

DISTRICT OF COLUMBIA

VOLUME 5 NUMBER 4
SEPTEMBER 2008

NURSE

REGULATION **E**XTENSION **P**RACTICE



MEET DOH DIRECTOR

Pierre N.D. Vigilance, MD, MPH

**SPECIAL SECTION:
Focus on HIV/AIDS**

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District of Columbia
Adrian M. Fenty, Mayor



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DISTRICT of COLUMBIA NURSE

Edition 20

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

Feel free to email your "Letters to the Editor" for our quarterly column: *IN THE KNOW: Your opinion on the issues, and our answers to your questions.* Email your letters to hpla.doh@dc.gov (Lengthy letters may be excerpted.)

“EVERY HEALTHCARE PROVIDER IS AN AMBASSADOR FOR HEALTH AND WELLNESS”



Board Executive Director Karen Skinner with the Director of the Department of Health, Dr. Pierre Vigilance. Ms. Skinner offers the Board of Nursing as a resource for assisting Dr. Vigilance in fulfilling DOH’s mission and suggests that the other health professional boards be used as a resource as well.

What is your top priority as Director of the District’s Department of Health (DOH)? What role would you like to play in improving healthcare in the District?

Dr. Vigilance: Public health’s primary role is not specifically in healthcare, but in health, generally. Promoting health. Protecting the public from various aspects of things that can be detrimental to their health.

The priorities of this department can be put in to three categories:

The first category is the **promotion of wellness**. [We must have a] comprehensive and integrated approach to wellness. [We are seeking to] not just address individual diseases, but also the environment in which District citizens live, the environment in which they eat, and the policies that affect both of those things, as well as have to do with and improve access to care.

The second category is **HIV/AIDS**. This is a priority for us because of the significant number of cases in Washington. There are a number of different conversations that you can have around HIV/AIDS that you wouldn’t have if you were just talking about hypertension, or diabetes, or cancer, or stroke; conversations specifically having to do with sexual orientation, sexual activity, and also to do with injection drug use.

The third category is about **public system enhancement**. The public health system is not just the health department; it is also the hospitals, the Primary Care Association, the community clinics, all the individual doctors and other health providers. We want to be able to provide some direction for all of those parties, as they are all trying to do the same thing—improve health outcomes.

Are there any healthcare concerns specific to the District that other jurisdictions don’t have to deal with?

For comparable jurisdictions, I think there are similar, if not the exact same issues. Places like Baltimore, Richmond, Detroit—any urban center. We are a little different in that we don’t have a suburb. The suburbs of DC are other states.

Dr. Shannon Hader [Senior Deputy Director of District’s HIV/AIDS Administration] recently attended a meeting of the Board of Nursing and spoke about HIV rates in the District and the importance of establishing routine HIV testing. Is there anything you would like to say on the topic of HIV?

There are so many things to say. Of critical importance is the fact that HIV is a completely preventable condition. There are a number of situations that we as individuals put ourselves in that could potentially harm us. With a bit more education, and application of that education toward behavioral change, we could reduce risk. People know what they need to do, but they don’t always do it. And that goes for a number of health issues. You ask men everywhere about condom use. They say they know they should use condoms but if you ask them if they use them regularly their answer is “No.”

So it is about matching knowledge with action. For us, it is trying to find a way to assist in doing that—through building capacity within organizations that are doing the work on the street, if you will, all the way through to improving access to condoms and doing more screening for STDs and HIV in non-traditional venues. Especially [doing outreach] to make HIV a less stigmatized disease by having more people tested as a routine part of medical care. So if you are involved in the healthcare system, then make those screenings something that is not so special. Nobody asks you if you want a blood pressure or cholesterol test: “Is it okay if I draw your cholesterol level? Is it okay if I check your blood pressure?” HIV’s got a different set of rules attached to it and it shouldn’t.

What would you like District citizens to know about DOH? Do you think the public is misinformed about any issues concerning the functions or resources of DOH?

I don’t think most people know what the Department of Health does in any jurisdiction. I don’t think DC is any different. That “**protect, promote, prevent**” function is something that people see as only coming up in an emergency. The emergency preparedness function is something people recognize that we may have a role in. They also associate us with restaurants a lot: “Who does the inspections of the restaurants? If I get sick in a restaurant, where do I call?” But with respect to the promotion of health-and-wellness and some of the policy pieces, [the public is usually not aware of DOH functions]. Even the HIV piece; I don’t think we are very well known for that work.

First of all, [citizens should know] that the Department of Health is made up of a thousand very hard working people who work all over the District basically trying to improve people’s health in a number of different settings. While we do provide most of the services to individuals who are underserved, we are here for everybody, be it in respect to substance abuse, HIV, or emergency preparedness or our regulation function or community health. But we do have a focus on making sure that people who don’t have access to resources gain access to services, either through us directly or by virtue of one of our networks through other primary care folks.

We’re here for everybody; we serve a broad range of functions. We are more than emergency preparedness.

How can we best use the District’s funds to tackle the healthcare concerns of the District?

We are working on a couple things. Of particular

importance is our efforts to become more efficient with respect to our business processes so we can be better stewards of the funds to which we have been given access. I know that there have been some challenges in our business processing in the past, and we are looking very closely at how we can do better with respect to that so we can be truly responsible and responsive to the needs of the people. What we are doing right this minute is making recommendations on the use of over \$150 million in capital development money from the tobacco settlement. We’ve already made use of some of those funds for noncapital functions. We have some RFAs [Requests for Applications] going out for chronic disease management for diabetes and obesity. But on the capital side, we’ve got a significant amount of money going out for projects such as enhancing the medical homes project we have been talking about, improving the Information Technology infrastructure of our primary care sites and improving access to urgent care as well, and some specialty care. Those are the main pieces and there will be additional pieces, too. We are trying to be sure we are appropriate in our placement of those resources, not just the type of things that we purchase, but also where we put them. Where are the best sites for primary care expansion? There are many in some parts of the District, and there are not so many in some other parts of the city, such as east of the river.

When you speak of urgent care centers, what are you envisioning?

An urgent care setting can either be just urgent care on its own or it could be an urgent care component to a primary care site that offers service beyond regular hours. We are trying to make access truly accessible. So if I am working 9 to 5, it doesn’t make much sense for my doctors to only be available from 9 to 5. It would be better if they were available alternate hours. In addition to that, I may not need to go to the emergency department, which is a place where a lot of people make use of services now because of the [late] hours. I may not need to go to the ED [emergency department]; my complaint may not be significant enough for that. An urgent care facility can potentially help take care of that. We will be looking at primary care as well as urgent care expansion.

Is the Department of Health planning to run the urgent care centers?

We’re not. As with many health departments, we are not in the business of providing primary medical care services. And that has been a change



Dr. Vigilance's Bio

The new Director of the Department of Health (DOH), Pierre N.D. Vigilance, MD, MPH, most recently served as Director and Health Officer for Baltimore County. Prior to that, he was Commissioner for Health Promotion and Disease Prevention at the Baltimore City Health Department. Dr. Vigilance received his Bachelor's Degree from George Washington University and, after attending medical school at Johns Hopkins University, he returned to the District to train in Emergency Medicine at Howard University Hospital. Dr. Vigilance has also earned a Master's Degree in Public Health from Johns Hopkins. Dr. Vigilance immigrated to the United States from the United Kingdom to attend college.

that has been going on for a long time. Not sure that we necessarily want to try to reverse that. But for certain things, we do remain in that realm—STDs, TB and HIV. There may come a time when there is not time for that either. More primary sites, too. You don't want people making an urgent care center their medical home, per se.

Do you have any requests of the DC Board of Nursing or of nurses in general?

Every healthcare provider is an ambassador for health and wellness. We all have a responsibility, no matter where we fit into the system, to talk the talk and walk the walk, if you will. The request I would make is not one that is necessarily easy to comply with, but if you are going to be in the health and wellness field, then **be about health and wellness** yourself and promote that within your family and for yourself as well. That is what [prompted] me make some changes for myself. It is sort of tough to tell someone else about lowering their cholesterol while eating something that raises yours. This is the challenge because I know in some respects culturally, and to some extent economically, it can be difficult at times to do that. Hopefully, there are some things we can do with respect to promotion of farmers' markets, promotion of cooking in a particular way. It is really easy to go down the street and buy something cheap but is bad for you. For healthcare providers, I don't know that economics is necessarily the issue. It's more about will. How willing are you to change things for yourself? The same things you tell your patients.

[Dr. Vigilance noted that although the District government can ban usage of transfat and limit tobacco use, it is still up to the individual to make healthy choices.]

For all of us, it's going to [require] changing behavior, especially eating. The HIV piece is important—but not everybody is sexually active. Everybody eats. [Bad] food choices and lack-of-exercise choices, etc., make that a major issue. I aspire to be on the level of physical fitness that the Mayor is.

Get fit and have your family and friends get on board with you. I have friends in the [healthcare] field [with bad eating habits and who do not exercise], but the light bulb has to go off for you. One of the best ways that healthcare professionals can assist the DOH is to live well by walking the talk.



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Board of Nursing Update

Board Actions: June, July

EDUCATION

Board members engaged in a lively discussion with the public attendees regarding the use and misuse of comprehensive examinations as exit examinations. The Board asked staff to plan a meeting with educators focusing on the use of comprehensive examinations.

REGULATING NURSING ASSISTIVE PERSONNEL (NAP)

The board has been asked to regulate the practice of NAPs. This first step in the process will be the development of a regulatory model. Stakeholders are invited to respond to the model or any regulatory issues regarding the implementation of this model. Issues to be addressed:

- Titling (CNA; HHA; PCA; Health care technicians, etc.)
- Setting (long term care, home, acute care, etc.)
- Patient population (chronic, acute, etc.)
- Skill set (specific task that can/cannot be assigned or delegated)
- Supervision requirements
- Testing requirements
- Level of Regulation-Registration/Licensure

APRN/RN/LPN REGULATION REVISIONS

The Board is finalizing the revision of nursing regulations, incorporating input received from the nursing community and national best practices.

HIV TESTING

Dr. Shannon L. Hader, Senior Deputy Director, DC HIV/AIDS Administration, met with the board to solicit their support in advocating for routine opt-out HIV/AIDS testing and education (see page 22).

NURSING SHORTAGE STUDY

Marilyn Biviano, (former) Director, Division of Medicine and Dentistry, Bureau of Health Professions, Health Resources and Services Administration, met with the board to discuss her interest in doing a nursing shortage study in conjunction with the Board of Nursing. Board members supported working with Ms. Biviano, along with other DC nursing organizations on this study.

Members of the public are invited to attend...

BOARD OF NURSING MEETINGS

Date: First Wednesday of the month

Time: 1:00 PM (Time subject to change)

Location: 717 14th Street, NW; 10th Floor Board Room Washington, DC 20005

Transportation: Closest Metro stations are Metro Center (take 13th Street Exit); McPherson Square (take 14th Street Exit)

If you plan to attend please call (202) 724-8800 to confirm meeting date and time.

September 3, 2008

November 5, 2008

October 1, 2008

December 3, 2008



ATTEND BOARD MEETINGS

During each board meeting, time is set aside for **Public Comment**. This is an opportunity for the public to discuss nursing related matters with the Board members. Public Comment is scheduled at 1:00 pm (subject to change) at the beginning of the Board's Open Session. You do not need to be on the agenda to speak.

If you are interested in receiving the Board's Open Session Agenda, send your request to hpla@doh.dc.gov.

FAREWELL FROM OUTGOING BOARD MEMBER KEVIN MALLINSON

For the past two years, it has been my pleasure to sit as an RN Board Member on the DC Board of Nursing. The actions and decisions of the Board focus on assuring that the education of nursing students is appropriate, rigorous, and trustworthy; the Board aims to maintain laws and regulations to effectively guide professional nursing practice. Issues that come before the Board for consideration—education, regulation, discipline—are crucial to protecting the health of our citizens.

It has become clear to me that competing issues in my life will continue to undermine my ability to attend regular Board of Nursing meetings and engage fully in its activities. While my commitment to the mission of the Board never wavers, personal issues keep me from providing the time and attention necessary to do justice to the issues at hand. For this reason, I am resigning my Board of Nursing position so that another nursing professional may have the opportunity to serve the District.

Over the previous decade, the Board of Nursing has emerged as a formidable force for the regulation of professional nursing practice in the District of Columbia. I am proud to have been able to participate in this process for the past two years. Thank you for the opportunity to serve as a member of the DC Board of Nursing.

Respectfully submitted,

R. Kevin Mallinson, PhD, RN,
AACRN

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What Every Nurse Should Know

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6.0 Contact Hours | \$36

Documentation: A Critical Aspect of Client Care

5.4 Contact Hours | \$32

End-of-Life Care and Pain Management

3.0 Contact Hours | \$18

Ethics of Nursing Practice

4.8 Contact Hours | \$29

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TOP 5 MISTAKES WHICH CAUSE DELAYS IN LICENSURE RENEWAL

1. MISSING DISCIPLINARY DOCUMENTS:

You answered "Yes" to a discipline question, but you did not provide supporting documentation.

Documentation is required when you submit the answer "yes" to a disciplinary question. If you have answered "yes" in error, you must submit a letter of retraction. Information provided will be reviewed prior to processing your renewal application.

2. MISSING CONTINUING EDUCATION DOCUMENTS:

You answered "No" when asked if you completed your Continuing Education (CE) requirements by June 30th. If you have completed your CE requirement but you answered "No" in error, you must submit evidence of having met this requirement.

3. YOU OWE TAXES TO THE DISTRICT GOVERNMENT:

If you answered "Yes" to the "Clean Hands" question or if we received a report from the DC Office of Tax and Revenue indicating that you owe taxes, your application will be delayed. You are required to submit proof, a letter from the Office of Tax and Revenue, regarding arrangements you have made to pay the outstanding debt in question.

4. BAD ADDRESS:

You did not notify the Board of Nursing that you moved. Please be reminded that you are statutorily required to notify the Board in writing of an address change within 30 days. If you fail to report your new address, you will not receive your license, and you may also be fined.

5. APRNs ONLY – FAILURE TO RENEW YOUR RN LICENSE.

Failure to renew your RN license.

You are required to renew both your RN license and your APRN authority. If you applied online, you have to renew each separately. Renewing your APRN authority does not automatically renew your RN license.

"DEFENSIVE DOCUMENTATION" CE PROGRAM

In early 2009, the Board of Nursing will co-sponsor a Continuing Education program on Defensive Documentation. Speakers will explain documentation formats, identify common legal pitfalls, review general rules regarding charting and discuss how documentation and malpractice go hand-in-hand. If you would like to be informed when date and location details are established, please send an e-mail to the program organizer at:

dcnursece@yahoo.com

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IN THE KNOW

Your Questions, Your Opinions

The Board of Nursing has established this IN THE KNOW column in response to the many phone calls and emails we receive. The Board often receives multiple inquiries regarding the same issue. Please share this column with your colleagues or 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.

REGARDING CONTINUING EDUCATION (CE): Please be reminded that you are NOT to submit CE materials unless a Board of Nursing staff member has asked that it be submitted. Unsolicited continuing education materials will not be returned or kept. Thanks.

Q My license expires June 30th. I know the license is good for two years. I am actually moving this August out of the state and will only need a DC license until July or mid August. Is there a temporary license I can get for

the two months or a discount since I only need it for a few months and not two years?

A We don't issue temporary licenses for persons who have been licensed. Supervised

Practice Letters (temporary licenses) are only issued to new applicants applying for licensure by examination or endorsement. And we don't prorate our licensure fee. If you are going to practice in DC after your license expires on June 30th, you will need to be licensed.

Discover Opportunity...



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Q I am inquiring if there is any supervisory practice letter for home care for any staff that has a nursing license from another state and wants to practice in the District of Columbia.

A A nurse hired to work in a home setting is eligible to receive a supervised practice letter. Please be advised that the responsibility for the supervisor is as follows:

5413.9 The supervisor shall be fully responsible for the practice by an applicant during the period of supervision and may be subject to disciplinary action for violations of the Act or this chapter by the applicant.

Their dignity stays intact.

Q I have recently completed my license renewal. Currently, I am a public health nurse working at the National Institutes of Health (NIH). I have attended conferences and passed the annual skills tests for NIH. I believe this will fulfill the continuing education requirement for the DC license.

A Your annual skills test would not count towards your CE requirement, but any continuing education conferences you have attended will count.



Nurse Staffing Agency Questions

Q What is a Registered Agent?

A "registered agent" is a person authorized to accept service of process (usually a complaint filed in a lawsuit) for another person – especially a corporation, in a particular jurisdiction.

Q How do I obtain a Registered Agent?

A The DC Department of Consumer and Regulatory Affairs has a "Registered Agent Combined Form" to establish a registered agent for a corporation at www.registeragent.com or on its Web site at <http://mblr.dc.gov/corp/forms/dcfp.shtm>.



CERTIFICATION NAME

CHANGE NOTICE: The name of the "Public/Community Health CNS certification" has been changed to "Advanced Public Health Nurse certification." The exam has not changed, only the name. If you have any questions, please send an email to SBONinfo@ana.org.



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NOTICE Regarding Company called “MedCEU”

Please be aware that the organization “MedCEU” is neither accredited by ANCC nor approved through any of the ANCC approvers, nor the DC Board of Nursing.



Licensure Status Check Available Online

You can now check the status of your licensure application online.

Go to <https://app.hpla.doh.dc.gov/mylicense/>; enter your Social Security Number and Last Name (as it appears on your licensure application). Once you have logged in, click on “View Checklist.”

The status of your application is available the next day after the application has been processed. As information is received or as action is taken, the information is recorded in the database and automatically posted to the Status Check. After you are licensed, this information is no longer available at this site. Once you are licensed, to view your licensure status, go to <http://app.hpla.doh.dc.gov/weblookup/>.

CE BROKER: TRACK YOUR CE RECORD ONLINE!

The DC Board of Nursing has partnered with CE Broker to provide secure electronic portfolios for nurses to manage the Continuing Education required for license renewal. The subscription is voluntary. With a subscription, you’ll gain access to your specific license renewal requirements and will be able to track your progress toward those

A screenshot of the CE Broker website. At the top right, there is a red banner that says "Free 7-day Trial Offer". Below that, there is a text box that says "If you've not already taken advantage of electronic continuing education tracking, sign up today... the benefits are great!". Below that, another text box says "With your \$17.50 annual subscription, you'll access the welcome screen. If you have any questions, please phone toll free 1-887-i-find-CE (1-877-434-6323)". Below the text boxes, there is a navigation menu with links: "Welcome", "Message Box", "Pending Action", "Messages Sent & Responses", "My Alert List", and "Archived Messages". Below the navigation menu, there is a "Welcome to your Communication Center!" message with a "COMPLETE CLICK" button. Below that, there is a section titled "What would you like to do today?" with four options, each with a "Go!" button: "View my Transcript(s) and compliance determination(s)", "View my Chronological Course History for a real-time display of programs completed as reported", "Self-submit completed continuing education, as allowed by your profession's rule", and "Set up personalized Alert notifications of upcoming course meeting specific requirements". Below the options, there is a "Set automatic continuing education deadline reminder notices" option with a "Go!" button. At the bottom of the screenshot, there is a URL: <https://www.CEBroker.com>.

requirements. However, educational providers may report completed course credit to your account regardless of subscription. The full array of interactive tools is available for an annual fee of \$17.50. Try it out with CE Broker’s free seven-day trial offer! Go to <https://www.CEBroker.com> and click the “District of Columbia Nursing Licensees” tab.

Practical Nursing Programs

Year to Date (6/30/08) Licensure Exam Results and Approval Status

PROGRAM	CURRENT QUARTER		YEAR TO DATE		APPROVAL STATUS
	04/01/2008 - 06/30/2008		07/01/2007 - 06/30/2008		
	#Sitting	% Passing	# Sitting	% Passing	
Capital Health Institute	12	91.67	12	91.67	Initial
Comprehensive Health Academy	39	82.05	146	86.30	Initial
Harrison Center for Career Education	0	0.00	4	75.00	Closed
JC Inc.	17	52.94	124	62.90	Conditional
Radians College (formerly HMI)	27	77.78	99	82.83	Conditional
University of the District of Columbia	39	82.05	138	82.61	Full
VMT Academy of Practical Nursing	56	71.43	151	74.83	Full
VMT Practical Nursing Program	0	0.00	1	100.00	Withdrawn

Professional Nursing Schools

Year to Date (6/30/08) Licensure Exam Results and Approval Status

SCHOOL	CURRENT QUARTER		YEAR TO DATE		APPROVAL STATUS
	04/01/2008 - 06/30/2008		07/01/2007 - 06/30/2008		
	# Sitting	% Passing	# Sitting	% Passing	
Catholic University of America	8	100.00	50	84.00	Full
Georgetown University	13	92.31	81	96.30	Full
Howard University	5	100.00	69	82.61	Conditional
Radians College	11	45.45	31	64.52	Initial
University of the District of Columbia	6	100.00	17	94.12	Full

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

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PRACTICAL NURSE PROGRAMS

Have Student Loans?

Get repayment help with the DC Healthcare Professional Loan Repayment Program

The District of Columbia Department of Health has established the DC Health Professional Loan Repayment Program to aid in the recruitment and retention of health care professionals and to provide services to medically underserved residents. The program provides loan repayment benefits to eligible providers in exchange for a commitment to practice full-time at a facility located in a designated shortage area. Applicants are required to serve a minimum of two years, with an option to extend their service for two additional years. Applications are accepted on a rolling basis; award determinations are made in September, and recipients are notified by October 1 of each year.

Program Eligibility:

- Be a United States citizen
- Be one of the following:
 - Registered Nurse, Nurse Midwife, Certified Nurse Practitioner, or Physician Assistant who has completed all required post graduate training,
 - Physician (with certain post-graduate training)
 - Dentist (with certain post-graduate training)
- Be licensed or eligible to practice in the District of Columbia
- Have no other obligation for health professional service to the federal or state government, unless the obligation will be completely satisfied prior to the beginning of service under the Program.

Preferential treatment will be given to:

- Residents of the District of Columbia
- Graduates of accredited District of Columbia health profession schools or program
- Residents of a Health Professional Shortage Area (HPSA) or a Medically Underserved Area (MUA) within the District of Columbia
- Applicants that are immediately eligible and available for service
- Applicants that commit to longer periods of service

- Applicants whose service obligation site is also a qualified Medical Homes DC provider
- Applicants practicing at a service obligation site at the time of application who have less than three years of employment at the facility
- Applicants who speak Spanish, French, Vietnamese, Korean or Amharic

Eligible Educational Debts: The Program will pay for the cost of education necessary to obtain a health professional degree. The Program will pay toward the outstanding principal, interest, and related expense of federal, state or local government loans and commercial loans obtained by the participant for school tuition and required fees incurred by the participant and reasonable educational expenses.

Tax Implications: For the purposes of the United States Internal Revenue Service, all loan repayment awards are considered income and are taxable.

Award Amounts: Health professionals (other than physicians and dentists) are eligible for up to \$66,000 over four years of service. For each year of participation, the Program will repay loan amounts according to the following schedule:

- For the 1st year of service, 18 percent of the total debt, up to \$11,800
- For the 2nd year of service, 26 percent of the total debt, up to \$17,200
- For the 3rd year of service, 28 percent of the total debt, up to \$18,500
- For the 4th year of service, 28 percent of the total debt, up to \$18,500

You may **download an application** from the District Department of Health Web site at www.dc.gov, or you may contact the loan repayment program at: DC Department of Health, Primary Health Program, Health Professional Loan Repayment Program, 825 North Capitol Street, NE, Third Floor, Washington, DC 20002. You may call the program at: (202) 442-9168 [FAX: (202) 535-1039].

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<http://nursing.cua.edu/vulnerablepeople>

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SIGNS OF IMPAIRMENT

A Personal Checklist for Alcohol and Drug Use

Check off the statements that describe
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- I frequently (once or twice a day) find that my conversations center on drug or drinking experiences.
- I drink or get high to deal with tension or physical stress.
- Most of my friends or acquaintances are people I drink or get high with.
- I have lost days of school/work because of drinking or other drug use.
- I have had the shakes when going without drinking or other drug use.
- I have been arrested for Driving Under the Influence of a substance.
- I have periods of time that can't be remembered (blackouts).
- Family members think drinking or other drug use is a problem for me.
- I have tried to quit using substances but cannot. (A good test is voluntarily going for six weeks without substances and not experiencing physical or emotional distress.)
- I often double up and/or gulp drinks or regularly use more drugs than others at parties.
- I often drink or take drugs to "get ready" for a social occasion.
- I regularly hide alcohol/drugs from those close to me so that they will not know how much I am using.
- I often drink or get high by myself.
- My drinking or use of drugs has led to conflict with my friends or family members.

If you or a nurse colleague exhibit these signs, please call Conceeta Wright for referral to our COMMITTEE ON IMPAIRED NURSES (COIN). COIN is a confidential program that helps nurses practicing in the District deal with substance abuse and mental health issues.

Call Ms. Wright at (202) 724-8846.

EMPOWER YOURSELF TO EDUCATE THE PATIENT



Colleen M. Rodak, MSN, CRNP, ACNP

"My patients continue to report to me horrifying and embarrassing stories of being ostracized — I use the word 'embarrassing' because the majority of these events occur within the context of health care provider/health care facility/insurance company interaction. The end to this stigmatization can be facilitated by properly educated, well-informed health care providers who can then advocate for HIV/AIDS patients not only with the patient sitting in front of them but also in the community at large. Only when we work together to eliminate this stigma will we see more testing and more public health efforts at prevention."

Colleen Rodak: The first time I cared for a patient with HIV/AIDS was in 1986; of course, at that time, testing for the HIV virus was new. Fears about the illness and its mode of transmission abounded. As a novice RN at the Veterans Affairs Medical Center (VAMC) in Buffalo, I volunteered to work with those affected by the disease. Nothing gave me more of a sense of purpose than

for reasons which were soon to be revealed. As my shift was ending, a colleague called me and said that Jessie kept calling for me, and every time someone walked into his room, he asked, "Is that you, Colleen?" (His eyes were completely obstructed by Kaposi's Sarcoma tumors). I told my colleague to tell Jessie I would stop by his room before leaving at 4 p.m. Jessie died that

Interview with Colleen M. Rodak, MSN, CRNP, ACNP
*Deputy Clinic Director, National Institutes of Health
National Institute of Allergy and Infectious Disease
Division of Clinical Research, Critical Care Medicine HIV Program*

to be there for a patient who felt, and in many ways was, abandoned by friends, family, and society.

I will never forget Jessie, a sailor who was dying from HIV/AIDS in 1987 alone at the Buffalo VA. It was the Christmas holiday season, but he had been abandoned by everyone he thought he could trust. So we, the nursing staff, were his new-found family. One day, I was assigned to care for him but was pulled mid-shift to another unit. This was not my first assignment with Jessie, but I felt a bit of trepidation leaving him that day,

evening around 9 p.m.; I left his side at 10 p.m. I struggled to find the right words for him during those last few hours, to comfort him, to make him realize that he was a special person and that his time in this world had a purpose. The most important thing that I did was just being present. I held his hand as he died. Several years later, I recounted this story to a few friends, and one replied, "Well, he died in the hands of an angel," and it was at that moment that I realized what a gift it was to share such intimate moments with someone and to ease their suffering. I also realized what an enormous responsibility it is to continue their fight after they leave us.

The crisis that swept Jessie up 20 years ago continues, especially where I work, in the District of Columbia. As health care providers, we all must be knowledgeable about the HIV virus, its effects on the immune system, and what local resources are available both to prevent and to combat HIV/AIDS. With every clinical encounter, I assess the risk factors of the patient for HIV/AIDS, ask about testing for the virus, educate the patient on prevention, and dispel myths surrounding the illness.

If you could speak to all nurses, what would be the best piece of advice you could give them regarding working with HIV/AIDS patients?

Ms. Rodak: If I could speak to all nurses, the best piece of advice I could give them regarding working with HIV/AIDS patients is that caring for these patients should not cause the health care provider any more anxiety than caring for patients with other chronic infectious illnesses such as hepatitis B virus (HBV) or herpes simplex virus (HSV). Patients will recognize quickly if you are anxious and hesitant to participate fully in their care.

Education of the patient is of paramount importance due to the chronic nature of this disease and our current inability to eradicate the virus. The nurse has to be prepared to focus on education in order to dispel myths about the disease, to reinforce strong holistic self-care in the patient, and to prevent the further transmission of the virus from the patient to partners.

First, educate yourself about the illness, its physiology, transmission, pharmacologic treatment, and adverse drug side effects. By doing this, you will be prepared to perform a comprehensive yet targeted physical exam. This will empower you to educate the patient about their illness and strengthen your ability to advocate for them in the clinical setting.

Second, develop an understanding of the history of this disease, not only with regard to medical progress but also

with regard to the challenges of social stigma and lack of access to appropriate health care. It is only through understanding the journey that each survivor has had to endure that one can appreciate their anxiety and fear and their need to be strong advocates for themselves. And with this knowledge, you, as the health care provider, will be able to advocate for those who are newly diagnosed with HIV/AIDS.

What do you think is the most important concept you would like to get across to the general public regarding HIV/AIDS?

Ms. Rodak: The most

important concept to get across to the general public regarding HIV/AIDS is that if we all work together to overcome the social stigma of the diagnosis, then HIV/AIDS **can be prevented**, and furthermore if HIV is acquired, it is eminently treatable—it does not have to be a “death sentence.” Prevention should be the number one priority from a global standpoint. Unfortunately, social stigma still exists regarding HIV/AIDS patients. My patients continue to report to me horrifying and embarrassing stories of being ostracized—I use the word “embarrassing” because the majority of these events occur



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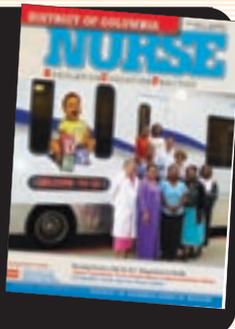
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within the context of health care provider/health care facility/insurance company interaction. The end to this stigmatization can be facilitated by properly educated, well-informed health care providers who can then advocate for HIV/AIDS patients not only with the patient sitting in front of them but also in the community at large. Only when we work together to eliminate this stigma will we see more testing and more public health efforts at prevention. With testing comes earlier diagnosis, which brings an overall improved prognosis for the patient.

What is your greatest barrier to providing quality care to your clients?

Ms. Rodak: The greatest barrier to providing quality care is a lack of access to care, such as health care insurance that would provide for well check-up visits and comprehensive preventative care as well as cover the cost of prescription medications.

Are there any specific things that you say to HIV/AIDS clients (or family members) to facilitate effective treatment?

Ms. Rodak: In order to facilitate effective treatment,

the first thing that must be done is a thorough assessment of the person's readiness to start an antiretroviral regimen. I then try to learn about their individual illness in order to understand and potentially alleviate their fears and anxiety in a nonjudgmental way. I support my HIV/AIDS clients with reminders about doctor appointments as well as medication reminders, whether it be verbal or written reminders or by medication device. I try hard to be there for my clients, to care, and to never stop learning about the virus and its treatment so that I can be a strong advocate for them.

What do you enjoy most about your work with HIV/AIDS clients?

Ms. Rodak: It is a privilege to be given the opportunity to experience their journey, rocky as it may be, with them. I enjoy alleviating the suffering, both physical and psychological, of my patients. I also enjoy helping patients become well-educated so that they develop into a strong advocate for themselves and even perhaps others who are going through the same thing. Oftentimes, it is actually through my patients that I gain the strength to carry on the fight against this formidable virus.

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Infants Infected with HIV from Pre-Chewed Food

Although it has been a rare occurrence, researchers have concluded that infants can be infected with HIV when they are given food that has been pre-chewed by a caregiver with HIV. Three cases were reported in the United States (two in Miami, one in Memphis) from 1993 to 2004, according to CDC scientists. In a research paper entitled, "Practice of Offering a Child Pre-masticated Food: An Unrecognized Possible Risk Factor for HIV Transmission," the authors indicate that "while all three cases raise the index of suspicion, two of the cases provide compelling evidence linking pre-mastication to HIV transmission. This route of transmission of HIV has not to our knowledge been previously reported. The risk of infant HIV transmission associated with pre-mastication of food deserves further investigation and has important global implications."

According to CDC epidemiologist Dr. Kenneth Dominguez, who co-authored the research paper, "Two of the caregivers—there was a report that there was poor oral hygiene and bleeding gums. There was likely to have been blood mixed with the saliva, which provides biologic plausibility for transmission through feeding the kids through this method. In the third case, we didn't have information about the oral hygiene of the mother. That's really important information. One of the things we want to emphasize is that it's not necessarily just the act of pre-masticating, but very likely it's the blood in the saliva that then gets into the child through—if the child is teething, the oral mucosa is somehow compromised. Either they're teething or they'll have some sort of other inflammation in the mouth, and that allows the virus to get into the child." The researchers noted

cases in Memphis and Miami where children became infected with HIV at the time they would have been teething. This kind of transmission is very rare in the United States because of better access to baby food and electric appliances for pureeing food. Pre-chewing food for infants is more common in countries where options for feeding are more limited.

Sources: <http://www.thebody.com/content/confs/retro2008/art45178.html> (The Body is a service of Body Health Resources Corporation) and <http://www.retroconference.org/2008/Abstracts/31723.htm>

New Scholarship Program

The Robert Wood Johnson Foundation (RWJF) and the American Association of Colleges of Nursing (AACN) have announced the creation of the RWJF New Careers in Nursing Scholarship Program. Scholarships in the amount of \$10,000 each will be awarded to 1500 entry-level nursing students over the next three years. Preference will be given to students from groups underrepresented in nursing or from a disadvantaged background. Through the scholarship program, funding will be available to schools of nursing with entry-level accelerated programs at the baccalaureate and/or master's level(s). By bringing more nurses into the profession at the baccalaureate and master's degree levels, the new scholarship program also helps to address the nation's nurse faculty shortage.

AACN will serve as the National Program Office for this RWJF-funded initiative. For more information contact the National Program Office at ncin@aacn.nche.edu or 202-463-6930, extension 232.

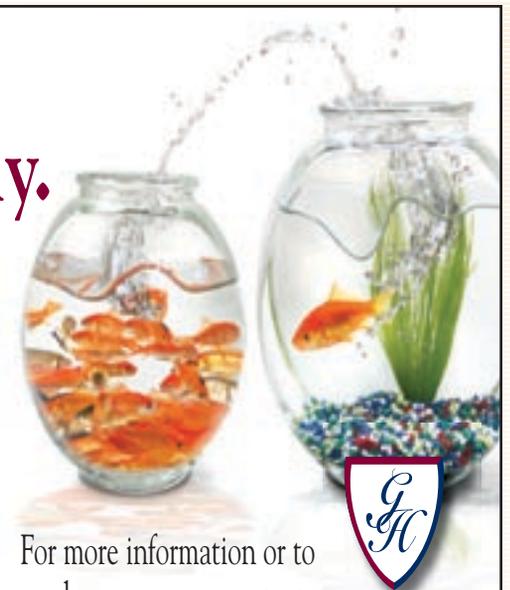
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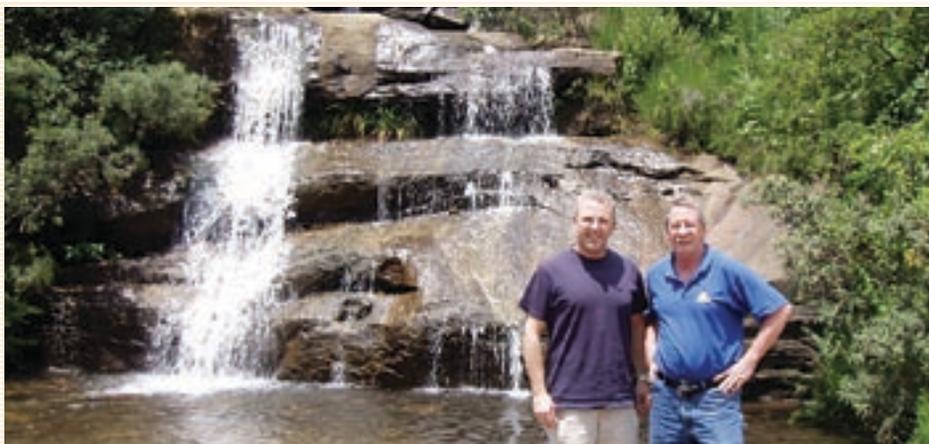
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Interview with R. Kevin Mallinson, PhD, RN, AACRN

*Principal Investigator, Nurses SOAR! [Strengthening Our AIDS Response]
Global HIV/AIDS Nursing Capacity Building program in
South Africa, Lesotho, and the Kingdom of Swaziland*



Dr. Kevin Mallinson (right), Principal Investigator, Nurses SOAR! (Strengthening Our AIDS Response) in South Africa at the Sani Pass near the Lesotho border with Dr. Michael Relf, Co-Principal Investigator of SOAR!. (Former Chair of the Department of Nursing at Georgetown, Dr. Relf has accepted a position as Assistant Dean for Undergraduate Nursing at Duke University's School of Nursing.)

If you could speak to all nurses, what would be the best piece of advice you could give them regarding working with HIV/AIDS patients?

Dr. Mallinson: In light of the recent trends towards “mainstreaming” patients with HIV/AIDS as if they have a chronic illness akin to diabetes, I would provide words of caution: having HIV disease is not the same as having an ordinary chronic condition. Nurses need to conduct a thorough and holistic assessment of the patient’s health. Persons with HIV/AIDS often experience ostracism, condemnation, and discrimination when disclosing their HIV status. The psychosocial burden of living with a life-threatening disease – and make no mistake at its capacity for morbidity and mortality – is compounded by grief, anxiety, and uncertainty in addition to social barriers such as poverty, racism, and homophobia. My best advice is to learn how to accept your patients

without making judgments and take the time to ‘listen’ to their story. Finally, provide support and validation of their individual experiences as persons living with HIV/AIDS.

What do you think is the most important concept you would like to get across to the general public regarding HIV/AIDS?

Dr. Mallinson: The most important concept I would communicate is that HIV/AIDS is not a disease of homosexuals, injection drug users, sex workers, and racial minorities. Rather, HIV/AIDS is a disease that affects people in our communities who deserve our love and support: our uncles, nieces, brothers, neighbors, and co-workers. When we objectify individuals into risk groups, we tend to diminish their humanity and assign shame and blame for their health status. HIV affects men, women, and children around the globe who have no ill intentions; they are simply living their lives in the presence of

an infection that is [largely] spread by sexual contact. Consequently, we should endeavor to express our love and understanding to persons with HIV/AIDS and challenge ourselves to learn more about the socio-economic barriers to maintaining healthy lives and effectively using safer sexual behaviors.

What is your greatest barrier to providing quality care to your clients?

Dr. Mallinson: The greatest barrier to the provision of quality HIV/AIDS care is nurse apathy. Nurses who do not challenge themselves to learn the fundamental concepts of HIV prevention, treatment, and care may inadvertently provide substandard care and ineffective patient and family teaching. I believe that HIV/AIDS remains – largely – a nursing-sensitive pandemic. Nurses have the potential to provide effective prevention interventions, focused treatment and symptom management, and compassionate palliative and end-of-life care. The main challenge is to have them perceive persons with HIV/AIDS as valuable, worthwhile human beings deserving of the best that nursing can offer.

Are there any specific things that you say to HIV/AIDS clients (or family members) to facilitate effective treatment?

Dr. Mallinson: To facilitate effective treatment, I don’t ‘say’ anything to persons with HIV/AIDS. Rather, I

'ask' questions. I probe if they are concerned about their future. I inquire about their fears and anxieties. I assess their quality of life and identify areas for improvement (e.g. gaining weight, reducing fatigue and increasing energy levels, or avoiding hospitalizations). Promoting adherence to treatment is more about achieving goals that the patient wishes to accomplish and less about our ability to provide good 'education.' If a woman is able to return to work and still has the energy to play with her two children when she arrives home, she is much more likely to maintain her medication regimen.



Dr. Rachel Gumbi (center), the Rector for the University of Zululand, South Africa, with Kevin Mallinson and Michael Relf.

What do you enjoy most about your work with HIV/AIDS clients?

Dr. Mallinson: Working in the HIV/AIDS area demands the best of my nursing education and expertise. I believe that the complex multi-sector, multi-layer aspects of HIV prevention, treatment, and care demand that I apply my knowledge and skills in pathophysiology, psychology, and sociology. I am challenged to understand the impact of policy decisions on the day-to-day lives of clients with HIV/AIDS. Whether my clients are in the southeast neighborhoods of Washington, DC, or the rural areas of the Kingdom

of Swaziland, they continue to be an inspiration to the strength and resilience of the human spirit. After 25 years, I continue to be amazed at the human capacity to face adverse conditions with a sense of self-respect, a commitment to loved ones,

and an optimism that life's worst barriers can be overcome. What I love most [not just enjoy most] about my work with persons with – or at risk for – HIV/AIDS is the extraordinary ability to demonstrate love and caring in the worst of the epidemic.

I strive to learn something new every day. And always set my expectations higher. As an employee at Kaiser Permanente, I am supported with resources and encouragement to realize my potential. Whether I'm pursuing educational opportunities or learning from people around me, I'm continually working towards being my best, both in and out of work. I chose a career in health care to help people. Kaiser Permanente shares this mission and wants the same for me. If you believe that personal and professional satisfaction comes from being your best, this is the place to put your beliefs into practice.

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HIV RAPID RESULTS: ROUTINE TESTING IS A POWERFUL TOOL

**HIV/AIDS SENIOR DEPUTY DIRECTOR SHANNON L. HADER, MD, MPH,
SPEAKS TO THE MEMBERS OF THE BOARD OF NURSING**



Dr. Shannon Hader

*Knowledge is Power:
By making the HIV swab test
routine (like a blood-pressure test),
healthcare professionals can
greatly decrease the percentage of
District citizens who are infected
but don't know it.*

AIDS is the #1 cause of premature death in the District, and “knowing your HIV status is power for action,” according to Shannon L. Hader, MD, MPH. Dr. Hader, director of the Department of Health’s HIV/AIDS Administration, spoke to the board at its July meeting. She told Board members and visitors that the District’s rate of HIV infection is twice as high as the rate of

infection in New York City, and that 25 to 50 percent of HIV-positive individuals in DC are unaware of their status.

Getting tested for HIV should be easy and routine, Dr. Hader told board members. “Patients don’t have to request to be weighed or to have their blood pressure taken,” she said. HIV testing should be routine also. “We need to make it as easy to get as other routine tests. Very few people are refusing to take the test; however, most people are not offered the test.” In DC, Dr. Hader said, there is no legal requirement for the long

consent forms that hinder medical professionals in other jurisdictions. There are two levels of testing available now, Dr. Hader said. An oral swab is for initial screening; a blood test can be given later to confirm the client’s status. Oral swab results are available in 20 minutes.

Clients Assume Test is Already Routine

Dr. Hader noted that many patients believe they have already been tested for HIV because they have been seeing a healthcare provider regularly. Clients who have had a pap smear, mammogram or blood profile are surprised to find out that HIV testing has not already been integrated into their medical

care. “A lot of people assume the test is routine,” Dr. Hader said. “Recent data indicates that three-fourths to four-fifths of clients with new HIV diagnoses in the District had contact with the healthcare system in the last 12 months.”

Now is the opportune moment for healthcare providers in the District to make HIV testing routine. Medical professionals should incorporate the HIV swab test into their list of routine testing. “This is a paradigm shift for the medical community,” Dr. Hader said. Soon, in the District, medical professionals will offer the test routinely, with an opt-out policy in place.

Nurses As Leaders: Raise Expectations

“Nurses—as direct providers—can be huge leaders” in this effort, Dr. Hader said. Nurses have a powerful and respected voice with clients and within the community at large. “The best prevention is intervention,” Dr. Hader said. When we let clients know that they are HIV positive, they get linked into care and work to prevent transmission to others. We must raise our expectations for our capacity to get our population tested, Dr. Hader said. When testing was initiated in DC in 2005, she told attendees, 45,000 persons were tested out of a population of 600,000. “However, in the country of Botswana, which has a population of 1 million people, 450,000 people were tested.”

Debunking Stereotypes

Black Americans are 80 percent of new diagnoses in DC. (This figure does not include African immigrants.) According to Dr. Hader, 40 percent of cases were through heterosexual transmission, 20 percent were through men having sex with men, and 15 percent occurred because of drug use [remaining 25 percent undetermined]. And although the most common age of diagnosis occurs for persons in their 30s or 40s, clients in their 50s have the same chance of diagnosis as those under 30.

“DC is the face of the modern epidemic,” Dr. Hader said. “The stereotype is that the people who are ‘at risk’ are those who have sex with all sorts of people and are taking all kinds of drugs. You don’t need to be a three-times-risk-individual to be ‘at risk.’ Many persons who are infected are individuals with only one partner.”

Role of the Board

What can the Board do to promote routine testing?

Get the word out to nurses!

CONTACT THE HIV/AIDS ADMINISTRATION TO GET YOUR TEST KITS

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Washington, DC 20002

On the Web:

www.doh.dc.gov/hiv.



Routine testing is a must. Many persons with HIV do not engage in high-risk behaviors and do not know they are infected. Many have only one sexual partner.

CULTURAL COMPETENCY AND HIV/AIDS

A Workshop for Healthcare Professionals

The program "Challenges and Strategies for Communicating Effectively with African Clients about HIV/AIDS" was presented in June 2008. The program featured speakers Georgina N. Bukenya, LLB, LLM, Policy Associate with Global AIDS Alliance; Miniabiyi Trego Ford, BA, Medical Case Manager, Howard University Hospital; Ijeoma Otigbuo, PhD, Professor of Microbiology, Director of HIV/AIDS Awareness Center; and Jeanne Tshibungu, MD, HIV Outreach Specialist, Ethiopian Community Development Center. Priscilla Mendenhall served as moderator and project consultant. The speakers provided PowerPoint presentations which highlighted the statistics of HIV/AIDS rates, the enduring impact of colonialism and traditional beliefs. The program was sponsored by La Clinica del Pueblo, Mary's Center for Maternal and Child Health, and the District of Columbia Primary Care Association (which hosted the program) with funds received from the District of Columbia Department of Health.

by Nancy Kofie

Nursing practice in the District not only requires a mastery of the science of treating disease, it also requires the art of interpersonal communication, which often includes the cultural competency needed to effectively serve the diverse ethnic client population of DC. In June, the District of Columbia Primary Care Association (DCPCA) offered a program entitled "Challenges and Strategies for Communicating Effectively with African Clients about HIV/AIDS." The program featured speakers with family connections in Africa, with extensive knowledge and experience in community outreach, and who had obtained their university degrees from institutions in Africa, Europe and the U.S.

HIV/AIDS presents many challenges for nurses serving immigrant clients. DC residents who have emigrated from other countries often bring both dreams of financial success and the cultural heritage of their home country. Often, there are language barriers, client privacy concerns, financial obligation to support dependents living both "back home" and on U.S. soil, and (as is true in most U.S. communities) there exists undisclosed sexual activity and the exchange of cash for sexual favors.

"We are not trying to stereotype," program facilitator Priscilla Mendenhall told attendees. "We are using generalizations to develop culturally competent clinical care. When people come to America, they do not leave their history behind. People come here with experiences in their hearts and minds. You should address their fears." Ms.

Mendenhall noted the use of traditional medicine which incorporates the use of herbs as well as "the supernatural and the interpersonal."

However, no client is a walking stereotype. Immigrant clients are still individuals – with varying opinions, outlooks and varying levels of conscious and unconscious loyalties to traditional modes of healing.

African Clients 101

Speaker Georgina Bukenya—an attorney and Kenyan-born Ugandan—opened the session by distributing blank maps of Africa and challenging participants to write in the names of all the countries they could. "Africa is not a country—it is a continent," Ms. Bukenya said. "Your clients come from different countries, and they are proud of their countries. Let them know that you know that."

Attendees were given a quick overview of the continent's history, the devastating effect of colonialism, touched on traditional beliefs in curses and witchcraft, and informed participants that less than 10 percent of Africans have access to HIV testing and counseling. As you work with immigrant clients here in the U.S., you may want to keep in mind the history and culture of Africans in Africa.

When you meet new immigrant clients, variations in etiquette may cause a moment of awkwardness, but do not be discouraged. At the workshop, the speakers demonstrated the various ways your African clients may greet you. Depending on your age, your

client's age, how long you have known the client, and their country of origin, your client may offer to shake hands, bow, kneel, courtesy, or hug. Keep in mind that the client may have a different perspective on personal space—so do not stand too close before you feel out the situation. If, during the course of the visit, your client does not look you in the eye, it does not necessarily mean that she or he does not like you or is trying to hide something; it is a sign of respect.

Communication with individuals may be hindered by language barriers and privacy concerns. In attempting to gain information on the client's history or when attempting to discuss test results, you might need to use a staff member who is NOT from the client's home country. An interpreter may be helpful to gain information from some clients, but a client concerned with keeping sensitive information private may not want to talk to an interpreter who could potentially reveal information to a third party within their expatriate community.

Good communication is key, and your efforts to build communication can begin with outreach to the community. To breakdown the stigma associated with HIV/AIDS, you or your facility may want to host a health fair that features a person from that culture that has HIV.

Time and Date

There could be confusion over something as simple as time and date. For example, speaker Miniabiyi T. Ford noted that for Ethiopian clients, make sure you are on the same page when discussing your client's age or the time of an appointment. "The Ethiopian calendar has 13 months—12 months of 30 days each, followed by a 13th month of five or six days." The Ethiopian New Year's Day is in September. There is a seven-to-eight year difference between the American calendar year and the Ethiopian calendar

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4601 Martin Luther King Jr. Avenue, S.W.
Washington, D.C.20032 or Fax to (202) 574-5395

year. America is currently in the year 2008—however, the current Ethiopian year is 2000. When giving instructions regarding medication and setting appointments, note that Ethiopian clients may tell time differently. For Americans, 1:00 a.m. in the morning occurs in the dark; for Ethiopians, a new day has begun once the sun has risen. So, the American 7:00 a.m. is the Ethiopian 1:00 a.m.

Here are some of the barriers healthcare professionals may face when offering care to immigrants:

NEGATIVE FEELINGS ABOUT THE WEST: Client may have a lack of faith in Western medicine and feel that it is cold and mechanical. Client may harbor resentments and suspicions that HIV/AIDS was brought to Africa by the West.

STIGMA AND DENIAL: Individuals may not want to discuss HIV/AIDS due to strong stigma against persons with HIV/AIDS. Some clients may even deny the power of the disease by stating that a relative or friend, who had the disease and died, died of another illness, not AIDS.

UNABLE OR UNWILLING TO DISCUSS: Client may not be able to speak English. Client may not want to speak to an interpreter if that person is a member of his home-country immigrant DC community (because of privacy concerns). Clients may not want to disclose sexual relationships which occur outside of marriage. Young ladies may be having sexual relations with older men for financial gain. A client may be reticent during medical visit and prefers to discuss treatment options with a family member.

LOYALTY TO TRADITIONAL PRACTICES: Client may feel more strongly committed to following traditional healing practices than obtaining Western medical assistance. Or client may want to receive Western treatment in tandem with traditional treatments.

HIV/AIDS Stigma

“The stigma can kill,” program speaker and college professor Ijeoma Otigbuo told attendees. Professor Otigbuo—who teaches at Montgomery College and is originally from Nigeria—said that her own in-laws (husband’s family) “didn’t want to have anything to do with me” after they found out that her sister had AIDS. Professor Otigbuo spoke of some of the denial she saw back in her home country. HIV is spread from soldiers to young girls, she said, and the religious leaders don’t want to discuss it “even though there are pregnant teenage girls sitting in the front pew.”

One attendee from Ethiopia told attendees that the stigma is great for HIV-positive African immigrants in the U.S. because “people view you as a failure ... you are supposed to buy a house and to send money home.” The speakers noted that clients should be informed that HIV positive persons who receive treatment will be better able to continue to work for many years to come.

Why would nurses want to work in this field? When workshop participants were asked why they chose to offer care or services to the population they serve, one attendee told participants: “I do this work because I have loved and lost too many people.” Professor Otigbuo added, “Seeing [my sister] in pain was agony for me.”

Skepticism and Outreach

Some client skepticism about the Western medical procedures is grounded in previous personal experiences.

Dr. Otigbuo told participants that in Nigeria she observed that some blood at a medical facility which had been marked as “screened” had in actuality not been screened. You may have to reassure your client of the integrity of the safety procedures in your facility.

A skeptical attitude may also be grounded in their home country’s history. When Africans were colonized by European countries, they were often told the Western presence was “good” for the indigenous people. When this edict proved untrue, some skepticism about the West developed.

Speaker Miniabiyi T. Ford also reminded participants about the infamous “Tuskegee Experiment” in the U.S. and noted that not all such skepticism is irrational. Ms. Ford, a native of Ethiopia (Bajan-Ethiopian), is a medical case manager at Howard University Hospital and has done considerable volunteer work as a counselor for Ethiopian immigrants in the DC area on matters of health services, cultural adjustment, housing, education, and employment. Ms. Ford urged attendees to utilize the institutions of the immigrant community to do outreach and break through the skepticism of the population. She recommends you make connections via:

- churches
- mosques
- restaurants
- clubs
- Parent-Teacher Association
- publications produced by and for immigrants

- African markets (such as the Florida Avenue market)
- and word of mouth.

Complex Beliefs

Ms. Ford spoke of the complexity that can be present in an immigrant client's religious and traditional beliefs. Although a client may have deeply-held beliefs in traditional medicine and the supernatural, "it is not necessarily the bedrock of their religious beliefs," she said. Even among the most devout Christians and Muslims, clients will utilize indigenous traditional beliefs and remedies "just in case." It is not necessarily their religion.

Education, religious values and traditional cultural beliefs mingle together and sometimes assert themselves in unexpected ways. Physician Jeanne Tshibungu explained how traditional fears regarding the supernatural can sometimes permeate the family—even if those beliefs were not necessarily preached to the younger generation. Dr. Tshibungu, who obtained her medical degree in Italy and did her residency in Belgium, told participants that her grown children changed their minds about leaving home to rent an apartment after disapproving aunts and uncles expressed displeasure. "I don't want to be cursed [by an aunt or uncle]" the grown children told Dr. Tshibungu.

Collaborate with Clients

The speakers urged attendees to partner with their clients rather than being patronizing with them. Do not have the attitude that "I know what is best for you." Include the client and family in medical decisions. However, as one nurse at the workshop asked: Where do you draw the line? She spoke about a client she'd had: "How [culturally] sensitive do you have to be before someone dies?" At what point do you force Western medicine on your client? It is a delicate balance that sensitive caregivers must determine—respecting traditional beliefs while providing the best care Western medicine has to offer.

There is no easy formula for caring for a client from another country—there will be variations with all individuals. However, there are some strategies to keep in mind:

DON'T STEREOTYPE: DON'T assume that all foreign-born clients hold certain beliefs, but DO keep in mind that there may be some traditional beliefs that may be in the back of the client's mind that could consciously or unconsciously prevent him/her from fully "cooperating" with your plan of care.

AVOID CONTROVERSIAL SPECULATION: DO address the client's condition, but DON'T engage in conversations with the client regarding the belief that "white people brought this disease." Do not confirm or dispute client speculations on the origin of the HIV/AIDS virus, but say, "I am not here to address the controversy; I am here to address what we can do to treat your condition and enable you to continue to function."

SUPPORT NETWORK: Assist your client in identifying and building support systems.

INSIDE HELP: If possible, identify at least one person in the client's family to whom the client may disclose their condition. Involve younger people in the family or any family member for whom the stigma may not be as great.

OUTSIDE HELP: Keep in mind that some clients may specifically NOT want anyone from their home country to know they are HIV positive due to privacy concerns and worry that the diagnosis could become known within their expatriate community.

FEMALE ROLE: If a wife seems hesitant to speak while her husband (the family spokesperson) is in the room, have the husband and wife sit in different rooms and interview them separately.

REALISTIC EXPECTATIONS: Asking a wife to tell her husband to wear a condom may not be a realistic request and will probably only prompt questions like "You don't trust me?" or "What are you doing behind my back?"

CONFORMING: Encourage your client to conform to your facility's standard procedures by assuring them that your facility conforms to stringent safety standards. Alleviate their fear that the treatment they are receiving is harmful or slipshod.

COMMUNITY OUTREACH: Do outreach via organizations in the community, hold health fairs and screenings, and partner with the traditional healers that service the community.

REDUCE THE STIGMA: Reduce the stigma so that clients will agree to be tested; if possible, recruit an immigrant community member who is HIV positive to speak at outreach events.

GAIN VISIBILITY: Gain visibility for your organization by placing advertisements in African immigrant oriented publications, such as the African Yellow Pages or Ethiopian Yellow Pages.

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Nursing Practice

Male/Female Roles

If you are speaking with a client accompanied by their spouse, keep in mind that some women will not contradict their husband in public, Professor Otigbuo told participants. The husband fulfills the role of the spokesman of the family. Also, some women don't want to appear smarter than the husband in public. But, as observed by Dr. Otigbuo—who has served as Chair of Biology at Montgomery College and is founder and director of the school's AIDS Awareness Resource Center—although the wife may not contradict her husband in public, "they will fight on the way home." If husband and wife come in together, have them sit in separate rooms so you can encourage each one to express themselves equally and openly.

Building Rapport

As you work with your client, jot down relevant names and facts in your notes, such as the name of your client's son or daughter. Ask about his or her mother or brother. By asking about your client's family or interests, you will build a stronger rapport with your client.

Once a bond of trust is established, you may find your immigrant clients become more attached to you than your U.S.-born clients. Physician Jeanne Tshibungu told participants about the warmth that is common practice in the client/provider relationship back in her home country (Democratic Republic of the Congo): "If you are a medical doctor in Africa, it is different. You are case manager—you are everything." Dr. Tshibungu said back in her home country when, for instance, she was recognized on the street by the sister of one of her clients, the sister would say, "Oh, you are the doctor of my sister!" and the two would sit and socialize—as if the healthcare provider is a member of the family.



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Names and license numbers are published as a means of protecting the public safety, health, and welfare. Only Final Orders are published. Pending actions against licensees are not published. Consent orders can be accessed by going to Professional Licensee Search at www.hpla.doh.dc.gov.

Kudos!

Amy P. Harper, MSN, ACNP-BC, of George Washington University Hospital, has been approved to serve as a member of the DC Board of Nursing's APRN Advisory Committee.

APRNs Wanted to Join BON Advisory Committee

The DC Board of Nursing's APRN Advisory Committee needs new members. If you are interested in serving on this committee, send your resume to Board Executive Director Karen Skinner at Karen.skinner@dc.gov or mail it to the Board of Nursing, 717 14th Street, NW, Suite 600, Washington, DC 20005.

Stories Wanted

Florida nurse Sue Heacock is writing a book "to remind nurses why we are so special, to increase retention of great nurses, and to attract other quality people to the profession."

Ms. Heacock is seeking submissions from nurses:

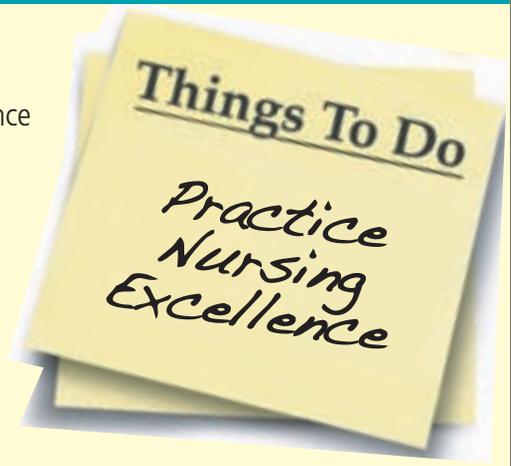
- Stories should be five paragraphs or less, humorous and/or inspirational, and exhibit the heart of nursing.
- The author must include his/her name, practicing city/state, and an e-mail address for future contact.
- The deadline is the end of the year. All stories can be e-mailed to imsueh@yahoo.com. Nurses whose stories are chosen will be contacted.

Nurses whose stories are chosen for publication will be contacted

individually for consent. (Favorite story from Ms. Heacock's career: "On my first day as a school nurse, I was being shown around campus by the headmaster. A first grader came running up and asked the headmaster who I was. She introduced me and the student said, 'Thank God. I fell down yesterday and cut my finger. I think I have rabies now.' He looked at me with bright blue eyes and asked me if I could take the rabies away so he didn't make his dog sick!"

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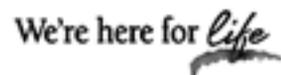
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EOE

COMMUNITY/PUBLIC HEALTH NURSES MAKE A DIFFERENCE EVERY DAY

August 2008

Sr. Rosemary Donley, PhD, ANP-BC, FAAN
Eileen Sarsfield, MSN, PHCNS-BC
Cynthia Leaver, PhD(c), RN

Sr. Mary Jean Flaberty, PhD, RN, FAAN
Agnes Burkhard, MSN, RN

The American Nurses Association (2008) chose *Making a Difference Everyday* as its 2008 theme for Nurses' week. This article discusses how community/public health nurses make a difference every day in the health and well being of people. If you look at the public and professional literature, nurses are generally perceived to be helpful, caring and competent. The overarching theme in the literature, the bottom line, is that nurses can be trusted.

Most persons who chose nursing thought that they could make a difference in the world; and help people have better lives. Nursing education refined these aspirations and motivations. Students modified their definitions of what does it mean to help; they learned how to help; and they learned to treasure the helping experience, the nurse-patient relationship. Nurses also learned that the work of nursing is very important, although it is often misunderstood and taken for granted. Nurses usually are not given status or named to positions at policy or decisional groups. American hospitals have colored and shaped public perceptions of nurses and the work of nursing. Many people equate nursing practice with high intensity medicine and acute care practice. Consequently, community/public health nursing is the best kept secret in nursing and health care.

Make a difference; make the work of all community/public health nurses well known, recognized, and respected.

Within the past five years, various community/health professional groups have issued or revised seminal documents:

- The American Nurses Association Scope and Standards of Public Health Nursing Practice (2007)
- The National Association's Clinical Nurse Specialist Statement on Clinical Specialist Practice (2003)
- The Quad Council's Public Health Nurse Competencies (2003)

Although these documents do not fall in the class of recreational reading, they provide authority and structure for practice and should be discussed, evaluated, and used, not only by the community/public health nursing community, but also by persons in county and state governments who share responsibility for the health of the citizens. Beyond publicizing and disseminating these important policy documents, community/public health nurses and their leaders need to enhance the visibility and importance of the work of public health nurses.

There are positive and less recognized models for making the work of nursing known. Nurse practitioners and nurse anesthetists have created a niche for their practices. On the other hand, nurse midwives and clinical nurse specialists have not captured the interest, imagination and positive attention of regulators and the public. Community/public health nurses can learn from the example of their practitioner and anesthetist colleagues, and strive to create a new identity (brand), a new niche and new market (creative outreach strategies). What do we emphasize as we make a difference by making ourselves known?

Population based practice

Community/Public Health Nurses need to describe their practice in contemporary language: population based, holistic and comprehensive, oriented to health promotion and illness prevention, and community-centered. By definition, community/public health nurses are concerned with populations. This does not mean that they ignore the individual, the group or the family. It means that the individual, the group and the family are understood in all their complex social, physical, emotional, cultural and spiritual dimensions. It means that the part (the individual, the family, the group) is seen in relation to the whole (the population); it means that population-based evidence informs assessment and risk analysis and guides policy development and outcome oriented assurance activities.

Holistic and comprehensive

The applications of Healthy People 2010's (2000) Dimensions of Health help community/public health nurses and all nurses break out of medical models and highly specialist forms of practice. Community/public health nurses view their populations as being influenced more by their environments, their life style choices, their access to health care, especially preventative and promotional health care, their interactions with the policies that effect health and access to health service, than they are by their genes, biology or disease states.

Oriented to prevention and health promotion

Since the days of the legendary epidemiologist, John Snow (1855) and Florence Nightingale (1860), community/public health nurses have recognized that clean water, sanitation, good hygiene, healthy food, exercise and safe environments are essential components of health. Today the public accepts even embraces, healthy life styles and clean, safe environments. Community/public health nurses need to claim the Dimension of Health's (2000) message as their own and assert themselves as champions of health promotion and disease prevention in their communities.

Community based

Community/public health practice is community based; it is part of the neighborhood; it is close to schools and homes. As health care is increasingly delivered in the community, community/public health nurses assure continuity of care. Whether they visit pregnant immigrant women in their homes, assure that their patients have safe hand offs to hospitals for delivery or follow them; and assess their babies at home, in the clinics, and later in day care and school, the orientation of community/public health nurses is on healthy starts, well moms and kids, and the forging of partnerships with public (WIC, Medicaid, SCHIP, food stamps, housing, TANF) and private agencies (pro-bono immigration or legal services, church groups, food banks, and schools) to assure that mothers and families are educated, supported and empowered to take charge of family health.

The communities in Maryland, Northern Virginia, and the District of Columbia are increasingly diverse. New immigrants come to schools, churches, clinics and emergency rooms, and health departments. Unlike the last large wave of immigrants, new immigrants come from Asia, Central and Latin America and Africa (Derose, Escarce & Lurie, 2007). They do not speak English and they are not white. Many of them are working at several low paying jobs to support themselves and their families. To complicate life more, some of the new residents have immigration problems which make them wary of seeking preventative care (early prenatal care, well baby checkups, and immunizations). When the immigration factor, a relatively new phenomenon, is combined with strong cultural and linguistic patterns, the absence of social/family support, and distance from the public health home and affordable transportation, vulnerability is increased and health status is at risk. If an outsider looked at the public descriptions of Metro DC, it would surprise them that new immigrants are a major focus of community/public health nursing practice.

Understanding the changing face of public health nursing, The Catholic University of (CUA) School of Nursing offers three advanced community/public health graduate programs: Immigrant, Refugee and Global Health Nurse Specialist, the Community/Public Health Nurse Specialist Educator programs, and a blended role program which prepares Community/Public Health Clinical Nurse Specialists and Family Nurse Practitioners. These MSN programs prepare graduates to sit for appropriate certification; students can opt for full or part time study.

The Immigrant, Refugee, and Global Health Nurse Specialist program is a graduate program to prepare advanced public health nurses to meet population health needs and improve access to health care, decrease barriers and reduce health disparities. Recognizing that many community/public health problems in the United States are also world health problems, the program focuses on global health and addresses the health status of immigrants and refugees, a vulnerable, growing subset of the population within the United States.

The Community/Public Health Nurse Specialist Educator program prepares advanced public health nurses to teach in associate and baccalaureate degree programs, staff development programs, community health programs, managed care programs and health care organizations. Students develop clinical and educational skills that improve community-based care of vulnerable people and reduce health disparities.

The family nurse practitioner and advanced community/public health nurse blended program prepares nurses to evaluate, manage and treat individuals and families. They are also educated to plan, direct, implement and evaluate population-based health care in vulnerable communities.

Call CUA School of Nursing at 202-319-6873 or email sarsfield@cua.edu for more information about the public health nursing programs and the application process.

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Snow, J. (1855). On the mode of communication of cholera. London: John Churchill, New Burlington Street, London.

Derose, K., Escarce, J., Lurie, N. (2007). Immigrants and health care: Sources of vulnerability, 26 (5), 1258-1268.

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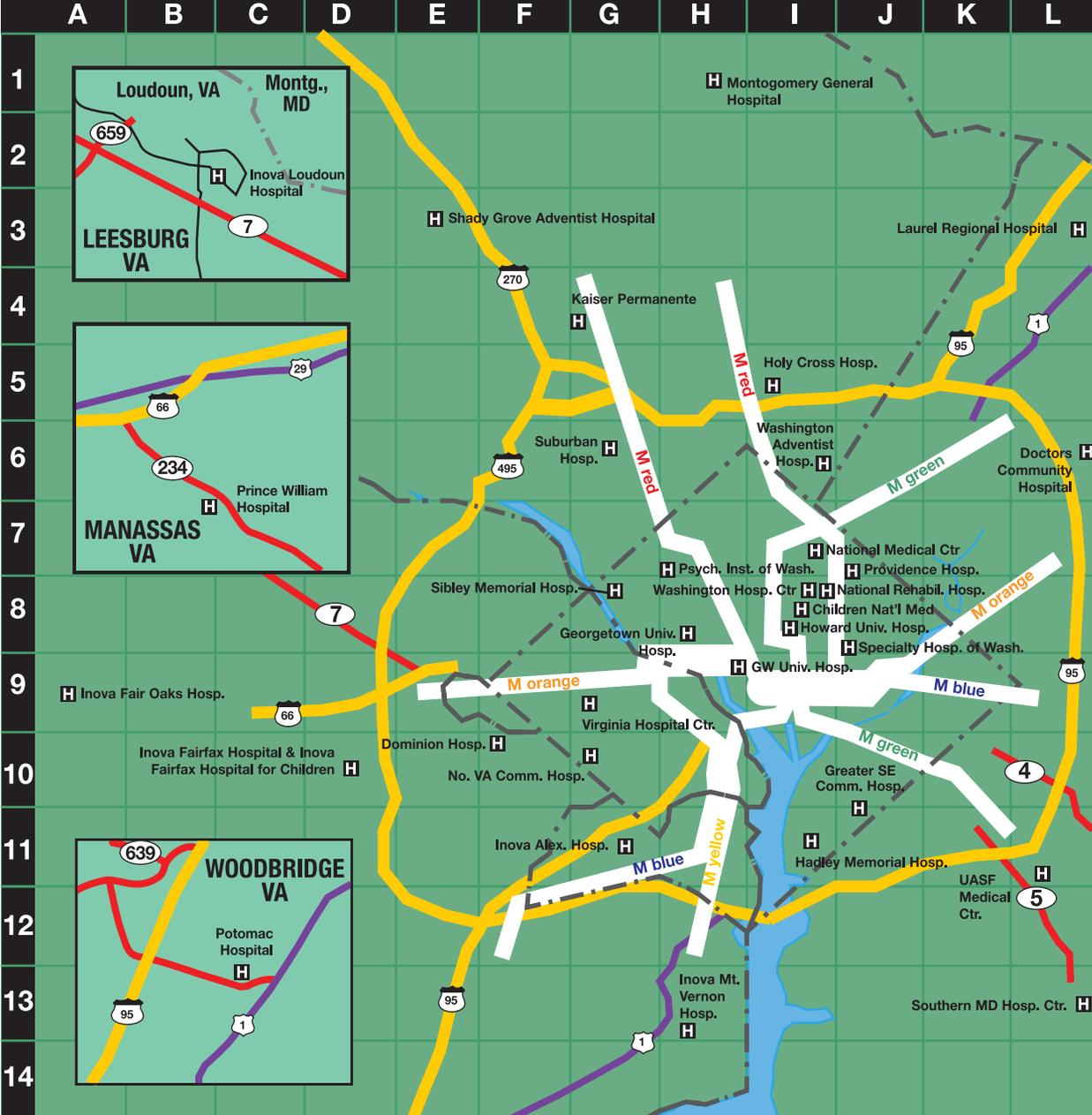
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