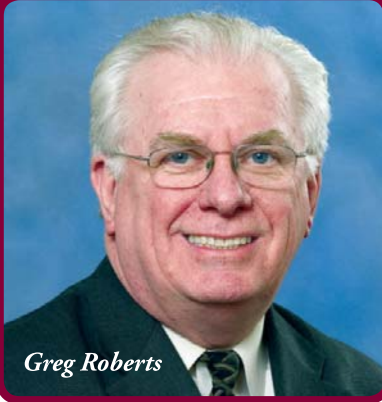
DHS: ADDICTIONS AND MENTAL HEALTH DIVISION

OSH RECOVERY TIMES

Volume 6, Issue 12 1 December 2010

Message from the superintendent


Greg Roberts

Last month, we celebrated the opening of the first part of the new hospital with a dedication ceremony. At the event, I had the honor of speaking about my vision for the new hospital. Unfortunately, the gymnasium where the dedication was held has a strict occupancy capacity per the fire code, and this limited the number of people who could attend. So, for those of you who were not there, I want to share with you what I said that day. What follows is a condensed version.

The hard work has just begun. It's not time to sit on our laurels now that we have this shiny new facility. Now is when we roll up our sleeves and focus on continuing to improve the care and treatment for the people we serve. The therapeutic environment of the new facility will enable us to continue the momentum of improvements already underway at the hospital.

This is the second time in the past five years that I've been the administrator at a newly built state hospital and been part of the closure of an 1880s-era Kirkbride facility. My first experience was with the Greystone Park Psychiatric Hospital in Morris Plains, N.J., which has truly become an excellent treatment center. Based on my experiences there, I can speak with confidence about what the new hospital represents and the changes it will bring.

As you know, we've already started moving in. We've been using the kitchen since September, the workshops for vocational services since October, and we began evaluation services in November. More than 100 staff are already working in Harbors. When people move, they bring lots of baggage, and a lot of concern has been expressed publicly about the kinds of baggage the hospital is bringing into the new building. I'm here to talk about the good things we are going to bring.

The first and most important thing we are bringing to the new hospital is hope. Hope is the essential ingredient for a successful recovery. To reach our goals, we all need to believe that our patients will get better. Research has clearly demonstrated that recovery from psychiatric disorders is not only possible, but is more than likely for most individuals.

(continued on page 2)

In this issue...

Message from the superintendent.......1

Colloquium Series: START at Oregon State Hospital.............3

HEART is here to help........................4

Your Pharmacy and Therapeutics Committee.................6

Infection Control corner.........................7

Your Quality Improvement Department................8

Oregon State Hospital celebrates opening first phase of new facility........................9

The ultimate recovery sport...........10

OSH new hires and retirees................12

December 2010 EDD events..............12

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

Message from the superintendent

Continued from page 1

The new hospital will be a place of healing, where staff:

- Have confidence in their ability to help a person recover, as well as in the person's ability to recover;
- Treat each other and patients with dignity and respect;
- Inspire hope that each person's plans and goals can be achieved;
- Become non-reliant on force and coercion, including seclusion and restraint;
- Listen to patients instead of directing them; and
- Let patients take the lead in their own recovery.

This brings us to the second thing we bring to the new hospital – person-centered care. Each patient has to be the primary participant in his or her own treatment planning process, and the treatment plan has to:

- Be based on the patient's expressed goals and aspirations;
- Aim for self-determination;
- Have meaning for the patient and be "owned" by the patient; and
- Be based on the patient's abilities, accomplishments and strengths – focusing on what is strong with the patient, not what is wrong with the patient.

We also bring "wellness," something that needs our full attention and effort. Studies show that the life expectancy of people with mental illness is 25 to 27 years less than people without it. That is simply intolerable, unacceptable and inexcusable. Physical well-being goes hand-in-hand with recovery. Moving forward, we will identify effective ways of integrating mental health and primary care so we are effectively treating the whole person.

We bring knowledge. Treatment itself has to include, as much as possible, evidence-based practices — core sets of interventions that have demonstrated effectiveness in decreasing symptoms, enhancing skills and/or improving quality of life. The use of evidenced-based practices links research with reality.

Finally, we bring an invitation to families, mental health consumers and community providers to be part of the improvement and change process. As patients take charge of their own treatment planning process, they will need training and encouragement. Patients will likely need help to recognize their own strengths and to focus on their potential. To that end, family, friends and consumers, or "Peer Bridgers," become vitally important partners in the effort as supporters and mentors.

Family education programs will play an essential role, and we will expand them, working with the local chapters of the National Alliance on Mental Illness (NAMI) to demonstrate transparency and to genuinely solicit their expertise.

Consumers will be employed at Oregon State Hospital, eventually one per treatment team, to educate patients and staff in their unique way about recovery being possible, likely and real.

Community providers, from whom we receive patients, and to whom we expect to return patients, are becoming and will continue to be true members of the treatment teams. This means being involved in the treatment planning process from the time of admission, throughout the hospitalization and especially as discharge approaches.

(continued on page 3)

Message from the superintendent

Continued from page 2

The hospital is just one part of the statewide continuum of care, and we must never lose sight of our goal for patients reentering the community to live their lives. We all (staff, consumers, families, community providers and advocates) must work together to realize the promise that this wonderful new building represents.

As we move in and the hospital continues to transform, there will be good days and bad. But the overall direction will be positive, and, in the end, Oregon State Hospital will become the recovery-oriented, recovery-based hospital we all want and need it to be.

Sincerely,

Greg Roberts
Superintendent

Colloquium Series: START at Oregon State Hospital

By Callie H. Lambarth

As you may know, the Planning, Analysis and Research (PAR) group hosts a monthly colloquium series on various topics of interest to the hospital. Recently, PAR welcomed forensic psychologist Alexander Millkey to discuss the implementation and application of START (Short-Term Assessment of Risk and Treatability), an assessment tool used at the Oregon State Hospital (OSH).

Dr. Millkey outlined the evolution of risk assessment techniques and discussed why START was adopted at OSH. START has dynamic risk factors, includes an assessment of strengths and vulnerabilities, relies on an interdisciplinary approach and is intended to help guide treatment. In addition, START forecasts risk on multiple domains for up to three months and is designed for a range

(continued on page 5)

HEART is here to help

Information provided by Julee Engelsman, Hospital Employees Assistance Response Team

We at the Oregon State Hospital value our staff and volunteers, and we recognize the essential role they play in our mission of delivering high-quality, compassionate, cost-effective and respectful psychiatric services.

Providing inpatient psychiatric services can be both difficult and stressful. Staff and volunteers may be called upon to perform their duties in situations that hold the potential for both physical and psychological harm.

When traumatic incidents occur, it is the hospital's goal to provide assistance for critically affected staff and volunteers. The Hospital Employees Assistance Response Team (HEART) provides the tools people need to effectively cope with their experiences.

A traumatic incident is an event that may result, or has resulted, in acute psychological distress for the involved staff or volunteers, including incidents involving death or serious injury, suicide or serious attempt, assault, sexual abuse and other work-related events.

The mission of HEART is to provide crisis support to reduce the harmful effects of critical incident stress for all Oregon State Hospital staff. Critical incident stress is caused by overwhelming emotional response to a traumatic incident. It may be an immediate or delayed response (days, weeks, months), and has the potential to interfere with a person's ability to function both on the job and at home.

HEART is comprised of 48 responders from various disciplines throughout the hospital, including mental health technicians, mental health services, social work, etc. Portland campus is represented as well. This multifaceted approach matches each situation to the appropriate responder. HEART responders are trained by the International Critical Incident Stress Foundation in critical incident stress management. This training is widely used by other agencies within Oregon, such as corrections, police departments, fire departments and other high-risk professions to respond to the critical incidents faced by their staff.

HEART administers a variety of confidential services, including defusing, debriefing, individual consults and follow-up services. Defusing is conducted at the hospital shortly after the incident, usually within three to four hours. It consists of a mini-debriefing to help prevent and lessen symptoms created by a critical incident. Defusing is support provided to all those involved in the incident prior to the end of their shift.

Within 24 to 72 hours after an incident, HEART conducts a debriefing, which includes a confidential non-evaluative discussion of thoughts and feelings resulting from the incident. During the debriefing, participants are educated about the possible stress-related symptoms that may occur.

HEART also conducts individual consults for concerns related to the incident. When necessary, staff and volunteers who need one-on-one counseling will be referred to the Employee Assistance Program (EAP) or team clinicians.

In the weeks or months following the incident, staff and volunteers can contact HEART for an additional debriefing session, phone or personal follow-up.

Remember, HEART is here to help.

(continued on page 7)

Colloquium Series: START at Oregon State Hospital

Continued from page 3

of populations, including those in hospital, community and corrections settings. Finally, START has a growing base of research to support its use, application, reliability and validity.

The implementation of START at OSH began more than two years ago with the formation of the START Implementation Team (START IT), comprised of Alexander Millkey, Brooke Howard, Darci Walker, Callie Lambarth, Elena Balduzzi, Nat Thomas and Steven Wilson. The authors of START came to OSH to provide training for Psychiatric Security Review Board (PSRB) and OSH staff, followed by unit trainings by START IT. Hospital-wide policy was established, requiring START to be completed within 10 days of admission, every subsequent 90 days, following any critical event and prior to Risk Review hearings. Policy also states that goals on the Master Treatment Care Plan (MTCP) should reflect key and critical items on START. Ongoing education and training opportunities were, and continue to be, offered regularly through the Education and Development Department (EDD), in addition to periodic trainings for PSRB members and attorneys general.

Currently, START is being used in Risk Review hearings with forensic and civil patients, and OSH-Portland is completing START at least every 90 days for all patients. In addition, a former START IT psychologist is conducting training and supervision for community-based providers. Finally, START IT has examined the descriptive data based on STARTs completed for forensic patients in 2009.

Dr. Millkey also provided several examples of how START is currently being used to inform treatment. Notably, at OSH-Portland, Eric Bergreen and Nicole Wirth took a lead role in linking each item on START with treatment mall groups to help develop strengths and/or mitigate risks in each area, while also accounting for patients' level of motivation or current step in the discharge process. OSH-Salem staff also developed a similar set of interventions and responsivity issues to consider for each key or critical item.

While START IT has been successful in these areas, Dr. Millkey outlined several places where the Hospital needs to improve in order to fully implement START at OSH. For example, OSH needs to engage more than just psychologists who specialize in risk assessment to reflect the interdisciplinary nature of START. Second, START IT needs to work with the interdisciplinary teams (IDTs) to ensure there is enough time and that the entire IDT is present to complete the START. Finally, hospital staff need to understand that START is a tool to identify strengths and guide treatment, not just a risk assessment instrument for use at Risk Review hearings.

Despite the challenges still facing START implementation, START has been positively received by PSRB and several community providers. It is encouraging that community providers have attended trainings offered through EDD and are receiving ongoing consultation and supervision from a former START IT psychologist. The use of START at OSH and in the community could provide a common language to help bridge the gap in the continuum of care between patients' stay at OSH and subsequent community placements.

Thanks to Dr. Millkey for presenting and to all who attended the colloquium. The PAR colloquiums are held at noon on the last Monday of every month. The next colloquium is scheduled for noon, Jan. 31, in EDD conference room #2. Clinical Pharmacy Manager Cydreese Aebi will be presenting on the use of PRNs at the hospital. If you have ideas or suggestions for future colloquium topics, please contact Aaron Dunn, PAR chief analyst, at 503-947-1029 or through GroupWise to explore how we may be able to support your needs and interests.

Your Pharmacy and Therapeutics Committee

To learn more about how OSH operates, last month you read about the Emergency Preparedness Committee. This month, we profile the Pharmacy and Therapeutics Committee, with a shorthand name of P&T.

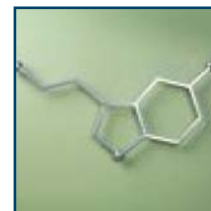
The challenges faced by the P&T Committee are as varied as the medications, supplements and seemingly non-stop new drugs coming to market. Chaired by a physician, committee membership is comprised of representatives from Pharmacy (of course) and Quality Improvement, as well as the CNO, the CMO, a clinical dietitian, supervising RNs from some of the units, and other physicians. This group meets on the third Thursday of each month.

Purpose: The Pharmacy and Therapeutics Committee advises the Medical and Allied Health Professional Staff (MAHPS) in all matters pertaining to the use of drugs. The Pharmacy and Therapeutics Committee is responsible for 1) developing and maintaining a formulary of drugs; 2) monitoring the need for educational programs related to drug use; 3) studying problems related to the distribution and administration of medications; 4) coordinating with the Medical Department on drug use review programs; 5) reviewing adverse drug reactions; 6) advising Pharmacy in the implementation of effective drug distribution and control procedures; and 7) reviewing medication variance data.

If a patient has an adverse reaction to a medication, P&T reviews the case and makes recommendations. If a patient wants the newest supplement (that may contain five times the caffeine of a cup of coffee), P&T reviews the implications of such supplements. With the patients' needs first in mind, P&T reviews the costs of the newest pharmaceuticals and whether patients can afford the medication once they leave the hospital.

With the new hospital, one of the larger Pharmacy & Therapeutics initiatives includes work around a computerized medication dispensing system. The new system will help monitor and ensure the correct medications are available for the people we serve.

Lately, the P&T Committee has begun tackling the challenges related to medication diversion and prescription drug abuse. Many staff have already been offered an opportunity to participate in a survey about drug abuse and drug diversion. The survey includes perceptions and values related to medications, non-medication alternatives and how we, as an organization, approach these varied perceptions and the drug abuse challenges. Drug abuse and drug diversion are issues that all health care organizations face. OSH, to ensure quality patient care and meet all accreditation standards, must also address these difficult issues.



For more information about hospital committees, please visit the OSH Committee Wiki at the following web address: *http://wiki.hr.state.or.us:8080/display/OSHCOMM/Home.*

Infection Control corner

By OSH Infection Control Department

Have you ever thought about the keyboard that you touch being a health hazard?

How many people use the same workstation day in and day out? How many different workstations do you touch in a day? If many people use a workstation, the risk increases of passing colds, flu or other illnesses between staff via the keyboard.

Have you thought about what nourishment the keyboard is receiving if you eat at your workstation? When you eat at your workstation, tiny food particles fall on your keyboard, inviting bacteria to grow at your fingertips. Eating at your workstation also invites rodents that walk across your keyboard and spread harmful bacteria. So, don't eat at the computer. Wipe down your telephone, desktop, computer keyboard and mouse at least daily if not more often.

And, as always, follow best-practice guidelines for hand-washing.

HEART is here to help

Continued from page 4

Critical incident stress

It is important for OSH employees and volunteers to recognize the symptoms of critical incident stress and how to access HEART services.

To contact HEART, call 503-945-9470.

Immediate symptoms may include

Thinking:

- Poor concentration
- Difficulty making decisions
- Disorientation
- Confusion

Feelings:

- Grief reactions
- Shock-like states
- Inappropriate patterns

Physical symptoms requiring medical attention:

- Difficulty breathing
- Chest pain
- Erratic pulse
- Collapse
- Dizziness
- Headache
- Signs of severe shock
- Elevated blood pressure

Other physical symptoms

- Muscle tremors
- Nausea, vomiting

Long-term symptoms

- Any of the symptoms previously listed
- Insomnia
- Nightmares
- Flashbacks that can be sight, sounds, smells, taste and/or touch
- Sudden, severe anxiety
- Panic attacks

Your Quality Improvement Department

By QI Department

Here is what is coming your way in 2011! In an effort to provide more comprehensive quality improvement services, your QI staff will initiate a new process for all units in 2011. Previously, QI staff, treatment care plan specialists and a few other staff conducted spot chart audits. In a given month, perhaps three to ten charts were audited on a single unit. Periodic environment of care audits have occurred on all units as well. The QI Department is taking a more systematic approach in 2011.

From OSH staff observations and outside consultants, we know we can keep improving for the people we serve: the patients of OSH and people of Oregon. Feedback from OSH staff received in the last year has been that more detail more often is needed to identify both what is working well and what we must improve.

Starting with our newest units in Harbors, soon after the patients move in, a four-step process will occur.

1. In the first step of the first week, QI staff along with treatment care plan specialists (TCPS) will conduct a half-day review of all patient charts on a unit. All of the charts on one unit will be audited. The audit will be in greater detail than ever before, with all of the specifics of who, when, where, what, etc. Both quantitative and qualitative measures will be reviewed. This will occur at least every six months on all units.
2. The next step, in the second week, has two elements to it.
   a. The chart audit data will be tallied and submitted to the unit, discipline chiefs and the Medical Records Committee. This information will be posted on the QI Wiki site. Quality Council will receive quarterly summaries.
   b. Quality Improvement staff will assign a liaison to each unit, to work with the mental health supervising RN (unit manager), the TCPS and discipline chiefs to both recognize the successes and to strategize how to make continuous improvement.

3. An environment of care (EOC) audit is the third step that occurs in the third week of the unit review. Working with the unit staff, QI staff can identify accreditation standards that are being met and those that still need attention. If there is a new or pending work order, QI will help get it moved along. As with the chart audits, the EOC audit will go to the unit

(continued on page 9)

Your Quality Improvement Department

Continued from page 8

manager, discipline chiefs and the QI Wiki. (The QI Wiki can serve as a clearing house for OSH staff to see what might be considered best practice on unit to apply to their own unit as well.)

4. Week four on the assigned unit will bring a mock accreditation tracer, focusing on the care provided to a single patient. A patient will be selected from one of the following categories: new admission, pending discharge, or high risk areas such as seclusion or restraint, falls, pain medications, refusing care or treatment, etc. Once a patient is selected, that patient's care will be traced through all of the departments that provided services to that patient, including a review of the human resource files of the staff involved with that patient. **This is the same process that accrediting agencies use when evaluating hospitals**.

With this process, we will learn what is working well and what may even be considered best practice. Those best practice elements will spread to all of the units along with lessons learned. This approach will constantly and continually improve services at OSH.

Oregon State Hospital celebrates opening first phase of new facility

By Rebeka Gipson-King, OSH Communications Officer

On Nov. 18, patients at the Oregon State Hospital, family members and stakeholders joined state leaders at a dedication ceremony for the opening of the new Oregon State Hospital's first phase.

The ceremony began with a song by the patient bell choir, followed by five speakers: Oregon Health Authority Director-Designee Dr. Bruce Goldberg, Governor Ted Kulongoski, Senator Peter Courtney, Administrator of the Replacement Project Linda Hammond, Superintendent Greg Roberts, and Rex Gorger, a patient. The patient rock band, the "PRNs," provided a lively closing to the event.

"This is a place of new beginnings and a place where patients come first. A place where care is patient-driven and a place where care is patient-focused," said Governor Kulongoski. "This marks a new era for mental health care for Oregon."

When complete, the new hospital will be 870,000 square-feet and house up to 620 patients from around the state. The next phase of construction is scheduled to open during the summer of 2011, and the final section of the hospital is scheduled to open toward the end of next year.

The new building will help in the transition to recovery-based care by providing smaller units, treatment malls where patients attend group sessions during the day, and rooms designed for patients to participate in the creation of their own treatment care plans.

"The hospital is just one part of the statewide continuum of care, and we must never lose sight of our goal for patients reentering the community to live their lives," said Superintendent Roberts. "We all must work together to realize the promise and the hope that this wonderful new building represents."

THE ULTIMATE RECOVERY SPORT

By the OSH RSD and QI staff

Name an international, competitive team sport that is self-regulated or self-directed … no referees, even at the most competitive level. There is only one sport that matches this description.

Name a sport played right here at the Oregon State Hospital, all year round, rain or shine. Name a sport played by men, women and co-ed teams on most college campuses, in high schools, middle schools, around town, in 42 countries. Name a sport played by hundreds of thousands of people worldwide. Name a sport where everyone is welcome, everyone is accepted, everyone is supported. Name a sport where you feel free.

Name a sport whose official rule "*relies upon a* ***spirit*** *(Spirit of the Game or SOTG)* ***of sportsmanship*** *that places the responsibility for fair play on the player. Highly competitive play is encouraged, but never at the expense of mutual* ***respect*** *among competitors, adherence to the agreed upon rules, or the basic joy of play. Protection of these vital elements serves to eliminate unsportsmanlike conduct… Such actions as taunting opposing players, dangerous aggression, belligerent intimidation, intentional infractions, or other 'win-at-all-costs' behavior are contrary to the Spirit of the Game and must be avoided by all players.*"

There is only one sport like this: Ultimate or 'Ult' (not to be called ultimate 'Frisbee' because Frisbee is a brand name).

'Ult' has been happening at OSH for a couple of years now, facilitated by several of the Recreational Services Department (RSD) staff including Erik Luvaas and Brendan McClean. On Thursdays at 2 p.m., over at the 50 outdoor area and soon in the outdoor areas of the new building, discs will be soaring.

So, why do some of the patients at OSH play? Here is what a couple of patients say:

"I play for the team emphasis. I like being part of a team in sports and having the team succeed."

(continued on page 11)

THE ULTIMATE RECOVERY SPORT

Continued from page 10

"I have high expectations. I have to dive for the disc sometime in the game. I expect that from me and from others. Sometimes I have to remember others are still learning and tone my expectations down."

That last quote was from a patient working through some frustration during the game. He was able to identify that it was his own issue, not the other teammates'. That is an amazing strength to recognize, all from a game of 'ult.'

Ultimate may even be the best sports model for many recovery concepts, such as self-direction, hope, meaningful activity, individual and group choices, connection with and support of others. It respects an individual's space as it is a **non-contact sport**. Playing ultimate permits individuals to push themselves to their individual maximum potential

(overcoming limitations) while still working with and collaborating with a team (support system).

To play ultimate, you do not have to be the fastest, tallest or best thrower. You just have to want to play. There is no gear, no equipment (other than a disc), just desire. You are accepted for where you are at. The game combines running with hand-eye coordination, shifty moves and throws, strategy and, of course, teamwork. It is non-stop, end-to-end action. And no refs … you call the fouls on yourself and sometimes others. Disputes are resolved by those involved, not outside parties. Next time you see people tossing, join in. You are **always** welcome!

A final quote from one person we serve may sum it all up… "I'm free! When I am playing ultimate, I could be anywhere playing it. I love it!"

December 2010 EDD events

Following is a list of classes being offered at the OSH Education and Development Department (EDD) during the remainder of December. Classes are located at EDD unless otherwise noted. For more information about these classes, call 503-945-2875.

Pro-ACT refresher:
Held in building 40C conference room 3
Dec. 7-8 (7, 8 a.m. to 5 p.m.)(8, 8 a.m. to noon)
Dec. 9-10 (9, 8 a.m. to 5 p.m.)(10, 8 a.m. to noon)
Dec. 21-22 (21, 8 a.m. to 5 p.m.)(22, 8 a.m. to noon)
Dec. 28-29 (28, 8 a.m. to 5 p.m.)(29, 8 a.m. to noon)

OSH driver's training:
Held in building 40C conference room 2
Dec. 16 (1 p.m. to 5 p.m.)

General orientation:
Held in building 40C conference room 1
Dec. 1-3 (8 a.m. to 5 p.m.)
Dec. 6 (8 a.m. to 5 p.m.) Room 2
Dec. 6-10 (8 a.m. to 5 p.m.)
Dec. 13 (8 a.m. to 5 p.m.) Room 2
Dec. 13-17 (8 a.m. to 5 p.m.)
Dec. 20 (8 a.m. to 5 p.m.)

Informed consent process:
Held in building 40C conference room 3
Dec. 15 (1:30 p.m. to 3 p.m.)

CMA pharmacology:
Held in building 40A large conference room
Dec. 16 (1 p.m. to 5 p.m.)

Interventions to prevent dysphagia:
Held in building 40C conference room 3
Dec. 22 (2 p.m. to 4 p.m.)

Nursing orientation:
Held in building 40C conference room 3
Dec. 7 (8 a.m. to 5 p.m.)
Dec. 14 (8 a.m. to 5 p.m.)
Dec. 21 (8 a.m. to 5 p.m.)
Dec. 22 (8 a.m. to 5 p.m.) Day 2 room 1

ED day/CPR:
Held in building 40C conference room 2
Dec. 14 (8 a.m. to 5 p.m.)
Dec. 28 (8 a.m. to 5 p.m.)

Wellness mind/body connection:
Held in building 40C conference room 3
Dec. 8 (1 p.m. to 4 p.m.)

Trauma informed care:
Held in building 40C large conference room
Dec. 21 (1 p.m. to 5 p.m.)

Learning styles: coworkers dynamics:
Held in building 40C large conference room 3
Dec. 16 (1 p.m. to noon)

Harbors training days:
Held in Harbors gym
Dec. 7-9 (8 a.m. to 5 p.m.)
Dec. 14-16 (8 a.m. to 5 p.m.)
Dec. 28-30 (8 a.m. to 5 p.m.)

Wellness mind/body follow-up:
Held in building 40C conference room 3
Dec. 17 (1:30 p.m. to 4:30 p.m.)

Behavioral decision making-7CEU:
Held in building 40C conference room 3
Dec. 2 (8:30 a.m. to 4:30 p.m.)

OSH new hires and retirees for December

Welcome to OSH

Name	Position
Susan M South	Clinical Psychologist 2
Andrew R Stover	Clinical Psychologist 2
Catherine S Bibens	Food Service Worker 2
Christopher A McNabb	Food Service Worker 2
Rebecca Mock	Food Service Worker 2
Tracie J Stapleton	Food Service Worker 2
Merilyn Trapero	Food Service Worker 2
Antonio D Villasenor	Food Service Worker 2
Jamie S Xiong	Food Service Worker 2
Cory J Bierd	Licensed Practical Nurse
Katrina M Giese	Licensed Practical Nurse
Catherine Roberts	Licensed Practical Nurse
Raymond Shoun	Licensed Practical Nurse
Apryle R Tessman	Licensed Practical Nurse
Burton Dollarhide	Mental Health Registered Nurse
Courtney R Linhart	Mental Health Registered Nurse
Christine L Mundy	Mental Health Registered Nurse
Renee L Thunell	Mental Health Registered Nurse
Vernon L Engstrom	Mental Health Therapist 1
Heidi K Becker	Mental Health Therapy Tech
Loraine R Blake	Mental Health Therapy Tech
Johnny A Budiel	Mental Health Therapy Tech
Daniel L Davis	Mental Health Therapy Tech
Candis J Graves	Mental Health Therapy Tech
Patrick B Hobbs	Mental Health Therapy Tech
Cody N Hugie	Mental Health Therapy Tech
Karren S Maldonado	Mental Health Therapy Tech
Jammie Ann Nelson	Mental Health Therapy Tech
Alicia R Phillips	Mental Health Therapy Tech
Cher Yao Chen Chen	Physician Specialist
Karen Berger	Psych Social Worker
Stacey Castor	Rehabilitation Therapist
Daniel J Wright	Supply Specialist 2
Robert Spinuzza	Support Services Supervisor 2

Promotions and reassignments

Name	Position
Estelle M Fromm	Mental Health Therapist 2
Amber Marie Steckler	Mental Health Therapist 2
Stephanie Susee	Mental Health Therapist 2
Lauren E Quinlan	Operations and Policy Analyst 2
Simrat Sethi	Supervising Physician

Retirees

Name	Position
Linda M Gaines	Mental Health Therapist 1