

# BULLETIN

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## HEALTH OFFICER NOTES

Penny Borenstein, MD, MPH



### SUSTAINING OUR HEALTHCARE WORKFORCE

Nationally and here in SLO County, we are facing a critical shortage of healthcare professionals in the workforce. Staffing shortages and projected needs have been concerns for many years and, as with so many issues, the COVID-19 pandemic has exacerbated these long-standing problems.

Many of us have seen the statistics about workforce shortages and have also keenly felt these shortages personally, either as employers seeking to hire and retain qualified staff or as patients seeking care. My team and I have spent hours strategizing how to continue meeting community needs while seeking to fill empty positions. I also remember being startled when I moved to SLO County 15 years ago and couldn't find a primary care provider.

These concerns reverberate across the fields of physical health, behavioral health, and oral health. Their impact is especially acute for patients who already face challenges to attaining care, such as difficulty with the cost, transportation, scheduling, or language access.

While our local Public Health Department does not regulate or manage our health care workforce, we do play a role as a convener, bringing together organizations to discuss and address some of these complex challenges in a systemic way. This approach helps us amplify each other's work and limit duplication, making the most of limited resources. It also positions us to more effectively attract funding to support our collective efforts.

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In October of 2019, we hosted a forum with community partners focused on strategies to recruit and train health professionals and discussion of the community health worker model. In 2023, we re-energized this effort by establishing the SLO Healthcare Workforce Partnership, a group of 33 local healthcare leaders representing 18 health, education, and workforce organizations.

The Partnership seeks to build sustainable collaborations among partners to implement long-term solutions. They plan to invest in strengthening and diversifying SLO County’s physical, behavioral, and oral health workforce to address both current and emerging needs. This is not a short-term project.

As with so many issues, the factors involved are not all within our sphere of influence. The Partnership is taking a strategic approach to address community-level concerns (such as the effect of housing costs on attracting workers) and more specific healthcare workforce concerns (such as local clinical training opportunities).

The partnership began with a deep dive into the local situation. Several findings stood out:

**Shortages at all levels.** While it’s common to talk about the shortage of nurses and doctors, worker shortages exist at all levels of the organization chart and are especially acute for roles such as medical assistants, dental assistants, and psychiatric technicians.

**Discrepancy between data and lived experience.** In its 2023 assessment, the Office of Statewide Health Planning and Development identified “designated shortage areas” within SLO County for mental and dental health but not for primary care—although we hear consistently that difficulty accessing primary care is a major pain point for our residents. The Partnership is investigating possible explanations for this disconnect, such as data including retired providers who remain licensed, the inclusion of providers serving patients in corrections facilities, or the proliferation of concierge medicine.

**Gaps in equitable representation.** Hispanic and Latino residents make up more than 23% of SLO County’s population but only 5-10% of top-level healthcare positions such as registered nurses, physical therapists, physicians, and nurse practitioners.

**Need to focus on retention as well as recruitment.** When we look at projected 5-to-10-year shortfalls in the number of qualified workers needed for different roles, we see gaps caused by growing need, anticipated retirements, and workers leaving their jobs. Retaining those workers goes a long way to addressing these projected shortages.

**Partnership Members Include:**

- Cal Poly State University, SLO*
- California State University, Monterey Bay*
- CenCal Health*
- Center for Family Strengthening*
- Central Coast Medical Association*
- Community Health Centers of the Central Coast*
- Compass Health*
- County of SLO Behavioral Health & Public Health (incl Oral Health)*
- Cuesta College*
- Dignity Health*
- Promotores Collaborative of SLO County*
- REACH/Uplift Central Coast Coalition*
- SLO County Office of Education / SLO Partners*
- Tenet Health*
- Tolosa Dental*
- Transitions Mental Health Association*
- Workforce Development Board*

You can find detailed data at [slohealthcareworkforce.org](http://slohealthcareworkforce.org). The collaborative then used this data, along with research about best practices, to develop a strategic action plan. Strategic priorities include:

**Recruitment and retention of healthcare staff.** This includes strategies to recruit staff to fill open positions and to retain existing staff.

**Healthcare career pathways.** This focuses on developing local pipelines and training programs for physical, behavioral, and oral health.

**Fund development and advocacy.** This focuses on identifying funding opportunities to support healthcare workforce development in SLO County.

**Sustainable partnership operations.** This is about intentionally sustaining our effort to foster productive partnerships and long-term solutions among community, education, and clinical partners.

Although there are not quick fixes, I believe meaningful progress in this area is possible. I extend my gratitude to those serving as part of the Partnership and supporting its work. I also invite you to get involved if you are passionate about this issue. You can visit [slohealthcareworkforce.org](http://slohealthcareworkforce.org) and complete the contact form to learn about opportunities that may be a good fit for you and your organization. Please keep an eye out for a community forum in 2024—I would love to hear your input and see you there.

Thank you for your attention,



# RSV: NEW PROTECTIONS FOR INFANTS AND CHILDREN

Rick Rosen, MD, MPH, Deputy Health Officer

Winter is a time for holiday cheer and family gatherings. It's also a time for respiratory viruses to thrive. With COVID-19, much of our focus has been on the grandparents—those 65 years and older. However, one fact that came to light in December is that we really need to think about the grandkids and soon-to-be grandkids. The U.S. experienced a significant increase in hospitalizations for respiratory illnesses during the month of December. Surprisingly, those age 0-4 represented the largest number of hospitalizations due to viral respiratory infections during that month—about 40% more hospitalizations per 100,000 population than those age 65 and older.

That's a big deal not only because we worry about the little ones but also because there just aren't a whole lot of staffed pediatric hospital beds available. That's true locally, regionally, and at the state level. When a surge in respiratory viral illness hits and the family of a sick little one can't find a hospital bed locally, it's often hard to find a bed anywhere within hundreds of miles.

For small children, the big culprit when it comes to winter hospitalizations is Respiratory Syncytial Virus (RSV). Typically, RSV hits the upper respiratory tract first, causing symptoms like runny nose and cough. About 1 in 4 infected children will develop lower respiratory tract disease, like bronchiolitis or pneumonia, and that is generally when treatment is needed. Between 1-3% of all American children are hospitalized during the first 12 months of life for RSV lower respiratory tract disease. Each year, 100-300 children younger than 5 die because of RSV illness. RSV is clearly seasonal, with onset in mid-September to mid-November, a peak typically in December or January, and trails off in April or May.

However, there is reason for some winter-time cheer. For the first time in our history, options are available to all families in the U.S. that are highly effective in preventing severe illness from RSV in children. The first option is nirsevimab, a monoclonal antibody recommended for all babies under 8 months of age entering their first RSV season, and for children ages 8-19 months who are American Indian/Alaska Native or have either severe immunocompromise, cystic fibrosis, or chronic lung disease associated with prematurity.

During clinical trials, the efficacy of nirsevimab was 80.6% in preventing RSV-associated hospitalization and 90% in preventing admission to an intensive care unit (ICU). The antibody treatment was tolerated well by babies, with about 1.2% of recipients experiencing any sort of side effects such as a rash or injection-site reaction. The supply of nirsevimab was initially limited but is now adequate. Our Public Health Clinics have nirsevimab available for the uninsured and families covered by Medi-Cal. Other families who are interested should speak with their healthcare providers.

The second option is Abrysvo, an RSV vaccine available to pregnant people during 32-36 weeks of pregnancy (in the third trimester) to protect their babies after birth. Abrysvo is recommended for pregnant individuals through the end of January; beyond that time frame, it does not offer much in the way of protection for the current RSV season. Abrysvo, which is also approved for older adults, is widely available at pharmacies and at our Public Health clinics.

During clinical trials, Abrysvo decreased the risk of RSV hospitalization for babies by 57 percent in the first 6 months of life. The vast majority of mothers and their infants will need only Abrysvo or nirsevimab, but not both.

If you see babies or expectant parents, I urge you to share information with them about Abrysvo and nirsevimab. Both products will still be around—and I hope nirsevimab will be more widely available—next year. The potential benefits to our youngest children and our healthcare system are enormous. ■

## Optimizing RSV Protection for Infants



### Prenatal Vaccination

Administer prenatal RSV vaccine (Abrysvo) during 32-36 weeks' gestation, Sept-Jan. Most infants born to vaccinated birth parents will not need nirsevimab.



### Nirsevimab 50mg

For infants < 5kg and < 8 months without prenatal vaccination: administer within the first week of life (or ASAP after) for those born during RSV season.



### Nirsevimab 100mg

Administer for infants ≥ 5kg and < 8 months without prenatal vaccination. For palivizumab-eligible, follow AAP recommendations when nirsevimab is not available.



### Nirsevimab 200mg

Administer 2 100mg doses for children 8-19 months who are AI/AN or have severe immunocompromise, cystic fibrosis, or chronic lung disease



1930s 1920s

**San Luis Obispo County Public Health Department opens in 1923**

The "County Health Center" opened in 1923 thanks to a \$5,000 grant from the Rockefeller Foundation matched by the Board of Supervisors. Emerging from WWI and the influenza pandemic of 1918, we saw efforts across these decades to protect against infectious diseases like influenza and tuberculosis, and to "stamp out" sexually transmitted diseases like syphilis.



1950s 1940s

**Vaccines protect against influenza and polio**

Throughout WWII, we saw the development of the influenza vaccine, first available to service members in 1945 and the public in 1946. San Luis Obispo received its first iron lung in the 1940s, before the arrival of the polio vaccine to the central coast in 1957. In 1943, the "Summer of Smog" gripped Los Angeles, where residents thought the city was under a chemical attack, leading to California's first air pollution control law.



1970s 1960s

**Increased attention to environment's impact on health**

In 1965, Medicare and Medicaid programs were created, making comprehensive healthcare available to millions of Americans. Also in 1965, the first record of a well permit was issued in SLO County. Well water safety was at the top of mind following an outbreak of Typhoid fever linked to a water well in Nipomo. The permitting of private water wells became a function of Public Health in the 1970s.



1990s 1980s

**AIDS epidemic changes the world**

The 1980s came to be defined in large part by the devastating impact of HIV and AIDS, with the first official reporting in 1981. Today, Public Health continues to provide services to prevent the spread of HIV and follows up individually with every person in our county who receives an HIV diagnosis. In the 1990s, San Luis Obispo became the first U.S. city to protect health with a major public smoking ban.



2010s 2000s

**Public Health responds to bioterrorism and infectious diseases**

In 2009, our Public Health Laboratory began serving as a Laboratory Response Network (LRN) lab for biothreat testing for SLO, Santa Barbara, and Ventura counties. Also in 2009, the SLO County Medical Reserve Corps was created in response to the H1N1 pandemic. Across the 2010s, Public Health responded to outbreaks of pertussis (2010), Ebola (2014), and Zika (2016).



2020s

**Looking forward, knowing we are still early in this decade**

The 2020s began almost immediately with the arrival of COVID-19 in our community. Public Health responded while maintaining a wide range of services for the community to prevent illness and protect long-term health. We are in a better place today thanks to preparations built on years of experience, partnerships across our community, and the protection of vaccines developed by scientists who were able to build on decades of foundational research.



# BEHIND THE NUMBERS: INCREASE IN LEGIONNAIRE’S DISEASE

Since 2021, SLO County has seen elevated levels of Legionnaire’s Disease. Before 2021, we had a 10-year average of 1 case per year (2011 to 2020). In 2021, the identification of 9 resident cases led to the investigation of an outbreak; this increase has sustained outside the outbreak with 7 and 11 resident cases identified in 2022 and 2023, respectively.

**Why is this happening?** Legionnaire’s Disease has increased statewide and nationally. The cause of this increase has yet to be determined; one theory is that changes in maintenance and cleaning during the pandemic contributed to increased legionella growth in water systems. The increase has also led to greater awareness and more testing.

**What is the Public Health Department doing?** The Public Health Department investigates all resident cases of Legionnaire’s Disease and potential outbreaks. The Public Health Laboratory now offers rapid urine antigen tests for legionella, providing presumptive results the same day, compared to two to five days for conventional urine tests. The Lab also attempts to culture all respiratory samples to obtain isolates for whole genome sequencing, which provides genetic data that can help match environmental and clinical specimens. The Public Health Department is heavily invested in the prevention of Legionnaire’s Disease, especially as it continues to burden our communities.

**What can you do?** Healthcare providers are asked to test for legionella in patients with pneumonia of unknown etiology. A urine specimen is typically collected for testing; rapid collection of sputum/bronchial wash for culture is also important. We ask that providers collect a sputum/bronchial wash as soon as they suspect Legionnaire’s Disease, even if urine antigen results are pending, and send specimens to the Public Health Laboratory. ■

## REPORTED CASES OF SELECTED COMMUNICABLE DISEASES

DISEASE	YEAR 2022					YEAR 2023				
	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Total Cases	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Total Cases
AIDS	0	<5	0	0	<5	<5	<5	<5	<5	6
Campylobacteriosis	12	17	31	19	79	19	36	36	18	109
Chlamydia	230	207	168	213	818	263	208	206	212	889
Coccidioidomycosis	31	36	39	37	143	27	21	32	140	220
Cryptosporidiosis	<5	<5	<5	5	13	<5	<5	<5	0	8
E. Coli	<5	10	7	6	23+	5	6	7	<5	18+
Giardiasis	<5	<5	<5	<5	8	<5	8	0	<5	15
Gonorrhea	42	59	65	37	203	53	51	42	33	179
Hepatitis B	<5	<5	<5	<5	10	<5	<5	10	6	23
Hepatitis C (Community)	27	36	18	19	100	22	20	19	16	77
Hepatitis C (Correctional)	12	11	13	8	44	12	13	9	10	44
HIV	5	<5	<5	<5	10	5	<5	6	<5	16
Legionellosis	0	<5	<5	<5	7	<5	<5	<5	<5	11
Meningitis	<5	<5	5	<5	13	<5	7	<5	<5	15
Pertussis	0	<5	0	<5	<5	0	0	<5	<5	<5
Salmonellosis	6	9	19	12	46	10	11	14	11	46
Shigellosis	<5	<5	<5	<5	7	<5	<5	5	<5	12
Syphilis (All)	25	27	27	21	100	26	24	18	12	80
Tuberculosis - Active	0	0	0	0	0	<5	<5	<5	<5	10
Tuberculosis (Latent)	10	<5	7	5	22+	7	5	9	5	26
Vibrio	<5	<5	<5	<5	8	<5	<5	<5	<5	<5

Case counts may change over time as a result of de-duplication efforts, case follow-up ending, and/or as a result of historical tests or retroactive findings. All cases are for San Luis Obispo County residents only. For more information, please visit [slocounty.ca.gov/epidemiology](http://slocounty.ca.gov/epidemiology).  
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## WHAT'S NEW AT PUBLIC HEALTH?

### **Mixteco interpretation is available by phone and video for all Public Health Department services.**

Interpretation is provided through Herencia Indigena, which specializes in professional medical interpretation in variants of Mixteco specific to California's Central Coast. A growing population of Mixteco speakers lives in SLO County, with most arriving in the past three years and working in agriculture. Mixteco is spoken with more than 81 variants and is not written. Phone interpretation is also available in 240+ languages via Language Line. To learn more or refer patients, call us at 805-781-5500.

### **The Public Health Laboratory helps train aspiring laboratorians for careers locally and across California.**

The lab is an approved training center for the Public Health Microbiologist Trainee program. This 6-month intensive program provides education on the technical aspects of microbiology, from bacterial staining to sequencing a viral genome. Aspiring trainees can learn more and apply at [bit.ly/PHL-Training](http://bit.ly/PHL-Training). The lab also hosts Clinical Laboratory Scientist students for weeklong rotations in mycobacteriology. Students learn about culture and processing techniques, as well as enhanced safety measures for handling agents that cause tuberculosis. In these ways, the laboratory is helping to sustain the future of laboratory testing.

**Increasingly high doses of nicotine in electronic smoking devices make quitting tobacco more difficult for both adults and youth.** Providers can support quitting by prescribing nicotine replacement therapy



Local interpreters provide Mixteco interpretation for Public Health services, including both clinical and program services

(NRT) when indicated. Both adults and youth need support of friends and family and access to both counseling and NRT. When prescribed by a physician, NRT is covered by insurance, including Medi-Cal. For more information, see recommendations from the American Academy of Pediatrics or contact us at 805-781-5540.

**Our Maternal Child Health team is collaborating with Cal Poly as part of an NIH-funded national consortium to promote heart health in families who receive evidence-based home visiting services.** Cardiovascular disease is the leading cause of death during pregnancy and in the year after giving birth. Promoting heart health starting during pregnancy may prevent later development of heart disease and improve long-term health outcomes for parents, children, and families. To learn more, contact Sarah Lack, MSN RN PHN, at [slack@co.slo.ca.us](mailto:slack@co.slo.ca.us).