

July 2019





### **CCDPH Nursing Departmental Goal**

• To inform, educate and empower people about their health care and concerns.

•To refer those without a primary physician, to a primary medical home, and Cook County Health.

Provide additional referral resources and support for the infant and family.



## CCDPH

Integrated Health Support Services (IHSS)





### **Integrated Health Support Services (IHSS)**

- Adverse Pregnancy Outcomes Reporting System (APORS)
- Genetic (New Born Hearing Screening, Hepatitis B)
- Breast & Cervical Cancer Program (BCCP)
- Vision and Hearing Screening
- Tuberculosis (TB)





### Adverse Pregnancy Outcomes Reporting System (APORS)

#### **APORS:**

- State funded infant follow-up program (visits 2,4,6,12,18 & 24 months)
- Collects information on Illinois infants born with birth defects or other abnormal conditions.

#### **Purpose:**

- To conduct surveillance on birth defects
- To guide public health policy in the reduction of adverse pregnancy outcomes and
- To refer children who require special services to correct and prevent developmental problems and other disabling conditions.





### Adverse PregnancyOutcomes Reporting System (APORS)

#### **Eligibility**

- Cook County resident
- Any income level

#### **APORS Criteria**

- Born at less than 31 weeks gestational age
- Infant was part of a triplet, or higher birth
- Positive drug toxicity diagnosis, signs/symptoms, or mother admits to drug use during pregnancy
- Diagnosed with a congenital anomaly; a serious birth defect





### Adverse Pregnancy Outcomes Reporting System Process

ноspitals complete an APORS Infant Discharge Record (IDR)



Illinois Department of Public Health (IDPH)

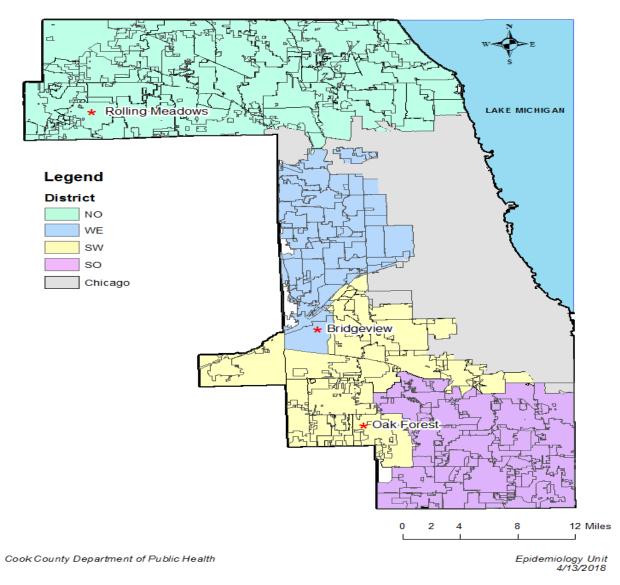


**Local Health Departments** 





#### **Cook County Department of Public Health APORS Coverage**







#### **APORS Staff**

- Twenty-one (21) Public Health Nurse 1
- Three (3) Supervisors
- Seven (7) support staff
- 4 District Areas
   North District/Rolling Meadow
   West District/Bridgeview
   Southwest District/Bridgeview
   South District/Oak Forest







### **Public Health Nurse Role in APORS**

- Bridge the gap between the hospital and home
- Monitor and reinforce immunizations
- Communicate with Primary Care Providers
- Refer clients to Cook County Health and County Care
- Conduct assessment/screenings (Physical, Developmental, Perinatal Depression and Sleeping Arrangements)
- Educate
- Referrals for evaluation and treatment
- Mentor Student Nurses (St. Xavier and UIC) & Preventive Medicine Residents (CCH)

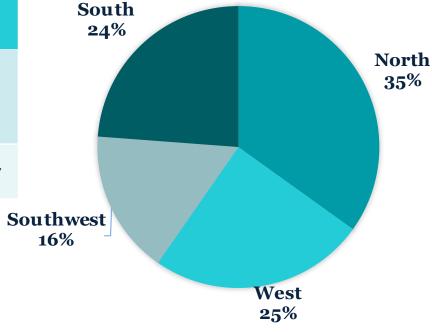




### Total Number of APORS Families & Visits October 2017 – May 2019

	North District	West District	Southwest District	South District	Total
Total # of APORS families with at least 1 visit	1205	855	570	822	3452
Total # of Visits	5627	4214	4545	4161	18547

### TOTAL # OF APORS FAMILIES OCTOBER 2017 TO MAY 2019



### Additional Collaborative Public Health Nurse Roles

• Communicable Disease Department, support response;

Measles outbreak

Ebola Virus

Influenza Virus H1N1

- Environmental Health Services (EHS) –Lead Program;
   Joint visits with the Lead inspectors
   Lead level monitoring.
- Emergency Preparedness and Response Unit (EPRU)
   Annual EPRU drills (Flu clinic, STI screenings, Hep A vaccine)
- IDPH Initiatives
   STI screenings
   Hep A vaccines



### Food Insecurity

**APORS Families** Special Project Around Social Determinants





### **Food Insecurity Questions**

"Within the past 12 months, we worried whether our food would run out before we got money to buy more.

Within the past 12 months, the food we bought just didn't last and we didn't have money to get more." Yes or no?



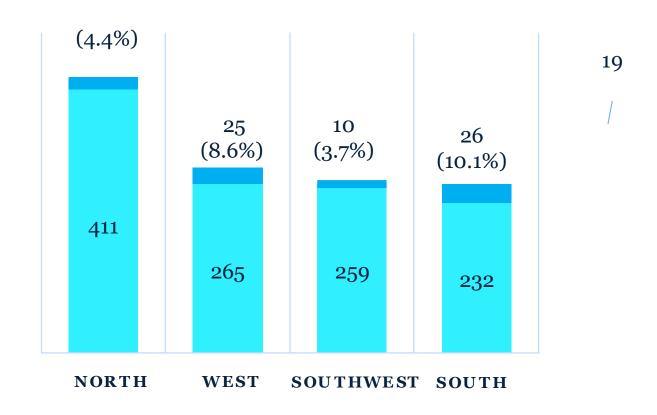
### Food Insecurity Data Collection Process

**Objective:** To collect baseline data on new APORS families' food security.

Time Period: October 2017 – May 2019



# Food Insecurity among APORS Families in Suburban Cook County OCT 2017-May 2019 - responses by district







### **Survey of Nurses**

1. What resources did staff see or clients mention, that prevent the families from obtaining food?

- 2. What resources would clients need to obtain food/healthy food?
- 3. What resources did the nurses feel were needed to assist clients with obtaining food?
- 4. Of the resources provided what could Public Health Nurses provide/implement to assist clients?



### Nurse Responses;

What resources would clients need to obtain food/healthy food?

- Farmer Markets
- WIC, SNAP
- Food Pantries
- Neighborhood grocery stores
- Hunger Hotline
- Cash
- Affordable housing

### Client Responses to Food Insecurity

- Job Loss
- Money Issues
- Seasonal Workers
- Transportation Issues
- Lack of or no grocery stores in the area
- Problems with re-certifying for SNAP, WIC, and Medicaid
- Lack of documentation (driver license, utility bill, etc.)
- Immigration status (undocumented)
- Lack of awareness about available programs
- State/Federal Budget cuts secondary to government change/shutdowns



### **Next Steps**

- Create a list of resources and programs
- Distribute food in daycare centers, grammar and high schools
- Collaborate with faith-based organizations, schools, and other community agencies
- Collaborate with local food pantries to have more accessible hours
- Work with the Northern IL Food Bank to extend the hours of service and/or weekend hours
- Better integration with Mary Sajdak and Integrated Care Service Care Coordination staff
- Link to existing CCDPH initiatives



# Thank you.



