decisions with increasing numbers.

ii. Daily conversations – as the program grows. Snowballs. Catch up. Constant communication to slow them to the sites. Work in progress to say the least.
    - Will it be resolve before contract negotiations?
        a. Trying

iii. CPOE? ORW and DCI meant to be October. We are doing the pilots at the ladies prisons because contained, to see the challenges and fix them there. Worked in the past with fusion etc.

11. **Nurse Practitioner Pay – not competitive.**
Since covid they have been acting in the stead of Psychiatrists and being paid so much less. Not competitive with community either.

NP Pay Increase Supporting Docume

KS: Nurse Prac at OSC. Spec you provided. P=broad strokes. Job duties scope.
What we do in MH for Nurse Prac is pay grade 15 with minimum of step 5. $92.97 minimum. Might not even have the experience for it. Step five automatic. Community comparison is with four year experience. We do that already. Also NP requires us to have a collaborative agreement with ALP which also factors in.

KR: NP field is getting flooded. Now seems like schools are pumping them put. It's generous already with R&R bump up. Can't see going different directions. But with number of NPs in the field now it go in the opposite direction. Supply and demand. We have no problem filling these positions. We have to give the NP to the new grads in the barg unit first which I don't like.

12. **Belmont Nurse position revisit**
Carry over from last APC

- Kevin: won't be getting a new position at this time.
    - Why: based on workloads.
- Kevin: Joe Murphy will have to address. What is it for, workload or positions, what else are you doing and how utilizing.
Workload, Schedule, Where you putting your people.
    - Our schedules and staffing aren't every weekend etc.
        - I'd like to see all that.
        - Spread the staff out to use where needed.
        - Not getting changed right now.
        - Open to the creative scheduling but they didn't want to do it.
- Mansfield and Allen Oakwood.
- CCI is killing it.

13. **Teamwork Incentive for COs reissued effective August 1, 2023, based on vacancy rates**.
Why not nurses/MH? Nurses and MH have similar vacancy rates yet get no such incentive to help alleviate mandation. "Look after our people. "Take care of our staff; they will transform our

offenders"? (AOCI, CCI, CRC, DCI, FMC, LeCI, LoCI, MaCI, ManCI, MCI, ORW, PCI, SOCF, TCI and WCI).
What needs to happen for nurses etc. to get it?

- DO: not apples to apples. Vacancy rates during covid were enormous, had to be an incentive to make up for the vacancies.
  - But it was just reissued.
    - It's been going slowly and surely going away. It will end statewide September 30th, even for those vacancies with enormous vacancies.
- Vacancy rates are significantly down. Not to say not those outliers. We've improved. We're trending in the right direction. To that end you'll see the end of the incentive. Let's hope we continue to see stride and improvement. W
- KR: our vacancy rate has improved quite a bit. 17 nurses in two months. We're at pre-covid rates now.
- Right now, it's around 19%.
  - GS: COs got it at 18%.
  - GS: How much have you paid out to COs that we haven't been getting when we've been shorter.
    - We'll get you that data.

Pay
Range $XXX - $XXX
Longevity pay after five years
Overtime opportunities
Comp time
Shift differential
Recruitment and Retention Supplement at select institutions and classification.

Medical Coverage

- 80/20 PPO Plan ~~Quality, affordable, and competitive medical benefits are offered through the Ohio Med PPO plan.~~

Dental, Vision and Basic Life Insurance

- Free Dental, vision and basic life insurance premiums ~~are free~~ after one year of continuous service.

Time Away from Work and Work/Life Balance

- Paid time off, ~~including vacation, personal, and sick leave~~
  - 2 Weeks vacation accrual in first year, and carry over
  - 80 hours sick leave per year
  - 40 hours personal leave per year
- 11 paid holidays per year
- Childbirth/Adoption leave

Ohio Public Employees Retirement System

- OPERS is the retirement system for State of Ohio employees. The employee contributes 10% of their salary towards their retirement. The employer contributes an amount equal to 14% of the employee's salary. Visit the OPERS website for more information.

Deferred Compensation

- The Ohio Deferred Compensation program is a 457(b) voluntary retirement savings plan. Visit the Ohio Deferred Compensation website for more information.

Educational Benefits
$3,500 per fiscal year for tuition reimbursement and/or Professional Development activities.

Bargaining Unit Representation
All non-exempt employees have Union rights through SEIU District 1199