

LIVEWELL NURSING

NURSE'S NOTES

By: Angela Mitchell, CNO

Dear Readers,

Welcome to the May edition of our Nursing Newsletter, where we proudly honor the exceptional nurses who make a difference in the lives of our community members across San Diego County. As we celebrate Nurses Month, we are thrilled to showcase the impactful work of nurses in various public health centers, hospitals, and departments within our health and human service agency.

In this special edition, we are excited to present a collection of evidence-based posters from six public health centers, two hospitals, Aging and Independence Services, and multiple branches within the Department of Public Health. These posters highlight the innovative and effective practices that our dedicated nurses have implemented to improve the health and well-being of our community members.

From epidemiology and immunizations to TB control, public health preparedness and response, children services, sexual wellness, and everything in between, our nurses exemplify the theme "Nurses Make the Difference" through their commitment to delivering high-quality, evidence-based care to those in need. Their unwavering dedication to promoting health, preventing diseases, and enhancing the overall quality of life for our residents is truly inspiring.

The posters featured in this newsletter serve as a testament to the exceptional work of our nurses and the positive impact they have on the lives of those they serve. Through their hard work, compassion, and expertise, our nurses have made significant contributions to the overall health and well-being of our community.

As we celebrate, let's take this opportunity to express our heartfelt gratitude to all the nurses who make a real difference every day. The dedication and compassion of our County of San Diego nurses truly set them apart as healthcare heroes, and we are immensely grateful for the positive impact they have on the places where we live, work, and play.

Join us in celebrating Nurses Week by exploring the evidence-based practices highlighted in this newsletter and recognizing the remarkable achievements of our nurses. Thank you to all the nurses who tirelessly work to improve the health and well-being of our community members. Your commitment to excellence truly makes a difference. Happy Nurses Week!

With Gratitude,



Angela Mitchell, Chief Nursing Officer, County of San Diego

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SUBMISSIONS

Please e-mail submission (ideas, photos, articles, trainings, dates, accolades, local or national news, etc.) to Araceli.Casas@sdcounty.ca.gov

For consideration in next issue, please submit entries by close of business on June 14, 2024. Submission limits: 125-275 words

June Topic: Self Care



**Access the County's EBSCO
Health Homepage using a
Universal Link**

<https://my.openathens.net/>



COUNTY OF
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LIVE WELL
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Nurses Make the Difference

Aging & Independence Services Nurse Team



PERSON CENTERED CARE

Goal: to improve quality of life, advance equity, and foster dignity for older adults and persons with disabilities by providing nursing leadership and essential services for health, safety and independence.



PRACTICE EXCELLENCE

Intervention: the AIS Nurse Team developed the "Nursing Minute" which provides evidence-based education to AIS colleagues and peers on specific health topics that affect the population we serve.



**NURSES
MAKE THE
DIFFERENCE**

LEADERSHIP

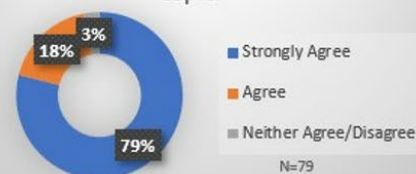
Outcome: the AIS Nurse Team provided "Nursing Minute" presentations to over 300 AIS staff and conducted the first customer satisfaction survey.

Peer feedback:

"Very clear and important information."

"It was just the right amount of information and time allotted."

The Nursing Minute presentation increased my knowledge about this topic.



PHS ADMINISTRATION: NURSING UNIT

Relaunch: Clinical Quality Management (CQM)



Leadership



**NURSES
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Equity, Diversity, and Inclusion



Practice Excellence



❖ **Role:** Clinical Quality Management (CQM) assures quality across core public health services that are the responsibility of Public Health Services (PHS). Historically, these services have been conducted at Rosecrans and in HHSA Public Health Centers (PHC). Currently, PHCs are managed by the Medical Care Services department. CQM activities include:

- Clinic assessments
- Policy and procedures oversight
- Risk mitigation activities
- Clinical outcomes monitoring
- Program outcomes monitoring

❖ **Situation:** CQM Coordinator position vacant and meetings on hold due to pandemic response

❖ **Interventions:** Plan in place to relaunch CQM Program in 2024

- CQM Coordinator position filled in Fall 2023
- Revised CQM Charter
- Revamped CQM Work Plan

❖ **Outcomes:** Meetings reconvened in February 2024. Two steering meetings completed (February, April) and one general meeting (March).



North Central Public Health Center

Hansen's Disease (HD) Clinic



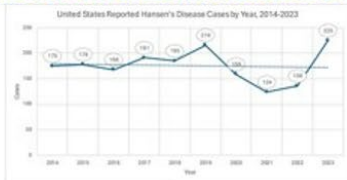
Goal: Apply for grant funding to support specialized care from HD team at N. Central

Intervention: In Spring 2023 N. Central Nursing team in collaboration with MCS reviewed and analyzed historical data to inform the application process for HRSA grant funding

Outcome:

- Grant awarded in September 2023
- 25-30 cases continue to receive treatment at N. Central PHC
- PHN Supervisor sent for training at Baton Rouge; plan to send staff RN in September 2024

Since 2022 HD cases have continued to increase



Source:HRSA.gov/hansens-disease; May 2024

Early intervention is necessary to minimize morbidity



Source:HRSA.gov/hansens-disease; May 2024

Sustainability & Equity

Orthopedic Artifacts at National Hansen's Disease Museum

National Leprosarium



Photo credit: Kenya Moses



**NURSES
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Person Centered Care

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Fall Prevention

San Diego County Psychiatric Hospital (SDCPH)



Person Centered Care | Leadership | Practice Excellence | Collective Synergy | Equity, Diversity & Inclusivity

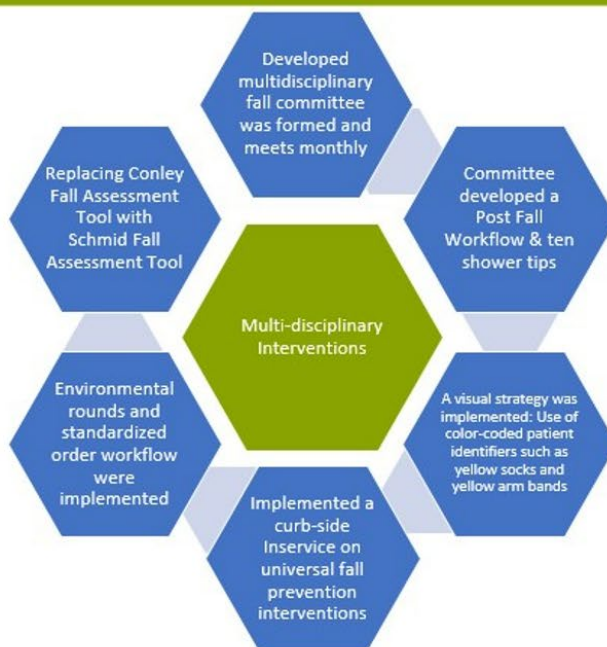
GOAL

To implement a Fall Prevention Program by Spring 2024



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INTERVENTIONS



OUTCOME



YOU can PREVENT a Fall!

Universal Interventions: common sense interventions for every patient all the time, regardless of risk status.

Tips on how to prevent slips, trips and falls.

- ☐ SEE SOMETHING, DO SOMETHING
- ☐ Uncluttered, dry floor
- ☐ Well-fitting footwear
- ☐ Yellow visual identification (e.g., bracelet clasp, non-skid socks)
- ☐ Mobility awareness
- ☐ Handoff communication specific to fall risk
- ☐ Purposeful rounding

San Diego County Psychiatric Hospital



NURSES MAKE THE DIFFERENCE

Rapid Implementation of Enhanced Barrier Precautions (EBP) Edgemoor DPSNF



Person-Centered Care



Leadership



Practice Excellence



Collective Synergy



Equity, Diversity, and Inclusivity

Goal: Define the who, what, when, where, and how to implement Enhanced Barrier Precautions (EBP) in Edgemoor in a less than 30 days.

Background:

- There is increased spread of dangerous Multidrug resistant organisms (MDRO) e.g. *Candida auris* and carbapenem resistant organisms in health care.

Candida auris Confirmed Cases San Diego County



- High risk is prolonged hospitalizations, large wounds or tubes that provide an entry into the body.
- Late March, 2024, we were notified of expansion of federal infection control program regulations (CFR 483.80) to incorporate CDC recommendations for Enhanced Barrier Precautions with implementation date for all US nursing homes by 4/1/2024.
- Edgemoor's team considered unique elements of Edgemoor DP SNF in our implementation plan (higher than average staffing, long stay, low rate of hospitalization, single rooms, high air exchange and no history of any of these MDROs in facility).

Enhanced Barrier Precautions (EBP) reduces transmission of multidrug-resistant organisms (MDRO) through targeted gown/glove use during high contact resident care activities, defined as 6 moments.



Interventions:

- Created assessment based on risk factors and resident-centered approach.
- Implemented overall education strategy including specific targeted education to involved disciplines.
- Developed new policy, signage and supply plans to provide PPE and reminders at multiple sites, redundant communication with Kardex, 24-hour report emails and oversight.

Outcome:

- All Edgemoor residents (154) were screened for risk factors for clinically significant MDRO infections by a team lead by nurses on the nursing units with train the trainer approach.
- Enhanced Barrier Precautions were implemented for identified residents (e.g. individualized personal protective equipment (PPE)).
- Individualized education was assigned to all staff. Within two weeks, >82% of nursing staff completed the training.
- '1 to 1' in-person training was completed with 100% of staff assigned to residents on Enhanced Barrier Precautions.



Individualized PPE



NURSES MAKE THE DIFFERENCE

Reshaping Latent TB Infection Service Delivery

SOUTH PUBLIC HEALTH CENTER



Innovation | Quality of Life | Health Equity

Person-centered Care | Leadership | Practice Excellence | Equity, Diversity and Inclusivity

Goal

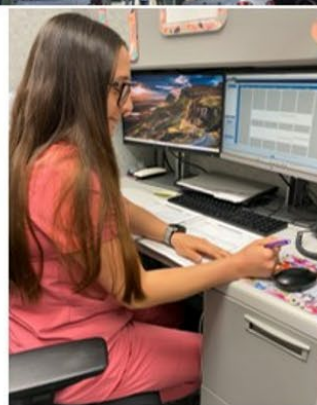
- To maintain/increase treatment completion rates among clients referred for latent tuberculosis infection (LTBI) treatment in the South Public Health Center (PHC)

Context

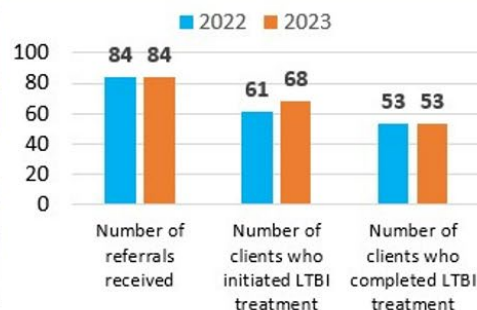
- Clients experience barriers to access in-person LTBI services (intake, follow-up assessment, medication pick-up) due to varying issues:
 - Increasing homelessness crisis
 - Extended US-Mexico border wait times for clients who work in San Diego and reside in Mexico
 - Other impacts post-COVID pandemic

Interventions

- Offer telehealth LTBI services to the South Region community, specifically by:
 - Collaborating with the Tuberculosis Control team to obtain necessary paperwork for the intake process
 - Working with the Pharmacy team to ensure timely delivery of LTBI medications
 - Partnering with Quest Diagnostics to assist clients in scheduling laboratory appointments for treatment monitoring



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Outcomes & Lessons Learned

- From 2022 to 2023, a **63%** treatment completion rate was maintained among clients who were referred for LTBI treatment in the South PHC
- Lessons learned from this initiative:
 - Identify dedicated LTBI nursing team to provide close follow-up
 - Work with Agency Compliance Office to ensure compliance with telehealth policies

MOVING TOWARDS EQUITY, DIVERSITY, AND INCLUSIVITY

CENTRAL PUBLIC HEALTH CENTER



PERSON-CENTERED CARE • LEADERSHIP • PRACTICE EXCELLENCE • COLLECTIVE SYNERGY

VISION

***Health Equity:** Focus on policy, systems and environmental approaches that ensure equal opportunity for health and well-being through partnership and innovation.*

- ❖ Offer variety of services in one conveniently located facility in the heart of the community
- ❖ Actively recruit from the community for employment to provide services in their community
- ❖ Increase efforts to increase collaboration between departments and work together to provide comprehensive service
- ❖ All Central Public Health Center team in one location



ACTION

***Empower Workforce:** invest in our workforce and operations by providing support services and excellent customer service to ensure continuity of operations remains at its best.*

Central PHC team invested time, effort, ingenuity, and persistence to work together with leadership and other departments and make a new work home at Southeastern Live Well Center. It was a daunting task to move three locations to be reorganized into a new space. Together, the team provided the physical labor and strategic planning to make the new space work for us and our clients. It took many conversations, compromises and clever solutions, and we now have a place to work where we can feel supported, offer excellent customer service, and being easily accessible to the community.



POSITIVE IMPACT

Central Public Health Center Successfully moved to the Southeastern Live Well Center (SELWC) in July of 2023. This transition has resulted in:

- ❖ Increased in the total number of clinic services provided at the PHC. **From 2908**, 5 months prior the move **to 4109** within 5 months after the move
- ❖ Central PHC nursing and clerical participation in hiring halls at the SELWC to hire personal from within the community
- ❖ Reestablished Central PHC nursing partnership with the Department of Homeless Solution and Equable Communities and collaboration in events like: Check Your Mood, Love Your Heart.



East Public Health Center

Rural Health Discharge Program (RHDP)



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LIVE WELL
SAN DIEGO



Goals

- Promote equity by reducing disparities in underserved rural communities
- Promote self sufficiency and keep individuals healthy, safe and thriving at home



Interventions

- Provide targeted case management to rural clients
- Meet clients where they're at to promote client-centered care
- Provide client-centered care with dignity and respect
- Spread awareness of rural disparities by speaking at community events



Outcomes

- Provided 394 total nursing/County Fire resources
- Decreased readmission rate for enrolled clients
- Clients can navigate resources independently
- Clients have the necessary resources and education to stay at home longer

Data as of 04-17-2024

Equity, Diversity & Inclusivity

30 Day Readmission Rate - Non Enrolled Clients	Increase in Readmission among non-Enrolled Clients	Average Days to Readmission - non-Enrolled Clients
5.9%	60.5%	16.7
30 Day Readmission Rate - Enrolled Clients	Program Enrollment Rate	Average Days to Readmission - Enrolled Clients
3.7%	39.2%	26.0

Person-Centered Care



PHS: Epidemiology and Immunization Services Branch (EISB)

Protecting the Community: Measles Response



PRACTICE EXCELLENCE

- **Strategic Initiatives: Health Equity and Community Safety.** EISB PHNs respond to local cases of Vaccine Preventable Diseases (VPDs) and other communicable diseases.
- On February 1, 2024, the first measles case since 2019 was identified in San Diego County. A second, unrelated case of measles was identified on March 30, 2024.
- EISB Public Health Nurses, Medical Directors, and leadership swiftly acted and initiated case investigation and contact tracing.
- The goal was to reach all exposed individuals prior to their potential infectious window to determine immunity, provide IgG testing or post-exposure prophylaxis (PEP), and provide quarantine requirements to prevent additional exposures.



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NURSING LEADERSHIP

A nursing response team and leadership structure were established, with a Contact Tracing Team Lead, PEP Team Lead, Quality Assurance Lead, and Testing Lead.



OUTCOMES

Contact Tracing Team:

- 2 index cases
- 785 contacts investigated

Post-Exposure Prophylaxis Team:

- 12 PEP IG administrations
- 13 PEP vaccine administrations

Testing Team:

- 67 measles titer IgG specimen collections

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PHS: HIV, STD, & Hepatitis Branch / Sexual Health Clinic

Doxy-PEP Program



Equity, Diversity & Inclusivity	Collaborative Synergy	Practice Excellence
<ul style="list-style-type: none"> • April 2023, CDPH recommends the promotion of Doxy-PEP, a compelling biomedical intervention to prevent bacterial Sexually Transmitted Infections (STI) by up to 60% • August 2023, Doxy-PEP Program implemented in all County of San Diego Sexual Health Clinics. • Intervention aimed at reducing STI rates for low income, LGBTQ+, homeless and other at-risk populations served by the clinics. <div data-bbox="59 946 330 1096"> </div> <div data-bbox="343 946 614 1096"> </div> <p data-bbox="131 1105 471 1130">SANDIEGOCOUNTY.GOV</p>	<ul style="list-style-type: none"> • Clinicians, Public Health Nurses (PHNs), and Registered Nurses (RNs) at the clinic collaborated to implement the Doxy-PEP program effectively • Staff RNs provided initial education, and managed both the collection and processing of specimens. • PHNs provided continued education, follow-up interviews, and data collection / documentation. <div data-bbox="683 1002 921 1100"> </div> <div data-bbox="958 1011 1151 1093"> <p>NURSES MAKE THE DIFFERENCE</p> </div>	<ul style="list-style-type: none"> • 227 clients currently enrolled. • Follow-up interviews report high rates of satisfaction with program. • The CDC acknowledged the County of San Diego Sexual Health Clinic and its team as a Promising Practice, citing their potential to enhance clients' health through the implementation of Doxy-PEP. <div data-bbox="1207 912 1477 1086"> </div> <div data-bbox="1483 912 1760 1086"> </div>



OFFICE OF NURSING EXCELLENCE



STRATEGIC INITIATIVES: Sustainability + Equity + Empower + Community + Justice

EQUITY, DIVERSITY & INCLUSIVITY

**Public Health Nursing
Home Visitation Programs**
For Fiscal Year 2022-2023



**Total Families
Served: 1,213**

**Total # of
Visits: 7,847**



**Nurse Family-Partnership &
Maternal Child Health**

PERSON-CENTERED CARE & PRACTICE EXCELLENCE

**Lactation Education &
Certification for all Home
Visiting PHNs**



**31 PHNs are Lactation
Education Consultants
& 5 currently enrolled**

**2 PHNs are Certified
Lactation Consultants**



**As of April 2024, there are 46
PHNs in Home Visiting**

COLLECTIVE SYNERGY & LEADERSHIP

**PHN Residency Program Retention
Rates**

Spring 2022: 100%
Fall 2022: 86%
Spring 2023: 75%
Fall 2023: 93%
Overall: 88.5%

For FY 22/23 Foot Teams distributed over 1,000
hygiene kits

**Outcomes
FY 22/23**
(collaborative efforts continue)

**# Hepatitis A
Vaccines**

211

**# Mpox
Vaccines**

171

Flu Vaccines

335

**# Naloxone Packages
Distributed**

709

COVID-19 Vaccines

Primary Series = 91

Boosters = 280



**NURSES
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Social Events Improve Retention at North Coastal and North Inland Public Health Centers

Leadership

Goal

To see a 5% decrease in addressable client attrition during all Nurse Family Partnership program phases from 2022 to 2023.

- Public health nurses (PHNs) work together to create a budget, make flyers, advertise to clients, purchase food, plan activity stations, and decorate the event space.
- In 2024-2025 PHNs will take turns acting as the lead for the seasonal events. This opportunity allows the PHNs to practice delegating, problem solving, and creativity.



LIVE WELL
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Person-Centered Care

Intervention

In-person social events were hosted for each season in the calendar year. Each event provided a photo session, crafts, and snacks for families to enjoy.



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Practice Excellence

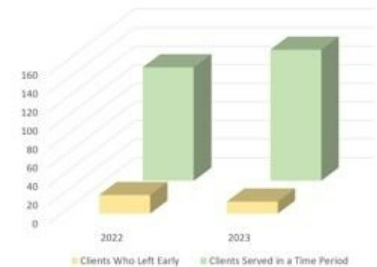
Outcome

The goal was surpassed from 2022 to 2023! There was a 7% reduction in client attrition during the testing year.

Families greatly enjoyed all the events. Those in our rural communities have communicated their appreciation for hosting an event close to where they live.


Next steps: In-person social events will be integrated into regular practice and the number of rural social events will be increased.

Date Range: 1/1-6/30 for each calendar year



PHS: California Children's Services Transition to Adulthood Planning



Person-Centered Care	Practice Excellence	Collective Synergy
<p>GOAL</p> <p>Ensure timely transition planning services for CCS clients to promote optimal health and independence once these clients leave the CCS program.</p> 	<p>INTERVENTION</p> <p>Organized in-person transition planning workshops for clients and families ages 17-21.</p>   <p>NURSES MAKE THE DIFFERENCE</p>	<p>OUTCOMES</p> <ul style="list-style-type: none"> • Held two workshops in FY 2023-2024 with a total of 47 clients and families attending. • Workshops held in Vista and El Cajon at the Medical Therapy Units. • Utilized community partners as panelists to provide information on managed care plans, transitioning to adult providers, durable medical equipment, transportation, conservatorship and community resources and supports.

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PHS: MATERNAL, CHILD, & FAMILY HEALTH SERVICES

HEALTH CARE PROGRAM FOR CHILDREN IN FOSTER CARE (HCPCFC)



Person-Centered Care

GOAL:

In collaboration with the Child and Family Well Being Department, HCPCFC strives to ensure the health care needs of children and youth in out-of-home placement are met.



Equity, Diversity, & Inclusion

INTERVENTION:

- Assisted with healthcare case planning.
- Coordinated healthcare services.
- Helped with obtaining timely medical and dental exams.
- Participated in case consultations.
- Created and updated Health and Education Passports.
- Provided psychotropic medication monitoring and oversight.

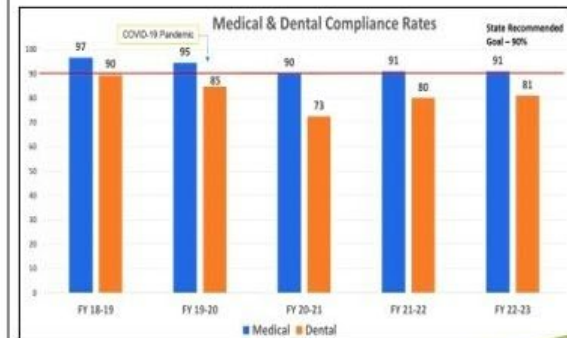


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Collaborative Synergy

OUTCOME:

- 1,590 children and youth in out-of-home placement served
- 92% received timely medical exams
- 81% received timely dental exams



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PHS: PUBLIC HEALTH PREPAREDNESS AND RESPONSE DISASTER TRAINING AND EPIDEMIOLOGY/BIOTERRORISM UNIT



Collective Synergy

Person-centered Care

Leadership

Community Engagement

Partnership

Communication

Goal

PHPR Nurses set out to provide various disaster trainings to County Public Health Nurses (PHN), our PHPR team members, nursing students, PHN residents, and our San Diego Healthcare Disaster Coalition (SDHDC) partners.

Training enhances knowledge, allows participants to gain insightful tools, and prepares them for potential disasters.

Through our leadership, and collaboration with internal and external partners, we strive to meet the needs of our workforce to better serve our community.



Interventions

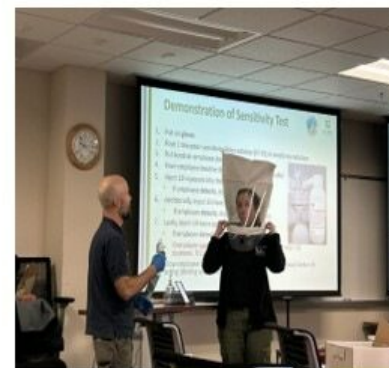
- **Stop the Bleed trainers:** PHPR Nurses became registered trainers, preparing us to train others in bleeding control measures.
- Working with our healthcare partners, we identified their disaster training needs & conducted a **CHEMPACK** training and tabletop exercise.
- Collaborated with internal and external partners to coordinate and conduct various presentations and shadowing opportunities to nursing students and PHN residents.
- Provided education & training to County staff members, driven by the mutual desire to meet the needs of those in our community.



**NURSES
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DIFFERENCE**

Outcomes

- STB Training of the trainer (TOT) to **17** hospital staff
- STB TOT to **35** SDHDC clinical staff partners
- STB TOT to **54** County PHNs
- Chempack training & tabletop exercise to **43** San Diego first responders and hospital staff
- **50** Student nurses and PH Nurse Residency Program shadowing opportunities
- RPPA training to **20** County staff
- Fit Tester training to **38** County staff
- Fit tested **140** County staff



PHS: TUBERCULOSIS CONTROL AND REFUGEE HEALTH BRANCH (TBCRH) APPLYING THE NURSING PRACTICE MODEL



EQUITY, DIVERSITY, AND INCLUSIVITY

Access to health care is a human right and we strive to eliminate health and social inequities

- TBCRH nurses care for and educate clients, with respect and cultural humility.
- In a year of unprecedented cases, TBCRH nurses are proud to provide excellent and equitable care to all, by addressing disparities of social determinants of health.
- TBCRH nurses see the client as a whole person, while removing barriers to living a **Healthy, Safe and Thriving Life.**



2023 OUTCOMES

Intake Team

- 602 presumptive TB case reports processed

Clinic Team

- Assisted in 872 provider visits
- 811 nurse visits conducted

Field Case Management Team

- 350 clients case managed with active TB disease

Contact Investigation Team

- 422 contacts were provided timely evaluations, multiple follow ups and treatment care coordination



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