March 13, 2025

Senator Deb Patterson, Chair

Senator Cedric Hayden, Vice Chair

Senate Health Care Committee

RE: Support SB 24 -1

Chair Patterson and Members of the Senate Healthcare Committee,

Good afternoon. My name is Dr Tracy Svoboda I am a psychiatric nurse practitioner and have been working at Deer Ridge Correctional Institution for six years. I am a nurse practitioner with a BA in sociology and MDIV in counseling and BSN, MSN and Doctor of Nursing. My degree program had an emphasis in the care of populations, a track which provides experienced nurses with a deeper understanding of the gaps in care affecting populations of interest on a local, national and global scale. Before coming to corrections, I worked as a cardiac stepdown nurse, a hospitalist, I had a stand-alone federally funded primary care clinic and worked in inpatient psychiatric care and outpatient mental health. I am board certified as a psychiatric mental health nurse practitioner and family nurse practitioner by the American Nursing Credentialing Center (ANCC). I am proud of the support I give Adults in Custody (AICs). It is demanding, and the need far exceeds the ability of the two Psychiatric Nurse Practitioners that are assigned to my facility without additional support and assistance to the mental health providers. I am giving this testimony as a member of AFSCME Local 2376.

I have never worked in any environment with so little support for medical professionals. I function in my role working four 10-hour days in the medical suite. I have chosen to take the on-call hours offered which boosts my pay but also causes me to work 24 hours day /365 days a year. I do this to keep continuity with my patients and with my workplace. I do all my duties as a Psych NP including evaluations, diagnosis and assessment, acute mental health emergent care, follow up care, and release medications, but I do not have any OS2 -office, reception or medical assistant support. I, myself, am being called upon to do all those tasks as well.

When I ask for office help, I am told we are not budgeted for that level of support. I do all my own scheduling and caseload management, within the DOC 400 and paper charting methods. I manage all my own interDOC messages from Adults in Custody (AICs), called Kytes, and I do my own filing. I pull all my own charts and room my own patients. A typical day entails arriving at 530 get shift report, collect Kytes, pull charts, open computer, see patients between 6:30 and 10:15 and after confirming all AICs are accounted for (called “count”), I continue to see my patients from noon until the last available appointment before the next count at 415p. In between I have very limited time for charting, filing, and emailing as I have mandatory meetings weekly during the count time.

As Nurse Practitioners at our facility, we function as a self-sufficient unit, but we are also called upon to collaborate with BHS, security and medical staff. So, in addition to all of these duties we all attend collaborative meetings which cut into our ability to manage our patient load. Currently, we paper chart, which involves multiple internet platforms which do not communicate with each other and multiple forms of paperwork to conduct simple tasks, such as changing a diagnosis or referring patients for therapeutic class.

There are two PMHNPs at our facility, and we split the caseload of AIC's who need medication management. When I was hired I had about 180 patients when there were less than 900 AICs at our facility. There are now approximately 1050 AICs and growing. I have a caseload of 250 which caused management to allow us to have a third Psych NP remotely to cover about 35 patients to help to keep our caseload around 235. The Nurse Practitioner that helps us remotely also has a caseload for another DOC facility. So, our workload was not eased by this addition. It only helps with the numbers on paper, and we have been told this is a temporary fix, until we can get used to the higher caseload demands. In our environment we treat those requesting medication, so the number of actual mental health patients in our population capacity of 1200 has the propensity to be much higher at any given moment.

Within our system, psychiatric nurse practitioners have requirements for follow up care, so even the most stable patient will be seen a minimum of three to four times a year. By contrast, this sets our profession apart from a medical nurse practitioner, who may have a larger caseload including those who might only be seen once a year for a physical. Our caseloads are considered "maximized" at 250 because of the higher acuity of our patients who need caseload management and coordination of care within the DOC. I believe that a caseload for Psych NPs between 200-250, based on acuity, could be manageable but ONLY with more staffing assistance.

I have raised a flag to our management requesting such assistance, and was told it's okay because we will have an electronic health record coming one day and likely won't need as much support staff. While there are some parts in our system which may be aided by an electronic health record there are many systemic issues of DOC healthcare that will not be aided by a EHR. I have been told there is no budget for additional office staff—even though I am aware of many other systems, both in DOC and in other healthcare systems, which have electronic health records, all of which have ancillary staff for medical providers. I choose to remain in this work as I feel called to provide excellent care to this population. I am only asking that you enlarge the budget to equip me and my fellow provider in health services and behavioral health with the basic necessities to do just that, safely.

Thank you for the opportunity to testify. Please support the dash one amendments to SB 24, so that I and my colleagues can appropriately support our patients with industry specific, minimum staffing ratios and be able to give an appropriate level of healthcare to the adults in our custody.

Tracy Svoboda, DNP

PMHNP-BC/FNP-BC

Member AFSCME Local 2376