VOICES FOR OHIO'S CHILDREN

ADDRESSING THE INFANT MORTALITY CRISIS IN OHIO

May 2014

OHIO'S HIGH INFANT MORTALITY ADVERSELY AFFECTS US ALL—FROM THE PREGNANT WOMAN AND HER FAMILY TO THE OHIO BUSINESSMAN.

ABOUT
VOICES FOR OHIO'S CHILDREN

To build a greater community, we must begin with greater kids. Voices for Ohio's Children helps ensure that the needs of Ohio's 3 million children are prioritized at the local, state and federal levels. Our advocacy plays a big role in educating and influencing the community and public officials about sound public policies that help children succeed.

OUR MISSION

Voices for Ohio's Children advocates for public policy that improves the well-being of Ohio's children and their families by building nonpartisan collaborations among the private, public and not-for-profit sectors.

OUR VISION

is for children's interests to be at the top of every community's agenda so all of Ohio's children are poised for success.

THE CONTRIBUTORS

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OHIO'S INCREASING INFANT MORTALITY RATE IS AN ALARMING TREND THAT GREATLY IMPACTS NOT ONLY OHIO FAMILIES BUT ALSO OUR COMMUNITIES.

CONTENTS

FOREWARD

The facts are clear and compelling and the steps towards improvement are defined. So, what else is needed to save our newborns and infants from dying in Ohio? By reading this report from Voices for Ohio's Children, you will understand how Ohio's high infant mortality rates put everyone at risk – from the pregnant woman and her family to the Ohio businessman – we are all adversely affected. From Cleveland, with the unfortunate designation as the "Infant mortality capital of the U.S." to Cincinnati, our Ohio cities have infant death rates more than twice as high as New York City.

This report outlines the strategies known to improve infant survival: our babies need to be born full term, they need to be breastfed, they need to sleep on their backs in a safe environment and they need to be fully immunized. Infant survival starts with a healthy mother. Pregnancies should ideally be planned to help mothers have healthy, full term pregnancies. Planning requires easy and affordable access to family planning and "medical homes," where women can be encouraged to stop smoking, eat healthy, improve their blood pressure and their weight, and reduce the stress in their lives. Once pregnant, these women need early access to prenatal care. If women are at risk for a preterm baby, they need to be treated with progesterone. After delivery, they need support for breastfeeding and access to health care providers who can guide them to safely space their next pregnancy. But how do we "package" and deliver these known strategies?

Every week at our Columbus Moms2B programs, I meet women most at risk for losing an infant. These are pregnant, mostly African American women living on incomes of less than $800 per month. They tell me about the barriers they face trying to find transportation, stable housing, a good job and good child care. They share their struggles to obtain healthy food and early access to prenatal care. I know they also need better access to ongoing medical care to treat their chronic hypertension, anemia, diabetes and asthma. These barriers are compounded by their stresses at home. I am amazed at the resilience of these pregnant and parenting women. They and their families are determined to have healthy babies and raise a healthy family. And there are many ways we can help.

This brief from Voices for Ohio's Children outlines important Ohio efforts underway, including the Ohio Perinatal Quality Collaborative and the Ohio Collaborative to Prevent Infant Mortality. New money has been designated to bolster local and statewide maternal and child health programs. Ohio State Senators Shannon Jones and Charleta Tavares have traveled the state highlighting this issue. They have also introduced bills to expand resources to address infant mortality. But more local involvement is needed. Everyone can do their part from volunteering at a food pantry and making sure pregnant and parenting women are given priority, to helping assure these women have safe housing and transportation. Please join Voices for Ohio's Children and others who are working to make a positive difference in the lives of Ohio infants and families.

Patricia Temple Gabbe, MD MPH
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The Ohio State University
and Nationwide Children's Hospital,
Founder/Director of Moms2B

THIS REPORT OUTLINES THE STRATEGIES KNOWN TO IMPROVE INFANT SURVIVAL

Introduction

Between 2006 and 2011, 6,737 children in Ohio died before reaching their first birthday.[i] Ohio's increasing infant mortality rate is an alarming trend that greatly impacts not only Ohio families but also our communities. While the national infant mortality rate continues to decline, Ohio's rate continues to grow accompanied by increasing disparities among population groups.

This brief looks at a number of ways in which we can tackle the high infant mortality rate in Ohio and eliminate existing disparities. Several important programs and initiatives have been highlighted. By reviewing successes that have been achieved, we bring attention to new strategies and opportunities for further progress in our goal of ensuring healthy children.

THERE ARE A NUMBER OF WAYS IN WHICH WE CAN TACKLE THE HIGH INFANT MORTALITY RATE IN OHIO AND ELIMINATE EXISTING DISPARITIES.

The Numbers

Infant mortality is defined as the death of a baby within their first years of life.[ii] Deaths occurring between birth and 27 days (neonatal period) account for approximately two thirds of all infant deaths, and deaths between 28 and 364 days (postneonatal period) account for the remaining third.[iii] Infant mortality rate (IMR) is measured as the number of deaths of children under the age of one per 1,000 live births.[iv]

International

According to the most recent data, the United States ranks 31 (out of 40) in infant mortality rates among Organisation for Economic Co-operation and Development (OECD) member countries.[v] This places the United States higher than the OECD average (4.3 in 2010) and higher than the IMR for other developed countries including the United Kingdom, Canada, Germany, Italy, and Japan.[vi] Between 1970 and 2010, the average rate of decline in IMR in the United States has been lower than the average for OECD member countries,[vii] meaning reduction in IMR has occurred at a slower rate in comparison to other member countries.

National

In 2011, the U.S. IMR was 6.05.[vii] Overall, the U.S. IMR has been declining over the past several decades. Between 1960 and 2000, the U.S. IMR declined by nearly 75% (from 26.0 to 6.91),[ix] and after a brief period of stagnation, declined an additional 12% between 2005 and 2011 (from 6.87 to 6.05).[x] This decline has been propelled by increased access to primary care, wider availability of neonatal care, and better nutrition.[xi] Over the next several years, the national rate is projected to continue to decline.[xii]

Even though this overall decline has been promising, alarming racial disparities continue to exist. Historically, the IMR for babies born to non-Hispanic black women has been twice that of non-Hispanic white women.[xiii] Babies born to American Indian or Alaska Native and Puerto Rican mothers have also historically experienced higher infant mortality rates.[xiv] Preliminary data for 2011 maintains these disparities, indicating a national infant mortality rate of 5.05 for infants of non-Hispanic white mothers, 11.42 for infants of African American mothers, and 5.27 for infants of Hispanic mothers.[xv]

Ohio

While the U.S. as a whole has been making strides to lower the national IMR, Ohio continues to struggle. In 2010, the National Center for Health Statistics ranked Ohio as the 5th worst in the United States for infant mortality, ranked 47 out of 53 which include states and territories[xvi] and recently, Cleveland was designated the "infant mortality capital" of the United States.[xvii]

In 2011, Ohio's overall infant mortality rate was 7.87 (compared to the U.S. IMR of 6.05),[xviii] resulting in 1,086 infant deaths during the year.[xix] This rate is slightly higher than the rate for 2010 (7.68), but has remained close to 7.7 for the past 5 years of recorded data.[xx] While the national IMR is projected to decline over the next several years, Ohio's IMR is projected to rise.[xxi]

Mirroring national level trends, Ohio is experiencing large disparities in infant mortality rates among population groups. The National Center for Health Statistics has ranked Ohio the 2nd worst in the nation for infant mortality rates among African American children.[xxii] In 2011, the IMR for infants of white mothers was 6.41[xxiii] and 6.8 for infants of Hispanic mothers.[xxiv] In comparison, the IMR for infants of African American mothers was more than double that of either white or Hispanic mothers, measuring 15.96.[xxv]

Responding to the Numbers

In response to the ongoing concern for the high U.S. IMR, in 2010 the reduction of the IMR was listed as one of the objectives of Healthy People 2020—a 10-year health agenda launched by the U.S. Department of Health and Human Services. Healthy People 2020 establishes a national goal to reduce the U.S. IMR to 6.0 by 2020. In light of the ongoing decline in the U.S. IMR, the Secretary's Advisory Committee on Infant Mortality (SACIM) believes that the objectives should be adjusted, and recommends a target IMR of 5.5 by 2015 and 4.5 by 2020.[xxvi]

Societal Impact

Besides being an extremely troubling marker for maternal and infant health, a high infant mortality rate also signals an even greater societal concern. Factors that affect the health of the entire population can also affect the health of infants. Consequently, the infant mortality rate is often used as an important indicator of the overall health of a society,[xxvii] "reflecting a society's commitment to the provision of: high quality health care, adequate food and good nutrition, safe and stable housing, a healthy psychosocial and physical environment, and sufficient income to prevent impoverishment." [xxviii]

Parents and families experience a wide range of emotional reactions from the trauma of losing a child. These psychological reactions include depression, anxiety, disassociation, and anger and may exist for months or years following the loss of their child.[xxix] In addition to the immediate and devastating effects an infant's death has on parents and family, society is also economically affected by infant mortality and its leading causes, primarily preterm birth. In 2005, the Institute of Medicine estimated the annual societal economic burden associated with preterm birth in the United States to be in excess of $26 billion.[xxx] This number includes medical and educational costs, as well as lost household and labor market productivity.[xxxi]

In Ohio, health care costs during the first year of an infant's life (including medical costs for newborns born with complications, longer average impatient stays, and complicated deliveries)[xxii] are 10 times higher for preterm than full term infants: $38,438 versus $3,953, respectively.[xxiii] Consequently, prematurity costs Ohio $1 billion per year. For many low-income families, these costs are unfeasible. As a result, Medicaid and, in turn, Ohio taxpayers must bear a heavy cost burden, covering approximately 40% of Ohio's births.[xxxiv] For Ohio employers, direct health care costs for premature infants during the first year of life average $46,004.[xxxv]

IN THE FIRST YEAR, HEALTH CARE COSTS ARE 10 TIMES HIGHER FOR PRETERM THAN FULL TERM INFANTS.

Leading Causes & Underlying Factors

THE TOP FIVE LEADING CAUSES OF DEATH IN ORDER: CONGENITAL MALFORMATIONS, PREMATURE/LOW BIRTH WEIGHT, SUDDEN INFANT DEATH SYNDROME (SIDS), MATERNAL COMPLICATIONS OF PREGNANCY, AND ACCIDENTS.

IN OHIO THE LEADING CAUSES OF INFANT MORTALITY INCLUDE:

1... Premature birth and low birth weight
2... Serious birth defects
3... Sudden Infant Death Syndrome (SIDS)
4... Maternal complications in pregnancy
5... Injuries [xxxix]

FROM 2006 TO 2009, THESE FIVE CAUSES ACCOUNTED FOR 61% OF ALL INFANT DEATHS IN OHIO.[xl]

To best understand how to address the issue of infant mortality, we must first understand the causes. The most recent data indicates that the leading cause of infant death in the United States in 2011 was congenital malformations, including deformations and chromosomal abnormalities.[xxxvi] The remaining top five leading causes of death include, in order, disorders related to short gestation and low birth weight, sudden infant death syndrome (SIDS), maternal complications of pregnancy, and accidents.[xxxvii] Together these top five causes accounted for 56% of all infant deaths in the United States.[xxxviii]

In addition to medical causes, there are a number of behavioral and demographic factors that have been shown to influence pregnancy health outcomes and correlate with higher rates of infant mortality. These factors include maternal age, low socioeconomic status, under-education, race, and preconception health.[xli] Recent efforts have been made to account for many of these factors—particularly race and lower socioeconomic status—and the role they play in an individual's life as social determinants of overall health. These different factors result in multiple exposures over a person's lifetime, and when balanced against available health resources, may translate into health and birth outcome inequity.[xlii] To eliminate these disparities, a life course perspective has been encouraged and adopted at both the national and state level.[xliii]

Tackling Infant Mortality

In January 2013, the Secretary's Advisory Committee on Infant Mortality (SACIM) provided a number of recommendations to the U.S. Department of Health and Human Services, providing a framework for a national strategy to reduce infant mortality.[xliv] SACIM acknowledged breastfeeding, family planning, smoking cessation, immunization, and safe sleep as proven and effective interventions for reducing infant mortality.[xlv] The Committee also provided the following strategic directions:

1. **Improve** the health of women before during, and beyond pregnancy;
2. **Ensure** access to a continuum of safe and high-quality, patient-centered care;
3. **Redeploy** key evidence-based, highly effective preventive interventions to a new generation of families;
4. **Increase** health equity and reduce disparities by targeting social determinants of health through both investments in high-risk, under-resourced communities and major initiatives to address poverty;
5. **Invest** in adequate data, monitoring, and surveillance systems to measure access, quality, and outcomes; and
6. **Maximize** the potential of interagency, public-private, and multi-disciplinary collaboration.[xlvi]

The U.S. Department of Health and Human Services, Health Resources and Services Administration has also begun to build a Collaborative Improvement and Innovation Network (CoIIN). This network allows states to share best practices related to reducing infant mortality, receive information from national experts, and track progress.[xlvii] Ohio is a participating state in the Region V CoIIN.[xlviii]

Finally, the Association of Maternal and Child Health Programs analyzes current practices and programs, identifying emerging, promising and best practices through the United States that are related to reducing infant mortality rates.[xlix]

THE CoIIN ALLOWS STATES TO SHARE BEST PRACTICES RELATED TO REDUCING INFANT MORTALITY, RECEIVE INFORMATION FROM NATIONAL EXPERTS, AND TRACK PROGRESS.

What is Ohio Doing to Address Infant Mortality?

In early 2009, at the request of Governor Ted Strickland, the Ohio Department of Health established the Infant Mortality Task Force in order to reassess Ohio's overall infant mortality rate, examine disparities among different populations, and make short and long-term recommendations for reducing those disparities and Ohio's infant mortality rate in general.[l] In their final report, the Task Force provided 10 recommendations to reduce the infant mortality rate in Ohio, including increasing public awareness, developing comprehensive services for women and children, reducing preterm birth, and promoting equity.[li] In addition, the Task Force recommended the establishment of a consortium to implement and monitor the recommendations of the Ohio Infant Mortality Task Force. A consortium, the Ohio Collaborative to Prevent Infant Mortality, was established in 2010 and is presently organized into 5 workgroups addressing coordinated health care, disparities and racism, data quality improvement, education and outreach, and public policy.[lii]

Moving forward, Ohio has implemented a number of programs and collaborations to address the leading causes and contributing factors of infant mortality. Infant mortality is listed as a priority in Ohio's 2012-2014 state health improvement plan,[liii] with approximately $3.1 million allocated per year in the Fiscal Year 2014-2015 state budget for initiatives addressing the largest contributing factors to infant mortality: safe sleep practices, smoking cessation for pregnant women, and increased progesterone use.[liv] Altogether, a total of $6,233,376 in General Revenue Funds was allocated in the FY 2014-2015 budget for these three programs under the Infant Vitality line item (GRF 440474).

Premature Birth and Low Birth Weight

Prematurity ranks as the number one cause of infant death in Ohio.[lv] One out of every eight babies born in Ohio, more than 15,000 a year, is born before 37 weeks of gestational age, qualifying as preterm.[lvi] In 2011, 12.7% of infants born in Ohio were preterm, compared to 11.7% at the national level.[lvii] In the same year, Ohio ranked 15th in the nation for low birth-weight, with 8.1% of infants weighing less than 2,500 grams (5.5 lb.) at the time of birth.[lviii] In addressing the issue of premature birth, Ohio has accepted the Association of State and Territorial Health Official's (ASTHO) President's Challenge, the Healthy Babies Initiative, to decrease prematurity by 8 percent by 2014.[lix]

Some factors that have been associated with preterm birth include low or high maternal age, low socioeconomic status, history of preterm births, infection, high blood pressure during pregnancy, race, late prenatal care, stress, tobacco and alcohol use, substance abuse, back-to-back pregnancies, and early induced labor.[lx]

In 2007, the Ohio Perinatal Quality Collaborative (OPQC) was formed. This network of perinatal clinicians, hospitals, and state agencies have focused on preventing scheduled

EFFORTS TO REDUCE BLOODSTREAM INFECTIONS HAVE RESULTED IN A 20% DECREASE IN PREMATURE INFANTS AMONG 24 PARTICIPATING NEONATAL INTENSIVE CARE UNITS.

INFANT MORTALITY IS LISTED AS A PRIORITY IN OHIO'S 2012-2014 STATE HEALTH IMPROVEMENT PLAN.

births prior to 39 weeks of gestational age (39-week project), identifying and treating eligible women with the hormone supplement progesterone to delay labor[lxi] and reducing bloodstream infections. As a result of the 39-week project, from September 2008 to March 2013, 36,200 babies were delayed to 39-41 weeks.[lxii] This resulted in 950 fewer neonatal intensive care admissions, saving approximately $19 million in health care costs[lxiii] Supplemental progesterone has also been effective in delaying preterm birth.[lxiv] Efforts to reduce bloodstream infections have resulted in a 20% decrease in premature infants among 24 participating neonatal intensive care units.[lxv]

Decreasing premature birth and low birth weight continues to be a top priority. The FY 2014-2015 state budget provides $1,265,952 to "educate prenatal care providers so they can better identify, screen, treat and track outcomes for women eligible for progesterone supplementation in Ohio."[lxvi] Additionally, a new collaborative research program has been established between the March of Dimes and a number of Ohio universities and hospitals, aimed at identifying unknown causes of prematurity. March of Dimes will invest $10 million into the program over the course of 5 years.[lxvii]

SIDS and Sleep-Related Deaths

Every week in Ohio, more than 3 infant deaths are sleep-related, with suffocation the leading cause of injury-related death.[lxviii] Sleep-related deaths in general accounted for 14% of all infant deaths in Ohio in 2010, more than any other single cause except prematurity.[lxix] In Ohio, SIDS accounts for the majority of infant deaths after the 28th day of life.[lxx] To combat the prevalence of SIDS and sleep-related deaths, the Ohio Department of Health has implemented the Safe Sleep Campaign to educate parents and caregivers with a uniform message on safe sleep practices.[lxxi] Recommendations are based on the American Academy of Pediatrics' ABC recommendations–alone, on their back, in a crib. Additional sleep initiatives, such as the Safe to Sleep Campaign, are being incorporated into existing programs such as Help Me Grow and WIC.[lxxii] The FY 2014-2015 state budget allots $847,855 to the campaign, with $50,000 committed from the Ohio Children's Trust Fund, and $10,000 from the American Academy of Pediatrics.[lxxiii]

Congenital Malformations

Congenital anomalies are responsible for approximately 20% of infant deaths prior to 1 year of age. Of these deaths, 25% is attributable to critical congenital heart disease (CCHD).[lxxiv] Following the passage of Senate Bill 4 in 2013, CCHD will now be added to the list of required newborn screenings, with screening results being tracked by the Ohio Department of Health.[lxxv]

Smoking Cessation and Drug Use

In the United States, 5-8% of preterm deliveries, 13-19% of low birth-weight deliveries, 23-34 % of SIDS, and 5-7% of preterm-related deaths can be attributed to smoking during pregnancy.[lxxvi] In Ohio, the percent of women who have smoked during pregnancy (19.2%) is double the national average (9.3%).[lxxvii] Additionally, women covered by Medicaid insurance are more likely to smoke before and during their pregnancies, compared to women without Medicaid insurance.[lxxviii] As part of the 2014-2015 state budget, lawmakers allocated $1,002,981 each year to implement the 5 A's smoking cessation tactic (Ask, Advise, Assess, Assist, and

Arrange), a program developed and tested by experts at the Agency on Healthcare Research and Quality.[lxxix] Currently, 14 Child and Family Health Services care sites and 13 Special Supplemental Nutrition Program for Women, Infant, and Children sites across the state have implemented the 5 A's program.[lxxx]

Racial Disparities

As discussed above, the large racial disparities in birth outcomes remains a problem for Ohio. Racial disparities in IMR are higher in all Region V states (Ohio, Indiana, Michigan, Minnesota, and Wisconsin) and may be attributed to higher preterm births.[lxxxi] These disparities may also be attributed to various social determinants of health (such as poverty).[lxxxii] In early 2013, CityMatCH and the Ohio Department of Health announced a new 3-year collaborative, the Ohio Institute for Equity in Birth Outcomes, to evaluate and implement initiatives to address inequalities in birth outcomes.[lxxxiii] As part of the collaboration, teams will engage in 2 local equity projects: one employing upstream strategies (strategies targeting larger social solutions to address the root causes of health inequities, such as education, housing, labor, etc.), and another employing downstream strategies (targeting more specific clinical interventions, including family planning, safe sleep, maternal stress prevention, etc.).[lxxxiv]

OHIO SENATOR'S REFLECTION:

"Ohio's infant mortality rates are abysmal and are an indicator of our communities' overall health status. Our babies need voices and actions to ensure that they live beyond the age of one. We have a moral and ethical responsibility to eliminate infant deaths in Ohio and the even more disturbing disparities in deaths among African American babies. Our legislative, policy and funding efforts are aimed at making certain that all babies are born healthy and safe."

SEN. CHARLETA TAVARES (D-COLUMBUS)

IN OHIO, THE PERCENTAGE OF WOMEN WHO HAVE SMOKED DURING PREGNANCY (19.2%) IS DOUBLE THE NATIONAL AVERAGE (9.3%).

Recent Legislation

Recognizing the need for a comprehensive, statewide effort to address Ohio's alarming infant mortality rate, in February 2014 State Senators Shannon Jones and Charleta Tavares introduced a package of legislation to reduce the number of infant deaths in the state. A total of five bills were introduced, each focusing on a particular part of the problem. The legislation was inspired by a 2013 statewide tour of the Senate Standing Committee on Medicaid, Health, and Human Services, aimed at better understanding the infant mortality problem and the needs associated with it across the state.[lxxxv] In addition to the five bills, Senators Jones and Tavares jointly sponsored Senate Bill 198, which designates each October as "Sudden Infant Death Syndrome Awareness Month." The five bills are summarized below.[lxxxvi]

SENATE BILL 276:
Improving Safe Sleep Education

This bill would require the Ohio Department of Health to establish the Safe Sleep Education Program, and distribute materials to all entities currently required to provide Shaken Baby Syndrome materials to parents.[lxxxvii] It would also require all birthing hospitals, maternity units, and freestanding birthing centers to screen for a safe sleep environment available to an infant prior to discharge.

SENATE BILL 277:
Infant Mortality Commission

This bill would establish a 13-member commission to inventory state services, resources, and their funding streams available to address Ohio's high rate of infant deaths.[lxxxviii]

SENATE BILL 278:
Death Scene Investigation

This bill would require the use of the Sudden Unexplained Infant Death Incident (SUIDI) Reporting Form (designed by the US Centers for Disease Control and Prevention) whenever a child one year of age or younger dies suddenly when in otherwise apparent good health.[lxxxix] The bill also requires a copy of the form to be sent to the appropriate child fatality review board or regional child fatality review board for uniform, comprehensive data collection and reporting.

SENATE BILL 279:
Federally Qualified Health Center Pilot Project

This bill would establish a two-year pilot program using the "Centering Pregnancy" model developed by the Centering Healthcare Institute to improve birth outcomes.[xc] Four pilot programs will be implemented across the state in FQHCs or FQHC look-alikes—two in rural areas and two in urban areas. The goals of the pilot program include decreasing the number of infants born preterm and/or low-birth weight, increasing the number of pregnant women who begin prenatal care, stop smoking, and are screened for depression, HIV, diabetes, and poor oral health, and increasing the number of women who breastfeed. The Ohio Association of Community Health Centers will help ODH with the pilot program's implementation. The bill also appropriates $500,000 in Fiscal Years 2015 and 2016 for the pilot program.

SENATE BILL 280:
Postpartum Care & Reimbursement for Non-Medical Services

This bill would require case management services for postpartum care to be included in the Medicaid managed care system, and earmarks $25 million from Medicaid savings to be granted by ODH for community-based services not covered by Medicaid and intended to reduce infant mortality.[xci]

Conclusion

Following the establishment of the Infant Mortality Task Force in 2009, Ohio has made a number of important moves in realizing the imperative goal of lowering Ohio's IMR. However, for the sake of infants, families, and our communities, more progress is needed. By focusing our attention and resources to programs and initiatives that address the leading causes of infant mortality, and encouraging collaborations beyond the health and medical sectors, we can work to reverse Ohio's devastating IMR trend. Through adoption of a life course perspective—taking into account the various behavioral and demographic factors that can impact health and birth outcome inequity—we may be better able to contemplate and implement solutions to reduce disparities in birth outcomes. The result of these efforts is healthier children, and consequently, a healthier society.

OHIO SENATOR'S REFLECTION:

"Right now, Ohio is coming in nearly last in the nation for infant mortality, which is an unacceptable standard. We lose too many babies in Ohio before they reach their first birthday and many of these cases can be prevented with proper training and education."

SEN. SHANNON JONES (R-SPRINGBORO)

HEALTHIER CHILDREN = A HEALTHIER SOCIETY

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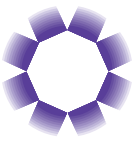

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