The Reduction of Infant Mortality in Illinois

2014 Annual Report
Dear Governor Rauner and Members of the General Assembly:

It is my pleasure to present The Reduction of Infant Mortality in Illinois Annual Report for Fiscal Year 2014. Illinois is unique in its effort to integrate the delivery of Family Case Management (FCM) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) for low-income women, infants, and children. The Department of Human Services has been able to blend the delivery, financing, monitoring, and evaluation of these programs through innovation and performance management.

The Department has maintained high rates of immunizations, breastfeeding, well-child care, and developmental screenings. As a result, the absolute rates of premature birth and very low birth weight 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.

We continue to make progress, but we must also recognize the recurring racial disparity in infant mortality. An African American infant born in Illinois is still more than two and one half times as likely as a Caucasian infant to die before reaching one year of age. While we have made tremendous strides in our efforts to date, this disparity shows that we still have much work to do.

I look forward to working with each of you to continue improving the health of all Illinoisans.

Sincerely,

James T. Dimas
Secretary
Annual Report
Fiscal Year 2014

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EXECUTIVE SUMMARY

Illinois' infant mortality rate for 2011 (i.e., year that corresponded with the fiscal year of this report) was 6.6 deaths for every 1,000 live births, tied for lowest rate for the state of Illinois. In 2007 the rate was also 6.6 for every 1,000 live births. The absolute number of infant deaths equals 1,062, while the lowest recorded, is high in terms of personal loss and lives lost.

The Illinois Department of Human Services (IDHS) helps to reduce this loss through the integrated delivery of the Family Case Management (FCM) program and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). These programs combined, serve 40 percent of all infants and 77 percent of Medicaid-eligible infants born in Illinois. IDHS supplements these statewide programs with targeted initiatives such as Better Birth Outcomes 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 - IDHS monitors the performance of the FCM and WIC programs on several short-term health status indicators. At the end of State Fiscal Year 2014 (SFY2014), performance on each indicator was as follows: FCM-eligible children (i.e., up to age 13 months) with health insurance was 88.6 percent; Fully-immunized one-year-olds in FCM was 81.4 percent; Infants in WIC who were breastfed exclusively at 12 weeks was 9.7 percent; Children in FCM who received at least three well-child health care visits during the first year of life was 88 percent; Infants and children receiving developmental screening in FCM was 89.3 percent; and Women and infants active in either FCM or WIC who are also enrolled in the other program was over 90 percent.

Racial and Ethnic Disparities in Infant Mortality – Illinois’ infant mortality rate has declined by 40% since 1986. Despite the steady progress, a significant disparity in infant mortality rates persists between African American and Caucasian infants. IDHS and various organizations are creating interventions designed specifically to reduce racial disparities in health care and health outcomes. The interventions include an increased focus on care of high-risk pregnant women through Better Birth Outcomes, a campaign to reduce elective late preterm deliveries, and an improved perinatal health care system. Breastfeeding is a significant determinant of infant health. Illinois is in the forefront of promoting breastfeeding initiation and exclusivity via WIC’s Peer Counselors who help women initiate and continue breastfeeding. Enhancement of services directed to preventing very low birth-weight such as Better Birth Outcomes holds significant potential for lowering the disparity between African American and Caucasian infant mortality rates and Illinois’ overall infant mortality rate.

Improved Health Status - For the past 14 consecutive years infants born to Medicaid-eligible pregnant women who participated in both FCM and WIC have been found to be in better health than those born to Medicaid-eligible women who did not participate in either program. In 2010, the rate of very low birth weight was about 50 percent lower than that among non-participants, and the rate of premature birth was about 28 percent lower. For both measures, the rates were also significantly lower (i.e., 15 percent and 13 percent, respectively) than the general population who received no services.

Fiscal Savings - In addition to the significant health benefits afforded by FCM and WIC, Illinois’ investment in these programs saved the state on average over $200 million each year in Medicaid expenditures. Those expenses for health care in the first year of life were almost 18 percent lower among dual-program participants than among non-participants in 2010.
INTRODUCTION

For the fiscal year for this report, the latest infant mortality statistics are for 2011. In that year, Illinois’ infant mortality rate was 6.6 deaths for every 1,000 live births. The statistic represents improvement from the 2010 rate of 6.8 deaths per 1,000 live births and from the 2009 rate of 6.9. It ties the lowest rate ever reported in Illinois, 6.6 per 1,000 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’ success in maternal and child health services is due in part to the Illinois 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 Family Case Management (FCM) program and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) during pregnancy substantially improves infant health. This improvement contributes an estimated annual savings of over $200 million in Medicaid expenditures for care required during the first year of life. Additional savings from avoided special education, disability and rehabilitation support service costs potentially accrue over a lifetime.

PROGRAM DESCRIPTIONS

IDHS administers a maternal and child health (MCH) strategy for the reduction of infant mortality. The strategy integrates two large-scale programs, the Family Case Management (FCM) program, and the Special Supplemental Nutrition Program for Women, Infants and Children, more commonly known as WIC. Another element of the MCH strategy is the Better Birth Outcomes (BBO) program which targets pregnant women with identified medical and socio-environmental risks that are amenable to interventions, which ultimately may decrease costs, improve health outcomes, and decrease morbidity and mortality in pregnant women and infants. BBO targets geographic areas of the state where data indicates higher rates of premature births in the Medicaid population.

The integration of these programs is supported and enhanced by the shared use of Cornerstone, IDHS’ maternal and child health management information system. This system collects and reports all information necessary for the operation of the FCM, WIC, and Better Birth Outcomes (BBO) programs. Cornerstone provides an integrated record of the services provided to each participant and a service plan that identifies the services 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.
Family Case Management is a statewide program that provides comprehensive maternal and child health care services. IDHS funds 105 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 determined by program-required minimum standards, case managers’ clinical judgment, and expertise and knowledge of the client’s identified needs and situation. Beginning mid-year 2013, IDHS shifted the program’s focus to pregnant women. Accordingly, FCM providers are required to increase their pregnant caseload by 10 percentage points each service year. Also, the timeframe for completion of a perinatal depression screening was changed to reflect current recommended guidelines for screening at or after 20 weeks gestation.

In January 2013, a more intensive care coordination program directed exclusively to the needs of high-risk pregnant women was initiated in 22 communities. Known as Better Birth Outcomes (BBO), the program distinguishes high-risk women from those of lower-risk with the use of a standard assessment process. Prenatal education curriculum, as developed by the March of Dimes, is provided to each participant either by a registered nurse or a master’s trained social worker. Care coordination among medical and social service providers is the hallmark of the program. Communication mechanisms between prenatal care providers and BBO care coordinators are in place. Interfaces between the state’s large information systems (e.g., Medicaid Claims, Vital Statistics, and Cornerstone) alert care coordinators of at-risk women, inform the care providers and coordinators of the services being delivered, and report performance in terms of services delivered and pregnancy outcome.

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) seeks to improve the health of women, infants, and children; reduce the incidence of infant mortality, premature births and low birth weight; promote breastfeeding; and 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 97 local agencies to provide WIC services, including local health departments, not-for-profit health care agencies and social service agencies.

Chicago Healthy Start Initiative (CHSI) ceased operations on May 31, 2014, due to the grant funds ending. The program provided 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 provided two essential enabling services, episodic child care and transportation, to remove common barriers to care. CHSI targeted 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 was supported by a grant from the federal Maternal and Child Health Bureau.
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 State Fiscal Year 2011 (SFY2011) through SFY2014 budgets by program component are presented in Table 1.

The FCM program is supported by several funding sources that include 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. IDHS 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 $14 million per year without an increase in IDHS’ appropriation for the FCM program.

As noted earlier, IDHS initiated Better Birth Outcomes (BBO) in 22 communities in January 2013. Funding for the program as presented in Table 1 for 2013 reflects a half year’s support.

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 $80 million to the program’s food budget each year. Grant awards to local agencies are based on estimated caseload.
SERVICE DELIVERY SYSTEM

These services are delivered at the community level by grantees of 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 ensure 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 470 community health center and Federally Qualified Health Center sites in Illinois. Community health centers provide a complete array of primary health care services in medically underserved 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 Chicago Healthy Start initiative 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 FCM and WIC programs during SFY2014 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.

The caseload of FCM dropped for SFY2014. This is in part due to the continuing decrease in state funding. Furthermore, several community-based organizations and downstate health departments declined to be providers of FCM in recent years. The primary reason for their withdrawal from the program being finances; the late and slow payment of General Revenue funding hinders agencies’ ability to remain viable. Although caseloads were reassigned, the disruption of service delivery is evident in the caseload figures presented in Table 3.

<table>
<thead>
<tr>
<th>Type of Client</th>
<th>FCM*</th>
<th>WIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant Women</td>
<td>85,856</td>
<td>95,909</td>
</tr>
<tr>
<td>Postpartum Breastfeeding Women</td>
<td>NA</td>
<td>48,646</td>
</tr>
<tr>
<td>Infants</td>
<td>127,127</td>
<td>157,270</td>
</tr>
<tr>
<td>Children</td>
<td>20,711</td>
<td>186,575</td>
</tr>
<tr>
<td>Total</td>
<td>233,694</td>
<td>488,400</td>
</tr>
</tbody>
</table>

Source: Cornerstone
*FCM does not have a category of postpartum breastfeeding women.
The FCM and WIC programs together reach 40 percent of all infants and 77 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 FCM and WIC programs. Approximately three-fourths of African American, Hispanic, single, and teen-aged women who give birth in Illinois each year participate in the FCM or WIC programs. The programs are reaching their intended target population. Refer to Table 4.

**Table 3**
Total Number of Persons Served in FCM and WIC Programs by Program and State Fiscal Year

<table>
<thead>
<tr>
<th>Program</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>FCM</td>
<td>345,769</td>
<td>342,428</td>
<td>329,658</td>
<td>312,389</td>
<td>288,159</td>
<td>266,635</td>
<td>252,234</td>
<td>233,694</td>
</tr>
<tr>
<td>WIC</td>
<td>519,250</td>
<td>532,753</td>
<td>549,086</td>
<td>553,342</td>
<td>538,782</td>
<td>520,557</td>
<td>503,237</td>
<td>488,400</td>
</tr>
</tbody>
</table>

Source: Cornerstone

**Table 4**
Number and Percent of All Live Births and Live Births to FCM or WIC Participants by Demographic Group
Illinois, Calendar Year 2010

<table>
<thead>
<tr>
<th>Group</th>
<th>All</th>
<th>FCM or WIC Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>White</td>
<td>124,807</td>
<td>75.6%</td>
</tr>
<tr>
<td>Black</td>
<td>28,937</td>
<td>17.5%</td>
</tr>
<tr>
<td>Asian, Native American &amp; all others</td>
<td>11,254</td>
<td>6.8%</td>
</tr>
<tr>
<td>All</td>
<td>164,998</td>
<td>100.0%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>37,321</td>
<td>22.6%</td>
</tr>
<tr>
<td>Single</td>
<td>66,787</td>
<td>40.5%</td>
</tr>
<tr>
<td>Teen</td>
<td>14,955</td>
<td>9.1%</td>
</tr>
</tbody>
</table>

Source: IDPH Vital Records and IDHS Cornerstone via the IDHFS Enterprise Data Warehouse (EDW)

**PERFORMANCE**

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

1. Enrollment in both FCM and WIC
2. First trimester enrollment in FCM
3. Initiation of breastfeeding in WIC
4. Three or more well-child visits to FCM infants before age one
5. Fully immunized infants in FCM
6. Health insurance coverage of infants and children in FCM
7. Developmental screening of infants and children in FCM
IDHS 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](http://www.dhs.state.il.us/page.aspx?item=31152) for provider and public access.

1. Enrollment in Both FCM and WIC
Since 1998, IDHS has pushed for the integration of FCM and WIC services. An evaluation of Medicaid-eligible women found that those who participated in FCM and WIC 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 2014, 93 percent of WIC participants were participating in FCM and 95 percent of FCM participants were receiving WIC services.

![Program Integration of WIC & FCM](image_url)
2. First Trimester Enrollment in FCM
Enrollment in FCM services during the first trimester of pregnancy is essential to ensure maximum impact on the health of the mother and newborn infant. The graph below shows there has been a relatively steady rate over the last several years in the proportion of program participants who enrolled in the programs during the first trimester of pregnancy.

Local 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.

IDHS also takes advantage of its computer technology to increase the proportion of Medicaid-eligible pregnant women who enroll in FCM and improve the proportion of women who enroll in the first trimester of pregnancy. Local FCM service providers are indirectly linked to IDHS’ 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. Breastfeeding Exclusivity in WIC

The American Academy of Pediatrics (AAP) recommends exclusive breastfeeding for about 6 months, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant, a recommendation concurred to by the WHO and the Institute of Medicine. In 70 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 exclusively breastfed their infants for 12 weeks after giving birth.

The rate of breastfeeding exclusively among WIC participants varied from 9.3 percent to 10.4 percent in SFY2014.

![WIC Participants' 12 week Breastfeeding Exclusivity SFY2014](image-url)

Source: Cornerstone
4. Three or more Well-Child Visits to FCM Infant before Age One

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 American Academy of Pediatrics 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.

IDHS 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.

Source: Cornerstone
5. Fully Immunized Infants in FCM

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

The graph shows the proportion of children between 12 and 18 months of age who were active in the FCM program and had received:

- 3 doses of diphtheria, pertussis, and tetanus vaccine;
- 2 doses of oral polio vaccine; and
- 2 doses of Haemophilus influenza type B vaccine.
6. Health Insurance Coverage of Infants and Children in FCM

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

The graph displays the proportion of children in the FCM program who were covered by public or private health insurance. Starting in SFY2012, only FCM program providers were evaluated on this measure. Prior to that, both WIC and FCM providers were evaluated.
7. Developmental Screening of Infants and Children in 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.

IDHS monitors the proportion of infants in the FCM program who have been screened for issues associated with physical and/or cognitive developmental delays at least once a year.

The graph displays the proportion of 12-month-old children in FCM or WIC who had been screened for developmental delays at least once in the prior 12 months. Beginning in SFY2010, 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
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 (i.e., 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 FCM and WIC 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 FCM and WIC has been substantially better than that of infants born to Medicaid-eligible women who did not participate in either program. In particular, as of the analysis performed on the 2010 birth data, the rate of premature birth is almost 30 percent lower among participants in both programs. The rate of very low birth weight is almost 50 percent lower and Medicaid health care expenditures during the first year of life are almost 20 percent lower.
Very Low Birth Weight
The very low birth weight rate among women who participated in both FCM and WIC was 1.28 percent in 2010, about one-half the rate observed among Medicaid eligible women who did not participate in either program during pregnancy (2.45 percent).

Source: IDPH Vital Records and IDHS Cornerstone via the IDHFS EDW
Infant Mortality
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 FCM and WIC programs.

Racial and Ethnic Disparities in Infant Mortality: The Persistent Challenge

The graph presents the 2011 infant mortality rates of African American, Caucasian, and Illinois’ entire population. The rate among African Americans, while the third lowest on record, is at an unacceptably high level of 13.6 per 1,000 live births.

Illinois’ infant mortality rate has declined by 40 percent since 1986. Despite the steady progress, a significant disparity in infant mortality rates persists between African American and Caucasian infants (See Table 5). An African American infant born in Illinois during 2011 was 2.6 times more likely than a Caucasian infant to die before reaching his/her first birthday. This disparity has persisted for many years and must no longer be accepted. To that end, IDHS in partnership with other organizations committed to improving maternal and child health among all Illinoisans and creating interventions designed specifically to reduce racial disparities in health care and health outcomes. These strategies include 1) participating in a statewide Prematurity Prevention Task Force that was tasked with development of a set of recommendations that were presented to the Illinois legislative body in October 2012, 2) increasing focus on care of high-risk pregnant women through Better Birth Outcomes, 3) partnering with March of Dimes on a campaign to reduce elective late preterm deliveries, 4) developing an Illinois Blueprint on Breastfeeding, 5) partnering with IDHFS on a number of Children’s Health Insurance Program Reauthorization Act (CHIPRA) workgroups aimed at improving perinatal health, and 6) joining the national Collaborative Improvement & Innovation Network (COIIN) initiative to improve perinatal outcomes, and most recently, participating in the formation of a statewide Perinatal Collaborative.

Breastfeeding is a significant determinant of infant health. Illinois is in the forefront of promoting breastfeeding initiation and exclusivity. Effective January 2013, the Hospital Infant Feeding Act (HIFA) makes Illinois the first state in the nation to require that all birthing hospitals adopt a policy promoting breastfeeding. In the WIC program, Peer Counselors are used to help women initiate and continue breastfeeding. As noted above, the Peer Counselors are mothers who have personal experience with breastfeeding and are trained to provide basic breastfeeding information and encouragement to new mothers. Peer Counselors are familiar with the resources available to WIC clients, have familiarity with the questions a new breastfeeding mother may ask, and recognize when to refer mothers to other resources during critical periods when mothers may experience difficulty. Peer Counselors are recruited and hired from WIC’s target population of low-income women and undergo training to provide mother-to-mother support in group settings and one-to-one counseling through telephone calls or visits in the home, clinic, or hospital.

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 Family Case Management and WIC 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 FCM and WIC service participants, providers and administrators. Despite these improvements, Illinois will realize minimal gains in its infant mortality ranking until the ratio of African American to Caucasian infant deaths is improved. Enhancement of services directed to preventing very low birth-weight such as BBO holds significant potential for lowering the disparity between African American and Caucasian infant mortality rates and Illinois’ overall infant mortality rate.
Programs, activities and employment opportunities in the Illinois Department of Human Services are open and accessible to any individual or group without regard to age, sex, race, sexual orientation, disability, ethnic origin or religion. The department is an equal opportunity employer and practices affirmative action and reasonable accommodation programs.