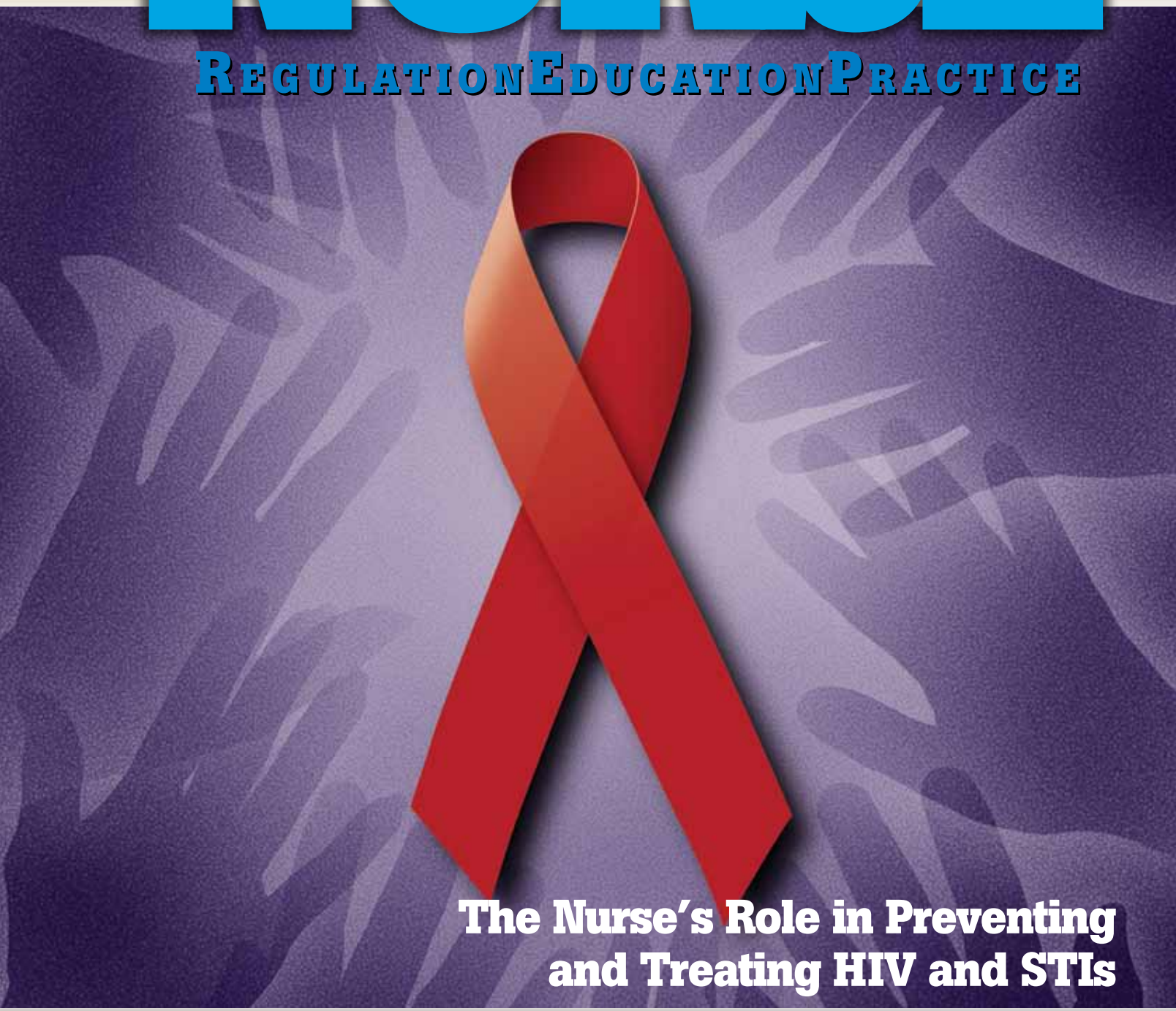
VOLUME 8 NUMBER 2
JULY 2011

DISTRICT OF COLUMBIA NURSE

REGULATION EDUCATION PRACTICE



The Nurse's Role in Preventing and Treating HIV and STIs

Government of the District of Columbia
Vincent C. Gray, Mayor

LPN Licensure Renewal has been Extended (page 7)

Guidelines for Reporting Practice Related Incidents to the Board of Nursing (page 8)

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DISTRICT of COLUMBIA NURSE

Edition 30

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DC BON Mission Statement: "The mission of the Board of Nursing is to safeguard the public's health and well being by assuring safe quality care in the District of Columbia. This is achieved through the regulation of nursing practice and education programs; and by the licensure, registration, and continuing education of nursing personnel."

Circulation includes over 22,000 licensed nurses, nursing home administrators, and nurse staffing agencies in the District of Columbia.

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Message from the Chairperson

In this issue of DC NURSE, guidelines are discussed for reporting practice issues to the Board (see page 8 for GUIDELINES FOR REPORTING PRACTICE RELATED INCIDENTS TO THE BOARD OF NURSING). As a nurse licensed in DC, it is important that you understand nursing regulation in the District and the role that the Board of Nursing has related to regulation and discipline.

The mission of the Board of Nursing is "to safeguard the public's health and well being by assuring safe quality care in the District of Columbia. This is achieved through the regulation of nursing practice and education programs and by the licensure, registration and continuing education of nursing personnel."

JUST CULTURE

A few months ago, the Board introduced the concept of "Just Culture" to members of the public during our Open Session. The Board had been looking at this concept over the last year and felt it was something that we would like to incorporate into our approach to discipline for nurses reported for violations of the Nurse Practice Act. The Board realizes that the concept is not something that will be effective unless the facilities in DC are aware of the principles of "Just Culture," and are willing to work at establishing an environment in which there can be discussion and reporting of errors and near misses without fear of retribution. Employers must be willing to focus on the behavioral choices of nurses, not merely the fact that an error occurred or that a bad outcome resulted.

REPORTING ENVIRONMENT

"Just Culture" is a term which was coined by David Marx, who is well known for his work in patient safety and safe systems design in a variety of fields. Although his work is not specific to health care professionals, the principles are certainly applicable. A major principle of "Just Culture" is that discipline needs to be tied to the behavior of individuals and the potential risks their behavior presents more than the actual outcome of their actions. It realizes that human beings are fallible, but do have control over their behavioral choices. It is about creating a reporting environment where staff can admit to making a mistake or seeing a risk, so that preventative measures can be implemented and patient safety maintained, while holding staff accountable for their behaviors.

BEHAVIOR NOT OUTCOME

"Just Culture" places focus on evaluating behavior not outcome and distinguishes between normal errors, unintentional risk-taking behavior, and intentional risk-taking behaviors. The Board realizes that often environment and systems need to be looked at, as well as the nurse who is being reported, if we are truly to improve patient safety and the quality of care for the patients in the District. The Board developed guidelines for reporting practice-related incidents to the DC Board of Nursing to "provide a mechanism for employers of nurses and the Board to come together to promote a culture in which we learn from practice errors while properly assigning accountability for behaviors, consistently evaluating events, and complying with mandatory reporting requirements."

E. Rachael Mitzner, BSN, MS, RN

NOT "BLAME-FREE"

Nurses must realize that this is not a "blame-free" response to all errors. It focuses on the behavioral choice of the nurse, the degree of risk taking, and whether the nurse deliberately disregarded a substantial risk. It holds the nurse who makes unsafe or reckless choices that endanger patients accountable for those choices.

We know that nurses in the District are committed to their patients and want to consistently give quality care to our residents. As a Board, we expect that you hold yourselves accountable for knowing and practicing within the DC Nurse Practice Act while continually striving to improve the quality of care in your facility and the District of Columbia. Thank you for choosing nursing and for being committed to caring.

E. Rachael Mitzner, BSN, MS, RN
Chairperson
DC Board of Nursing

Board of Nursing Update
February, April, May

LBGT ALLIANCE REQUESTS CULTURAL SENSITIVITY TRAINING

A representative from the LBGT (Lesbian, Bi-sexual, Gay, Transgender) Alliance asked the Board to include training in the Nursing Assistive Personnel (NAP) curriculum that would focus on working with this population; particularly for home health aides coming into the home, so that NAPs are aware of sexual orientation and gender issues.

At its April meeting the Board approved a curriculum that addresses cultural sensitivity regarding the LBGT population. This curriculum will be incorporated into the model curricula for Nursing Assistive Personnel programs.

TRAINED MEDICATION EMPLOYEES (TME)

The Board held a meeting with Trained Medication Employees (TME) trainers and employers to discuss the initiation of electronic testing for certification for TME applicants.

MEDICATION AIDES REGULATIONS

Setting-specific information was removed from the regulations. Previous draft regulations included language regarding the regulation of MA-Cs (Medication Aide-Certified) in intermediate care facilities, assistive living facilities and schools. Revisions focus on regulatory and training requirements for MA-C no matter the setting. Once certified, the MA-C is expected to follow the policies of the setting in which they administer medications.

JUST CULTURE AND DISCIPLINE REPORTING GUIDELINES

The Board is often asked by employers: At what point is it appropriate to report a nurse to the Board for the purpose of possible disciplinary action? To answer this, the Board developed Discipline Reporting Guidelines to provide a mechanism for employers of nurses and the regulatory board to come together to promote a culture that promotes learning from practice errors while properly assigning accountability for behaviors, consistently evaluating events, and complying with mandatory reporting requirements. The framework the Board has chosen to use in making disciplinary decisions is "Just Culture." The Guidelines will provide an overview of the "Just Culture" principals and how the Board will work with nurses and employers of nurses to implement these guidelines. [Page 8]

HIV/AIDS TO BE REQUIRED FOR CONTINUING EDUCATION

Mayor Vincent Gray has asked boards to require HIV/AIDS education as part of their Continuing Education requirements for licensure renewal. The Board agreed that as we develop new regulations we will require all persons under the authority of the BON to have a minimum of 2 (two) HIV/AIDS contact hours per renewal period.

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LICENSED PRACTICAL NURSING RENEWAL HAS BEEN EXTENDED UNTIL MONDAY, AUGUST 1, 2011

Due to the challenge LPNs have faced renewing their licenses in meeting the criminal background check requirements, the LPN renewal period will be extended until MONDAY, AUGUST 1, 2011. We are working to make the process easier and more efficient.

Live Scan appointments for persons wishing to have their CBC completed in DC have been extended until 8:00 pm, Tuesdays and Thursdays.

(See page 10 for more information on the CBC process.)

REMINDER: Trained Medication Employee (TME) Recertification

TRAINED MEDICATION EMPLOYEES (TMEs) please be reminded that your TME registration expires October 31, 2011 and renewal begins August 1, 2011.

REQUIREMENTS FOR RECERTIFICATION:

- Criminal Background Checks will be required for this renewal period.
- Completed application.
- Application fee of $59.00. Applications submitted after October 31, 2011, will be assessed a $20.00 late fee.
- Supervisory registered nurse's verification of the TME's continued adequacy of performance.
- Documentation verifying successful completion of 12 hours of board approved in-service training. [Please note: Do not send with recertification. Submit only per request from the Board].

The Board will recertify an applicant upon receiving a completed recertification application, the appropriate registration fee, affirmation [check "Yes" on the application that you have or will have completed your in-service training requirements by October 31, 2011.]

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Guidelines for Reporting Practice Related Incidents to the Board of Nursing

OVERVIEW

Just Culture

David Marx, an engineer and attorney, who is well known for his work in patient safety and safe system design, describes "Just Culture" as follows: ***On one side of the coin, it is about creating a reporting environment where staff can raise their hand when they have seen a risk or made a mistake. On the other side of the coin, it is about having a well-established system of accountability. A "Just Culture" must recognize that while we as humans are fallible, we do have control of our behavioral choices.***

The principle behind a "Just Culture" is this: Discipline needs to be tied to the behavior of individuals and the potential risks their behavior presents more than the actual outcome of their actions. A "Just Culture":

- *Places focus on evaluating the behavior, not the outcome;*
- *Requires leadership commitment and modeling;*
- *Distinguishes between normal error, unintentional risk-taking behavior and intentional risk-taking behaviors;*
- *Fosters a learning environment that encourages reporting of all mistakes, errors, adverse events, and system weaknesses (including self-reports);*
- *Lends itself to continuous improvement of work processes and systems to ensure the highest level of patient and staff safety;*
- *Encourages the use of non-disciplinary actions whenever appropriate (including coaching, counseling, training and education); and*
- *Holds individuals accountable for their own performance in accordance with their job responsibilities but does not expect individuals to assume accountability for system flaws over which they had no control.*

"Just Culture" encourages discussion and reporting of errors and near misses without fear of retribution. It is a culture that focuses on the behavioral choices of the practitioner, not merely the fact that an error occurred or that a bad outcome resulted from an error.

- "Just Culture" recognizes that perfect performance is not something that can be sustained, and errors will occur. It recognizes that the threat of disciplinary action does NOT prevent individuals from making errors.
- In a, "Just Culture", there is agreement that even the most experienced and careful nurse can make a mistake that could lead to patient harm. There is recognition that nurses will make mistakes and that perfect performance is impossible.
- "Just Culture" is not a "blame-free" response to all errors. It focuses on the behavioral choice of the nurse, the degree of risk-taking, and whether the nurse deliberately disregarded a substantial risk. It holds the nurse accountable who makes unsafe or reckless choices that endanger patients.

In fulfilling its mission to safeguard the public's health and well being by assuring safe quality care, the Board is committed to nursing practice regulation that is prompt, fair, and appropriate to public protection. The Board believes protection of the public can be facilitated by fair and just treatment of nurses who are involved in practice events. The Board reacts promptly to complaints and allegations of violations of the Health Occupations Revision Act and Board of Nursing regulations. All allegations are evaluated with respect to the merits of the individual case and the potential harm to the public. The Board's responses to substantiated violations fall within a continuum of remedial and disciplinary action.

The Board believes protection of the public is not enhanced by the reporting of every minor incident that may be a violation of HORA. This is particularly true when there are mechanisms in place in the nurse's practice setting to identify nursing errors, detect patterns of practice, take corrective action, and monitor the effectiveness of remediation on deficits in a nurse's behavior and practice including judgment, knowledge, training, or skill.

The purpose of this guide is to provide a mechanism for employers of nurses and the board to promote a culture that promotes learning from practice errors while properly assigning accountability for behaviors, and consistently evaluating events. As healthcare facility nursing leaders and DCBON staff review and discuss events, these guidelines, will be utilized so that matters are handled as consistently as possible.

The review of a practice issue by the employer may result in:

1. **Consultation Only** - Employer supports nurse and no further action is needed.
2. **Employer Directed Corrective Action** - Employer addresses incident with nurse through system intervention, internal disciplinary processes, and/or individual remediation.
3. **Formal Reporting** – Employer submits report/complaint to Board. Board then conducts inquiry and/or investigation according to established policies and processes.

NON-REPORTABLE INCIDENTS

Definition: Employee has failed to follow employment policies. They are generally not reportable as violations of HORA and therefore would not be addressed by the Board. There may, however, be circumstances that could merit the Board's attention. Nothing in these guidelines is intended to prevent or discourage direct reporting of a potential violation to the Board of Nursing. Please contact the Board's Practice Consultant with any questions about specific situations.

Examples of Non-reportable Incidents:

- No Call-No Show.
- Failure to complete a 2 week notice (abrupt termination).
- Refusal to accept an assignment.
- Rudeness or inappropriate verbal interactions with patients or staff.
- "Nodding" or falling asleep momentarily, unless this is a pattern of practice, or results in patient neglect or harm.
- Falsification of employment application (unless falsification relates to licensure status).
- Failure to follow agency policy (unless this is ALSO a violation of practice act).
- Failure to submit agency paperwork in timely manner (unless jeopardizes patient care versus reimbursement only).
- Mental/emotional problems or issues that do not impact or relate to the nurse's practice.
- Information related to mental or physical conditions of a nurse, when you are providing care for the nurse (which means information is protected).

Systems Issues

Definition: Incidents that are primarily the result of factors beyond the nurse's control.

Criteria: Some incidents, whether minor or significant, may be the result of or influenced by systems factors, as well as by individual factors. Organizational and nursing leaders are responsible for evaluating and addressing system impact on any incident or event, regardless of reportability. Opportunities for system improvements may exist independent of, or in conjunction with, opportunities for individual improvement.

EXAMPLES OF SYSTEMS ISSUES:

- Malfunctioning equipment.
- Staffing/work hour issues.

HUMAN ERROR

Definition: Nurse inadvertently did something other than intended or other than what should have been done; a slip, a lapse, or an honest mistake.

Examples of Human Error:

- One time medication error (wrong dose, wrong route, wrong patient, or wrong time).
- Failure to implement a treatment order due to oversight.

REPORTABLE INCIDENTS

Definition: Employee demonstrates at-risk or reckless behaviors. At-risk behaviors may be reportable if it is determined that the nurse does not appreciate the risk and has a pattern of at-risk behavior. Reckless behavior is reportable as violations of HORA and therefore would be addressed by the Board.

EXAMPLES OF AT-RISK, AND RECKLESS BEHAVIORS

At-Risk Behavior

Definition: Nurse makes a behavioral choice that increases risk where risk is not recognized or is mistakenly believed to be justified; nurse does not appreciate risk; unintentional risk taking. Generally the nurse's performance and conduct does not indicate that their continuing practice poses a risk of harm to clients or other persons.

Examples of At Risk Behavior:

- Exceeding scope of practice.
- Pre-documentation.
- Minor deviations from established procedure.

RECKLESS BEHAVIOR

Definition: Nurse makes the behavioral choice to consciously/willfully disregard a substantial and unjustifiable risk. Reckless nurse behaviors MUST be reported to the Board.

Examples of Reckless Behavior:

- Nurse leaves workplace before completing all assigned patient care (and does not report to another nurse) because he has a date waiting.
- Nurse observes patient starting to climb over bedrails but walks away without intervening.
- Nurse makes serious medication error, realizes it when patient experiences adverse reaction, tells no one, denies any knowledge of reason for change in patient condition, and falsifies documentation to conceal error.

The District of Columbia Board of Nursing wishes to thank the North Carolina Board of Nursing for its graciousness in allowing the adaptation of its "Guidelines for Evaluating and Reporting Practice Violations to the Board."

IN THE KNOW

The Board of Nursing has established this "In The Know" column in response to the many phone calls and e-mails we receive. The Board often receives multiple inquiries regarding the same issue. Please share this column with your colleagues and urge them to read this column. The more nurses are aware of the answers to these frequently asked questions, the less our resources will have to be used to address duplicate questions.

IMPORTANT NOTICE REGARDING CRIMINAL BACKGROUND CHECK (CBC)

Note from DC BON Staff:

Since the initiation of CBCs, we have received numerous inquiries from licensees concerning past and recent arrests/convictions.

To address these issues, we recommend: IF YOU HAVE HAD AN ARREST OR CONVICTION AT ANY TIME IN YOUR PAST, INDICATE "YES" ON YOUR APPLICATION.

If you indicate "No"—that you have never ever had an arrest or conviction—and your CBC indicates that you have, you may be fined $100 for falsification of your application.

MORE THAN SEVEN YEARS AGO:

If the **arrest/conviction occurred more than 7 year ago**, the offense will not be reviewed by the board. If you were arrested or convicted more than seven years ago, please indicate "Yes" on your application.

LESS THAN SEVEN YEARS AGO:

If the **arrest/conviction occurred less than seven years ago**, send court documents and provide an explanation of the event.

RECENT ARRESTS:

If you have had a recent arrest/conviction, what happens with your licensure status? It depends upon the offense, and whether or not the Board determines that the offense reflects upon your ability to practice. The Board will also consider issues such as:

- the nature of the offense
- your age, and
- how recently it occurred.

APRN CONTINUING EDUCATION

Q How many CEU credit hours are needed for Advance Practice Nurses (i.e. Nurse Practitioner, Nurse Anesthetist) when they renew their DC license?

A You will need 24 CEUs within the 24 months prior to the expiration of your license. For APRNs 15 of the 24 hours need to include a pharmacology component, meaning that it does not have to be a pharmacology program but some part of the program should include a focus on pharmacology. For example, if it is a course on diabetes, there should be information about the drugs used to treat diabetes.

APRN Regulation:

(c) Proof of completion of fifteen (15) contact hours of continuing education, which shall include a pharmacology component. A continuing education program, course, seminar, or workshop shall be approved by the ANCC or other nationally certifying organization recognized by the Board and shall be related to the certificate holder's specialty. Only continuing education hours obtained in the two (2) years immediately preceding the application date will be accepted.*

** American Nurses Credentialing Center*

CBC Hours Extended to 8:00 P.M.

Live-Scan Fingerprinting hours have been extended to 8:00 pm on Tuesday and Thursday. The Metropolitan Police Department (MPD) has extended the live-scan fingerprinting hours for health professionals. The extended hours are available for all categories of applicants: examination, renewal, reinstatement, endorsement.

- Fingerprint appointments can only be requested: by phone at (202) 724-8800 or email at doh.cbcu@dc.gov.
- Notification of appointments will only be given by phone or email.
- Each DC CBC applicant must pay a $50.00 fee for the criminal background check process.
- Each CBC applicant must present valid government ID prior to being fingerprinted.
- Facilities Please Note: Appointments for groups of over 10 applicants are available.

Address of the DC MPD:
300 Indiana Avenue, NW, 3rd Floor,
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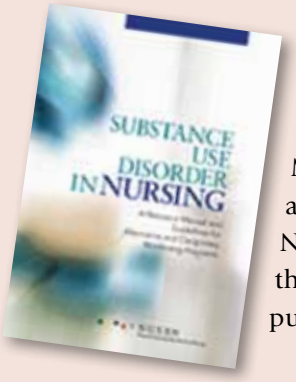
COIN CONSULT

Note from Committee on Impaired Nurses (COIN) Chairperson

Dear Nurses,
I would like to make you aware of a new publication entitled ***Substance Use Disorders in Nursing: A Resource Manual and Guidelines for Alternative and Disciplinary Monitoring Programs.*** This resource manual is a real contribution to nursing. — Kate Malliarakis, RN, CNP, MAC, Chair, Committee on Impaired Nurses.



Substance Use Disorders in Nursing: A Resource Manual and Guidelines for Alternative and Disciplinary Monitoring Programs is designed to provide practical and evidence-based guidelines for evaluating, treating and managing nurses with a substance use disorder. The result is a comprehensive resource of the most current research and knowledge synthesized from both the literature and the field. It is the hope of the National Council of State Boards of Nursing (NCSBN) that this manual is a helpful tool that can be used to implement better practices in helping the healers to heal themselves and at the same time helping to protect the public. While the manual was developed for alternative to discipline programs and boards of nursing in an effort to enhance program content and its delivery, it also provides essential theoretical and practical guidelines for clinicians, educators, policymakers and public health professionals. To download the manual, visit www.ncsbn.org/2106.htm.

COIN Committee chair Kate Driscoll Malliarakis was a member of the NCSBN Committee that developed this publication.

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LETTER FROM COIN PARTICIPANT

"When I first walked in those doors three years ago, all I thought about is that I was going to get that same addict song. The shame, and guilt had ridiculed me to the point of I felt worthless. You see when I became a nurse and took that oath to do no harm. What a disgrace to be an alcoholic nurse and attempting to heal people when I needed the healing. At first, I had to come to terms of what I had become and then what I wanted back in this journey of nursing. First I had to understand my gift and how to deliver it to others. After many years of dealing with other peoples defects, I did not attend to my own needs. Thank you to all the wonderful people at the DC BON for whom gave me back my caring hands and the art of nursing."

—Sincerely, Anonymous

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Date: First Wednesday of the month
Time:
9:30 a.m - 11:30 a.m.

Note New Location:
899 North Capitol St NE
Washington, D.C. 20002
Transportation: Closest Metro station is Union Station.

To confirm meeting date and time, call (202) 724-8800.

No August meeting

September 7, 2011

October 5, 2011

November 2, 2011

Decmber 7, 2011

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Practical Nursing Programs

Year to Date (03/31/2011) Licensure Exam Results and Approval Status

PROGRAM	CURRENT QUARTER 01 /01//2011 - 03/ 31 /2011 #Sitting	% Passing	YEAR TO DATE 04 /01/2010 - 03/31/2011 # Sitting	% Passing	APPROVAL STATUS
Capital Health Institute	20	80.00	98	80.61	Conditional
Comprehensive Health Academy	29	79.31	121	85.12	Full
JC Inc.	02	0.00	11	0.00	Withdrawn
Radians College (formerly HMI)	02	100.0	35	97.14	Full
University of the District of Columbia	37	81.08	99	77.78	Conditional
VMT Academy of Practical Nursing	25	64.00	142	59.15	Conditional

Professional Nursing Schools

Year to Date (03/31/2011) Licensure Exam Results and Approval Status

SCHOOL	CURRENT QUARTER 01 /01//2011 - 03/ 31 /2011 # Sitting	% Passing	YEAR TO DATE 04 /01/2010 - 03/31/2011 # Sitting	% Passing	APPROVAL STATUS
Catholic University of America	05	80.00	85	81.18	Conditional
Georgetown University	39	100.00	108	99.07	Full
Howard University	01	0.00	27	74.07	Conditional
Radians College	19	78.95	60	80.00	Conditional
Trinity University	06	66.67	06	66.67	Initial
University of the District of Columbia	14	50.00	29	44.83	Conditional

Source of NCLEX® Scores: NCSBN Jurisdiction Program Summary of All First Time Candidates Educated in District of Columbia
** Change in status.*

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Upcoming Board Of Nursing Continuing Education Opportunities

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CEUs: 8
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http://www.surveymonkey.com/s/D2XTF2N

DIABETES UPDATE 2011
September 16, 2011
8:00 am to 4:30 pm
Howard University Hospital – Basement Auditorium
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The Nurse's Role in Preventing and Treating HIV and STIs

Article and Photos by Nancy Kofie

It is an epidemic. Relative to our small population, the District of Columbia has the highest rate of HIV in the United States. It is not just a "young" or "gay" disease. The HIV rate among DC residents in their 60s is equivalent to the prevalence of the virus in residents in their 20s. The highest rate of new diagnoses is among African American heterosexual females between the ages of 40 and 49.

In March and April 2011, the Pensylvania/Mid Atlantic AIDS Education and Training Center—Howard University Local Performance Site (www.pamaaetc.org)—presented seven continuing eduction sessions on the topic of "The Nurse's Role in Preventing, Diagnosing and Treating HIV/AIDS, HPV and other Sexually Transmitted Infections." The interactive program was attended by nurses, social workers, Long Term Care directors, retirees, a local pastor and other participants from throughout the region.

NURSES AS RESOURCES

"Nurses are the resource that family members and community members come to," according to conference coordinator Marilyn Johnson, MAS, who serves as Director of Provider Outreach for the Pennsylvania/MidAtlantic AIDS Education and Training Center (PAMAAETC). "We organized this program to break down cultural biases and internal barriers. If we don't break down these barriers, no one else will." Reminding attendees of how, in the late 1980s, gay rights advocates fought for HIV/AIDS medications and treatment support, and how, during the Civil Rights Era, African Americans, "stared down dogs and water hoses," for civil rights, now is the time for DC to strongly advocate for the health of our community.

Ms. Johnson urged attendees to challenge their own assumptions and discomforts in thinking about HIV. The diagnosis of HIV, she said, should not be any more stigmatized than a diagnosis of diabetes. "Urge your friends and relatives to be tested. When someone asks you 'Why would I want to be HIV tested?', you could ask them 'Why wouldn't you want to be tested?' Each one of us is one sexual encounter, or one finger stick away, from HIV."

We must speak to each other and young people about HIV. Children today are not only bombarded with sexual images in advertising, some are exposed to the sights and sounds of the sexual activity of parents who bring "guests" home. Young people, old people, and those in-between need to know about HIV and STDs (now called Sexually Transmitted Infections, STIs).

SEXUALLY TRANSMITTED INFECTIONS

"Sexually Transmitted Infections are a huge epidemic in DC," according to Bruce W. Furness, MD, a CDC medical epidemiologist embedded at the DC DOH. "STIs are hidden epidemics" he said, because often they have no symptoms (that is why he advocates calling them infections rather than diseases). STIs are portals which lead to an increase of HIV infection because genital ulcers breakdown skin; HIV can enter through an open sore or inflammation. White blood cells are the cells the HIV virus likes the most. HIV attaches to white blood cells.

Dr. Bruce W. Furness

"DOH has surveillance data on chlamydia, gonorrhea and syphilis in DC," Dr. Furness told attendees.

CHLAMYDIA, "the silent sexually transmitted infection," is the STI most commonly reported to the CDC, and it can cause infertility. Residents between the ages of 15 and 19 have the highest rate of chlamydia. Sexually active persons under 26 should be screened annually. The medication used to treat chlamydia will vary depending on the client's ability for adherence. The more-expensive medication azithromycin can be given in a single dose, but the cheaper medicaton doxycycline requires a seven-day dose. Clients should be re-tested in three months.

BASIC FACTS

- HIV can be transmitted via blood, semen, pre-seminal fluid, vaginal fluid, or breastmilk.
- The Centers for Disease Control and Prevention (CDC) defines "epidemic" as an infection rate greater than 1% of population.
- The HIV test does not test for the presence of the virus, but tests for the presence of antibodies that have developed over time (about 3 months) in response to the infection.

GONORRHEA can lead to inflammation, disease and infertility. The CDC says it costs $1.1 billion to treat gonorrhea and its complications. Gonorrhea can cause a thick yellow or green discharge at sight of sexual contact, or there can be no symptoms at all. Dr. Furness noted: "One problem is that a lot of adolescent females cannot distinguish normal discharge from abnormal discharge. They are still getting to know their bodily changes." When treating Gonorrhea, as with tuberculosis, drug resistance can be an issue. "We are running out of antibiotic choices for treatment because of resistance. If an individual has gonorrhea, we treat them for chlamydia as well." Dual treatment is used due to drug resistance.

SYPHILIS is known as the 'great imitator,' Dr. Furness said. "It has symptoms indistinguishable from other diseases; it is often misdiagnosed." When a client is infected, 21 days later the patient gets a single sore or chancre that is round and firm, but painless. Sometimes clients experience alopecia [hair loss], or reddish brown spots or a rash on their palms and soles of their feet. (Syphilis ulcers and rashes can imitate scabies and herpes). If untreated, tertiary syphilis attacks the heart and brain. This STI affects all races of men, but few women.

IN THE SCHOOLS

"We are screening in the District's high schools to target asymptomatic individuals," he said. "After a talk with students, we give students the option to submit a urine specimen." With STI testing in the DC high schools, there is a 6-8% positive rate, he said, and we retest in 3 months to detect repeat infections. Nationally, about 40% of infected teens become reinfected."We earn the teens' trust. Not only do teens have a lack of knowledge, but teens often cannot access medical treatment without parents finding out. Fifteen to 19 year-olds have the most barriers to treatment for STIs." Teens need to know STIs can be transmitted through oral sex. No parental consent is needed for STI-testing for individuals 12 years old and older (in DC and nationally). In DC, 12 and up can get STI testing, family planning services, and mental health services without consent.

UTILIZING ALTERNATIVES

Alternative method of notification: "As technology changes, we at DOH are going to have to change," Dr. Furness said. This is especially true as DOH addresses the activity of some MSMs (men who have sex with men) who find sexual partners via the Internet. Sometimes, an infected individual will not know the address or phone number of a sex partner, just their email address. DOH staff contact individuals who have been exposed to STIs via email if no other contact information is available.

Alternative to clinic visit: Through patient-delivered partner therapy, a patient can carry medicine to a sexual partner who refuses to come into the clinic for treatment. "It is legal in the District and it is encouraged by the CDC," Dr. Furness said.

72-Hours Prophylactics: Dr. Furness also spoke about pre- and post- exposure prophylactic medications that can be taken within 72 hours of exposure or anticipated exposure. He also enthusiastically advocated the use of HPV vaccines.

ROBBER AND SHOOTER

"HIV and STDs are like a robber and a shooter," clinic physician John Hogan, MD said. *"I like to rob and you like to shoot,"* he said, half-joking, assuming the persona of a criminal: *"We make each other worse."*

Marilyn Johnson, MAS, Dr. John Hogan, and Anna White.

Dr. Hogan reviewed the various types of STIs, and recommended Hepatitis B testing for any client with jaundice (yellow skin, yellow eyes). He noted that Hepatitis C has occurred as a result of unsanitary tattoo parlors, and that herpes can occur when party-goers share sex toys.

BE NONJUDGMENTAL

"Present yourself as nonjudgmental when speaking to patients," Dr. Hogan said, "when they share information about what they do for money or fun. By your tone of voice and demeanor, let the patient know that you do not look down on them for such activities. Ask tough questions in a respectful manner, and be willing to handle honest answers when they are given. Some of your patients may participate in sex parties," he said. This is part of the patient's history. He encourages his patients to bring their "toys" to the clinic, some which feature knobs and spikes. "Find out if they are using toys which can break the skin in sensitive areas of the body, such as the anus. Find out what they did and what products (lubricants) they used, and if they travel

Continued on page 18

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abroad for fun, or travel 'back home' to visit relatives. Air travel has made some diseases more common in the US," he said.

RISK + RISK = MORE RISK

Ask your client about their non-sexual activities. Ask: "Do you smoke? Drink? How much?" A smoker is more likely to drink, and "persons who consume five drinks in one day are more likely to abuse illegal substances. Abusers are more likely to have risky behaviors such as sharing needles and having sexual activities without a condom," Dr. Hogan said.

"There is one big obstacle in fighting HIV today. People don't have any fear," Dr. Hogan said. "They don't remember days of the AIDS quilt and the heavy death rate in the days before protease inhibitors."

LEARN FROM YOUR PATIENTS

If a patient is adherent, conscientiously taking his medications, taking good care of himself, ask: "What caused the transition? What made it click?" Dr. Hogan has seen homeless drug-addicted patients get clean, get a home, and get a job. Like Socrates, Dr. Hogan said, "I ask questions. I have never been in jail, but I can speak with a patient I trust (who has been incarcerated) to learn about the transition from jail to release. What I was taught in books did not prepare me. Let your patients teach you how to practice."

GENDER CONSIDERATIONS

Female Patients: Female clients who date older men may be unable to assert themselves with their partner. Dr. Hogan requests that female patients ask their boyfriends to accompany them to the clinic; if the boyfriend arrives in the clinic, Dr. Hogan himself calls upon the boyfriend to be tested.

Male Patients: Men often do not come in when initial symptoms surface because they are "waiting for it to hurt," Dr. Hogan said. Ask your patients about the number of sexual partners they have had in the last 30 days. If a man says seven, 10 or 15 women—his actions pose a public health threat.

GET FAMILY INVOLVED

"Have a plan for keeping your patient engaged in treatment," Dr. Hogan said. A great tool for adherence to treatment is to get the patient's family involved: "If a patient does not want to tell his or her family, I ask them, 'Who in your family have you told? Who in your family do you trust?' Tell the patient to bring a trusted person with them to their appointment. Tell the relative: 'We have bad and good news. The bad news is that your (son, daughter, etc.) is HIV positive. The good news is that they are seeing a doctor, taking their medication, and the medication is working.' Show the relative the lab results, it works over 90% of the time," Dr. Hogan said. "If the patient has not yet told anyone in his or her family, help them to formulate a plan to do so."

WOMEN MORE VULNERABLE

"Women are more likely to get HIV from a man than vice versa. Semen has more HIV than vaginal fluid," said Crystal Waters, MSN, FNP-BC, a Family Nurse Practitioner at the Women's Health Center of the Howard University Center for Infectious Disease Management and Research (CIDMAR). A woman's vulnerability goes beyond physiology. According to Ms. Waters, younger women are particularly vulnerable to problematic love relationships (and HIV) because their romantic relationships are more critical to their overall happiness than is the case for older women. "They are more interested in preserving the relationship than anything else—including their own wellbeing," Ms. Waters said. With younger women, sex may be traded for help paying the bills. "Many late-entry patients have delayed seeking HIV or STI testing or treatment because of a fear of domestic violence."

QUICK TIPS FROM MS. WATERS

- Piercings: Ask patients, "Do you have any piercings I cannot see?"
- Communication: Do not take for granted that the patient understands. A young person may say "yes, I am monogamous with one partner, but not with the other."
- Douching: Discourage douching. Douching washes away the natural protections against HIV and STIs.
- Empower: 'No gloving, no loving.'—Empower young women to require condom use with this slogan. She must know that she has the power to make condom use non-negotiable.
- DC DOH's HIV, AIDS, Hepatitis, STD, and Tuberculosis Administration (HAHSTA): Clients needing condoms or dental dams should contact HAHSTA. (Clinic Location: DC General Hospital Campus, 1900 Massachusets Avenue, SE, Building 8, 202-698-4050.)

WOMEN BEYOND 50

With women beyond their 20s, who came-of-age decades earlier, the problem

Crystal Waters, MSN, FNP-BC

may be getting them to understand that STIs or STDs are the same thing as veneral disease. You might ask if they have had an STI, and they will say "no" although they have had "V.D." Another problem with women in their 40s and 50s is that they think they are not at risk. "African Americans are half of HIV/AIDS cases, and AIDS is the leading cause of death of African American women in many age groups."

TREATMENT

"An HIV positive client's medication regimen has to be tailor-made," Ms. Waters said. "Some drugs cannot be taken during the first trimester of pregnancy." If a patient becomes pregnant, you have to reevaluate the drug regimen." For the medication to work, the patient must be motivated to take the medication. Adherence is very important. "We also counsel women to use condoms once testing is done. Their partner might have a different strain of HIV."

LIFESPAN

Ms. Waters noted that the lifespan for living with HIV ranges from 19 to 25 years:

- black women – average lifespan of 20.6 years after diagnosis.
- black male - 19.9 years.
- white women - 22 years.
- white male - 25 years.
- Latino women - 24.2 years.
- Latino men - 24.6 years.

OTHER THOUGHTS

- Ms. Waters asked attendees to keep in mind that "The Downlow" (closeted men with male sex partners) is not a phenomenon restricted to African Americans. There is an equal presence of non-gay-identified MSMs (men who have sex with men) in white and Latino communities as well.
- "HIV patients are living longer," she said, "but there is a lot more inflammation: more cardiac risk, a higher level of cholesterol.
- HIV positive men can father children without passing on the HIV infection, she said. "HIV is present in semen, not the sperm. 'Sperm washing' is a process in which a sperm can be safely removed from the semen."

MAGIC JOHNSON, SEROCONVERSION, STIGMA, AND SALIVA

Lisa FitzPatrick, MD, MPN, an infection disease physician and associate professor at Howard University, sought to dispel two common myths regarding HIV positive retired NBA player Magic Johnson:

Lisa FitzPatrick, MD, MPN

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Continued from page 19

"One myth is that he is cured, and the other myth is that he is still living because he is rich."

HEALTH DOES NOT REQUIRE WEALTH

Dr. FitzPatrick said she has many low-income patients who are doing well in treatment. "It is treatable and patients can live for more than 20 years. Medicaid pays for the medicine, and because of AIDS Drug Assistance Programs (ADAP) we don't have a waiting list." She spoke about a patient who is a crack addict: "He told me: 'First thing in the morning I take my medicine,' even if he later gets high on crack. He is adherent. He has even put on weight and he's got a job now." She also spoke of a homeless patient who sleeps with his medication. "One-pill-a-day medication revolutionized treatment and adherence." A CDC-trained medical epidemiologist and co-Principal Investigator at PAMAAETC-Howard, Dr. FitzPatrick noted: "The virus is very crafty. We have to hit it at multiple targets."

HISTORY

Dr. FitzPatrick told attendees about the history of HIV/AIDS, beginning with a June 1981 *Morbidity and Mortality Weekly Report* (MMWR) on five young gay men with pneumocystis carinii pneumonia. Initially, AIDS was thought to be a disease only effecting the 4Hs—homosexuals, heroin addicts, hemophiliacs and Haitians. She also noted the effectiveness of the gay civil rights group ACT UP. (See 1993 movie "And The Band Played On" for dramatization of this period). Noting another important historical turning point, Dr. FitzPatrick said, "We started to see the mortality rate decrease when in 1996 a doctor discovered protease inhibitors."

SALIVA

Some attendees wondered if HIV can be transmitted by saliva. "HIV can show up in saliva if a patient has bleeding gums from oral health problems. It can be transmitted by oral sex, but saliva is a low risk." The HIV swab test does not test for HIV in saliva itself; it tests for the antibodies that develop in response to HIV.

THE WINDOW

"We must identify people in window period," Dr. FitzPatrick said. "We need your voices. HIV is no longer a silo issue." Clients test negative during the 12-week period of seroconversion, however, during that time they are HIV infected and highly infectious. The test is not positive because the body has not produced the antibodies the HIV test detects. During this 3-month window period, known as Acute Retroviral Syndrome (ARS), nonspecific symptoms may occur, such as fever, flu symptoms, feeling weak and tired, unexplained rash on trunk and arms, anemia, and swollen lymph glands.

If you have already HIV tested a patient who is not improving, he or she may need to be tested again to see if antibodies have developed. During ARS, the patient will have an extremely high viral load.

THE THIRD RAIL

The issue of confidentiality is "the third rail issue in HIV Treatment," Dr. FitzPatrick said. As a practitioner, you are not permitted to tell the patient's spouse or family members that he or she is HIV positive. You cannot even tell the expectant father if a pregnant woman is infected with HIV. "This is a challenge," she said, "We have had people who have had HIV 10 years and they still have not told anyone." What if a family member blatantly asks you if the patient is HIV positive Dr. FitzPatrick says: "Have the family member come into the room with patient, and corner the patient into answering the question."

OPT-OUT TESTING WORKS

"HIV is a treatable chronic disease, just like diabetes." The stigma should not deter testing. "Opt-Out testing is working in DC," she said. "As the health care professional, you can say: 'Today, as our standard of care, we will be testing (say the usual list of tests, include HIV test). If you don't want any of these tests, let me know."

TALKING THE TALK

If you, as a health care practitioner, have difficulty discussing sexual matters,

Anthony Cook, LGSW

you could benefit from participating in role-playing sessions. (If you do not feel comfortable, it is going to come through to the client). Attendees learned about the art of the chat from speaker Anthony Cook, LGSW, HIV Prevention Manager at a walk-in clinic at Congress Heights. Mr. Cook guided attendees toward developing an effective speaking style—nonjudgmental yet encouraging clients to become empowered towards healthier behaviors. "You will have conversations that make you feel uncomfortable, but do not react. A non-response gives them (clients) permission to share information about themselves."

When asked about his most effective method for getting clients to practice safer sex, Mr. Cook said the most effective way to gain client compliance is to provide the information in a nonjudgmental manner and then "put the onus on them." Only the client can control his or her behavior. People change when they come up with their own

ROLE PLAYING

Remind your clients that HIV can be transmitted through blood, semen, pre-seminal fluid, and vaginal fluid—during oral sex, vaginal sex, or anal sex and/or needles during IV drug use. HIV can also be transmitted through breast milk during breastfeeding.

Below are some suggested lines to say during the conversation:

- "Tell me what you know about HIV."
- "Do you always use condoms?"
- "Look at the expiration date. Condoms do have an expiration date."
- "Who is responsible for bringing condoms in the house?"
- "What kind of material are your condoms made of?"
- "Are they kept in a certain place?" [If condoms are kept in a place with a hot temperature, they may be damaged. Never wear two condoms at one time, this can cause them to tear and put both parties at risk of HIV, STD, and or pregnancy].
- "Do you think your partner has other partners?"
- "Have you been tested for HIV? Do you have 20 minutes? We are not singling you out. In the District, one in 20 people have HIV, Which is why we encourage everyone to be tested." Before administering the test, explain the procedure for administering the test and the possible results.
- "Are you ready for the results?" (If test is positive, explain that a physician will see the client to determine the viral load and CD4 or T cell count. Explain what these terms mean).
- If the client is not in a monogamous relationship, you can ask in a nonjudgmental way: "Can you minimize the number of partners you have? Is that an option?"
- When the client comes in on a subsequent visit, ask: "How did that work out?" (the safer sexual practices).
- Urge client to have a conversation with their partner: "Has your partner been tested? If your partner questions why you've gotten tested, or why you want him (or her) to be tested, let them know that one in 20 people in DC have HIV."
- At every session ask: "Do you have any questions?"
- Good conclusion to initial talk with client: "Considering what we have discussed, what can you do when you leave today to keep yourself safe?"

Urge client to come back for follow-up and to bring their partner to their next visit.

plan. Mr. Cook suggested a question you may pose to your client at the end of your talk: "Based on what we've discussed, what can you do today to make yourself safe?"

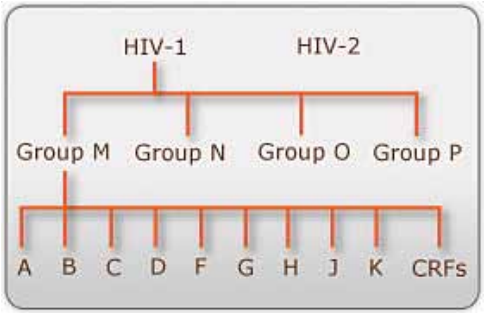
ORIGIN AND STRAINS

Gebeyehu Teferi, MD, of Unity Health Care, provided details on the initial development of the HIV virus. The first name given to the disease now known as HIV/AIDS was Gay-Related Immune Deficiency (or "GRID"). It was identified in 1983. Dr. Teferi noted that determining the epidemiology of HIV (and other infections) is difficult because you must go back 5 – 10 years to figure out what happened. Also, viruses change to try and survive. "They mutate," Dr. Teferi said. "Their purpose is to live."

There are many strains of HIV. There is HIV1 and HIV2. HIV1 is subdivided into strains M,N,O and P; strain M is subdivided

Gebeyehu Teferi, MD

into even more substrains (see chart below). "The subtypes are unevenly distributed throughout the world," Dr. Teferi said. "The more virulent subtype, D, is found in East and Central Africa. Individuals with a subtype D infection pass away in 1 to 3 years. D is a mean killer. It is more effective at binding to immune cells." Condom use is important for those who are already



HIV infected because, "a patient may be doing well on medication, then gets a superinfection from someone with a more virulent strain of HIV."

Dr. Teferi said the precursor to HIV appeared in 1931, and the first death from HIV/AIDS occurred in 1959. He reviewed the theories attempting to pinpoint the origin of HIV (which leapt to the human population from the nonhuman primates with the Simian Immunodeficiency Virus (SIV). Theories:

- Consumption of "bush meat"

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(chimp or monkey meat).

- Hunters' exposure to animal blood during butchering.
- People having sooty mangabey monkeys as pets.
- Exposure to virus via an oral polio vaccine grown in chimp cells. Some early vaccines contained Simian virus SV40, discovered in 1960.

"Take all of these theories with a grain of salt," Dr. Teferi said. Dr. Teferi said he does not believe that the transfer to human beings was the result of sexual activity between humans and animals.

At the end of 2008, there were 16,513 people living with HIV/AIDS in DC (3.2% of the population). "Fifty percent of people living with AIDS are African American," he said, "a group which is just 12% of the US population. MSM (men having sex with men) is still the number one method of transmission." For black males, the infection rate was 7.1%. Dr. Teferi noted these statistics, but reminded attendees that white residents should not be unconcerned about possible HIV infection because for white residents there is an infection rate over 1%, which is still considered an epidemic.

DETECTIVE WORK

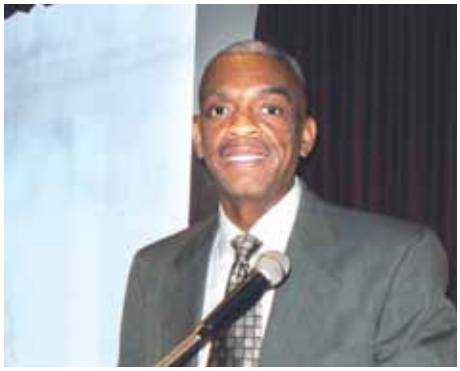
Dr. Teferi urged health care practitioners to consider all possibilities if an HIV patient's condition is not improving with medication. He told of a case where the client was obtaining the medicine but not taking it, but chose to use prayer alone to fight the disease.

PERSONAL JOURNEY

Attendees had the chance to hear the story of a man who has been HIV positive for more than 20 years. Wayne Dicks shared his personal history as a self-confident young gay man, who had sexual relations during high school with football players and other "down low" types. Born into a military family, Wayne attended the South Carolina military school, The Citadel upon his father's orders, despite the fact that Wayne was a straight-A student who wanted to become an interior decorator. Wayne excelled at The Citadel, eventually joined the military, and was stationed in Germany as a helicopter pilot. One day he went to the ER for lumps under his arms, was soon diagnosed with GRID, he was told he only had two years to live, and was discharged from the military in one day, with no benefits.

THANK GOD FOR FAMILY

It now has been 25 years since that incident. Initially, his parents didn't know he had HIV and he was too ashamed to tell them. Fortunately, when he did tell them, they were supportive. Gaining their support was empowering: "I could tell everyone," he said, "It was such an ego booster." Disclosure can be a boost for HIV positive individuals. "When you have the power to disclose your illness" it helps the patient so much. "Thank God for my family," he said. He earned a graduate degree from the University of South Carolina School of Public Health, although he added, at that time in South Carolina, people's attitudes toward HIV/AIDS was "so prehistoric," many did not want to hear his message.



Wayne Dicks

WORK WITH TRANSGENDER HEALTH

Mr. Dicks spoke about his work with North Capitol Street's Transgender Health Empowerment Center. Everyone needs to break down internal barriers—even an openly gay man like Mr. Dicks. Initially, he said, he was "afraid of transgenders" because of rumors that they could be violent, "but they are some of the nicest people. They have amazed me with their stories." He said he was surprised to hear that transgender prostitutes are the penetrator during the sexual encounters with "down low" clients, not the other way around. "And they don't believe in protection—it's a quickie and down-low men are not prepared."

Transgendered individuals "need a lot of special care," he said. "Put yourselves in their footsteps." He noted the difficulties transgendered youth face in using high school restrooms, as an example.

Mr. Dicks has been with the same partner for 20 years, and he urged health care professionals to take CE courses: "We have to learn about the people we serve."

Did you know? "Cheeking," Mr. Dicks says, is the act of applying a condom to a male sex partner using one's mouth, without him knowing that you are doing so.

IN THE DENTAL OFFICE

Dentist Derrick K. Eiland, DDS, is a participant in PAMAAETC's pilot program in which three dentists are providing HIV swab testing for patients. In addition, he is an expert at spotting HIV-related symptoms in the oral cavity.

"The mouth is one of first places HIV manifests," Dr Eiland. "Oral hairy leukoplakia (a nonpainful white plaque on the side of the tongue) is very common in patients with HIV.

Derrick K. Eiland, DDS

Encourage patients to look inside their mouths to see what is normal and what is abnormal. If you see something that is not normal (in a patient's mouth), refer them to an oral pathologist who can identify the condition with a swab or biopsy. Urge the patient to be HIV tested. If you ask the patient to be tested for HIV out of a place of love and caring, they will be receptive to the idea."

TALK TO YOUR PATIENTS

Don't be afraid to learn new things about people's lives. "A lot of things go on I didn't [previously] know about," he said. "If a patient says 'I don't have sex—I just touch.' Well, let them know that that can be risky behavior." The patient who is "touching" or "being touched" may be doing so during oral-sex practices. Does either partner have warts? Dental disease? Bleeding gums? Human beings are complicated beings, Dr. Eiland reminded attendees. "I talk in natural language that the patient can understand. I don't judge or condemn. I accept and love."

DIVERSITY OF SEXUALITY

Dr. Eiland's 24-hour dental office serves a diverse clientele. "Prostitutes come in with their pimps. A prostitute with her mouth bleeding, from a toothache, will be expected to go right back out on the street and perform oral sex." Be willing to step out of your comfort zone. "When you treat a 6-foot-4 transgender patient with breasts and wig, you may have to step outside of your comfort box." Be willing to do that.

Keep your ears open. If a male nursing home patient mentions, "I got a little friend that comes and tightens me up," Dr. Eiland said, that older gentleman may have just confirmed that he, too, is a good candidate for HIV testing. "Young ladies have children and need money," Dr. Eiland said.

Human nature dictates that most people delay seeking dental treatment until they feel it is absolutely necessary. Some people will function with sores in their mouth for quite a long time without going to the dentist. "Nobody likes going to the dentist–it is what it is," Dr. Eiland told attendees. Early detection of HIV is important, he said, because treatment works. "Patients are living longer with HIV, and they can do well on treatment," Dr. Eiland said. Having an education, conventional attire, and a high-status job, however, do not necessarily equate to a willingness to be HIV tested. Dr. Eiland told of an instance at a meeting where he and fellow dentists were learning to do HIV swap testing and each had the opportunity to be HIV tested themselves. The dentists didn't want to be tested: "I don't want to know," they said.

Dr. Eiland reiterated a message that other speakers also asked attendees to advocate in the community: Condoms should be used during oral sex!

TEENS

"She just got me so gah!" Adolescent Reproductive Health Specialist, Kerriann Peart of CITY YEAR began her talk by giving an example of a teen expression which provides information in a language you might not understand (e.g. "gah"=frustrated). Do you know what a teen means when you are told that a girl or boy is a "rolla"? (Has many sex partners.) "You don't have to speak slang," Ms. Peart said, "but do understand it." If you don't know something don't be afraid to ask teens, said Ms. Peart, the HIV/AIDS Outreach Prevention and Education Program Manager at the organization.

Adolescence is characterized not just by physical changes, she said, but by mental and emotional changes as well. She asked that attendees use accurate language when speaking to teens about HIV. "There is no difference between 'full-blown AIDS' and a diagnosis of AIDS. Just say AIDS. The notion of 'full-blown' perpetuates stigma and ignorance". Use clear language with teens and ask them to explain the language they use.

Talking to Teen Girls: Girls will often say, "I want to have sex because he loves me," and they don't think their boyfriend could possibly have HIV because "He looks good, he has a nice car, and he has Gucci shoes." Ms. Peart asks girls to recognize that, despite their emotions, "your body is not ready". "Having honest discussions about the physical and emotional changes that occur once engaging in sexual activity is essential in supporting young girls and boys, to make healthy sexual decisions."

Kerriann Peart

Talking to Teen Boys: Talk to boys, but not at the kitchen table--go to where they are: on the corner or on the basketball court. "Boys crave challenges," Ms. Peart said. You might ask: "Now that you know this information about HIV and STDs, how will you talk to your girlfriend about this issue?" "What is also important with educating boys and young men is having honest male figures around who can impart healthy sexual knowledge to these youth. It is one thing for me as a young woman to educate boys, but for a boy hearing the same information from a young man creates much more of an impact."

Condom Tips: check the expiration date; check package for holes, and do not tear open package with teeth.

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LGBTQIA

You may know what "LOL" stands for (laughing out loud), but do you know what LGBTQI stands for? Lesbian, Gay, Bisexual, Transgender, Questioning (or queer), Intersex. Some youth advocates add an "A" at the end: LGBTQIA (A = Asexual).

RESPECT THE YOUNG

Check your biases at the door when speaking to young people. "When speaking to teens, be a blank slate," Ms. Peart says, "let the teen write on that slate. When I speak in a non-judgmental manner, they let me know where they are." Also keep in mind that some teens may be in same sex relationships but do not consider themselves to be gay or LGBTQI. "Young people look at things in snapshots—just the "right here, right now. Their actions do not determine their identity. We have to move away from such preconceived notions as they cause youth to become isolated and potentially increase their risk."

"Youth know quite a bit and we must respect and honor them," Ms. Peart said. Let teens know it is okay to be empowered and define boundaries. She noted that the young people who are most vulnerable to HIV are teens who are homeless, mentally ill, who have no parents or support, and are faced with socio-economic and cultural barriers.

SENIORS AT RISK

Dorcas Baker, RN, BSN, ACRN, Site Director of the Johns Hopkins University Local Performance Site AIDS Education and Training Center, put it simply: Working with older adults with a focus on HIV is her area of passion. "The face of HIV is aging. With advanced treatment, people are living longer with HIV. Most patients in Maryland are in the 40-49 age group. Older people are being newly diagnosed." The CDC designates individuals who are 50 or older as "older adults." Today, about 25% of those with HIV are older adults; by 2015, 50% of those with HIV will bemore than 50 years old.

"Yes, they have sex," Ms. Baker, says of older adults. "Yes, they are at risk for STIs, and yes, they do drugs. Older adults are sexual beings. They have Viagra and Cialis. Sexual activity may not happen that often, but it does happen." As healthcare professionals, we must open our eyes. Traditionally, the HIV test has been the last possible consideration for some practitioners. "They will test for everything else first," she said. In Ms. Baker's practice, the oldest person she has seen newly-diagnosed with HIV was 94 years old, and the lady's husband had died 15 years prior.

Dorcas Baker, RN, BSN, ACRN

GETTING TO KNOW YOU

Many older adults do not see themselves at risk for HIV. If you don't ask them if they are sexually active, they will not volunteer the information. As a health care professional, become adept at gently weaving the topic of sex into the conversation. Broach the topic casually through a series of questions, Ms. Baker says: "Any relationships or dating?" "Do you go out?" "Do you drink?" "Do you dance?" "Are you sexually active?"

EARLY DETECTION

"We want to find them faster," Ms. Baker told attendees. Early diagnosis is key because older adults respond differently to HIV medications: "It is harder to get T cells up," Ms. Baker said. On the plus side, however, the vast majority of "older adults are very adherent. A 2005 study found that 95% of HIV positive older adults had a 95% adherence rate. Their viral load lowers because of good adherence, but it takes longer for their T cells to build up." Note: check with the HIV physician to find out if the patient is taking Viagra or Cialis, which works against some HIV drugs.

STUBBORN SENIORS

For those few who don't want to take their medications, use your creativity. Ms. Baker spoke about a patient who did not want to take his four HIV drugs. She encouraged him to be adherent by appealing to his veteran's values and military spirit. "Can you win a war with just the Navy?" she asked him. "No," he said, "You need the Army, Air Force and Marines." So she referred to his four HIV medications as the Army, Navy, Air Force and Marines. After that pep talk, he was adherent.

At the informational programs she holds in Baltimore, when seniors balk at hearing about HIV Ms. Baker asks: "Do you have a sister? Do you have grandchildren? You can help somebody with this information." This call to help others appeals to seniors who might otherwise refuse to listen to a discussion on HIV or another sex-related topic.

DRUG CATEGORIES

Jose Fernando Chavez, MD, of the Unity Health Care Anacostia Health Center, informed participants about the medications we currently have at our disposal to fight HIV. There are over 25 HIV drugs that fall within five major

categories: nucleoside reverse transcriptase inhibitors (NRTIs); nucleotide reverse transcriptase inhibitors (NtRTIs); non-nucleoside reverse transcriptase inhibitors (NNRTIs); protease inhibitors (PIs); and fusion inhibitors. Some medications are boosters to make other medications more effective.

Jose Chavez, MD

HIV DRUGS

"We are able to treat 90% of those diagnosed with HIV. We cannot cure HIV, but we can control it," physician Dr. Chavez, told attendees. "Why can't you cure HIV?" a participant asked. There is no cure because the virus is integrated into the HIV positive patient's DNA, Dr. Chavez said, "and once it is integrated into your DNA, the virus will only die when that cell dies."

PATIENT CHARACTERISTICS

"Practitioners must chose medications from two different classes to control mutant viruses," he said. "In prescribing medications, we have to consider the patient's characteristics." Drug interaction can be a huge concern, he said. You have to consider any non-HIV drugs the patient may be taking. The patient may want to take the same medication as someone they know. "She may want to take the same medication her sister takes. Explain to the patient that the regimen that your sister is taking may not be right for you." Prescribers must consider factors such as: Is the patient pregnant? Or, would the patient be capable of adherence if the medication has to be taken more than once a day?

MEDICATION ADHERENCE

Dr. Chavez says health care practitioners must "assess adherence, even if there are no problems. Patients become complacent, and stop taking their medications. Do counseling at every single visit." If a patient is getting HIV treatment, then their partner needs to be tested also and/or in treatment. "Early intervention is key because the older and higher the viral load, the more rapidly the patient will deteriorate," Dr. Chavez said.

HIV patients can live more than 20 years with the disease, and they may bear children without passing on the infection: "Unity has many pregnant HIV patients and no babies born with HIV," he said.

FIFTH VITAL SIGN

Temperature, pulse/heart rate, blood pressure, and respiratory rate are the four vital signs. Opt-out HIV testing should be the fifth vital sign, according to Carolyn D. Thompson, MA, who is Deputy Bureau Chief, Prevention, for the DC Department of Health's HIV, AIDS, Hepatitis, STD, and tuberculosis Administration (HAHSTA). HIV testing should be routine.

OPT-OUT HIV TESTING

Opt-out testing is simple. Inform the client that they will be tested. Name all tests, including the HIV test, and then let them know that they should speak up if they would like to opt out of any test. The worst way to offer an HIV test, however, is to ask: "Do you want an HIV test?" Most people, for whatever reason, will be inclined to decline. Opt-out testing, which HAHSTA promotes, is a necessity in DC because: "one-third to one-half of all people infected are unaware of their status," she said. "When people are aware of their status, they are less likely to engage in high risk behaviors, and medications are available."

All age groups should be tested for STIs and HIV. HAHSTA tests for STIs in the high schools. "The same behaviors that lead to STIs lead to HIV," Ms. Thompson said. In the District, a separate written consent is not necessary and no pre-test counseling is required to test for HIV. However, "linkage to care is extremely important," Ms. Thompson said. "We do not support self-testing because then there would be no linkage to care, and the public health department would not know about the positive result. We want to get as much community input as possible. We want HIV testing to be just as routine as the flu shot. We need everybody who is HIV positive to be in care."

Ms. Thompson urged attendees to be accepting of those with a different sexual preference: "Gay youth with self-acceptance are more likely to use condoms," she said. "Those rejected early seek love in all the wrong places. We should make it so people don't have to build separate worlds away from their family, friends and neighbors" she says.

Carolyn D. Thompson, MA

RED CARPET PROGRAM

"There are people we never see because they do not have a medical home," Ms. Thompson said. "The ER is their medical home. HAHSTA's Red Carpet Entry Program provides medical care to DC residents diagnosed with HIV within the first 48 to 72 hours of diagnosis." The DC Department of Health wants all persons newly diagnosed with HIV to visit an HIV specialist right away. DC residents diagnosed with HIV without health insurance are eligible to access the

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Red Carpet Entry program, to obtain HIV medical care within one or two business days. Go to www.doh.dc.gov, call 202-671-4900, email redcarpet@dc.gov.

HAHSTA WANTS TO HELP

Earlier diagnosis equals timely referrals to medical care, support services, mental health, and substance abuse treatment, Ms. Thompson said. "HAHSTA is here to support your efforts," Ms. Thompson said. "We will come to the ERs. We provide tests and training," she said. HAHSTA strives to serve residents, organizations and providers. HAHSTA distributes three million latex condoms per year. "Contact HAHSTA if you need HIV test kits." HAHSTA's website offers information about their partner notification services, training and conferences, lists of partners, and

CONTACT PAMAAETC

If you are interested in the opportunities below, please contact the PAMAAETC Howard University site (contact info below).

- Nurse Preceptorships: Nurses and physician assistants are eligible for HIV preceptorships.
- Dental Office Testing: If you know a dentist who would like to participate in the HIV testing pilot program have him or her contact PAMAAETC.
- Speaker for Your Event: The speakers from the CE program may be available to talk to your group, contact PAMAAETC.

CONTACT INFORMATION:

Email: pamaaetc@howard.edu
Phone: (202) 806-0220
Fax: (202) 806-5226
Website: www.pamaaetc.org/lpsdc.htm
Address: PAMAAETC, Howard University, 600 W Street NW, Rm 114, Washington, DC 20059

WEB RESOURCES

- www.doh.dc.gov/HIV (DC HAHSTA)
- www.DCTakesOnHIV.com (DC HAHSTA)
- www.sticc.org (DC STI stakeholders)
- www.smyal.org (DC LGBT youth)
- www.aids-ed.org (for health care providers)
- www.ashastd.org (ASHA)
- www.adolescentaids.org
- www.inSpot.org (notification)
- www.goaskalice.com (Q&A site)
- www.CDC.gov/STD

"IN THE KNOW" ABOUT HIV ISSUES

CD4 or T-cell: CD4 cells or T-cells are the "generals" of the human immune system, HIV kills CD4 cells. CD4 that send signals to activate the body's immune response when it detects "intruders," like viruses or bacteria. Because of the important role these cells play in how the body fights off infections, it's important to keep their numbers up in the normal ranges. This helps to prevent HIV-related complications and opportunistic infections. (Source: www.AIDS.gov)

Protease Inhibitor: A class of anti-HIV drugs that prevent replication of HIV by disabling HIV protease. Without HIV protease, the virus cannot make more copies of itself. (Source: www.aidsinfo.nih.gov).

HIV Med history: In 1987, azidothymidine or AZT became the first drug approved for treating HIV disease. Currently, there are five different "classes" of HIV drugs. Each class of drug attacks the virus at different points in its life cycle—so the client taking HIV meds, will generally take three different *antiretroviral* drugs from two different classes. Taking more than one drug also protects against HIV drug *resistance*. When HIV reproduces, it can make copies of itself that are imperfect—and these *mutations* may not respond to the drugs. If the client follows the three-drug regimen, the HIV in the body will be less likely to make new copies that don't respond to the HIV medications. (Source: www.aids.gov).

ADAP: AIDS Drug Assistance Programs—nationwide state-programs to provide HIV medications to low income patients.

Prevention Methods: Abstinence; Vaccine (Human papillonavirus, HPV); Condoms (male and female); Diaphragm; Topic spermicides; Male circumcision; post exposure prophylaxis (PEP) for needlesticks; pre- and post-exposure antiretrovirals (PrEP).

Senior DVDs: "HIV in Older Adults" (http://www.acria.org/node/347) and "Seniors at Risk: Sex, Drugs and HIV" (http://www.urbansolutionsinc.org/seniors_risk.html)

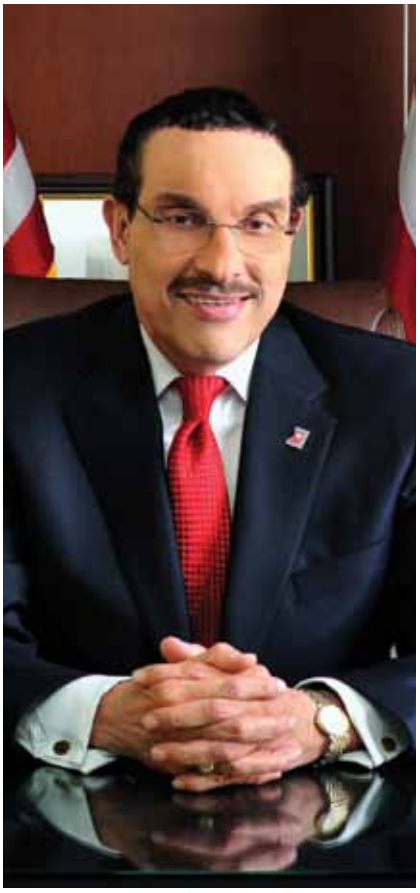
Transgender patients: Respect the transgender patient. Call them by the name they provide rather than their legal name.

their online guide to resources http://haadirectory.doh.dc.gov/, which includes nonmedical places to get tested.

Gita Kumar

VIIV PROGRAM

Community Specialist Gita Kumar of the ViiV company, informed participants about the ViiV Patient Assistance program which assists persons with HIV who need help paying for medications. The HIV patients they help are not necessarily impoverished but are unable to afford their medication. Contact ViiV at 1-877-7-ViiVhc (1-877-784-4842) or visit their website at www.viiv4you.com.



MAYOR GRAY ESTABLISHES COMMISSION ON HIV/AIDS: In February 2011, Mayor Vincent C. Gray announced the creation of the Mayor's Commission on HIV/AIDS. The Commission focus's on treatment, the needs of people living with HIV/AIDS and prevention to stop new infections. The DC Department of Health has taken steps to improve access and quality of care for residents living with HIV/AIDS immediately. "By bringing together HIV leaders from our best medical institutions, our universities, and the community, this Commission will ensure that we fight HIV as One City," said Mayor Gray. "The rate of deaths from HIV/AIDS has decreased, however we still have a 3% infection rate, every resident needs to take this disease seriously and be invested in ending new infections." Among the Commission's responsibilities are recommendations for the best ways to reduce barriers and promote HIV medical treatment, development of evidence-based HIV/AIDS policy recommendations for reducing HIV infection rates and recommendations regarding the collaboration among District agency programs and services. "We are seeing progress in our fight against HIV in DC, with the first reductions ever in new AIDS cases and deaths with AIDS along with increases in getting people into treatment quicker," said Dr. Akhter. "However, we continue to see the spread of HIV/AIDS throughout our community at an alarming rate, we are only going to stop this disease when we prevent new infections."

MAYOR GRAY ANNOUNCES HOST COMMITTEE FOR AIDS 2012 CONFERENCE: Mayor Vincent C. Gray has announced the creation of the Mayor's Host Committee for the XIX International AIDS Conference to be held in the District of Columbia from July 22-27, 2012. During the conference, at the Walter E. Washington Convention Center, the District will host nearly, 25,000 delegates from 200 countries. The Host Committee includes representatives from the tourism, medical and government communities to facilitate coordination for all aspects of the event.

Kudos!

Congratulations to Kate Malliarakis, RN, CNP, MAC, who has joined the Board of the National Association for Children of Alcoholics (NACoA). Ms. Malliarakis, Chairperson of COIN (Committee on Impaired Nurses), is an Assistant Professor at George Washington University's School of Health Sciences Department of Nursing Education, where she directs the MSN Nursing Leadership and Management Program. She has served in leadership positions at the White House Drug Policy Office and in leading consulting, academic, professional, and private sector organizations. Her many awards and recognitions include a Robert Wood Johnson Fellowship in the Executive Nurse Leader Fellows Program. Ms. Malliarakis is President of KAM Associates, a health care consulting firm specializing in substance abuse and leadership issues.

Kate Malliarakis, RN, CNP, MAC

COIN was established to assist licensed nurses impaired due to drug or alcohol dependence, or mental illness. COIN is an alternative to disciplinary action. See page 11 for the COIN CONSULT column.

Congratulations to DC Board of Nursing Executive Director Karen Scipio-Skinner, RN, MSN who was selected 2011 Black Nurse of the Year by the Black Nurses Association of the Greater Washington, DC, Area, Inc.

Karen V. Scipio-Skinner has served as Executive Director for the District of Columbia Board of Nursing since 2002. She received her BSN from North Carolina A&T State University and her MSN from Catholic University of America. She began her career as a psychiatric nurse at St. Elizabeths Psychiatric Hospital where she served as a staff nurse and head nurse with most of her time spent practicing as a nurse educator. She left St. Elizabeth's to accept a position as Director of Staff Development at Psychiatric Institute of Washington, DC. After leaving Psychiatric Institute, she worked as Training Supervisor for the American Psychiatric Association's Quality Assurance Department. Prior to accepting her current position as Executive Director of the Board of Nursing, she was the Nurse Associate for Practice, Education and Policy for the District of Columbia Nurses Association.

Karen Scipio–Skinner, RN, MSN

Mrs. Skinner has served on numerous Boards and Commissions. She was appointed by then-Mayor Marion Barry to serve as a member of the District of Columbia Board of Nursing and the Mayor's Blue Ribbon Panel for Health Care Reform. She was appointed by Mayor Anthony Williams to the Mayor's Health Policy Council. Ms. Skinner also Chaired the Robert Wood Johnson funded DC Nurse Consortium on Education and Practice. Currently she serves as a Board member of the National Capital Area YWCA. And in 2010 was elected, Chairperson of the National Council of State Board of Nursing's Executive Officer's Network. She was also appointed to the Board of Directors for the Alliance for Ethical International Recruitment Practices.

Mrs. Skinner has received the following honors: Selected by the Washington Business Journal as one of the District of Columbia's "Top Ten Lobbyists;" the District of Columbia Nurses Association's Nursing Practice Award, and in 2009 Ms. Skinner received the American Academy of Nurse Practitioners' Nurse Practitioner Advocate State Award for Excellence. In 2011she was selected by the George Washington University Center for Excellence in Public Leadership as a finalists for the 2011 Morris & Gwendolyn Cafritz Foundation Awards for Distinguished DC Government Employees.

Mrs. Skinner is a member of the American Nurses Association, Black Nurses Association of the Greater Washington DC Area and Sigma Theta Tau, Nurses Honor Society. She is married with two children.

CONGRATULATIONS DOH NURSES

Congratulations to Tamara Freeman RN, Nurse Specialist, with the Department of Health (DOH), Health Regulation and Licensing Administration, Health Care Facilities Division for her award and recognition from Sigma Theta Tau International Honor Society of Nursing , Gamma Beta Chapter as a recipient of the 100 Extraordinary Nurses on May 2, 2011. "Ms. Freeman has exhibited leadership during her tenure of 6 years with the DOH as one of the coordinators for the long term care survey team," says Sharon Williams Lewis RNC, MSA, CPM, Program Manager for the DC DOH Health Care Facilities Division. "She is also cross trained to inspect hospitals, home health agencies, outpatient physical therapy providers, and ambulatory surgical centers. Ms. Freeman freely gives of her time with a caring spirit as she provides guidance to provider stakeholders and team members. She is also an active member of the Chi Eta Phi Nursing Sorority, Inc., Lambda Phi Chapter."

Tamera Freeman

Congratulations to Veronica Longstreth RN, MSN, Supervisory Nurse Consultant, with the Department of Health, Health Regulation and Licensing Administration, Health Care Facilities Division for her award and recognition from Sigma Theta Tau International Honor Society of Nursing, Gamma Beta Chapter as a recipient of the 100 Extraordinary Nurses on May 2, 2011. "Ms. Longstreth exhibits achievement in her leadership of the hospital, end stage renal dialysis, hospice, and home health agency survey teams," says Sharon Williams Lewis RNC, MSA, CPM, Program Manager for the DC DOH Health Care Facilities Division, "She brings extensive experience as a corporate manager of a vast home health agency, case management consultant, and is active in her community always helping others. Ms. Longstreth is a health care leader with more than 32 years in nursing, 24 of those years in home care with 22 years in leadership positions. Ms. Longstreth demonstrates true commitment and dedication to the field of nursing."

Veronica Longstreth

Congratulations to the 100 extra ordinary nurse honorees recognized by the gamma beta chapter of sigma theta tau international honor society of nursing in may 2011.

Ahaghoto, Isu
Aina, Adetutu
Ali, Fazalit
Anderson, Lyndsay
Arowolaju II, Adebayo
Asiedu, Nana
Babalola, Florence
Baker, Alicia
Banaci, Alice
Ben, Delphine
Bibb, Sandra
Billingslea, Jacquelyn
Bolton, Jeffrey A.
Bradfield, Landis
Branch, Janet
Burnett, Donna
Burris, Ruthanne
Colbert, Schallery
Coscolluela, Marissa
Cowan-Grant, Ethlyn
Daramola, Bukky
Davelli, Catherine
DeFreitas, Laura
Deily, Katie
DelaCruz, Carlos
Elbalghiti, Janet
Etukeni, Margaret
Evans, Sylvia
Flood, Juanita
Freeman, Tamara
Funderburg, Erin
Gaeok, Kim
Gannon, Kristin
Gordon, Marjorie
Grandy, Lisa
Gresham, Dorothy
Groner, Kimberly
Hall, Brigitte
Harris, Lynette
Hedd, Annie
Henderson, Teka
Hinnant, Linda
Holt, Shaina
Hurlbutt, Tracy
Hutchinson, Donnette
Inouye, Lauren
Johnson, Andrea
Johnson, Michaele
Kalinoski-Murphy, Amy
Kpolie, Patricia
Lach, Susan
Lim, Maribel
Longkeng, Emilienne
Longstreth, Veronica S.
Macklin, Yvette
Main, Lauren
Martyn, Diona
McBride, Jessica
McCamey, Danielle
Merritt, Carlita
Mikulak, Lena
Myles, Rose
Olusoga, Felicia
Onyeiwu, Ifeoma
Ovedovitz, Jane
Pascall, Arlene
Philip, Binu
Poan, Hilary
Powell, Sandra
Randolph, Rudolph
Rodriguez-Santos, Graciela
Rossi, Christine
Rowe, Lorne Joy
Rozario, Provati
Rucker, Karen
Saucier, Leola
Schwartzman, Susan
Senior, Kathy
Singleton, Cynthia
Smith, Andrella
Solomon, Cindy
Starr, Jessica
Starrels, Elizabeth
Swayze, Sonia
Tejada, Zandro
Thomas, Ayanna
Toews, Laura
Ugoriji, Julia
Urso, Christina
Valentin, Melinda
Wagstaffe, Beverly
Ward, Michelle
Weijers-Farrar, Anna
Wells, Melanie
Westcott, Judy
Wharton, Diana
Wilkerson, Vanessa
Wilkerson-Roberts, Clydette
Williams, Lisa
Worthy, Tat'Yana

Board Disciplinary Actions

NAME	LICENSE #	ACTION
Samuel Addo	RN 960388	Revocation

Names and license numbers are published as a means of protecting the public safety, health and welfare. Only Final Decisions are published. Final Orders and the Certified Nurse Aide Abuse Registry can be assessed by going to www.hpla.doh.gov.

Non-Public Disciplinary Actions:	
Notice of Intent to Discipline	*16*
Referrals to COIN:	*0*
Consent Orders:	*18*
Request to Withdraw Application	*0*
Request to Surrender License	*0*
Letters of Concern:	*0*

Drug Disposal—Clean Out Your Medicine Cabinet!

To dispose of unused medications, the DC Board of Pharmacy and the Department of Health recommend the following:

- Take your prescription drugs out of their original containers.
- Mix drugs with an undesirable substance, such as cat litter or used coffee grounds.
- Put the mixture into a disposable container, such as an empty margarine tub, or into a sealable bag.
- Conceal or remove any personal information, including the prescription number, on the empty containers by scratching it off, or covering it with black permanent marker or duct tape.
- Place the sealed container with the mixture and the empty drug containers in the trash.

Public vs. Non-Public Discipline

Public Discipline: *Disciplinary actions that are reported to Nursys, National Practitioner's Data Bank and viewed in DC NURSE and at http://app.hpla.doh.dc.gov/weblookup/.*

Non-Public Discipline: *Disciplinary actions that constitute an agreement between the Board and the licensee and, if complied, are not made public.*

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April 24	Fun Day At Sea	--	--
April 25	Montego Bay, Jamaica	09:00 AM	06:00 PM
April 26	Georgetown, Grand Cayman	07:00 AM	04:00 PM
April 27	Cozumel, Mexico	10:00 AM	05:00 PM
April 28	Fun Day At Sea	--	--
April 29	New Orleans, Louisiana	08:00 AM	--

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