The Reduction of Infant Mortality in Illinois

The Family Case Management Program and Special Supplemental Nutrition Program for Women, Infants and Children
2011 Annual Report
The Reduction of Infant Mortality in Illinois

Annual Report for Fiscal Year 2011

Illinois Department of Human Services

January 2012
Dear Governor Quinn and Members of the General Assembly:

It is my pleasure to present The Reduction of Infant Mortality in Illinois: The Family Case Management Program and WIC Program Annual Report for Fiscal Year 2011. These programs have contributed to a steady reduction in the state's infant mortality rate, which reached 7.2 per 1,000 live births in 2008.

Illinois is unique in its effort to integrate the delivery of these two major programs for low-income women and children. The Department has been able to blend the delivery, financing, monitoring and evaluation of these programs through innovation and performance management. The comprehensive integration of maternal and child health programming is providing the foundation for future expansion and enhancement through the integration of additional service for this vulnerable population.

The Department has achieved uncommon results through this effort. Rates of prenatal weight gain, immunizations, breastfeeding, well child care and developmental screening have been steadily improving. Crude rates of premature birth and infant mortality among Medicaid-eligible pregnant women who participate in these programs are substantially better than those observed among similar women who did not participate in either program.

While we continue to make progress, there is a persistent racial disparity in infant mortality that must be eliminated. An African American infant born in Illinois is still more than two and a half times as likely as a Caucasian infant to die before reaching one year of age. Our current efforts are commendable, but they are not enough.

This tragic loss of life must not continue and its disparate impact on Illinois' minority communities must be addressed. I look forward to working with each of you to improve the health of all Illinoisans.

Sincerely,

Michelle R.B. Saddler
Secretary
The Reduction of Infant Mortality in Illinois
Annual Report
Fiscal Year 2011

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EXECUTIVE SUMMARY

Illinois' infant mortality rate for 2008 (the latest year available) was 7.2 deaths for every 1,000 live births. The absolute number of infant deaths—1,263—while the second lowest recorded is high in terms of personal loss and lives not lived.

The Illinois Department of Human Services (IDHS) helps to reduce this loss through the integrated delivery of the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and Family Case Management (FCM). These programs combined to serve 45 percent of all infants and 81 percent of the Medicaid-eligible infants born in Illinois. The Department supplements these statewide programs with targeted initiatives (Targeted and Intensive Prenatal Care and Chicago Healthy Start) for women whose chances of giving birth prematurely are greater than average and for infants who have a greater-than-average chance of dying before their first birthday.

Program Success - The Department monitors the performance of the WIC and FCM programs on several short-term health status indicators. At the end of fiscal year 2011, performance on each indicator was as follows:

- The proportion of WIC-eligible children with health insurance was 96.5 percent;
- The proportion of fully-immunized one-year-olds in WIC was 86.0 percent;
- The proportion of fully-immunized two-year-olds in WIC was 79.3 percent;
- The proportion of WIC infants who are breastfed was 69.1 percent;
- The proportion of infants in WIC who were breastfed through six months was 26.1 percent;
- The proportion of children in FCM who received at least three well-child health care visits during the first year of life was up to 87.3 percent; and
- The proportion of women and infants active in either WIC or FCM that are also enrolled in the other program was over 90 percent.

Improved Health Status - For 14 consecutive years, infants born to Medicaid-eligible pregnant women who participated in both WIC and FCM have been found to be in better health than those born to Medicaid-eligible women who did not participate in either program. The rate of very low birth weight has been on average over 60 percent lower than that among non-participants, and the rate of infant mortality has averaged 70 percent lower.

Fiscal Savings - In addition to the significant health benefits afforded by the WIC and FCM programs, Illinois’ investment in these programs saves the State approximately $200 million each year in Medicaid expenditures. Those expenses for health care in the first year of life were almost 30 percent lower among dual-program participants than among non-participants in 2009.
INTRODUCTION

In 2008, Illinois' infant mortality rate was 7.2 deaths for every 1,000 live births, an increase from the lowest rate ever reported in Illinois, 6.6/1000 live births in 2007.

Many factors contribute to the state's infant mortality rate. Medical and pharmacological treatments are available for the conditions that used to take the lives of infants who were born prematurely. Illinois maintains one of the best systems of hospital-based perinatal care services in the nation. Illinois' success in maternal and child health services is due in part to the Department of Human Services' ongoing collaborative efforts with both the Illinois Department of Public Health (IDPH) and the Illinois Department of Healthcare and Family Services (IDHFS).

Consecutive annual evaluations of infant mortality demonstrate that participation in both the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and the Family Case Management (FCM) program during pregnancy substantially improves infant health. This improvement contributes an estimated annual savings of approximately $200 million in Medicaid expenditures for care required during the first year of life. Additional savings from avoided special education, disability and rehabilitation costs potentially accrue over a lifetime.

While Illinois has made steady progress in the reduction of infant mortality, a significant disparity in infant mortality rates persists between African American and Caucasian infants. An African American infant born in Illinois during 2008 was 2.4 times more likely than a Caucasian infant to die before reaching its first birthday. This disparity has persisted for many years and must no longer be accepted. The IDHS has made the reduction of racial disparities in health status a top priority, especially among society's most vulnerable members.

PROGRAM DESCRIPTIONS

The IDHS has developed a comprehensive maternal and child health (MCH) strategy for the reduction of infant mortality. This strategy integrates two large-scale programs, WIC and FCM. The Department supplements these basic services with programs targeted to women who have a greater chance of giving birth prematurely. The Chicago Healthy Start Initiative (CHSI) and Targeted Intensive Prenatal Case Management (TIPCM) serve areas of the state with high infant mortality rates or significant racial disparities in infant mortality.
The integration of these programs is supported and enhanced by the shared use of Cornerstone, the Department’s maternal and child health management information system. This system collects and reports all of the information necessary for the operation of the WIC, FCM, Healthy Start and TIPCM programs, as well as other MCH services. Cornerstone provides an integrated record of the services provided to each participant and a service plan that identifies the services that the family requires. Staff members within and among agencies have access to a comprehensive record of the services provided to participating families. This avoids the problem of duplicative data collection and recording. Cornerstone promotes the integration and streamlines the delivery of MCH services.

State and federal funds support Illinois’ Infant Mortality Reduction Initiative. WIC is supported entirely by funds from the United States Department of Agriculture (USDA). FCM and TIPCM are supported by state-funds as well as federal funds including those from Titles V and XX and matching funds through the Medicaid program. CHSI is supported by discretionary grants from the federal Maternal and Child Health Bureau. These programs are described below.

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) seeks to improve the health of women, infants, and children; to reduce the incidence of infant mortality, premature births and low birth weight; to promote breastfeeding; and to aid in the growth and development of children. The program serves income-eligible pregnant, breastfeeding and postpartum women, and infants and children up to five years of age who have a nutritional risk factor.

Participants receive food “prescriptions” based on their nutritional needs. WIC foods include milk, cheese, eggs, adult and infant cereal and juice, peanut butter, tuna, salmon, whole grains, carrots, beans, and infant formula. Food-specific vouchers are printed on site at WIC clinics statewide. Participants obtain their WIC foods by redeeming the vouchers at program-approved grocery stores throughout the state and at WIC Food Centers in certain areas of Chicago. The Department grants funds to 99 local agencies to provide WIC services, including local health departments, not-for-profit health care agencies and social service agencies.

Family Case Management is a statewide program that provides comprehensive service coordination to pregnant women, infants, and high-risk children. The Department funds 108 agencies, including local health departments, community-based organizations and Federally Qualified Health Centers, to conduct FCM activities. Assessments are conducted and care plans are developed to address a wide range of needs, including health care, mental health, educational, vocational, child care, transportation, psychosocial, nutritional, environmental, developmental, and other services. Contacts with clients include home and office visits at a frequency necessary to meet the client’s needs. Most FCM providers are authorized to complete Medicaid Presumptive Eligibility applications for pregnant women and children and function as Application Agents for All Kids, Illinois’ health insurance program for children.
The Chicago Healthy Start Initiative provides services through four Chicago Healthy Start Family Centers that serve as "one-stop shopping centers" for intensive case management and linkage to prenatal care, pediatric primary care, family support, early intervention, substance abuse prevention, domestic violence prevention, and mental health counseling. The centers also provide two essential enabling services -- episodic child care and transportation -- to remove common barriers to care. CHSI targets the Hermosa, Near West Side, Near South Side, Douglas, Grand Boulevard, Washington Park and Greater Grand Crossing Community Areas in the city of Chicago. This project is supported by a grant from the federal Maternal and Child Health Bureau.

Targeted Intensive Prenatal Case Management (TIPCM). This program’s goal is to reduce the rates of premature birth and low birth weight. TIPCM enhances FCM by:

- Adding community-based outreach and retention strategies (including practical incentives for women);
- Lowering caseloads and increasing the frequency of contact between case managers and clients;
- Requiring case managers to be public health nurses or licensed social workers;
- Developing explicit linkages to medical care, substance abuse treatment, mental health care and smoking cessation services; and
- Adding access-related services such as transportation, interpreter services and childcare.

The program serves the following communities in Chicago: Austin, Auburn-Gresham, Avalon Park, Burnside, Calumet City, Chicago Heights, East and West Garfield, Humboldt Park, Morgan Park, North Lawndale, South Chicago, South Shore, Roseland, Woodlawn, and Washington Heights. In west suburban Cook County, the program serves the cities of Bellwood and Maywood. In southern Cook County, the program serves the cities of Calumet City, Chicago Heights, County Club Hills, Harvey, Hazel Crest, Homewood and Riverdale. Downstate the program serves Macon, Peoria, St. Clair, Vermilion, and Winnebago Counties. The Eastside Health District of East St. Louis also is served. In Will County, the project serves the following cities: Bolingbrook, Joliet, Mokena and Romeoville.

FINANCING

Illinois’ integrated maternal and child health program for the reduction of infant mortality is supported by a combination of state and federal resources. The SFY’08 through SFY’12 budgets by program component are presented in Table 1.
The WIC budget includes funds for program operations at the state and local levels (referred to as Nutrition Services and Administration, or NSA) and for the purchase of food. The food funds include an award from the USDA and rebates on the purchase of infant formula from Mead-Johnson. Rebates add an average of $75 million to the program’s food budget each year. Grant awards to local agencies are based on estimated caseload.

The FCM program is supported by several funding sources: General Revenue Fund, Title V - Maternal and Child Health Services Block Grant, and Title XX - Social Services Block Grant. Local health departments also add their own funds for the operation of the program. Federal matching funds supplement the state and federal appropriations. The Department has worked closely with the IDHFS since 1990 to obtain federal matching funds through the Medicaid program for FCM expenditures. Further, as units of local government, local health departments may receive federal match for the local funds they expend in support of the FCM program. This has increased the total amount of funds available for the FCM program by about $4 million per year without an increase in the Department’s appropriation for the FCM program. However, as presented in Table 1, state support for Case Management has eroded since FY2008; 17 percent less funding is directed to this service.

**SERVICE DELIVERY SYSTEM**

These services are delivered at the community level by grantees of the IDHS. Most often, these are local health departments. Community health centers and social service agencies also play an integral role in the delivery of primary and preventive care to pregnant women, mothers, infants, children and adolescents.

*Local health departments.* Local health departments have a unique responsibility to assess needs, develop policy to address community problems and assure that services are delivered to address those problems. Local health departments also are accountable to the public for the health of the entire community. Local health departments are well positioned to provide maternal and child health services in their jurisdictions.
Community Health Centers. There are 275 community health centers and federally qualified health centers in Illinois. Community health centers provide a complete array of primary health care services in medically under-served communities. Several are IDHS grantees for these and other programs. Erie Family Health Center, Near North Health Services Corporation and Mile Square Health Center have been partners in the CHSI for many years.

Community-Based Organizations. Several prominent community-based organizations in Chicago and suburban Cook County have participated in the FCM program and its predecessors, as well as the WIC program, since the mid-1980s. These organizations bring an extensive knowledge of the communities they serve, are familiar with the cultural diversity of their communities and employ staff who remain sensitive to community needs, beliefs and cultures.

CASELOAD

The number of persons served by the WIC and FCM programs during SFY 11 is presented in Table 2. FCM does not keep a separate count of the number of participating postpartum or breastfeeding women. However, under USDA guidelines, these women comprise a separate category of eligibility for the WIC program.

<table>
<thead>
<tr>
<th>Type of Client</th>
<th>Program</th>
<th>WIC</th>
<th>FCM*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant Women</td>
<td></td>
<td>108,381</td>
<td>97,696</td>
</tr>
<tr>
<td>Post Partum Breastfeeding Women</td>
<td></td>
<td>50,317</td>
<td>NA</td>
</tr>
<tr>
<td>Infants</td>
<td></td>
<td>175,497</td>
<td>145,127</td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td>204,587</td>
<td>45,336</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>538,782</td>
<td>288,159</td>
</tr>
</tbody>
</table>

Source: Cornerstone

*FCM does not have a category of post-partum breastfeeding women.

The caseload of FCM dropped for FY2011. Cook County Health Department (CCHD) and several downstate health departments declined to be providers of FCM. Although caseloads were reassigned, the disruption of service delivery is evident in the caseload figures presented in Table 3.

<table>
<thead>
<tr>
<th>Program</th>
<th>Fiscal Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2004</td>
</tr>
<tr>
<td>FCM</td>
<td>370,286</td>
</tr>
<tr>
<td>WIC</td>
<td>508,250</td>
</tr>
</tbody>
</table>

Source: Cornerstone
The WIC and FCM programs together reach over 45 percent of all infants and over 81 percent of Medicaid-eligible infants born in Illinois each year. Women who are at greatest risk for giving birth prematurely or having a baby with other health problems are over-represented in the caseload of the WIC and FCM programs. Approximately, three-fourths of African American, Hispanic, single and teen-aged women who give birth in Illinois each year participate in the WIC or FCM programs; the programs are reaching their intended target population. Refer to Table 4.

<table>
<thead>
<tr>
<th>Group</th>
<th>Live Births</th>
<th>All</th>
<th>WIC or FCM Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td>White</td>
<td>125,618</td>
<td>75.9%</td>
<td>51,547</td>
</tr>
<tr>
<td>Black</td>
<td>29,280</td>
<td>17.7%</td>
<td>21,003</td>
</tr>
<tr>
<td>Asian and Native American*</td>
<td>10,709</td>
<td>6.5%</td>
<td>2,686</td>
</tr>
<tr>
<td>All</td>
<td>165,607</td>
<td>100.0%</td>
<td>75,236</td>
</tr>
<tr>
<td>Hispanic</td>
<td>40,019</td>
<td>24.2%</td>
<td>25,841</td>
</tr>
<tr>
<td>Single</td>
<td>67,017</td>
<td>41.0%</td>
<td>51,524</td>
</tr>
<tr>
<td>Teen</td>
<td>15,953</td>
<td>9.6%</td>
<td>13,450</td>
</tr>
</tbody>
</table>

Source: Vital Records, Cornerstone
*Includes all other races.

**PERFORMANCE**

Program performance is measured against several short-term health status indicators among the women, infants and children enrolled in WIC, FCM or both programs. Measures include:

1. Enrollment in both WIC and FCM
2. First trimester enrollment in WIC and FCM
3. Initiation of breastfeeding in WIC
4. Three or more well-child visits to FCM infants before age one
5. Fully immunized infants and two-year-olds in WIC
6. Health insurance coverage of infants and children in WIC
7. Developmental screening of infants and children in WIC and FCM
The Department uses its maternal and child health management information system, Cornerstone, to generate quarterly reports on these performance measures. Agency performance provides the basis for ongoing technical assistance. These reports can be found at http://www.dhs.state.il.us/page.aspx?item=31152 for provider and public access.

1. Enrollment in Both WIC and FCM

Since 1998, DHS has pushed for the integration of FCM and WIC services. An evaluation of Medicaid-eligible women found that those who participated in WIC and FCM during pregnancy in 1996 had substantially lower rates of premature birth and infant mortality.

The graph below displays the proportion of clients in one program that are also enrolled in the other program. For example, the line labeled ‘WIC’ shows the proportion of WIC clients that were also enrolled in FCM. At the end of Fiscal Year 2011, 93.5 percent of WIC participants were participating in FCM and 95.5 percent of FCM participants were receiving WIC services.

![Program Integration of WIC & FCM](image-url)

Source: Cornerstone
2. First Trimester Enrollment in WIC and FCM

Enrollment in FCM/WIC services during the first trimester of pregnancy is essential to ensure maximum impact on the health of the mother and the newborn infant. The graph below shows that there has been a gradual upward trend over several years in the proportion of program participants who enrolled in the programs during the first trimester of pregnancy.

Local WIC and FCM agencies use a variety of strategies to reach low-income families in the communities they serve. These may include door-to-door canvassing, distribution of printed materials and use of mass media, as well as nontraditional methods that may be necessary to identify potential participants in hard-to-reach populations, such as persons who abuse drugs or engage in prostitution.

The Department also takes advantage of its computer technology to increase the proportion of Medicaid-eligible pregnant women who enroll in WIC and FCM and to improve the proportion of women who enroll in the first trimester of pregnancy. Local WIC and FCM service providers are indirectly linked to the Department’s Family Community Resource
Centers through an electronic data exchange. Each month, information about pregnant women who have enrolled in the Medicaid program is transferred from the Client Information System used by the Family Community Resource Centers to the Cornerstone system. The information is then distributed to local service providers and is ultimately used to conduct targeted outreach efforts.

3. Initiation and Duration of Breastfeeding in WIC

The American Academy of Pediatrics (AAP) states that infants should be breastfed for at least the first year of life and adds no limit for duration. In 40 local agencies, breastfeeding peer counselors are part of the WIC team, promoting breastfeeding, educating women on the “how-to’s” of breastfeeding and supporting breastfeeding mothers when they deliver and begin breastfeeding. WIC participants’ peer counselors are women from the community who have successfully breastfed their own infants. They receive specialized training to serve as peer counselors. Representing diverse cultural backgrounds, they offer encouragement, information, and support to other WIC mothers.

The graph displays the proportion of women who participated in the WIC program during pregnancy and began to breastfeed their infants right after giving birth.

The rate of breastfeeding at hospital discharge has increased among WIC participants from 63 percent in 2006 to 69.3 percent for SFY 2011.
The American Academy of Pediatrics recommends routine well child visits. Providers monitor a child's growth and development, provide preventive health care services (i.e., immunizations), screen for potentially serious health problems (i.e., lead poisoning or problems with vision or hearing) and inform parents through anticipatory guidance. The Academy recommends six such visits during the first year of life, to occur at one month, two months, four months, six months, nine months and twelve months of age.

The Department monitors FCM agencies to ensure that participating infants receive at least three well child visits during the first year of life. The graph displays the proportion of infants who met this standard.
5. Fully Immunized Infants and Two-Year-Olds in WIC

The graph below displays two performance measures and groups of children in the WIC program:

Source: Cornerstone
The line labeled “3:2:2” shows the proportion of children between 12 and 18 months of age that were active in the WIC program and had received:
- 3 doses of diphtheria, pertussis and tetanus vaccine;
- 2 doses of oral polio vaccine; and
- 2 doses of *Haemophilus influenzae* type B vaccine.

The line labeled “4:3:3:1” shows the proportion of children between 24 and 36 months of age that had received:
- 4 doses of diphtheria, pertussis and tetanus vaccine;
- 3 doses of oral polio vaccine;
- 3 doses of *Haemophilus influenzae* type B vaccine; and
- 1 dose of measles, mumps and rubella vaccine.

(Effective in the first quarter of 2007, the 3:2:2 report was modified to allow the WIC and FCM programs to use the same age range criteria of 12 to 18 months.)
Since 2000, the proportion of fully-immunized one-year-olds (3:2:2) increased from 70 percent to over 85 percent and the proportion of fully immunized two-year-olds (4:3:3:1) increased from 56 percent to almost 80 percent.

6. Health Insurance Coverage of Infants and Children in WIC

Health insurance is essential for access to health care services. Virtually every child on WIC is, by definition, eligible for the State of Illinois' All Kids program. The Department has been working with the IDHFS to increase the proportion of WIC-eligible children who also are enrolled in All Kids if they are not covered by their parents' health insurance. Local WIC/FCM agencies have been trained and certified by the IDHFS as "All Kids Application Agents." Local WIC and FCM program staff persons assist eligible families in applying for coverage through All Kids.

The graph displays the proportion of children in the WIC program who were covered by public or private health insurance.
When this project began in September 2000, a total of 86 percent of WIC-enrolled infants and children were documented in the Cornerstone system as having All Kids or private insurance coverage. Due to the continued efforts of local WIC and FCM agency staff, this proportion has steadily increased; by June 2011, almost 97 percent were documented as having health insurance.

7. Developmental Screening of Infants and Children in WIC and FCM

Infants and young children should be screened routinely for evidence of delays in cognitive, linguistic, motor, social and emotional development. Through routine screening, developmental delays can be promptly identified and therapy initiated.

The Department monitors the proportion of infants in the FCM program who have been screened for problems with physical or cognitive development at least once a year.

The graph displays the proportion of 12-month-old children in WIC or FCM that had been screened for developmental delay at least once in the prior 12 months. Beginning in FY10, the data for 12-month-old children in WIC was eliminated and only the data for 12-month-old children in FCM was used to measure this particular performance indicator.

*Source: Cornerstone
The Reduction of Infant Mortality in Illinois

OUTCOMES

Illinois’ integrated strategy for improving maternal and child health focuses on four outcomes:
  • Reducing the very low birth weight rate
  • Reducing the low birth weight rate
  • Reducing Medicaid expenditures during the first year of life
  • Reducing the infant mortality rate

Very low birth weight infants (newborns who weigh less than 3 pounds 2 ounces) require intensive medical care. While these infants represent less than two percent of all live births, they also account for two-thirds of the infants who die in the first year of life. Interventions that reduce the very low birth weight rate will also reduce Medicaid expenditures during the first year of life and reduce the infant mortality rate.

The integrated delivery of the WIC and FCM programs affects the state’s infant mortality rate and health care expenditures. The health status of infants born to Medicaid-eligible women who participated in both WIC and FCM has been substantially better than that of infants born to Medicaid-eligible women who did not participate in either program. In particular, the rate of premature birth is more than 30 percent lower among participants in both programs. The rate of low birth weight is 30 percent lower; the rate of infant mortality is more than 55 percent lower; and on average health care expenditures during the first year of life are almost 30 percent lower.

Very Low Birth Weight

The very low birth weight rate among women who participated in both WIC and FCM was 1.1 percent in 2009, almost a third lower than the rate observed among Medicaid-eligible women who did not participate in either program during pregnancy (2.9 %).

Medicaid Expenditures in the First Year of Life

The Department matches information from its maternal and child health management information system, Cornerstone, to vital records maintained by IDPH and the Medicaid Management Information System maintained by the IDHFS. This allows the Department to compare the perinatal health status of women and children who participate in several of its programs to Medicaid-eligible non-participants and the general population of pregnant women and newborns.
WIC and FCM, through the reduction in very low birth weight, contribute to a significant reduction in Medicaid expenditures during the first year of life.

As an example, TIPCM served 2,567 women during FY2011, 56 percent black and 96 percent Medicaid eligible. The low and very low birth weight rates for TIPCM recipients were 13.4% and 1.7%, respectively. These rates compare favorably to those reported for the general black population, 13.7 and 3% respectively. The potential costs averted by the program are enormous; all TIPCM recipients are at great risk of a non-normal birth. According to IHFS, in the Perinatal Health Care Report, 2010, a non-normal birth costs approximately $14,000 during the first year of life. Applying this amount to the births of TIPCM recipients (less those that were low or very low birth weight – 343) the state averted $30 million in costs of care that would have been necessary.
The Reduction of Infant Mortality in Illinois

**Infant Mortality**

**Infant Mortality Rate**

![Graph showing infant mortality rate from 1985 to 2008](chart.png)

Source: [http://www.idph.state.il.us/health/ifnant/cumrate.htm](http://www.idph.state.il.us/health/ifnant/cumrate.htm)

Illinois has made steady progress in reducing its infant mortality rate, in part, due to the improvement of birth outcomes as a result of at-risk women participating in the WIC and FCM programs.
RACIAL AND ETHNIC DISPARITIES IN INFANT MORTALITY: THE PERSISTENT CHALLENGE

Infant Mortality by Race - Illinois
1980 - 2008

Source: Vital Records

The graph presents the 2008 infant mortality rates of African American, Caucasian and Illinois’ entire population. The rate among African Americans, while the second lowest on record, is at an unacceptably high level of 13.9 per 1,000 live births.

Table 6 presents the ratio of African American to Caucasian infant mortality rates. While the state has made steady progress in the reduction of infant mortality, the racial disparity between African American and Caucasian infants has not appreciably improved. The benefits of technological advances and perinatal care for mothers and infants continue to be realized as seen by reductions in mortality for both white and black infants.

Racial disparity in health status is one of the top priorities of the Division of Family and Community Services. The Department will continue to work with partners at the federal, state and community level to identify, develop and implement new strategies to address this pressing health problem.

...
Table 6
Ratio of African American and Caucasian Infant Mortality

<table>
<thead>
<tr>
<th>Year</th>
<th>Ratio</th>
<th>Year</th>
<th>Ratio</th>
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<th>Ratio</th>
<th>Year</th>
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<tr>
<td>1981</td>
<td>2.1 : 1</td>
<td>1988</td>
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<td>2.5 : 1</td>
<td>2002</td>
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<td>1993</td>
<td>2.7 : 1</td>
<td>2000</td>
<td>2.5 : 1</td>
<td>2007</td>
<td>2.6 : 1</td>
</tr>
<tr>
<td>1987</td>
<td>2.2 : 1</td>
<td>1994</td>
<td>2.7 : 1</td>
<td>2001</td>
<td>2.5 : 1</td>
<td>2008</td>
<td>2.4 : 1</td>
</tr>
</tbody>
</table>

CONCLUSION

As reflected in this report, there is a wealth of data to indicate that Illinois’ infant mortality reduction programming is working to improve outcomes. Mothers, infants and children on Medicaid who participate in WIC and Family Case Management present better birth outcomes than those receiving Medicaid only. Prevention programming aimed at both individuals and communities is not only saving lives but also conserving limited resources. Health service indicators such as immunization rates, well child visits and insurance coverage are much higher now than in the recent past, due to the concerted efforts of WIC and FCM service participants, providers and administrators. Despite these improvements, Illinois will realize minimal gains in its infant mortality ranking until the ratio of black to white infant deaths is improved. Further enhancement of services directed to preventing very low birth-weight such as Targeted and Intensive Prenatal Case Management, and Chicago Healthy Start hold significant potential for lowering the disparity between black and white infant mortality rates and Illinois’ overall infant mortality rate.
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