

# OSH RECOVERY TIMES

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1

April 2009



## A history of outdoor therapy programming at Oregon State Hospital

By Todd Trautner, Outdoor Specialist

Hello to everyone in the OSH community. As part of my role in planning for the expansion of the Outdoor Experiential Therapy Program (OSH OETP) in the new hospital, I was asked to provide a review on important chapters of the outdoor therapy story here at OSH. I am happy to provide this portrayal of this wonderful history resulting in today's OETP. I hope you enjoy the read!

- Todd Trautner, OSH Outdoor Specialist, January 2009

The following historical perspective is based on interviews conducted in October 2008 by Todd Trautner, OSH outdoor specialist. A special thanks to Dean Brooks, Ralph Summers and Bruce Stock for their willingness to share their thoughts about the accomplishments and challenges of the program. The most recognition, however, goes to the thousands of OSH and Dammasch State Hospital (DSH) residents who have taken the adventure therapy challenge as a step towards recovery and wellness in their lives.

### 1969-1981: The tradition begins — the Dean Brooks years

#### 1969-71 Adolescent wilderness camp

In 1969 Dr. Dean Brooks began the difficult challenge of providing outdoor therapy opportunities for the residents of Oregon State Hospital. A pilot treatment model was designed for the OSH Adolescent Program. Dr. Brooks and other hospital staff implemented a four- to five-day therapeutic wilderness camp experience. The camp was located near Three Fingered Jack in the Oregon Cascades. The activities used were reminiscent of a typical summer camp format, utilizing arts and crafts, combined with various outdoor recreation activities. Little did Dr. Brooks know that this simple pilot project would lead to one of the most extensive and comprehensive wilderness therapy programs ever to be implemented at a state psychiatric hospital.

On a relaxing evening in 1971, at his Anthony Lakes cabin, while commiserating with world class mountaineers Lute Jerstad and Sherpa Tensing Norgay (a member of the first Mt. Everest ascent party with Sir Edmond Hillary), Dean and Lute conceived the notion that a large-scale wilderness adventure therapy program was possible at OSH.

#### 1972-81 The teamwork years

*Anthony Lakes 21-day adventure camp and Warm Springs 12-day adventure camp*

*An avid outdoorsman and mountain climber himself, Dr. Brooks was often seen running around the hospital grounds in the evening with a load of rocks in his rucksack training for his next mountain climb. More than once, Dean was spotted rappelling down the side of the hospital walls, practicing rock climbing techniques.*

*It was a natural step for Dr. Brooks to land upon the idea of utilizing outdoor adventure activities as a viable treatment strategy to assist OSH residents in their recovery. One hundred thousand dollars, and nearly 12 tons of mostly donated equipment, helped fuel the adventure programming odyssey that was about to begin.*

-Statesman-Journal, Nov. 20, 1981

Joined by Lute Jerstad and his cadre of trained wilderness instructors, Dr. Brooks gained nationwide recognition in 1972 by taking 51 severely mentally ill residents and 51 staff to the Anthony Lakes Wilderness area of Eastern Oregon. During this start-up period, OSH psychologist Dr. Delbert Young also played a substantial supportive role, overseeing the three mixed groups of 34 residents and staff. Each group had a psychiatrist and an observer. The staffing strategy paired residents and staff one-on-one so that they stayed together during all three phases of the 21-day experience. This brilliant strategy put residents and staff on equal ground. The three-phase 21-day wilderness treatment model ultimately proved

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### OSH Recovery Times

is edited by Jeff Jessel. Contact him at 503-945-2892 with questions, comments or suggestions.

# Piecing together continuous improvement: The word is getting out about OSH

By Rick Varnum, director of Strategic Planning

I have a rule of three. I'm sure I share that rule with many of you. When something happens three times, especially in short succession, it is time to pay attention.

As we all know we are experiencing unprecedented change at Oregon State Hospital. The cottages and the transitional treatment mall are open, the laboratory had a stellar survey from The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and much, much more is happening. There are so many changes it is sometimes hard to take it all in.

I employed my rule when I recently read three nationally published news articles. The first was the Grading the States 2009 report issued by National Alliance on Mental Illness (NAMI). The report, issued in March, is an in-depth study of America's health care system for adults with serious mental illness. In NAMI's last Grading the States report in 2006, Oregon received a grade of C-. In the current report Oregon's grade improved a bit to a C, which isn't a great score.

However, the comments related to the Oregon State Hospital were heartening to read. For example, "The state deserves recognition for collaboration with the Oregon Health Career Center's N2K Nursing Education Program, which allows OSH employees to participate in a fast track program to earn an RN." The report also recognized our emphasis on



evidence-based practices and recovery. One consumer was quoted as saying, "Services at the state hospital have been provided in very old facilities with limited staffing BUT many of the staff appear to truly care, which is amazing considering their extremely difficult and under compensated jobs." The report mentions the 2006 USDOJ report and our plan to build a replacement hospital and concluded by saying, "Leadership and sustained investment are needed to make progress towards achieving an evidence-based and cost-effective mental health care system."

The NAMI report came on the heels of an article published in the February issue of Healthcare Finance News, about the N2K program. Our own Nancy Frantz-Geddes described the students' experience: "You have to come to the program with the capacity to work and go to school. You need a rigorous support system in and out of the hospital." Nancy went on to say that this is "the best cohort of students we've worked with." Since the article was published, all N2K graduates have sat for and passed their nursing exams. All are now hard at work at OSH as RNs.

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## What's cooking in the kitchen?

By Patty J. Thompson



New meal service venues are opening at OSH.

The opening of the residential cottages created an unexplored area of service for Food and Nutrition Services (FNS). We created a frozen/reheat method for short-term meal service.

Meals are similar to what is practiced by most working families; cold cereal, fruit and toast at breakfast, soup and sandwiches at lunch with a full meal at dinner. FNS delivers food twice a week, including fresh fruits and vegetables. This menu plan will continue until all cottages are open and functioning in a normal routine. Eventually the cottages will be supplied raw products, which staff and residents will use to plan and prepare their own meals.

The first of April will see the opening of Café 35, which will be open Monday through Friday from 10:45 a.m. to 1:15 p.m. at the previous Sip-N-Safari location in the 35 building. Meals are available to staff and patients. Purchase an OSH meal ticket at the business office for \$2.75. The price includes everything from a cup of coffee to the full soup/salad and sandwich meal. There will be a specialty sandwich each day or alternate sandwich choices, soups, salads, fresh fruit, rice and vegetarian options on the menu. Watch your GroupWise for announcements about the grand opening. Guests previously having meals at the kitchen will be directed to this new venue.

In other news, trees and buildings are coming down around the kitchen in preparation for upcoming construction.

# Recovery International poised to expand

By Lani Wright and Deb Lamp

*Lani Wright RI leader and 50F mental health specialist,  
Deb Lamp, RI leader and Centralized Services mental health specialist*



As you may recall, our first touch with Recovery International occurred in late 2005 when two OSH residents asked Debra Lamp, OSH mental health specialist, to take them to an RI group meeting in Salem. Word spread as people began to learn and use the RI self-help system and saw how they increased their ability to deal appropriately with anger and fears, to interact more positively with peers and staff, and to lead more peaceful, calm and productive daily lives. With the permission of the Psychology Department chief and support from the RI organization, the first RI group at OSH took root in March, 2006. That year, Oregon awarded Deb Lamp and Recovery International the 2006 Mental Health Award for Excellence.

RI's success in Oregon comes out of its history and foundation as a cognitive-behavioral method for an effective, compassionate path to self-managed recovery from mental illness, behavioral disorders and the stress of everyday life. Through learning to change thoughts and control impulsive behavior, self-control and self-respect increase, and patients enjoy more peaceful and productive daily lives. The late neuropsychiatrist Abraham A. Low developed the system to reduce recidivism in his patients at the University of Illinois Psychiatric Institute; Dr. Low evolved the system into a self-help process and trained patients to lead peer groups. Founded in 1937, Recovery International (then Recovery Inc.) was the first self-help system aimed at those suffering from mental disorders.

RI does not offer diagnosis, treatment or counseling. Group participants are expected to collaborate with their own physician or mental health professional.

The OSH project was the first pilot to take the RI methodology out of community settings and into other organizations. At OSH, RI grew to as many as eight meetings, serving approximately 125 residents each week—25 percent of the patient population. Community-based RI group and phone meetings are also available when people are discharged, and can be included in conditional release plans.

Kathy Garcia, from Chicago, never graced the covers of *Newsweek* or *Sports Illustrated* (though perhaps she should have). Until she died last November, Kathy was the guiding light and pioneer of the huge changes RI is making in spreading the method to all those who can benefit from it.

Closer to home, OSH Mental Health Specialist Deb Lamp will travel to Recovery International in Chicago later this spring to accept the first award honoring Kathy Garcia's tenure of innovation as recent executive director of Recovery International. The award will honor Deb's own innovation and persistence in working with OSH and RI to establish the project. The OSH evidence highlighted how the methodology and program could be effective in any setting. Preliminary results? It is now being used in Los Angeles County jails, the Chicago school systems and the Montana State Hospital. Other pilots are being created in a variety of areas around the world. OSH was a valuable motivator in showing the organization the possibilities for the future of self-help mental health.

Due to a variety of factors, Recovery International is presently running only in the 50 building, with 35-40 people attending weekly. Some are displaying a "will to effort" to come from as far away as the cottages.

RI at OSH is poised for an infusion of training for leadership that could revive it in every corner of the hospital.



## Which electronic health record should we buy?

BHIP is moving ahead with the tasks required to purchase and implement the new electronic health record (EHR) for the Oregon State Hospital. The BHIP Request for Proposal (RFP) is currently out for bid. There is much interest from vendors throughout the world.

The process for selecting the vendor and EHR is formal and governed by state regulations, as well as best practices. The purpose of these formal steps and processes are to ensure that all applicants and proposals are treated and reviewed fairly.

Each vendor must supply BHIP with a proposal that meets strict form and criteria by the due date. Each proposal is then evaluated in a four-step process. Each vendor is scored by a review team. Review teams consist of OSH, DHS, and other staff who are experts in their area. In some cases a fifth step is used if the finalists are very close in the final evaluation scoring.

1. The first step is evaluation and scoring of the "Management Proposal." The Management Proposal evaluation consists of two parts. The first phase consists of an evaluation of each vendor's experience with projects of a similar size, mission and scope to BHIP. The second part of the evaluation examines the vendor "management approach" to the project, including: will the vendor provide on site "Project Management," how will key persons and subject matter experts be assigned and allocated and how will communication be carried out. This section will be weighted as 30 percent of the final score.
2. The second step is evaluation and scoring of the "Technical Proposal." The technical evaluation consists of two parts. First, the Technical Proposal is evaluated in terms of how fully do the services provided by the vendor satisfy and meet the requirements set forth in the BHIP functional requirements (the same functional requirements captured by BHIP over the last two years, and prioritized by OSH on November 18, 2008). Next, the Technical Proposal is evaluated in terms of how it meets the technical requirements set forth by BHIP, the BHIP functional requirements, Office of Information Services (OIS) and the State Data Center (SDC). This section will be weighted as 45 percent of the final score.

3. The third step of the evaluation consists of site visits and oral presentations for each vendor whose proposals are deemed responsive. Responsiveness is a term often used in contract administration reflecting whether a vendor's proposal included all required elements as set forth in the Request For Proposal. By itself, this section does not result in a numerical score, but results can influence the scoring of both the Management and Technical proposals. During the oral presentations, each vendor responds to a series of scenarios developed by BHIP and hospital staff representing typical functions and processes within the hospital. In other words, they must successfully demonstrate how their system and software can be used to do the actual hospital business and clinical functions. BHIP staff will also be conducting site visits within acute care or behavioral health hospital facilities for each of the top proposals. These visits will be to review, in whole or in part, current installations of the proposed solutions. The site visits will be limited to BHIP staff that will bring back and present the information to the evaluation teams.
4. The fourth step is evaluation and scoring of the "Cost Proposal." In this section a small cost evaluation team reviews the pricing of each proposal, and using a mathematical formula comparing pricing between all proposals, determines ranking and awards points for each cost proposal. This section will be weighted as 25 percent of the final score.

In some cases BHIP vendor selection may require a "Best and Final Offer" presentation and negotiation. Best and Final Offer is a process that can be used to differentiate vendors in the event no single vendor has separated from the rest of the field. The Best and Final Offer is used to drill down deeper into Cost, Technical and Management proposals to determine a "best fit" for OSH.

The processes outlined above are all intended to help OSH select the very best vendor and EHR currently available. Using this process, the vendor we select will be the best fit in terms of business needs, technical requirements and cost. It will not be a "lowest bid" solution. The decision we reach together will have a long lasting effect on patient care, staff safety, accreditation, and the future of OSH.



## Nutrition news you can use: Why is food safety important?

- 76 million cases of foodborne illness occur each year.
- 325,000 people are hospitalized annually from foodborne illness.
- 5,000 deaths each year are caused by foodborne illness.

### How does foodborne illness occur?

- Contaminated foods carry microbes and/or toxins into the body.
- Some microbes can overcome the body's defenses and cause infections.
- Onset of illness from microbial contamination varies from six hours to five days or more, with the exception of *Staphylococcus aureus*, which is usually rapid and acute.

### What are typical primary symptoms?

- Nausea
- Vomiting
- Abdominal cramps
- Diarrhea

### Ensuring food safety at home

- Wash hands often; effective hand washing may eliminate nearly half of all cases of foodborne illness!
- Wear disposable gloves if you have a cut or sore.
- Use clean scissors to open bags.
- Wash produce before cutting, cooking or eating (including all pre-packaged and pre-washed produce).
- Store washed produce in clean containers (Tip: before storing, use a salad spinner to dry washed produce).

- Use a clean utensil every time you taste food.
- Wash utensils and cutting boards thoroughly after each use with hot, soapy water and rinse thoroughly (or clean in dishwasher).
- Keep kitchen surfaces, appliances and tools clean using hot, soapy water and rinsing thoroughly.
- Wash dishcloths and towels in the washing machine hot cycle.
- Sanitize sponges daily by using a bleach solution or microwave wet sponge on high for 1 minute (The sponge will be very hot!)
- Replace sponges frequently.
- Do not use dish towels for multiple jobs.
- Store raw meat on the bottom shelf of the refrigerator.
- Use two cutting boards and two knives – one set for raw meat and one set for ready-to-eat foods.
- Discard boards with cracks, crevices or scars.
- Thaw food safely in the refrigerator, in a cold water bath (use a sanitized sink), or in the microwave (not on the counter).
- Store food in shallow containers to ensure rapid, even cooling.
- Add ice to thick items such as soup and chili to speed cooling.
- Refrigerate food promptly to below 40 degrees Fahrenheit.
- Pay close attention to use-by dates; use oldest items first.
- If in doubt, throw it out.
- Cook food to proper temperatures -- use a thermometer!
- Wash the thermometer in hot, soapy water and rinse well after each reading.

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## Piecing together continuous improvement: The word is getting out about OSH

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The third example of Oregon State Hospital making the national news was a retrospective article, “Images in Psychiatry – Oregon State Hospital 1883 – 2008.” The article appeared in the February 2009 issue of the American Journal of Psychiatry. It highlighted some of the rich history of OSH from Dr. Thomas Kirkbride’s innovative design to the filming of “One Flew Over the Cuckoo’s Nest.”

The news is getting out in many ways. We can be proud that our efforts are being noted by experts in the field. In addition to what has been published, representatives from the Maryland State Hospital recently called to inquire about our innovative use of the Short-Term Assessment of Risk and Treatability (START) assessment tool and staff from Western Washington State Hospital called to learn more about the Master Treatment Care Plan being used in Gero. Even though some local news reports focus on the challenges we face, let’s take heart that others see progress.

## OSH dashboard



OSH Dashboard - Fourth Quarter 2008

Key performance measures										
Indicator	Category	Current status	Desired trend	Goal		2008				2007
				Nat. avg.	OSH goal	4th qtr	3rd qtr	2nd qtr	1st qtr	4th qtr
Average daily census <sup>1</sup>	Utilization		↓	***	675 <sup>8</sup>	671	686	682	678	692
Percent of budgeted beds	Utilization		↓	***	***	99%	102%	101%	101%	102%
Average length of stay <sup>2</sup>	Utilization	***	↓	***	***	348	316	400	318	508
Indicator				Nat. avg.	OSH goal	4th qtr	3rd qtr	2nd qtr	1st qtr	4th qtr
Hours of treatment <sup>3</sup>	Service		↑	***	20	5.77 <sup>10</sup>	6.16	6.97	4.64	3.97
Hours of nursing service <sup>4</sup>	Service		↑	5.5	***	4.59	4.89	***	4.12	***
Indicator (Status measured against OSH targets)				Nat. avg.	OSH target <sup>9</sup>	4th qtr	3rd qtr	2nd qtr	1st qtr	4th qtr
Hours of restraint <sup>5</sup>	Quality		↓	0.52	0.46	0.35	0.32	0.24	0.48	0.65
Hours of seclusion <sup>5</sup>	Quality		↓	0.31	2.01	0.61	0.43	0.48	1.26	2.77
Indicator (Status measured against OSH targets)				OSH goal	OSH target <sup>9</sup>	4th qtr	3rd qtr	2nd qtr	1st qtr	4th qtr
Patient to patient aggression	Safety		↓	0	62	137	157	142	200	257
Patient to staff aggression	Safety		↓	0	26	331	256	253	212	84
Substantiated abuse/neglect <sup>6</sup>	Safety		↓	0	3	7	4	3	11	3
Elopements <sup>7</sup>	Safety		↓	0	0	0	2	5	1	3

<sup>1</sup> Average number of patients

<sup>2</sup> Length of stay for all discharged patients during the quarter

<sup>3</sup> Hours per patient per week (forensics, civil and gero)

<sup>4</sup> Hours per patient day, data provided is a one-week snapshot audit during the quarter in question

<sup>5</sup> Rate per 1,000 hours of care (restrictive events database reported to NASMPD Research Institute)

<sup>6</sup> Additions/corrections may be added pending resolution of open cases (cases reviewed by Office of Investigations & Training)

<sup>7</sup> Patient left hospital or assigned ward, or supervision of OSH employee while on OSH grounds or during supervised travel in community (Communications Center Report)

<sup>8</sup> Budgeted beds for current year (FY2008)

<sup>9</sup> 50 percent reduction of 2007 average

<sup>10</sup> Includes October through December 2008 treatment for GTS and ATS; FTS includes October 2008 only

Revised 4/2/09

## Nutrition news you can use: Why is food safety important?

(continued from page 5)

Heating foods to proper temperatures is important to prevent foodborne illness. The following chart lists minimum temperatures for food safety:

Food item	F°
<b>Beef, lamb and veal</b>	
Ground	160
<b>Roasts, steaks</b>	
Medium-rare	145
Medium	160
Well-done	170

Food item	F°
Ground chicken or turkey	165
Stuffing (alone or in bird)	
Boneless turkey roasts	170
Poultry breasts	
White meat roasts	
Poultry thighs, wings, drumsticks	180
Whole chicken or turkey	
Duck or goose	

Food item	F°
<b>Pork (all cuts and ground products)</b>	
Medium	160
Well-done	170
Fresh ham	160
Fully cooked ham, reheated	140
Eggs and egg dishes	160
Leftovers, reheated	165

## A History of Outdoor Therapy Programming at Oregon State Hospital

(continued from page 1)

very effective, resulting in the eventual discharge of all but eight of the original hospital residents who participated. The experiment to break hospital residents out of the institutional mold had worked.

A Life magazine feature article helped establish the support needed for the multi-day backpacking/ecology hikes, white water rafting descents and mountaineering climbs to continue for years. Additionally, Dr. Brooks stayed busy fund-raising for many years to keep the program active. The Collins Foundation was a fervent supporter of the program.

In reflecting upon these years of providing wilderness therapy at OSH, Dean, 93, said, "I am amazed at how much team effort was needed by all parties involved, to help make the adventure camps a success." Dean retired in 1981.

In 1981, carrying on the tradition established by Dean Brooks, David Graham and Bruce Stock were both very active implementing the outdoor programming, as were many residents and staff at Dammasch State Hospital. A series of modified 12-day adventure camps, based out of KAH-NEE-TA/Warm Springs, became the therapy model for a few years. These two-phase, white water rafting and mountaineering camps had replaced the three-phase 21-day therapy model. To this day, many former OSH and DSH residents and staff still have powerful positive memories of the days they spent shooting the turbulent Deschutes River rapids and scaling the airy exposed summit of Three Fingered Jack Peak!

(continued next issue)

### Whispering

The wind tickles my ear when it is near  
 Breath to utter a word so faintly is prescribed  
 Making me strain the brain to hear it compose  
 Lighting those eyes as the surprise is said  
 Who is a question of excitement?  
 What is the clarifying statement?  
 Giggling to the who and what  
 You mean to me that justice is wisdom  
 Flowing with answer into the ear canal  
 Channeling thought of a whispering word  
 Warm breath exposed to pronunciation  
 Answer is rhetorical from a breeze  
 Leaves are enduring words of this wind  
 Gushing, rippling tree leaves leave a question  
 Are you the one who created all this commotion?  
 Answering with another whispering word

By J. M. N., Consumer

## OSH new hires and retirees

### Welcome to OSH

Celisse L Adams	Mental Health Therapy Technician
Cydreese Aebi	Pharmacy Manager 1
Lindsey A Anderson	Mental Health Therapy Technician
Jose Andrade	Mental Health Therapy Technician
Jonathon K Applebaum	Food Service Worker 2
Mardell J Baker	Mental Health Registered Nurse
Washington Bakira	Mental Health Therapy Technician
Francisca T Cedillo	Mental Health Therapy Technician
Duke J Christensen	Food Service Worker 2
Nate J Clampitt	Food Service Worker 2
Brian Conner	Mental Health Therapy Technician
Katrina Deboer	Rehabilitation Therapist
David Eding	Mental Health Therapy Technician
Alllyn M Fitzgerald	Mental Health Registered Nurse
David H Gibbs	Mental Health Registered Nurse
Kimberly M Greiner	Mental Health Therapy Technician
Roger L Grider	Mental Health Security Technician
Doris Halpin-reyes	Executive Support Specialist 2
Shelly M Johnson	Food Service Worker 2
Matsuoki Kai	Physician Specialist
Daniel P Matarrese	Mental Health Therapy Technician
Donna Mellott	Mental Health Registered Nurse
Debra Morse-Little	Mental Health Registered Nurse
Stanley B Myers	Mental Health Registered Nurse
Lorraine Oakes	Mental Health Therapy Technician
Kevin Reloba	Licensed Practical Nurse
Joshua J Scull	Mental Health Therapy Technician
Donald R Tucker	Mental Health Specialist
Marie Watson	Transporting Mental Health Aide
Kayla Wilson	Mental Health Therapy Technician
Christine Winn	Mental Health Therapy Technician

### Promotions and Reassignments

Dana L Barber	Mental Health Therapy Technician
Jeanette M Bazan	Mental Health Therapy Technician
Jayson E Boaz	Mental Health Therapy Technician
Vincent E Boaz	Mental Health Registered Nurse
Milton L Brown	Mental Health Therapist 1
Jami Buckley	Mental Health Therapist 1
Cathryn Fuher Carson	Mental Health Therapist 2
Cherie L Cedillo	Mental Health Therapy Technician
Chrystal L Espinosa	Mental Health Therapist 1
Brittany M Geomans	Mental Health Therapy Technician
Sunny L Gonzales	Mental Health Therapy Technician
Kuno Jipping	Mental Health Therapist 1
Michelle L Kedrowski	Mental Health Therapy Technician
Natasha J Keller	Mental Health Therapy Technician
Danielle Kingsberry	Mental Health Therapist 1
Ann M Knapp	Mental Health Therapy Technician
Joanne M Lehman	Mental Health Supervising RN
Andrew A Manibusan	Mental Health Therapy Technician
Berdean Molan	Mental Health Therapy Technician
Sandra Moler	Mental Health Therapist 1
Coleman E Montgomery	Mental Health Therapy Technician
Christian Y Neice	Facility Maintenance Specialist
Pamela N Ogbeama	Licensed Practical Nurse
Regina Simon Orikannu	Mental Health Therapist 2
Joseph Samek	Mental Health Therapy Technician
Brittney K Schafer	Mental Health Therapy Technician
Maria C Serna	Mental Health Therapist 1
Donna A Shamblin	Mental Health Therapy Technician
Michael A Simmons	Mental Health Therapy Technician
Nanett R Thompson	Mental Health Therapist 2
Scott Forest Van Camp	Facility Maintenance Specialist
Andrea L Vink	Menatal Health Supervising RN

### Retirees

Uldis Liepins	Safety Specialist 1
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# EDD April 2009 events

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			<b>01</b> General Orientation 40C Conf Room 1	<b>02</b> General Orientation 40C Conf Room 1 CMA Pharmacology 40C Conf Room 3 8a-12p Driver's Training 40C Conf Room 2 1p-3p	<b>03</b> General Orientation 40C Conf Room 1 1:1 Precautions 40C Conf Room 1 1p-5p	<b>04</b>
<b>05</b>	<b>06</b> Contraband/Search Training 40C Conf Room 3 8a-12p Preventing Patient Abuse 40C Conf Room 3 1p-5p	<b>07</b> ProACT Refresher Training 40C Conf Room 3 8a-5p Healthy Emotions 40C Conf Room 2 8a-5p	<b>08</b> ProACT Refresher Training 40C Conf Room 3 8a-12p	<b>09</b> ProACT Refresher Training 40C Conf Room 3 8a-5p	<b>10</b> ProACT Refresher Training 40C Conf Room 3 8a-12p	<b>11</b>
<b>12</b>	<b>13</b> General Orientation 40C Conf Room 1 Boundary Issues 40C Conf Room 3 1p-5p	<b>14</b> General Orientation 40C Conf Room 1 Ed Day 40C Conf Room 2	<b>15</b> General Orientation 40C Conf Room 1	<b>16</b> General Orientation 40C Conf Room 1 Timekeeping Training 40C Conf Room 3 8:30a-11:30a	<b>17</b> General Orientation 40C Conf Room 1 1:1 Precautions 40C Conf Room 1 1p-5p	<b>18</b>
<b>19</b>	<b>20</b> Humor as a Therapeutic Tool 40C Conf Room 3 8a-12p Preventing Patient Abuse 40C Conf Room 3 1p-5p	<b>21</b> ProACT Refresher Training 40C Conf Room 3 8a-5p	<b>22</b> ProACT Refresher Training 40C Conf Room 3 8a-12p RN In-Service Day 40C Conf Room 1 Timekeeping Training 40C Conf Room 3 1:30p-4:30p	<b>23</b> ProACT Refresher Training 40C Conf Room 3 8a-5p	<b>24</b> ProACT Refresher Training 40C Conf Room 3 8a-12p	<b>25</b>
<b>26</b>	<b>27</b> General Orientation 40C Conf Room 1	<b>28</b> General Orientation 40C Conf Room 1 ED Day 40C Conf Room 2 RN Leadership Day 40C Conf Room 3 8a-5p <i>(Required for all new nurses)</i>	<b>29</b> General Orientation 40C Conf Room 1 Evidence Based Practice 40C Conf Room 3 8a-5p Active Listening 40C Conf Room 2 8a-12p Driver's Training 40C Conf Room 2 1p-3p	<b>30</b> General Orientation 40C Conf Room 1		