American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
MARYLAND CHAPTER
Speaking for Maryland Kids!
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Susan Chaitovitz MD, FAAP

President's Corner

About 2 years ago, the national AAP added child poverty as a top strategic priority. Based on data that living in poverty has a significant impact on a child's current and future health, the AAP took on the challenge of finding ways to minimize poverty and to mitigate its effects on children.

While this is a worthy aim and addresses the roots of many of the problems that pediatricians see daily in their practices, it feels overwhelming to figure out how pediatricians can address this issue. The Maryland chapter has been grappling with this for about a year and a half. We recognize that we need to work on many levels – individual patients, families, communities and state policies. Currently, we have a workgroup, under the leadership of our Emotional Health Committee, which is developing a parenting program targeting low-income, high-risk families that will promote resiliency through positive relationships. We a have a second group, chaired by Kate Connor, that is developing an office-based model to screen families for poverty-related needs and coordinate referrals in their communities. As always, our chapter continues to monitor relevant legislation in Annapolis and advocate for appropriate resources to support children and their families.

As practicing pediatricians, we recognize the impact that poverty has on children, but it is easy to become overwhelmed with the needs of our patients and literally, not know where to start in our attempts to support them. In November, 2015, the American Academy of Pediatrics published a policy statement entitled "Promoting Food Security for All Children." I think that this statement provides concrete first steps that pediatricians can incorporate into their practices to start helping families who are struggling and to open the dialogue with families about their challenges.

According to this policy statement, 21% of all children in the United States are living in homes that have food insecurity, defined as a household in which "access to adequate food is limited by lack of money or other resources." Food insecurity is linked to obesity, low cognitive performance, dysregulated behavior and emotional distress. The statement concludes by recommending some basic actions that we can take to address this with our patients and in our communities.

First, we need to screen all patients for food security. Research has shown that asking two questions reveals food insecurity with a sensitivity of 97% and specificity of 98%. Those questions are:

1. Within the last 12 months, we have worried whether our food would run out before we got money to buy more. Y/N

2. Within the last 12 month, the food we bought just didn't last and we didn't have money to get more. Y/N

Once we have identified which families in our practices have food insecurity, we need to identify community and government resources that are available to support our patients. Every pediatrician should know about programs like Women, Infants and Children (WIC), Supplemental Nutrition and Assistance Program (SNAP –

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President's Corner *continued from page 1*

formerly called food stamps), free and reduced-price school meals, and the summer food service program. We should also be aware of and refer to local food banks and soup kitchens. The Maryland Food Bank website, www.mdfoodbank.org, allows you to enter a zip code to find the nearest food bank.

On a community level, we need to advocate to continue and perhaps expand current programs, paying attention especially to the food quality. Organizations like Maryland Hunger Solutions, www.marylandhungersolutions.org, offer help in starting or expanding nutrition programs in your community and advocate for hunger-related issues in the state.

My New Year's Challenge to Maryland pediatricans: this year, ask patients about food insecurity and learn where your local food banks are. It is an easy first step toward addressing our patients underlying needs.

Message from the Executive Director

Paula K. Minsk, CFRE

2015 was a great year for the Maryland Chapter, and I am sort of sorry to see it go. The greatest highlight for me was that we won the Large Chapter of the Year award from national AAP last March at the Annual Leadership Forum in Chicago. We had been a finalist for a number of years and we finally clinched the title! (A baseball metaphor, for those who know me!)

Among our other accomplishments was the completion of the Race to the Top Early Learning Challenge, which was completed on December 31, 2015. Unfortunately, we had to say good-bye to our Grant Manager, Lynne Peters. For those of you who worked with her, you know about her professionalism, her passion for the project and her accomplishments. We completed the grant with the ability to send books out to most of our "expansion" sites to help give them time to find resources to continue the project without the grant support. Lynne posted on the ROR page, hosted on the MDAAP website, a full guide to sustainability which provides guidance to practices seeking the funding to continue the program. Lynne will be greatly missed, and we wish her the best of luck as she moves out-of-state.

We obtained some funding to continue the project for Baltimore City and Baltimore County, and we will, of course, continue the ROR mini-grants, which are funded through donations from our members to the MDAAP Foundation, led by Dr. Scott Krugman. More information about eligibility and applications will soon be sent to practices to which this applies.

Other areas of success for MDAAP in 2015 include successful quality improvement projects in the areas of obesity, autism spectrum disorders and epilepsy. We held many CME programs for members in conjunction with a number of statewide partners, and we have received grant funds for a transitions workshop this coming May 3 in Columbia. We were fortunate to receive grant funding from DHMH for a pilot ACES project, and we are waiting on the results of another application to DHMH for another project that will benefit the training needs of our members.

The bottom line for 2015 is simply this: MDAAP is here for our members. We have a large variety of committees which meet regularly and tackle some of the most important pediatric issues in our state and nationwide. If you have the time and/or the interest to get involved, please let me or Dr. Susan Chaitovitz, our president, know, and we'd be happy to make the connection for you to get active and be involved. This is your chapter--help us help you to provide the best for Maryland's kids.

My best wishes for a wonderful, happy and healthy New Year.

FINAL REPORT:
Heroin and Opioid Emergency Task Force

The Task Force divided its recommendations into seven areas: 1) Expanding Access to Treatment; 2) Enhancing Quality of Care; 3) Boosting Overdose Prevention Efforts; 4) Escalating Law Enforcement Options; 5) Reentry and Alternatives to Incarceration; 6) Promoting Educational Tools for Youth, Parents and School Officials; and 7) Improving State Support Services. Below are specific recommendations under each topic, highlighting when the recommendation focuses on the need for legislation or an action by a State agency.

It should be noted that prior to the discussion in the report on the recommendations, there is a statement that various stakeholders will be brought together, such as DHMH, local hospitals, skilled nursing facilities and law enforcement to develop a pilot program that establishes a full continuum of substance-use disorder services in a target area, including leveraging space in various health care facilities to provide care, residence and treatment for heroin and opioid use disorders.

EXPANDING ACCESS TO TREATMENT

Page 5:

1. Behavioral Health Administration (BHA) should hire a project coordinator and convene a steering committee of internal and external experts, including individuals involved in development of existing model strategies, to advise and plan development for the implementation of a Statewide Buprenorphine Access Expansion Program.

Page 6:

1. Department of Health and Mental Hygiene (DHMH) should review the substance abuse reimbursement rates every three years.
2. Legislation to require that the allowed amount a carrier uses to pay benefits to non-contracting providers be not less than 140% of the allowed Medicare amount. Applies only when the provider network is inadequate, not when patient voluntarily goes-out-of-network.
3. Legislation to require carriers to provide prospective enrollees with a list of providers for the enrollee's health benefit plan. List must be accurate upon publication and annually.

Page 7:

1. DHMH should expand access to training for certified peer recovery specialists by facilitating the travel of individuals who have completed the nationally recognized Connecticut Community for Addiction Recovery trainer of trainers (TOT) modules to Maryland to provide recovery coaching TOT modules for trainees to meet Maryland's certified peer recovery credentialing requirements.
2. BHA should develop a pilot to provide recovery support specialists to assist pregnant women with substance-use disorders in three targeted jurisdictions (not identified) with the highest rates of prenatal substance abuse.

Page 8:

1. Department of Public Safety and Correctional Services (DPSCS) should create a transition process allowing inmates leaving incarceration with known substance use disorders to be engaged with community resource providers. "All offenders should have made successful application for health insurance and have requisite medical, mental health and addictions appointments scheduled prior to release."
2. Maryland Higher Education Commission (MHEC) should develop strategies to incentivize colleges and universities to create collegiate recovery programs, which is a supportive environment within the campus culture that reinforces the decision to disengage from addictive behavior.

ENHANCING QUALITY OF CARE

Page 9:

1. Legislation to require mandatory registration and query of the Prescription Drug Monitoring Program (PDMP) when prescribing or dispensing controlled substances that contain an opioid or a benzodiazepine.
   - Initially begin with mandatory registration.
   - Goal of implementing a use mandate of the system within 2 years of the legislation's effective date (must conform to DHMH's estimated dates for when the PDMP's information technology and administrative capacity can be enhanced to support it).
   - Consideration should be given to tying the registration mandate to initial receipt or renewal of the CDS permit.
   - Use mandate should apply when prescribing or dispensing a drug to a patient for the first time to treat a specific condition and then at regular intervals after

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the initial query if treatment includes the use of an opioid and/or benzodiazepine.

- Legislation should provide for exceptions to the use mandate :
  - PDMP is unavailable for query due to technical problems;
  - In emergency situations, where accessing the PDMP would adversely impact a patient's medical condition;
  - In clinical situations that present a relatively low risk of drug misuse or diversion due to patients seeking drugs from multiple providers, including prescribing and dispensing to patients who are in hospice care, being treated for cancer-related pain or residing in nursing facilities and other facilities often served by a single dispenser.
- Legislation should also expand the types of clinical support staff that prescribers can delegate to access PDMP on their behalf to include unlicensed staff like medical assistants and emergency room scribes.

** Report describes the issues between CRISP and EMRs being separate and comments that the creation of a single sign-on connection between CRISP and a provider's EMR would ease the time and IT burden on clinical providers; however, the report falls short of any recommendation in this area.

Page 11:

Legislation authorizing any county in Maryland to establish an Opioid-Associated Disease Prevention and Outreach Program to provide outreach, education and linkage to treatment services, including the exchange of sterile syringes (only authorized in Prince George's and Baltimore City at present).

Page 13:

1. DHMH should select accepted performance measures and begin publishing provider-specific, regional and statewide performance data collected from providers and systems.
2. The Boards of Podiatry, Nursing and Pharmacy should require licensees to complete one credit hour of continuing education related to opioid prescribing.
3. Regulations to require some form of medication monitoring for Medicaid enrollees who are being prescribed certain opioids for more than 90 days for chronic pain arising from their conditions that are not terminal. This requirement would exclude cancer patients and others that may include hardship on the patient in certain cases. Report highlights Ameritox, which is a provider of medication monitoring. Ameritox reported that 48% of samples in Maryland contained a drug not prescribed by the doctor who ordered the screen, which is the second worst rate in the country, according to Ameritox.

BOOSTING OVERDOSE PREVENTION EFFORTS

Page 15:

1. BHA should contract with a web developer to create an online overdose response program-compliant training module to increase the number of certified trainees.
   - BHA should also track identifying information about trainees.
   - DHMH should identify a staff physician to issue a statewide order for dispensing to ORP certificate holders by licensed pharmacists (SB 526 of 2015), and then work together to develop a standing protocol requiring the pharmacists provide hands-on instruction to certificate holders on how to assemble and use the specific naloxone delivery device.
2. BHA should also develop a process to track naloxone dispensing through the PDMP.
3. DHMH, in consultation with the Maryland Chapter of the National Council on Alcohol and Drug Dependence and family advocacy organizations, should contract with a PR firm to develop a comprehensive media campaign to raise awareness of the Good Samaritan law in geographic overdose hotspots.

ESCALATING LAW ENFORCEMENT OPTIONS

Page 16:

1. Enactment of a state RICO law to prosecute those who engage in a pattern of wrongdoing as a member of a criminal enterprise.

Page 17:

1. Legislation to create a felony crime for the direct or indirect distribution of heroin or fentanyl, the use of which contributes to the fatal or nonfatal overdose of another. Legislation should establish a complete immunity for a person if evidence of the crime was solely obtained as a result of the person's seeking, assisting or providing medical assistance.

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Page 18:

1. Creation of a multi-jurisdictional Maryland State Police Heroin Investigation Unit.
2. Require all Maryland State Police heroin and opioid investigative activities be entered into Case Explorer.

Page 19:

1. Allow the Maryland State Police to negotiate the inclusion of inspectors from various parcel services (US Postal Service) into existing State Police parcel interdiction units as task force members.
2. DPSCS should examine their current Front Entry Search policy and procedures to determine whether they align with national best practices and, if necessary, modify them in order to assist in eliminating the introduction of contraband into all correctional facilities, as well as identifying ways to impose gradual disciplinary measures against correctional officers whose improper conduct enables the smuggling of contraband and illegal substances.

REENTRY AND ALTERNATIVES TO INCARCERATION

Page 20:

1. DPSCS and Governor's Office of Crime, Control and Prevention (GOCCP) should collaborate with the Maryland Judiciary to establish a day report center pilot program, which is a non-residential, on-site wrap-around service.
2. DPSCS should expand the Segregation Addictions Program, which is housed at the Maryland Correctional Training Center, to try to meet demand. No reference in the report to the exact "need" projections, but recommended adding three additional substance use counselors.

Page 21:

1. Legislation to develop a swift and certain sanctions grid for nonviolent offenders released on probation and parole whose offenses relate to their substance use disorder.
2. The GOCCP should incorporate a new goal into Safe Streets that will allow the local Safe Streets coalition to leverage appropriate resources to address the issue of violent crime related to drug trafficking, substance use, and addiction, with a focus on heroin and opioids. At the same time, peer recovery specialists should be incorporated into the Safe Street model. These specialists are those individuals who are in recovery or have life experiences from any life-altering events or disruption, and are willing to assist others who are in the recovery process .

Page 22:

1. DPSCS should establish a pilot Recovery Unit at Eastern Correctional Institution to house offenders who are engaged in drug programming and are invested in recovery. DPSCS should identify and train offenders with significant incarceration periods to work as peer mentors in this unit.
2. GOCCP should conduct a study of Maryland laws and regulations that establish "Collateral Consequences" of a criminal conviction. Study should identify those restrictions that appear overbroad and serve as unnecessary barriers to employment of ex-offenders.

PROMOTING EDUCATIONAL TOOLS FOR YOUTH, PARENTS AND SCHOOL OFFICIALS

Page 23:

1. Maryland State Department of Education (MSDE) should assist local school board in the development and promotion of a drug education and information segment on the school websites.

Page 24:

1. MSDE should assist school staff on training on the disease of addiction and signs that a student is abusing heroin and opioids. Information should be given out at school functions, especially pertaining to a sports injury.
2. MSDE should promote "refusal skills" in their curricula to help students resist peer pressure while maintaining self-respect.

Page 25:

1. MSDE should evaluate the success of the Frederick County Student-Based Film Festival and consider replicating it and incorporate a "social norm" theme that not everyone uses drugs.

IMPROVING STATE SUPPORT SERVICES

Page 25:

1. Department of Juvenile Services (DJS) should develop a questionnaire to be used during the Maryland Comprehensive Assessment and Service Planning assessment that will be specifically designed to guide DJS staff in a productive discussion with the youth and parent regarding opiates. Likewise, DHR should implement a comprehensive screening tool to identify clients and families affected by heroin and opioid use. If customers are found to be at risk, a more detailed assessment would be given and if determined at-risk, the customer would be referred to the appropriate resources.

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Page 26:

1. A Center of Excellence for Prevention and Treatment should be established under the Behavioral Health Advisory Council, but housed in an academic institution to serve as the main body to provide critical oversight or a unifying strategy and accountability for all prevention and treatment programming across the State.

Following the final recommendations, the report outlines the following:

Page 28:
Provides information on the nine grants awarded through the GOCCP aimed at tackling the opioid and heroin crisis – grants given in Allegany, Carroll, Charles, Howard, St. Mary's, Montgomery, Somerset Counties and Baltimore City.

Page 31:
Provides information on the $500,000 grant awarded by GOCCP for Medication Assisted Treatment reentry programs in nine counties, which focuses on the use of Vivitrol and extensive behavioral health counseling. As of November 4, 2015, approximately 304 clients have been evaluated and 61 accepted into the various programs. Twenty-one injections have been given in the detention centers and six injections I the community.

Page 33:
Provides a status report on items included in the Task Force's interim report.

- Pages 33-35: Outlines educational efforts by MSDE.
- Page 35: States that all 47 Maryland hospitals have committed to adopting and working with emergency medicine personnel and their staffs to implement the Maryland Emergency Department Opioid Prescribing Guidelines. Periodic updates will be provided by the hospitals to the Maryland Hospital Association on the progress of implementation. MHA is also committed to working with the Maryland College of Emergency Physicians to convene a meeting in the spring to discuss voluntary utilization of Maryland's PDMP and education and training needs for providers and patients.
- Page 35: Maryland State Police have begun facilitating trainings on the Good Samaritan Law and have developed a help card with the number of the newly created crisis hotline in Maryland.
- Page 35: The Governor's Office of Community Initiatives Interfaith Coordinator has identified at least 20 different facilities in Baltimore City and the in the Counties of Anne Arundel, Allegany, Calvert, Caroline, Carroll, Cecil, Charles, Frederick, Harford and Montgomery for inclusion in its database of faith-based organizations that provide addiction treatment services.
- Page 36: Maryland observed its first Overdose Awareness Week between August 30th and September 5, 2015.
- Pages 38-41: Detail additional monies given for treatment and awareness projects. Monies provided to:
- A.F. Whitsitt Center for expansion.
- 20 jurisdictions to support naloxone training and distribution under the Overdose Response Program.
- Behavioral Health Systems Baltimore to develop and implement specialized training and protocols for peer support specialists to conduct outreach to overdose survivors and linking them with treatment and recovery support services.
- Charles, Calvert and St. Mary's Counties for the implementation of a pilot overdose education and naloxone distribution program for at-risk individuals leaving incarceration.
- Anne Arundel County to expand supportive recovery housing for women with children (Chrysalis House)
- Behavioral Health Systems Baltimore to provide residential detoxification services with childcare services on site in Baltimore City.
- BHA working with the University of Maryland School of Pharmacy on the development of clinical guidelines for primary care practitioners that address, first, when opioid prescribing is or is not appropriate, and second, how to mitigate the risks of opioid prescribing, should it be initiated. Goal is to begin development process, in consultation with subject matter experts and stakeholders, in December, 2015.
- Dorchester County to replace outdated mobile data terminal and overtime for additional investigations.
- Maryland State Police Gain/Heroin Disruption Project.
- Ocean City Police for installation and implementation of license plate reader technology.

Just $25 Can Change a Child's Ability to Succeed

By: Lynne Peters, Grant Manager

"One of the greatest gifts we can give a child is the ability to read." As pediatricians, you have seen the reality of this quote. That is why there are over 130 practices in Maryland who have incorporated the Reach Out and Read program into their well visits for children between the ages of 6 months and 5 years. Reach Out and Read (ROR) is a national, non-profit organization that promotes early literacy by making books a routine part of pediatric care. ROR trains doctors and nurses to advise parents about the importance of reading aloud to their children. The program also gives new books to children at well visit check-ups from six months to five years. By building on the unique relationship between parents and medical providers, ROR helps families and communities encourage early literacy skills so children enter school prepared for success in reading.

The Reach Out and Read program has been scientifically proven to improve children's receptive language scores, and parents who have children in this program are more likely to read to their children at home. To date, fifteen peer-reviewed research studies have been published on how the Reach Out and Read program improves early literacy skills in children between 6 months and five years.

Research is also being done on what impact certain stimuli have on a child's developing brain. The most recent research, published online August 3, 2015 in the journal *Pediatrics*, conducted by Dr. John Hutton and his team, showed that the more often children had story time at home, the more brain activity they showed while listening to stories in the research lab.

But research alone cannot show you the full impact the Reach Out and Read program has on both the patient and the provider. Below is how one provider, just starting out in her pediatric journey, sees the program.

How Reach Out and Read impacts my practice

"As a pediatrician, I take pride in bringing a smile to my patient's face. I love when I am able to walk into the exam room, ask my patient if he or she would like a new book and watch the smile creep across that child's face. Even better is when the child has learned that they are able to get a book at the pediatrician's office, and they ask you for their new book. I then enjoy walking hand-in-hand with my patient to the Reach Out and Read closet, where that child is able to pick out a brand new book. I get to watch as that child stares at the shiny new cover, flips through the glossy pages, or runs back to the exam room to show their mother or father the new gift they just received! I love to be able to sit in the exam room and assess the development of that child using the new book in their hands. I am able to point to the animal on the front of the book and ask them, "What animal is this?" or to the color of the ball and ask them, "What color is this?" I am able to assess their ability to make up stories and make pretend. I am able to make their visit to the pediatrician about more than immunizations, lab work, stethoscopes, otoscopes, ophthalmoscopes, heights and weights. I am able to make it interactive and fun. I'm able to bond with that child. I'm able to share the joys of reading. That is what makes Reach Out and Read such a special program. Being able to make a child smile over a book makes my job that much more rewarding."

Shannon A. Solt, D.O., Sinai Hospital of Baltimore
Pediatric Resident, PGY2

So what does this have to do with you? In order for the Reach Out and Read practices to supply new books for the almost 200,000 children reached, they need money to purchase the books. Even at $2.50 per book, it can cost anywhere from $500 to $20,000 per year depending on the size of the practice to sustain the Reach Out and Read program. The Foundation of the Maryland Chapter of the American Academy of Pediatrics provides "mini-grants" twice a year to assist practices in continuing their Reach Out and Read programs. To fund

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these mini-grants, we are asking our members to consider giving a donation to the Foundation. A donation of $25 will provide a practice with enough books to get one child through the entire program. To help "inspire" your generosity, you can help provide the following to young readers:

$50	Provides 20 new books and helps 20 families
$100	Provides 40 new books and helps 40 families
$100-$299	Provides between 40-120 new books for children
$300- $499	Provides six months of books to children at one small clinic
$500- $999	Provides one year of books to children at a small clinic
$1000- $2499	Provides six months of books to children at one large clinic

With your support last year, we were able to give out almost 7,300 books to children through the Reach Out and Read program. This year, we would like to raise enough funds to purchase 10,000 books.

To make a donation, please contact Paula Minsk, Executive Director, at 410-878-9702 or paula@mdaap.org.

For your convenience, we have included a donation form in this newsletter.

We are grateful for your support of this important project.

Pediatricians Needed for Service Trip to Honduras in June, 2016

We are seeking pediatricians to join us on a medical brigade to Honduras from Friday, June 17 to Saturday, June 25, 2016. The brigade is conducted by OCHO (Organization for Community Health Outreach) and has been traveling to the same village in Honduras for over 15 years. Our multidisciplinary group will see about 1500-2000 patients during the week providing primary care. We have also worked with the village to build a water treatment facility and have provided medical equipment for a new medical care center. We are currently in the process of raising funds to build a school and rehabilitation center for developmentally disabled children, which will be the only one of its kind in Honduras.

Please contact Ken Tellerman, M.D. if you are interested in participating or wish to learn more about our project.

OCHO is a non-profit organization established in Baltimore. You can learn more about our organization by visiting our website at OCHO.org

Ken Tellerman, MD, OCHO Medical Director (pediatrician)
Work: 410 243-8632 • email: ktpedmd@aol.com

Save the Date

Pediatric Council Meeting
Date: January 26th
Time: 4-6 pm
Location: MedChi

Residents Day
Date: January 28th
Time: 8 am-1 pm
Location: House Office Building

Leadership Council Meeting
Date: March 2nd
Time: 6-8:30 pm
Location: MedChi

FREE Transitioning Patients to Adult Care CME
Date: May 3rd
Time: 6-9 pm
Location: Wellness Center at HCGH

☐ **Yes, I want to support the Maryland Chapter, American Academy of Pediatrics Foundation in its work to support early literacy in our state.**

Your gift may be tax deductible to the fullest extent of the law.

Enclosed is my gift of $_____

☐ Check enclosed Please make your check out to: MDAAP FOUNDATION and return to MDAAP FOUNDATION- 1211 Cathedral Street, Baltimore, MD 21201

☐ Please charge my credit card ☐ Visa ☐ Mastercard

Name on card_____CVV no. (from back of card, 3 digits)_____

Card number_____ Exp Date._____

Signature_____

My name_____

Address_____

City, State & Zip_____

Email address_____

Questions? Please contact Paula Minsk, Exec Director at 410-878-9702

Have you ordered MDAAP Foundation gift cards for friends and family?

You may also call the MDAAP office (410-878-9702) to place your order for holiday cards on the phone.

Commentary: We can do more worldwide to stop preventable diseases

By Edisa Tokovic Padder
December 14, 2015

Reprinted from the Baltimore Sun/Howard County edition, December, 2015)

I am a pediatrician and a mother of three young children. During the summer months, our family of five traveled to India. Like any mom, I was worried about the luggage, car seats and kids not liking the spicy food when we got there, but on the second day of the trip, a mother brought an 18-month-old child with a fever, rash and "sick-looking eyes" for me to examine, and everything fell into perspective. The child had measles, which is a disease I have never seen as a U.S.-trained physician. I have been trained to save lives, but I felt helpless with a child who had contracted measles. This lovely boy was so sick that he could not stand on his own feet. In 2014, measles killed more than 300 people a day around the world, and yet it is a disease that can be prevented with a low-cost vaccine.

Recently, I saw a 9-year-old boy in my suburban Maryland office who moved from Gambia. His mom requested an urgent appointment, because he was not allowed to go to school since he had not received any immunizations, including the measles vaccine. From these examples, it is clear that whether you live in Laurel, Md., Delhi, India or Banjul, Gambia, vaccine-preventable illnesses should matter to all of us. We are all interconnected.

We can save lives by making vaccines available to all children everywhere. Currently, there is bipartisan legislation in Congress that would do just that, the Reach Every Mother and Child Act of 2015 (S. 1911/H.R. 3706). The bill, supported by the American Academy of Pediatrics, coordinates a U.S. government strategy to accelerate the reduction of preventable maternal, newborn and child deaths worldwide, helping the United States achieve its commitment to work with countries around the globe to end these preventable deaths by 2035.

The U.S. Agency for International Development leads the U.S. government's work in maternal, newborn and child health, and much progress has been made with the agency's efforts. In fact, both the rate and actual number of deaths of children under 5 years has fallen by half in just 25 years and, over the same time period, the number of measles deaths has fallen dramatically. Still, more can be done to ensure these efforts are coordinated and focused, delivering aid to vulnerable populations while monitoring progress and providing accountability.

As I write, Rep. Chris Van Hollen (D-MD-8) is the only member of the Maryland delegation to support the Reach Every Mother and Child Act. In the past, Sen. Benjamin Cardin (D-MD) has also demonstrated leadership on this issue. Currently, Rep. Van Hollen is among 33 bipartisan co-sponsors in the U.S. House of Representatives. The U.S. Senate version of the bill has five sponsors, including three Democrats and two Republicans. I am calling on the rest of the federal leaders in our state to follow Rep. Van Hollen's example and support this important legislation in order to save lives.

In this time of world crisis, where we are losing innocent lives at home and abroad, here is an opportunity for all of us to agree. Together, we can end preventable maternal, newborn and child deaths around the world within a generation – that is my message as we approach this year's holiday season, and that is the better world I want my kids to grow up in. What will your holiday message be?

Edisa Tokovic Padder is a community pediatrician in Columbia and Laurel, and an active member of the Maryland Chapter of American Academy of Pediatrics Section on Early Childhood. http://www.baltimoresun.com/news/maryland/howard/laurel/ph-ll-column-padder-20151214-story.html

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