**State of Ohio Chapter**
**ODRC Agency Professional Committee Meeting**
**August 2026**

Time: 1:00pm – 3:00pm
Location: SEIU 1199 Columbus Office
Chairpersons: Don Overstreet, Geoff Davies
Recorder: Geoff Davies

**Attendees:**

**Union Delegates/Committee Members:**
Geoff Davies, SEIU 1199
Gary Spradlin, Nurse 1 – SOCF
Justina Ellis, Nurse 1 – MACI
Michelle Pore, Psych/DD Nurse – MCI
Rene Doubrava, CNP – LORCI
Dejanairah Remmer, BHP2 – CRC
Denise Dunn, Nurse 1 – CCI
Jennifer Forbes, Nurse 1 – LOCI
Juli Lambert, CPS – RICI
Lisa Ragland, Nurse 1 – RCI
Sandra Gladding, Psychology Assistant 2 – NERC
Shelly Dearmond, Psych/DD Nurse – DCI
Jessica Kleeman, Psych/DD Nurse – AOCI
Ethan Rittenhouse, CPS – SCI (Teams)
Christy Flood, BHP2, ORW (Teams)
~~Laurie Shroyer, Psy/DD Nurse – GCI~~
~~Sherri Perry, Nurse 1 – NERC~~

**ODRC Management**
Don Overstreet, LRO3, Bureau of Labor Relations
Beth Hogon, Chief, Bureau of Labor Relations
Alison Vaughn, Assistant Chief, Bureau of Labor relations
Jared Robinson, Chief of Correctional Healthcare.
Lyneal Wainwright, Internal Reentry Administrator – not attending
Kevin Runyon, Medical Operations Director
Kelly Storm, Behavioral Health Director
Ercia Bradley, Regional UMC (for Lyneal)
Crystal Duncan, Medical Education Manager
Catherine Simerl, HCM Administrator 1
Roberta Banks, DD HR
Amy Whitmore, Medical Operations OSC
Lyndsey Sestile, Legal
Janet Crawfords, Personal
Brian Kowalski, Social Sciences Research Supervisor
Keisha Dillon, IT

**SEIU-1199 – AGENDA**

1. **New Ids - replacement cost of $50. Also, general policy discussion.**

**Keisha Dillon, Management:**

Badges do not have GPS in anyway or tracking.

Dual tech – access control for doors e.g. More in APA and OSC for doors

Also will be used eventually for timeclocks. Current timeclocks are end of life, so this was good opportunity. In process of upgrading timeclocks within next few weeks.

Other features: drawing BWC and readers

Multifactor auth for workstation. For several years our institutions have been excepted from DAS requirement. OSC and APA required to use MFA. They use DUO. So now we're not excepted. Badges are our solution

Field staff use phones to authenticate using duo. We cannot mandate phone so using badges.

Installing reader at workstations, put in pin and will go you in to use Microsoft products. MyOHIO, OHID, kronos, My pay etc. That's a DAS requirement.

Forget badge?

- can download duo to personal phone if you want.
- Some pilot sites have temporary badges that can be used.
- If no temps then you would have to go home and get it.
- CCI and Ross have the badges. If forget will just need to get with Warden's designee.
- Will be tracking who is forgetting badge
- Cost of replacement badge. Policy still under review. Its $14. (not $50, we took your concern into account)

Questions, concerns:

Medical?

- Still gave it use current process for fusion. Waiting to integrate fusion.
- White stickers are a proximity sensor. Timeclock, drawing keys. Those stickers will go away in phases.
- Badges were first, timeclocks were simultaneous. Other systems will be phasing in.
- Key watcher system will be what we look at next.

- New badge is more secure, has a chip in it that can't be cloned. New badge cannot be cloned.

How long until just one badge?

- Can't speak to budget. From IT perspective I have folks trying to find solutions to making key watcher system compatible, it's just about budget.
- Rolling out to all institutions? Current schedule is through may next year, depending on other coordination and projects. Moving target.
- Almost 80 timeclocks will be end of life April 30, 2027 so tentatively by then.

Will temp ID be limited?

- We can make adjustments based on frequency. Currently only five times.
- Don: badge is increasingly becoming considered as equipment. Responsibility of employees to make it so. We don't want to look at accountability for someone who continually loses their equipment.

Will temp badges have full access, are they assigned to you, how will work?

- You'll register it like you would. It doesn't get you through doors. It would be just for workstation and you turn it in at end of shift. Bring your badge next shift.

COs have lockers to put their stuff in. Would we be able to do that? Badge in my locker by timeclock?

- Don't know if every institution is set up that way. The lockers are outside the entryway. Can be talked about locally.

Replacement cost?

- Cash office or business office in the field.

Inmates not wearing their IDs with no accountability. Perception issue. Important for morale.

- That would be local matter. Raise it.

If badge is damaged in course of work, would it be charged?

- No not if damaged in course of work. Use DRC1000. For damaged lost and forgotten.

Being sent home?

- No it won’t happen. Will be temp badges. Will not be part of the policy.

2. **Elimination of Psych/DD RN and other MH Positions and converting them to BHP. Institutions involved so far: RICI, GCI, ORW, AOCI, NCI**

Why are you doing this? What is your goal?

Kelly Storm:

Electronic MAR (EMAR). We were looking at HER able to achieve and the scope of practice and needs of facilities. As positions comes open we have to approve whether or not to fill. As some of them come open we looked at converting them to BHP who are able to fill a broader scope of clinical services. Case by case. Will continue to have MH Nurses, not eliminating. Not moving away from it.

EMAR: we used to have to do medical and compliance manually but with EMAR its not as time consuming and looked at that job duty.

Shelly Dearmond:

EHR is not efficient at all. Several discrepancies. Compliance is never right. Were non complaint with 2 registered nurses trying to keep up. Policy is meant to be 10th of each month, its impossible. We'll check errors and trying to see pts. Several areas not being consolidated.

- Kelly. We had complaint about that (not Dayton) and we looked and didn't find any. I need specifics to show that. If report to Hildreth have him tell me.

Mediation compliance is calculated for length of script. We're held by policy it must be monthly.

Shelly:

By eliminating the classification position. At Dayton we do.... (Shelly reads out a very long list). Also Psych nurses have a caseload.

Shelly: Review KITE system and respond, medication interventions, MH charts still, ALPs schedules – we do them and make passes, AIMS assessments, metabolic, VS assessment, EKGs, treatment teams x1 week, hot weather precautions review for ORW, metabolic for psychotropic meds, informed consents, teleconference forms (RIB, medication etc.), compliance monitoring medication groups, discontinuation groups, etc.,

Do you see the need for RNs to be in the department? Who d'yall think is going to do all these talks when medical is short and even if full wouldn't be able to. At DCI majority of pop is on MH caseload.

Don: nice job of outlining all you do and we know you do. But Kelly said it's case by case. It's not a blanket thing.

Runyon: a lot of the inmate is driven by security. It's an institution operational issue to be addressed there. We have them looking at this. It's a big deal, it's every day. We have folks looking deep into that.

Pore: we have multidisciplinary team. We have all of them. We have been dwindling over the years from PAs, Psychology. The team meets because we bring discipline different outlooks. We have Tx Team 4x week. We discuss all the cases. RN will have different than SW. Respect for the disciplines is waning and why are we going against best practice.

Kelly: so, we're not eliminating, we're looking at service delivery and population. The wide spectrum of services we provide, so we'll continue to have nurses, they will continue to exist. There is a role for that. Some of the other positions we supplemented are the inability to recruit and find them. We've had to make those decisions. But I do agree the nursing component is important, but we've looked at the vast role.

Poer: so, what are psych nurse not meeting?
KS: psych assessment, crisis precautions, individual therapy, caseloads are smaller, not able to do RH screens (5205s, not 5404), so there are roles within the model that they are able to do. So it looking at foundation of services and what does the facility need?

Spradlin: every high MH caseload. Lots of events. Our number are 7 spots but we only have 4 held. What are we holding four.

Kelly: that was held from RTU. They're not going to be filled. They're held just in case.

Spradlin: 3 open BHP2s

Storm: again, from RTU. Anything that needs to be posted will be posted.

Geoff: so what are the parameters, the benchmarks? What consultation will staff will there be? What chance do they have to advocate?

Kelly: We have the discipline. I would encourage them to talk to their regional or to me. We look at the missions, medication list.

Geoff: no, that's not a consultation.

Don: they're looking at it and you're advocating. But operational need will always rest with management. But before you make those changes will we meet with you locally, yes absolutely.

Yes we would have that discussion throughout.

Are you putting the consultation before the decisions, and with the nurses not just management?

Storm: Yes, when we decide it's a thing we would look to do we would consult. We're not going to consult if we decide not to. But we would have the consultation leading up to it. And we did do that and changeout decision based on those consults with the nurses at CRC.

Remaining duties: yes they could be absorbed by BHP and we're not getting rid of the nursing. Especially those things that could be done by for example, the HITs. Or things you're doing now that you don't need to be doing.

Geoff: And the more medical oriented aspects?

Storm: we'll continue to work with the nursing staff. Covos we'd have with the facility and collab with medical. We haven't had to give any to medical yet where we've done it.

Kleman: We all have caseload of 40.  Those situations when a nurse out long term. BHP positions are not getting filled now. We have the biggest MH in Ohio. If you take this person as a nurse who does PC everyday upstairs. Looking at the EMAR you'll think we're not doing anything, but it's not reflective of what we're actually doing. And we can't hire BHPs now is it going to actually help?

Storm: we would fill valid positions, and what the long term vacancies are. But we need to look at it from a statewide perspective and service delivery and the classifications of

For AOCI I will talk to Brooke about covering that for that one nurse. But we would also talk about how we're utilizing current staff.

Geoff: so, what are the parameters, benchmarks, metrics and such that you would look at?

Storm: its not about money it about classification, job description, and service

Kleman: SWs at my facility are upset why you would out another SW there, they feel better rt have nurse monitoring. Also the BH positions aren't getting filled.

Sandra: Psych Assistants. We are the dinosaurs, but you'll still post them?

Storm: Missions, ALPs caseloads, Mandated meds, overall caseload, nurses, core kind of things.

3. Dayton Correctional Institution - Nurse 1 Recruitment and Retention Application rejection

**Brief discussion notes:**

Davies: Current R&R clearly not working. Nurses are being mandated, they get all the intoxes, still only have 5 nurses. It's still a mess.

32 intoxes on one shift last Monday.

Runyon: they said they didn't have it. They do Money is not the issue. The issue is Dayton. New HCA. Its not working well. Its functionality. It maintain staff now.

Shelly: It is the money. Working under the current conditions.

At what point does increasing the R&R

Runyon: We've hired more and they've quit because ea. dysfunctionality, not money.

Ragland: they're being told now leave time will not be approved unless have three nurses on shift.

Runyon: I'm looking at agency hours and we're only one nurse short. There are staff there so I didn't understand that.

Davies: The vacancy rate was 65%, then 54, now 45. What point do you reach?
Runyon: if can't get applicants or agency.

Geoff: could you review the hiring practices and process with communication of expectations: new nurses

Kevin: We tell institution we can hire on the spot. Know there are challenges with HR.

Dearmond: needs also to be clear to agency when they come on the shift expectation, not catering to them.

Davies: Also please let them know they also let them know that yu will be mandating them on their good days

Runyon: well, we still want to take the job…

4. **Case Manager TO at WCI**

From 2nd quarter local labor management meeting:
Case managers
Unbalance caseload and higher needs for some caseloads
Current population: 1000
Four case managers. The TO is still there. Never been eliminated.
We are exceed 250 per case manager and 500 per unit manager. Have 1100 now.
Don: it's a numbers game. If numbers go up they will reactivate the position. Unfortunately the needs may be higher in areas.
Hoover: we have six non specialized units. We have all levels.
Brant: with its mission, RTU expansion,
Overstreet: they will be getting more inmates and will be reactivated.
Hoover: his case laid may be over 384 and other less. 250 is not real.
Lyneal will say redistribute.
Hoover: that's not practical, we have every level. We've got level 1 and death row.
There are safety and security issues and
Davies: let's get Lyneal down here.

APC Discussion:

Bradley: confused about numbers. Its 1006 and six now. Its been holding steady. Its not at the positions where they need to be activated. They have units closed and not full. We reached out to Gray and he said they're not intending to be opened. If there's more information to increase the levels. That's not communicated to use.
Storm: the RTU will actually decrease the population.
Quire unlikely.
Davies: the impression I got from local management was not enough
Bradely: they're staffing are the same as at other comparables. They're certainly not reaching a number that justifies. For the ratios.
Bradley: we talk plenty of times to management caseloads for population not geography and to raising to make it more equitable.
Davies: When does the local population mean that ratio doesn't matter?
Brdley: I'd love to hear from them what it is.
Davies: Can we get someone from OSC to attend next FPC if necessary?
Badley: yes

5. **Nurse 1 staffing and OTP/MAT at Institutions**

Staffing is inadequate for the increasing participation.

Davies: Can we get requested data.

CMS are the site specific to that. Then guest site where we get meds delivered and we get them out.

We do look at OTP numbers, intoxes and impact , systemically what we do to combat these things. We can look at impact of man hours being used for the pill calls for the timeframes. Not only the time but the space.

Forbes: we're a delivery site.

In additional to every we pull two nurse for OTP PC and weekly two nurse for counting. We have 2 nurse on the floor

- two nurses taken off the floor everyday.
- Count days for the meds takes two.
- Officers get moved, and get resistance and safety issue.

It's a huge burden for us and we're getting tired of it.

Overstreet: for the numbers: has there been an increase?
Whitmore: we do have someone keeping the numbers. I can say we are at a point where we're not doing more because we don't have enough. I don't have the #s but can get. But we're not adding more because we don't want to stress staff now.

Runyon: our manpower hours would speak to it.

Forbes: 350 hours since January for OT for OTP. We have people coming in for overtime. MH nurse help, WIC helps, HCA helps. That doesn't help.

We're not afraid of work we just want to do it safely.

Dearmond: we were told at DCI their going to start new process with the two nurse who I don't know who or how they're going to do.

Geof: when does it come?

Runyon: if you want to add staff I don't have the tap to turn on. It has to come from somewhere else. I have to show the need and the hours and the productivity. And

appropriate schools. When I have the data for it and project the numbers. I hear you, I understand the burden and with the intoxes. It's just a matter of requesting.

Union: Also there's things like us ordering the meds rather than CMS then we don't have to count, its just pharmacy.

Forbes: Robin murphy last year worked out why we need more staff at London. We're lacking staff as it is with OTP on top. Why not take the program out.

Ragland: we're telling you time and again. How many intoxes can an OTP have before being taken off? Because they're not doing it? It hurting us.

Runyon: I'll certainly take your concerns forward. When it comes to staffing.

Forbes: when will there be some follow up?
Runyon: would be able to give you some thoughtful analysis by next APC.

Dearmond: there a big incident with Controlled substances at DCI. Used to be containers, now we're being pharmacy. Why not keep them like they were, individual sealed so security not seal.

Overstreet: I'll look into the security concern so of officers being pulled at LOCI.

How many are in the program and when do you think you should be adding staff to account?

Background and reference: May 2025, Controlling Board Funding Request from DRC

https://controllingboard.obm.ohio.gov/Print/PrintCBRequest?id=166e0067-3aa6-446f-8f39-b134ebbd8667&utm_source=chatgpt.com

*Approved funding was initially used to establish five opioid treatment program (OTP) medication units at four institutions to pilot the program through a partnership with the Ohio Department of Mental Health and Addiction Services (OhioMHAS).Since the inception of this program, the need for treatment of opioid use disorder has expanded beyond initial estimates. The pilot program was expanded to six delivery medication units utilizing the hub/spoke model.*

*Over the past year, the Department has experienced a thirty-five percent (35%) increase in the number of patients served with over 850 incarcerated persons currently in active treatment. This has resulted in unbudgeted expenditures. Opioid Treatment Programs and Medication Unit services are presently being provided within ten (10) facilities:*

- *Correctional Reception Center (CRC)*
- *Ohio Reformatory for Women (ORW)*
- *Lorain Correctional Institution (LorCI)*
- *Grafton Correctional Institution (GCI) and Grafton Reintegration Center (GRC)*

- *Allen Oakwood Correctional Institution (AOCI)*
- *Toledo Correctional Institution (ToCI)*
- *Warren Correctional Institution (WCI)*
- *Lebanon Correctional Institution (LeCI)*
- *Pickaway Correctional Institution (PCI)*
- *Dayton Correctional Institution (DCI)*

*The comprehensive allocation of services throughout these ten institutions has allowed access to the OTP for incarcerated persons at higher level security facilities and those requiring specialized housing. The census is expected to continue to increase substantially as more Ohio jails are providing MOUD (medications for opioid use disorder) services which will be continued upon admission to DRC in accordance with the Americans with Disabilities Act (ADA).*

*Based on the current program growth rate, the Department expects the number of patients served within the next year to increase by an additional twenty-five percent (25%). Due to this anticipated growth and limited space, additional funding is critical to expand OTP services inclusive of telehealth appointments and medication delivery units at two additional facilities (LoCI, SCI).*

6. **Historical and current levels of intoxication** and management's strategy to reduce and provide more support for Nurse 1

32 intoxes on one shift last Monday at DCI

Security increase etc. are fine. Great.

- Scanner are useless
- Search is useless – pockets and socks?

What is happening with local prosecutors?

- But when the drug changes or the factors change and its back again what support doe the Nurse 1s have? What is the contingency plan for the spikes?

Don: drug interdiction is a big deal for us. We talked about that in pervious . We know drugs are still getting in. We don't take lifting up pants legs and that lightly. Are there other ways? Probably but we're welcome to any suggestions. With that being said drugs are getting in an intoxes create an undue hardship on everybody, mor especially the nurses. It has a ripple effect. We may have other info we can provide you once we get some clearance form legal for MAT/OTP and also Intoxes.

Brian Wittrupp:

I'm central office research and eval. We support ops with data. The two plain ways that we track is

1. Misconduct system. Its easy to say RIB. We also incorporate the hearing officer. Also recently looking at your intoxication events. I think eventually this data will get to you. The two metrics are correlated together, although misconduct events are a but greater than intoxes, but they generally tracks.
   There are also intelligence meeting going on, RIB and such quarterly. Last time I did Intoxication event analysis was through May 2026. Before May 2024 the data wasn't reliable because of consistent reporting. We think 2024 is from where we can trust it.
2. July 2024 is when intoxes and misconduct was at the highest level. It has on aggregate gone down. We do see monthly spikes and specific institution.
3. For misconduct to count it has to be at the RIB.

What ultimately is being dome with the data?
its given to operations.

Don: sure we're being crushed and waylaid.

Beth: I can tell you it goes to strategy to decide where to do a clear out, where to do the dogs, take immediate action to address.

Brian: I get requests for Cob because timely and precise.

Kevin: it take the intoxes data and call security to prod them along. Also dorms. I know we're changing policy on equipment coming in. Increase warehouse awareness.

Director banks also focusing.

Don: we'll take action where there are trends.

Spradlin: your numbers are very skewed. We go down to ER med pass. I took fist four blocks and ran 9 guys out for intoxes. Because staff will just let them lay there with anything. If we pulled out every high person nothing will get done. So we're putting nursing license on the line, I have to pull them off I m require by my license. Its not showing how bad it really is. Two months ago whole institution was high.

Geoff; it's a liability for license to follow the previous line from mr gray that if they're not disruptive just leave them.

Justina: you say collectively we're on the same page for reporting what are you looking at?
Brian: no I said pre-2024 data indicates it was not rolled out everyone wasn't reporting. I'm not sure when it started that RIB and intoxes were lining up.

Geoff: what point of elevated intoxes in one place does it then trigger help for nurse and what would that be if anything?

Overstreet: I don't know if there is. We're dealing with it as an agency

Dearmond: and where are we housing them?

Ragland: officers aren't shaking them down either. By the time they sober up and where going someplace they've already shoving it somewhere and they're just taking it with them.

Kleman: in 2015 when I started there were rules for the guys. There were so many, and now it. I had 17 intoxes in one shift. I said why can't we just lock the yard down? You still got these people going put and around?
Overstreet: that's up to the management officer. They will implement controlled movement or do a search or have SRT come in to mitigate as quickly as possible.

Forbes: pilot program in 4 days at LOCI. HCA is still filling in the blanks.

Suspected intoxes in infirmary for 4 hours. We're to call an on-call inmate to come and counsel inmate while intoxicated in infirmary during the event.

It risks confidentiality. Have to watch the inmates in the infirmary. Officers. Why are inmates counseling other inmates while they are intoxicated.

Runyon: first I've heard of it. We know we can't stop it coming in but we can slow it down so everyone is trying different things. Idin tike it'll impact on our staff but sometimes we do need to think outside the correctional box.

Right but why not recovery services.

Spradlin: right but if he's high its not doing anything wherever it is

We need to get holistic services involved

- Surprise staff shakedowns? Friends tell them. Proactive not reactive please.
- Why not switch to shots more, not daily pill.

7. **Mgt items: 31-SEM-02 Standards of Employee Conduct - policy change**

Beth Hogon:

I sent this to you June 17. So should have proposed changes.

We are in process of updating the policy. Will go through them. I have a copy of them with me.

Policy currently says you'll receive a copy and will sign for it. We are updating it to be electronic and we're just updating that because we've been doing it.

Return of property must be done on termination. So you have to tun in your computer eg or we'll start collections.

Regarding fines, it will be a generalized statement rather than citing a specific union requirement. Page 9 will now just say see applicable CBA etc.

Rule 16 about no bribes. We're adding "misusing official position for inappropriate purpose or personal gain" (cant use points card for a state field fill up. Or travel, if your making plane reservation you cant get the point s for your own personal travel.

Rule 26 not a bunch really. Instead of one big, long sentence its divided into subparts. Regarding report personal arrests. Now says notify a supervisor, because people can't figure this out.

Subparts then broken down but also added "any traffic citation"

Lindasy: it's a DAS requirement. Your not going to get in trouble its about insurability. If there is a citation issued to you. And being the subject of a court issued protection order.

Traffic citation is new.

DRC1000

Alison: this has cost someone their job. He didn't report an arrest on the weekend. He got out and didn't report it. We won that arbitration. The employee admitted he called his wife.

Shelly: domestic dispute?

No, traffic

Geoff: at what point does traffic violation leading to admirative actions or restriction?

DAS will do it based on entire record.

Its State time. So you cant drive you're now car on state time.

Alison: talk to josh on the arbitration for the PO. But there was testimony from DAS in that.

Lindsey: there is a probationary status coverage. There is a lookback period. What happens is DAS send quarterly report and to institutions. So LROs should be working with employees.

Is there a specific policy we can review?

- Don will send.

Juli: I understand as soon as possible but when would that be? As soon as you get out? Yes.

Rule 28 – adding tasers to list of equipment to maintain and control

8. **OBBB - tax exempt status of "learned professionals"**

Who set the parameters? Who determined how to determine?

Why are case manager and Class spec? Not exempt?

Are other agencies doing it? Did you get a directive?

Who detriments your test and why so low bar?

DJ: closing: OT and FLSA OT. Why? What? Why are there two slots?

Is the DRC designation controlling?

Lyndsey Sestile, Legal:

DAS reached out to every agency about the reporting requirements. Until then we did not know. I discovered that the OT is not going to be taxed. It will be OT that you earn only under FLSA. And when qualified the means only the overtime premium, not the whole thing. And there is a cap and it phases out depending on income.

DAS instructed us to report on W2 what amount is qualified. They asked us to go through every employee and tell them who ineligible. That's because of OAKS. A lot of people have FLSA because that how were doing it, nit because of actual status.

You have to meet both tests. Salaried and duties.

We went through all the classifications. We did not keep track of why we said they were not eligible. Because lots would fall into several categories. So we just identified one and move don.

So we provided DAS that list. It would be better if the FLSA check box meant something but it doesn't.

But also there will now be another box (OBBB) that will be checked only if you get it as a result of the law.

What is changes is there won't be the line that says eligible.

Whether our determination is determinative to IRS? – I don't know, we were directed by DAS. You should work with your tax preparer, I don't know. All we were asked was to indicate this.

Did we talk to other agencies? We did not. Even though we share classifications we may use them different in terms of their description . So I don't know what they've done. They have that

Remmer: OT and FLSA OT. Why? What? Why are there two slots?

Remmer: half of my OT was coded as OT and half was coed as FLSA. But there is already a line that says OT. How can I be told it doesn't apply but its on my check?

Settle: we don't know what the other box is for. OAKS is generating that box. It may be contract who are getting it but now. But the question for the OT essentially is does the federal law apply.

Remmer: so there is something on my paycheck that doesn't apply?

Sestile: I've not seen two lines. That is question for DAS.

Janet Crawford (can talk to Jackie Masters (Payroll Administration) to get an explanation.

Remmer: how you came to the conclusion: are you using all the items or just one or two?

Sestile: it was giant project with a deadline. We started at the top of the list and if we found one exemption we marked them and moved on. It didn't matter if it was multiple though.

Davies: for the nurses though?
Sestile: FLSA when they talk about salaried they don't mean that. Even the governor is paid hourly. So if I work all my hours in a year 2080 I will get a specific salaried. Non salaried is an unfixed total. It pay as you go. There is case law that out there. So does a nurse meet that as salaried.

Davies: So its youre guaranteed 2080 hours. There no such thing as unpaid leave or Starbucks and McDonalds workers get paid on their hours and may not get all of them, they get sent home when its not busy. But we receive guaranteed 2080 hours per year and off our balances run out then there are administrative action that will happen

Why are case manager and Class spec? Not exempt? Why are they on the list?

Sestile: don't remember why. I just know that what we're looking for are duties and salaried. A lot of the test focuses on how much control do I have, the judgement and discretion aspect. When we looked that them we determined they didn't fall into any exemptions.

Spradlin: can you go back to a review why they were not? RNs were but LPNs were not.
Sestile: DOL has made that decision, LPN are not learned professional.

Davies will draft a communication for 1199 members and send to Sestile to ensure what we communicate is accurate according to DRC's perspective.

NEXT APC NOVEMBER 4