**DRC/1199**
**Agency Professional Committee Meeting**
**Agenda**
**March 9, 2023**

**SEIU Union Delegates**
Geoff Davies, Union Organizer, Committee Co-Chair
Erica Cruz, Case Manager, NERC
Sandra Gladding, Pa@, NERC (Executive Board Member)
African Grant, Case Manager, TCI
George Poullas, Nurse 1, OSP
Dejanairah Remmer, Bhp2, CRC
Jennifer Shantie, Nurse 1, LOCI
James Snowden, Nurse 1, GCI (Executive Board Member)
Gary Spradlin, Nurse 1, SOCF
Jesse Glass, Nurse 1, MANCI
Nicola Zayas, BHP1, OSP
Trevor Jackson, Nurse 1, BECI

**DRC Management Representatives**
Don Overstreet, LRO3, Committee Co-Chair
Lyneal Wainwright, Internal Reentry Administrator
Kevin Runyon, Medical Operations Director
Kelly Storm, Behavioral Health Director
Beth Hogon, Chief, Bureau of Labor Relations (Teams)
Roberta Banks, Chief Bureau Personnel (Teams
Brian Wittrup, Chief Inspectors Office

**Nurse and MH Recruitment Update**

Everything we say you come back with platitudes.
We want safe days off.

- Current staffing numbers in institutions
- What improvements have R&R supplements?
- Plan moving forward?

Kevin: R&R. Significant increases in multiple facilities. Data I pulled position roster vacancies and filled and step level they're at. How many new on the different TOs etc. What I'm seeing is we're hiring at advanced step but the retention is working but we're not seeing the brining new people in. Like CRC, PCI, Lebanon, Madison, Marion. Still have folks stepped out. Not seeing new coming in.

Kevin: I've asked for report of turnover, who cam and when left/why. Why aren't we able to retain. Still at the same 265 vacancy rate and the 20% aimed at those facilities not moving the needle. Advanced step hiring. A lot of time money isn't the only answer. Is it the environment?

Snowden talks.
Don discusses further R&R: Geoff. Sure

Jesse: MCI cut two nurses. Schedules changed every two months to figure it out. Our voices were not heard. So at Manci we work every third weekend and we do shift exchanges. When you have good days but you can't plan for them. Having to take days off to secure good days. But then nurse tells me I am going to mandated. Then I have to protect myself and affect other nurses, vicious cycle no guaranteed days off. Too consistently and too often is the problem. In hospital settings tenured nurses are elevating because agency making more. Same problem now here. Higher step hire now makes others bitter.

KR: I'd love to do all that, but part of problem is entire team agreement. Faith that someone isn't going o screw you over. I'm bleeding managers now too left and right because nursing staff being paid more.

KR: you'll have to mandate e but should be final last thing. Open communication to explain would help and improve the process.

Allen Oakwood – mandating all over, worse now than before.
Lucasville – management not doing anything to recruit. We're done with mandates, starting to refuse. Enough is enough, I'll ride it out. Working one double a week and mandate on good day you get one day off a week. How do you expect that to work?

AOCI does it, Lucasville do it – bookending. They have LOA.
Grafton – if I'm off on w/e and I have reservations etc. then they pass me over.
Lucasville – we have voluntary OT counts as mandate. We have that agreement in place.

Geoff: stop mandating on good days.
Kevin: I'll gladly tell manager to stop doing that but they're brunt too because the minute someone burns them…

Ask for the meeting. Reset the trust

Poullas: I think it's a good idea. We don't need to be on the same page. But step hiring

Kevin: the step is a toll we've never had, we're using it more.
KEvin: I've no idea how it would look or even possible to match for current people here.
George: we'll present.

Kevin: matching? Step is based on experience not vacancy rates. Its not willy nilly. And we're udtied too.
George: cant we match others here to that level? Retention issue.
KR: but a nurse of 14 years out there isn't going to start at 14 here because

Pilot for non mandation? Yes, let's get it on. And schedule the follow up.

Gladding: on peer support team. Morale is low wherever I go. I know a nurse offered a job at Grafton. He didn't take it because no-one seemed happy there. Tension in the air. No one had anything positive to say. On top of that I was dealing with inmates. Don't have to deal with that on the outside.

Kevin: I'll gladly take suggestions.

Snowden: we want to be marketable, successful and go home when we're done.

**OSP Mental Health Staffing Plan**

Current situation:

- We have been short of staff for 7 months. We have been denied retention and recruitment. We are working every other weekend, every other holiday, and overtime every week. We are exhausted. We have had two suicides in the last 4 months. We are not able to keep operating under these conditions.

- We are beyond over worked and utterly exhausted. My position is supposed to work 20 hours a week at TCI and 20 hours a week at OSP. I have not worked at TCI even once since June or July.

- Weekend on call
  Split between Zayas and Flood up until supervisor put himself on this year after complaints. Still majority is between two people.

- Most of our clinical tasks are put into orders, not including our MH rounds and sometimes other interactions that we have with offenders, or teaching MH classes for example. We are not even able to put orders in all of the time or notes in all of the time due to how busy we are when we are here.

- Constantly being pulled away to crises

- Fusion order history shows that volume has increased dramatically while staffing has decreased with load shred now between two people where before was up to six.

| BHP | Jan-20 | Feb-20 | Mar-20 | Jan-21 | Feb-21 | Mar-21 | Jan-22 | Feb-22 | Mar-22 | Dec-22 | Jan-23 | Feb-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FLOOD | 43 | 22 | 0 | 11 | 4 | 10 | 48 | 50 | 50 | 290 | 276 | |
| HOLT | 0 | 0 | 0 | 19 | 9 | 2 | | | | | | |
| MERWIN | | | | 0 | 0 | 0 | 91 | 107 | 57 | 0 | | |
| NORTON | 0 | 0 | 0 | 29 | 27 | 22 | | | | | | |
| SOPKOVICH | 42 | 46 | 26 | 3 | 2 | 82 | 142 | 166 | 194 | 0 | | |
| WECHT | 0 | 0 | 0 | 25 | 44 | 48 | 61 | 69 | 95 | 0 | | |
| ZAYAS | 52 | 44 | 26 | 12 | 26 | 30 | 71 | 74 | 100 | 306 | 266 | |
| **TOTAL:** | **137** | **112** | **52** | **99** | **112** | **194** | **413** | **466** | **496** | **596** | **542** | |

What management have said:

Kelly Storm December 2021:

- Maria King, regional admin, and Chris MHA there have put together a staffing proposal in reviewing. 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.

May 2022:

- Maintains the biggest issue is movement and environment.
- A request needs to me made for R&R and have advised management at ORW applies.
- Also requested MHA to increase their clinical role.
- Sopkovich: it is not movement its staff. We are back to back with caseloads, we do not have enough people. It's the amount of referrals, kites, assessments, crises

Supervisor Rossavanes February 2023:

- There are current 2 file time openings. Posted since July 2022.
- Both staff members have worked copious amounts of overtime
- I have submitted my 3rd R&R request earlier this week. The first two were denied.

Poullas: we don't want to lose Zayas and Flood, they're very good. Medical staff want that support for them too. Increasing wages, etc. cant afford to lose more staff. We deal with these patients too. The three pts we lost in the last year, its not easy. One is too many.

Kelly: I appreciate you. Give some history and where we are today.
We review numbers annually. When the hsoptirally OSP position was remove it was based on caseload numbers. Previous R&R was denied because had apps. Those fell through. This request has now gone through committee and to the director for approval. My expectation is that Chris should do clinical work as well.

**Staffing Ratios 2021 provided by Kelly Storm**

| Position | RTU | Outpatient | Reception Process | Multi-missions. Special populations. Large RH pop | Comment |
|---|---|---|---|---|---|
| MHA4 or MHM | | | | | 1 – every institution |
| MHA3 | | | | 1 (for large institutions w/ 24/7 MH or multiple missions – deemed by OSC | |
| Psychiatrist | 1:80 | 1:300 | 1.5 / Male .5/ Female | | ALP assigned & ratios determined by chief psychiatrist – ratios are per ALP - not separate categories (i.e. don't get both ratios) |
| APN | 0 | 1:300 | 0 | | |
| Psych RN | 1:25 (+6) | 1:200 | 1:50 | | |
| LISW/Psychologist | 1:80 | 1:150 | 1:80 | add 1 -per OSC | |
| LSW/Psych Assistant | 1:50 | 1:100 | 1:80 | add 1-3 per OSC | |
| Activity Therapist | 1:30 | 0 | 0 | Add 1 per osc | |
| Psychiatric Attend (varies & assigned per OSC leadership) | 3-5 | 0 | 0 | 1 | |

NZ: you said three staff. I may have low caseload but many of my contacts aren't caseloads. Its crisis, 5404, life events. Even when we had three we were barely meeting bare minimum for treatment plans.
Kelly: I appreciate you advocacy and we lean on you for your advocacy and experience. Our annual staffing review is coming up. But also state wide.

Ideal situation for Kelly: we review and take into account contacts and ratios. Haven't spoken to ideal staffing levels. 3.5 is current openings. In addition to Chris as supervisor. He is able and should be performing clinical – watches, assessments etc.

Geoff: what about this fusion data? Indicates huge increase.
Kelly: there's lots of automatic orders. Then staff can put in manually. Id have to look at the origin and actual meaning of them. Not necessarily a measure of productivity. Not saying you're not busy, but it doesn't t fully embrace.

Filling the two positions would assist.
Wat was the recommendation? There's no percentage attached to it yet. Director decides that.
Timeline? No, we would meet. Il update the team when set.

Sandy: I just get to the point I want to cry. We're not keeping staff NERC either. We hope R&R works but we're just here hoping. Training new people that are leaving. If supervisors aren't pulling their weight, on call and doing an eval here and there, not helpful. Then retaliation of complaints. So I just don't care anymore. You just don't have the chance to breathe w=and when you do something else happens.

KS: MH acuity has increased throughout the state. We're doing important work. I would encourage the job audit for BH and SW.
BH/KS: we do not oppose waiving the limit to allow more than 3 reviews.

Jesse: what all are you looking at? Not al the orders paint an accurate picture of the work. Marion and Mansfield have same numbers but age of inmates is more, increase annual physicals etc. But Manci is huge LPH and RH that Marion doesn't have. move sheets etc.

Kelly:
Kevin: we look at numbers, chronic care, distances, split camps, RTU associated etc., acuity, multiple chronic cares etc.

**Belmont Medical Staffing – taking one position?**
Losing second shift position

Belmont is one of the few institutions with full medical staffing. Why punish them?

- our emergency logs were down, but we showed this to be a clerical error.
- 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.

**BELMONT**

Trevor: Belmont we don't have trouble. No one is asking us. Look at what we do as a model to recruit and retain. 1. We're nowhere near a major city. We're rural. We are one of the highest paid positions in the area. Even the starting wage is a $3 pay increase. No-one is going somewhere with five vacancies. Hiring one doesn't stop the bleeding. New period come is an know I'm going to get mandated this much. Nope
Also we don't work five 8s. majority work 10s and alternate weekends. We were self scheduling when I cam here. 4 tens, most senior picked first. That went away and we went to 8 and as new employee I said I'll leave. We stayed with tens. Recently our nights said we'd rather have four days on and three off. Better work with management. Also we don't have many agency. Most we've had is two. We don't have that problem until now where I feel we're doing really well and the state now says we're cutting a position from you. We're down 200 inmates. But our workload has continued to increase. Went for having 2-3 OT in march and now we're at 22 vacant shifts on second. My major fear is we wont be able to replace nurses and we'll fall into the trap that others are in.

KR: I'll look at that schedule, 22 vacancies.
TJ: its not just that position, its LPNs too. We had to cut from second t keep first.
KR: it was cut based on chronic care, acuity etc said earlier.
TJ: can we see a report? It doesn't t fell that way.
KR: that's why I'll look at it. Where and how utilized. I can look at that.
TJ: like fusion orders not whole thing. We taking 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 hem, then seg.

**Genesis Contract – when/if renewal?**
Lucasville - status? Of six nurses we have we've recruited them all. If we're doing all that what is genesis doing? We cant get the contractors. Why are they offering so little? We want them, we're short. But offering lower pay isn't getting it when other institutions getting Tier 3 pay. Local management cannot change it.

KR: SOCF heard a nurse not offered an appropriate tier wage, we did ask Genesis to look at it. I'll have someone review the postings and get with Genesis.

GS: we interviewed an doffer job and then Ingenesis offer the rate and they turn it down. Unless you can fix that as soon as they hear it they're not coming.
KR: they need to know the wage before they come. I'll call them tomorrow.

**Staff assaults**
December 2022:
*Kevin: lets see what the numbers are, and the particular places. The data will show, and what are the problems in the places?*
*Don: We'll get more educated on what course of actions are being taken. Inexperienced employees may be fearful. We'll do some research on the back end and give you and update.*

Don: outside of the initial violence data review that and we'll discuss. We do monitor and track assaults on staff and they take appropriate action. Each institution is different.
Tom Schweitzer: the Ernie Moore monthly violence data report. Whatever happens is reported out. You can review. Higher level prisons will have more violence.

**Rule 14 violators - Accountability for inmates, protection for employees**
December 2022:
*We need to know here and when and do a thorough follow up. Schweitzer will help and be involved once we identify and drill down.*

Brian Wittrup
Updating RIB. Mid June. Will be training. Piloting at sites now. Feedback is making people's lives easier. Linking to sanctions automatically. Working to link it to commissary. Limits procedural mistakes because will prompt and ask for info before proceeds. Cut down due process errors.

Expanding to 74 rules from 61. Policy changes. Forms and computer based DOTs changes
Previously could see what violation was without reading report. New system will classify each incident with a number. Will link incidents together also. More specificity. Breaking down into major categories. Added electronic devices. Then sexual misconduct expansion. Old rule about non consensual conduct. Four new differentiation around Rule 14. Sexual harassment included. Also stalking rule. Pattern of conduct. Allows us to track
Tier 1 offenses now could out you in level e, which is highest and now extra orison time. 5000 inmates done under this.
Fighting broken out into different rules. Encouraging a disturbance. Fighting separate. More meaning. Also taken out "instigation"
Added Resistance to Authority and Disrespect. Rule 23 refusal to accept housing assignment now specific broken out. 5.4 an be use for SB201 to add time. Refusing sex offender treatment can be used this way.
Drugs have been expanded – Rule 39 could be anything and everything. Alcohol and hooch possession and manufacturing. From being drunk. Refusal to submit test.

Geoff: Great, identifying is important. Got to have the right rules. What about enforcement? How does this help with actual deterrence and protection of staff?
Staffing and willingness

Brian: cant speak to it, this is information management. About identifying the people. We have record numbers of conduct reports. No indication of slowdown. More now to RIB than ever before. The computer but it's up to the human being to take action, report etc.
Grant: would there be instruction on ho to write the ticket that will add more time. SB201.
BW: Yes, the Tier 1 offences re identified in policy.
RIB will build in those things itself. It will kick it up.
This system will track and will have a dashboard, its harder for something to get dropped or untimely/past due. More difficult to fly under the radar.
Can be viewed Remotely – wardens, deputies, regional, office of prisons. Huge transparency. Good feedback systems need transparent. Not designed specially to police what people are doing with it but it is an effect.

June something.
Gladding: We don't always know what the infractions are, not all of them. We used to have the cards on badges. Can we get that.

Brian: expandable cards yes. Also a desk top calendar looking thing that will have them. Also, all the rules are embedding in the system, so you can see them.

Rue 14 will be Tier 1, exhibitionist conduct etc. Sexual harassment. Read the rule to see what it is. All of them would be violent offences. All will be tier 1 offences. Additional time.

So I'm thinking an increase in enforcement would lead to an increase of higher level security. What about staffing to meet?

Do we have sufficient staff for this? More level E? going to Lebanon, OSP?
Brian: Should be. Lebanon is now much less population. The ratio of staff to incarcerated is higher now. Its improved. We should look at each prison and any shifts of population and clientele and adjust appropriately there. We struggle places of course but

**Inmate suicide/attempts**
Increasing reports from staff of suicides and attempts. What are the numbers, is this an issue or just in specific areas. Just being in specific areas doesn't make it less important.
CRC: mgt feel its high statewide, but not that high? Push from central office for each to provide add'l MH services. MH groups in TPU. Great but where is that coming from? Coloring boos and crayons to TPU wont stop suicides, but what is the answer? Increasing MH rounds.
NERC: Receive no proactive. Each Inst. On how to handle situation. Its double digits now, was single. Peer support activated more now. They're not consulting MH. Not able during count times which would be more effective. Not able to provide pencils and crayon because security, but can if they're suicidal. No sense. Reactive. Trying to stop getting to suicide level but can because security reason? Not consistent, to consulting or using research to make decisions.

OSP: we've had three successful in last year, and have 500 inmates. Staffing is an issue. Red flag. We need to see the people we need and give the care, we're not able to.

SOCF: same. Higher security has more, that's why we want 2 nurses on 3rd but management deny

LoCI: Human service assistant: inmates doing rounds in the hole. Have a whistle. Supposed to look for signs of crisis.

MCI: same. Pilot project here. TPU only, Range Walkers" Social Human Service Assistants

NERC: peer support inmates. First responder. They do some counseling. Its been a nightmare reeling them in. They think they're therapists. Same at CRC. More work than benefit. But is a work in progress.

FMC we have "nurse apprentices" who are cadre that trained to "assist" nursing staff

AOCI: do inmates practice under us? Who is responsible?

Subcontracting inmates is a problem. The lines crossed. Health and Safety issues. Confidentiality issues. Need more staff and proactive measures. Why can inmates do this but MH can pick up CO OT?

Kelly: HAS are meant to walk talk and refer. In RH settings. Would make referrals to MH. Could hand out packets or coping materials. They do not report to us though, we do not have oversight, its ops.

We do have credentialed peer supports. Facilitate with MH supervisors. Can run programming with or without staff. Can be assigned by licensed clinical and to talk to someone on watch.
New Tier Walkers – Tim Buchanan in operations over it and we consult and support it. Not using our peer supports in that role. They are Stevens Ministry Trained out of Religious Services.

Increase suicide and attempts: this year we've had four deaths. Last year we had 20 total, all time high. We have implemented ????  measures throughout agency. MH manger and Administrators have to conduct rounds in RH, which is where they mainly happen. Done some concerted training on 5404 screenings. Rolling out some trainings and policies
We review the outside medical trips. Thos individual engaged in repetitive self harm. Expand specialized mental health housing beds (n upcoming budget). And can get them triaged to right level of beds. Acuity continues to go up because substance abuse so partnering with them to direct with treatment and right care. YTHEYRE SHORT TOO!
Support services also looking how to best support staff. Focus. Its traumatizing.

Geoff: great but if Rec Services are short not helpful.

Kelly: time, that is why we're trying to do specialized mental health beds. Trying to put the tools in place for people to have the time and support.  Leveraging via path tablets. How to put content on them for individuals to reach out to. It can help with something they use kite for.

Specialized mental health beds- specialized mental health, RTUs etc. Also Sugar Creek. Elevate people to them, consistent waitlist, higher level of care and then RTU and DTPs at certain institutions. Increase beds with increased. This would then manage  backlog and elevate care.

**Physician verification - update**
BH: we can look at policy, if PCP signs it, not doctor. We can review the policy. Update it as a result of technology, makes sense. Telehealth etc.

Roberta Banks: we do have physician verification under review and when leadership has reviewed we'll report back.
Don: I've been in contact with Colin Jackson about contract language about the employer having the right to require the written signed statement by a statement maybe challenging during these times with virtual. We'll report back out next time. Needing DAS as well. Also OCB for an MOU.

**Case Managers Plan - update Our Plan**
Lyneal Wainwright
Its not a manual, its a list of action items.

- Looking at Case management Academy. Met with SMEs who are creating PowerPoints and lesson plans. Looking to Launch in September. 80 hour course for all incoming CMs. Also training on reentry approve programs.
- If in CM position wont take whole 80 hour. Will be 16 hour refresher training and for unit managers who were never case managers.  Quarterly updates thereafter. Same as everyone in unit, except sergeants.

- Case management responsibilities – reviewing all the assignments CMs gave to what can take away. E.g. visitation, AP1s can process that . But we're iding some people still not rolled those to secretaries for varying reasons
- Hire case managers with skills for case management. Changed screening criteria for the spots, making it case management specific. We're sitting in on every interview for last few months.
- Unit Manager must have 3 years case management experience
- Gateway Integration into DOTS. Trying to make sure all the OCSS info. You used to be able to see placements that you now cant see. Looking at that. Met with APA and IT the other day.

Late nights and weekends?
LW: we've had two meetings both cancelled. No sign off yet. I cant give a date. We have another meeting scheduled with the director.

Grant: Case Manger academy: we have three CMs with les than 2-3 years on the jobs. What's the limit, 80 vs 16?
LW: its incoming, not current for the 80.
GD: what if I want to do it? As a new Case Manger?
LW: I can ask, may be some issues with people just trying to get out of work.

**Union Time Tracking**

BH: I'm asking just do work on union time when you've requested it. The whole point of the report was someone claiming union time while working second job. Record union time.
If its de minimis time away from work, couple minutes wherever we don't care. Don't change what you've been doing unless you haven't been doing it.

APC time_ sort out what works best for us there.
Beth: within reason yes. If you're at your institution you get that plus travel time if your coming into Columbus. If your not getting the travel time that should be work time, so that does need to be work time at the institution for the release time. The LROs need to provide the release time AND resources to participate.
If at SEIU then certainly travel time etc. and caucus.
If its on teams you need to be at the institution.

Don: If having problems and isolated reach out to me to fix.