ALA_MD Asthma Testimony - SB 180_1-17-23.pdf
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Position: FAV

American Lung Association Testimony Senate Bill 180
Education, Energy, and the Environment Committee
January 17, 2024
Support

Chair Feldman, Vice-Chair Kagan and Members of the Committee:

Thank you for the opportunity to provide comments on Senate Bill 180, Public and Nonpublic Schools – Auto-Injectable Epinephrine and Bronchodilators – Use, Availability, Training and Polices sponsored by Senator Fry Hester. The American Lung Association ***strongly supports*** this bill as originally drafted as it will allow schools in Maryland to provide more immediate access to medications for students with asthma or suffering from respiratory distress. Asthma can be a deadly disease if flare-ups are not treated immediately, this bill has the potential to save lives and keep kids safe in schools.

The American Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease, through research, education and advocacy. The work of the American Lung Association is focused on four strategic imperatives: to defeat lung cancer; to improve the air we breathe; to reduce the burden of lung disease on individuals and their families; and to eliminate tobacco use and tobacco-related diseases.

Asthma impacts millions of lives and has a tremendous impact on our nation's healthcare system and economy. In the U.S., close to 25 million Americans, including 5.5 million children have asthma. In Maryland, approximately 93,000 children have asthma. Asthma is also responsible for more than $50 billion annually in healthcare costs and causes 7.9 million missed school days and 10.1 million missed days of work nationwide.

Because asthma attacks can occur at any time and often without warning, children with asthma should always have access to medication that can quickly reverse the blockages in their lungs. This life-saving medication, called a short-acting bronchodilator, is easy to administer, inexpensive, and very safe.

Unfortunately, when children do not have asthma medication, which can occur for a variety of reasons such as forgetting it or not being able to afford it, schools have few options. A parent may not be immediately accessible or close enough to respond promptly. Even if they can, there is a delay during which the asthma attack often gets worse. In such cases, the school must call 911. Doing so is likely to lead to an ambulance transport costing $500 or more and an emergency department visit costing thousands more. Such events also take children out of the classroom for days at a time and further impede their learning.

These adverse events are largely avoidable with a simple low-cost solution: stock medication or inhalers. Schools can purchase a single inhaler containing a short-acting bronchodilator along with inexpensive disposable spacers that can be used for **anyone** who experiences the sudden onset of cough, shortness-of-breath, and chest tightness that signals an asthma attack.

It is critical as outlined in the proposed legislation that school staff other than school nurses are trained in the signs and symptoms of asthma and when it is appropriate to administer the rescue medications. In Maryland there is not a school nurse present in every school building and while we recognize that is a significant need, we believe that because of **the safety of the medication used and the life-threatening implications of an asthma attack it is imperative that we train other staff to assess, access and administer the required medication** that would potentially save a student's life.

SB 180 also provides the important liability protections for the prescriber, the school and the person who administers the medication in good faith. As we mentioned the medication used for treatment of asthma attacks is safe and effective. As part of a research project in the Sunnyside Unified School District in Tucson, Arizona that evaluated the stock inhaler project, researchers found that school nurses were afraid that giving the medication could potentially expose them to liability, so it is imperative that the liability protections as outlined in the bill remain.

SB 180 is critically important as it allows schools to maintain a stock supply of asthma medication for student use when medication is otherwise unavailable. It represents a simple and low-cost solution to a problem that could save both lives and money. In total, 18 states have passed legislation or have administrative guidelines in place allowing schools to stock asthma medications. However, there are key provisions that should be included in this legislation to ensure it will as effective as possible which are included in SB 180. These include:

- Making sure the legislation applies to all public and nonpublic schools.
- Applying the legislation to both students who have been diagnosed **with asthma and students suffering from respiratory distress** that may not have been diagnosed yet as many kids with asthma are not diagnosed until after their first attack.
- Ensuring that school staff other than school health officials are required to be properly trained in the proper use and administration of the stock asthma medication.
- Making certain that all school staff, officials, or health care providers involved in administration or prescribing of stock asthma medication receive liability protection except in cases of willful or gross negligence.

The Lung Association thanks the Maryland General Assembly for their continued commitment to the health and wellbeing of the residents of Maryland and the desire to protect Maryland students. The Lung Association ***strongly supports*** Senate Bill 180 as drafted and encourages swift action and favorable report to move the bill out of committee and passage by the General Assembly to protect students in schools across Maryland.

Sincerely,

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A Goldsborough_stock Albuterol in Maryland Schools

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Stock Albuterol in Maryland Schools

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Stock Albuterol in Maryland Schools

In recent years, there has been a paradigm shift in asthma treatment in the school setting. There is widespread support across the US for stock albuterol in schools. For several years, this legislation, which would benefit children with asthma in Maryland, has not passed. This paper describes the evidence supporting passage of legislation that would allow stock albuterol in Maryland schools.

I work as a pediatric nurse with the Division of Pediatric Pulmonology at Johns Hopkins Hospital with many years of experience caring for children with asthma. This paper expressed my own views.

Asthma is a chronic inflammatory condition of the lungs that affects many children in Maryland (Lowe, et al., 2022). Nationally, asthma affects 6.5% of children with higher prevalence and increased morbidity in low-income and minority groups (CDC, 2023; Volerman, et al., 2021). In Maryland, asthma prevalence is higher than the national average. Asthma affects 7.6% of Maryland children and approximately 20% of Baltimore City children (Maryland.gov; (Papp, et al., 2019). Children with asthma are more likely to miss school and have breathing problems that prevent them from fully participating in school when they are present (Lowe, et al., 2022; Volerman, et al., 2021). My work has given me insight into the health disparities in our communities, especially in Baltimore City. There are many at-risk children both in Baltimore City and around the state of Maryland who would benefit from this legislation. Many of our patients do not have access to albuterol inhalers due to the financial cost of the medication and the burden of getting medication administration paperwork completed.

Current guidelines recommend that all children with asthma have access to rescue medications, like albuterol, while at school (Lowe, et al., 2022; Volerman et al., 2021). But

fewer than 12% of students have access to this life-saving medication while at school (Lowe, et al., 2022). Barriers to access to rescue medications include difficulty accessing medical care, difficulty obtaining asthma action plans, difficulty obtaining the medication and a valved holding chamber for administration, and lost or expired medications (Papp, et al, 2019; Volerman, et al., 2021). To help overcome these barriers and ensure access to albuterol at school, at least 18 other states have enacted legislation allowing the use of stock albuterol in school (Lowe, et al., 2022). The National Association of School Nurses (NASN), the American Thoracic Society (ATS), the Allergy and Asthma Network (AANMA), and the American Lung Association (ALA) recommend that states pass laws allowing stock albuterol in schools (Volerman, et al., 2021).

In other states, albuterol inhalers are stocked in schools for use in a breathing emergency (McCaughney, et al., 2022). Albuterol is a common bronchodilator, which comes in an easy-to-use metered dose inhaler (MDI), is used to treat bronchospasm in pediatric asthma (McCaughey, et al., 2022). Albuterol is safe; the benefit of using it for breathing problems outweighs the risks even in children who do not have an official asthma diagnosis (Papp, et al., 2019). The most common side effects are sore throat and jitteriness (Papp, et al., 2019). It can cause increased heart rate and blood pressure; these side effects are dose dependent, transient and rarely have serious consequences (Papp, et al., 2019).

Legislation allowing stock albuterol in schools in Maryland would benefit our students, many of whom have asthma. Increasing access to stock albuterol in schools in Arizona led to a 20% decrease in 911 calls and a 40% decrease in hospital transports (McCaughey, et al., 2022; Papp, et al., 2019). Access to stock albuterol allows school nurses and trained staff to manage asthma attacks quickly, safely and effectively (Papp, et al., 2019). Students are able to return to class rather than leaving school for the hospital (Papp, et al., 2019).

As the lead asthma nurse for my division, I teach children, adolescents and their caregivers when to use albuterol. Many of our patients have both asthma and food allergies; they have both albuterol and epinephrine on hand. Our practice is enriched for this dual diagnosis. In my experience, there is no confusion about recognizing the signs of food allergy reaction versus the signs of an asthma attack. I am also the parent of children with asthma and food allergies; my own children, both school-age and college-age, have no confusion about whether they're having an allergic reaction or asthma symptoms.

Nurses in Maryland, especially pediatric nurses and school nurses, should support legislation for adoption of stock albuterol in schools. This legislation benefits children in Maryland, especially those from low-income or minority groups. This policy makes good sense and should provide peace of mind both for school nurses and to parents.

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Written Testimony SB 180 2.pdf
Uploaded by: Elaine Papp
Position: FAV

Senate Committee
Education, Energy and the Environment

Written Testimony for SB 180:
"Public and Nonpublic Schools – Bronchodilator Availability and Use – Policy (Bronchodilator Rescue Inhaler Law)."

Prepared by: Elaine M. Papp RN MSN COHN-S(R), CM(R) FAAOHN

Thank you for the opportunity to provide written testimony on this SB 180. My Name is Elaine M. Papp. I am a Master's prepared Registered Nurse. I retired from my full-time job in 2015. In 2017, through a contracting agency, I began working as a school health nurse in Baltimore City Schools, two to three days per week. After a serious asthma emergency at a high school in Baltimore City, I began advocating to place stock albuterol inhalers (bronchodilator rescue inhalers) in all Maryland schools as emergency medication.

Below, I share the circumstances that led to my advocacy, provide information on how our advocacy group developed, our rationale, some statistics on asthma in Maryland. In addition, I include my perspective as a nurse and advocate regarding training non-medical personnel to administer the bronchodilator rescue inhaler in an emergency and potential program costs.

CIRCUMSTANCES LEADING TO MY ADVOCACY FOR PLACING EMERGENCY ASTHMA INHALERS IN ALL MARYLAND SCHOOLS

In 2018, I saved a student's life, but lost my job! I was working as a school nurse, at Vivien T. Thompson Medical Arts Academy, a Baltimore City High School. A student with exercise-induced asthma experienced a serious asthma flare. She had an albuterol inhaler at school. But, as I learned from other students, her albuterol inhaler was locked in the gym teacher's desk. The gym teacher was not in the building. I have no idea why the gym teacher stored the student's inhaler without letting the health unit know. I can guess why the student did not have doctors orders in the health unit as I explain below. The result was that I, the school health nurse, I had no doctor's order for an inhaler in the students health file. even though she had a prescribed albuterol inhaler on the school premises. Without doctors orders in the health unit the student is considered to be undiagnosed for purposes of administering medication.

While the principal, teachers and other staff tried valiantly to find the keys to the gym teacher's office and desk, the student lost consciousness. I, without an asthma inhaler to administer, watched the unconscious student as she gasped for air at a rate of 70 breaths per minute and her heart raced at 124 beats per minute. I believed that the student was dying. I believed she would have a maximum of 15 minutes to live now that she had lost consciousness, unless she was treated with an albuterol inhaler.

I knew the situation was life threatening. As a school nurse, I had to act. The ambulance had not yet arrived. Waiting for it could have cost this student her life. Thus, I requested that the principal find me any student's rescue inhaler (albuterol inhaler). Because albuterol Inhalers are universally used as rescue inhalers for people with asthma and are given in a standard dose, I knew it would be safe and effective to provide her with another's inhaler. . I made the best choice at the time. I gave her another student's albuterol inhaler. I did this by placing the inhaler into the students wide-open mouth. depressed the canister, puffing the medication into the students's mouth. Because she was gasping for air so rapidly, the puffs of albuterol were

able to reach their target. The medication reached her lungs and immediately began to release the bronchospasm.

Within a few minutes after administering the albuterol, her respiratory rate lessened, and her heart rate came down. Soon the student regained consciousness. Her mother arrived, and I told her what I had done. She was grateful. By the time the ambulance arrived, the student was sitting in a chair, talking to her mother. The paramedic said, "I guess it was more important for the dispatcher to get a cup of coffee than to tell us where we needed to go.

I saved the student's life but lost my job. I made a choice. I broke the rules to save the student's life. The rules:

1) Never give a student another's medication.
2) Never give a medication if you do not have doctor's orders in the student health file.

Recognizing the problem was the system, I began a quest to get emergency rescue inhalers as stock medication in all schools in Maryland.

OTHER ORGANIZATIONS WHO SUPPORT PLACING ASTHMA INHALERS IN ALL MARYLAND SCHOOLS AS AN EMERGENCY MEDICATION

I began this grassroots effort as a political novice with an informal, ad hoc group of advocates. I began working with a pediatric pulmonologist from Johns Hopkins University (JHU), a pediatrician from JHU, and an emergency pharmacist from JHU. We obtained support from the Allergy Asthma Network, the American Lung Association. Our ad hoc group also worked with a nationally recognized researcher and expert on asthma in schools from the University of Arizona who was working on this issue nationwide. . Over the past two years we have enlisted the support of individual school health nurses, respiratory therapists and nurse practitioners.

In September of 2021, the American Thoracic Society (ATS) published its policy on Asthma in schools. ATS recommends that all schools in the United Staes have asthma rescue inhalers as a stock emergency medicine. They also recommend all the provisions we include in our SB180 bill. We are in the forefront of an important movement.

OUR RATIONALE

The most common scenarios in which stock emergency albuterol inhalers will be needed school are variations of the situation I experienced. Other examples are: a student who does not turn in paperwork or provide an inhaler to the school nurse, or teenagers who carry their own medication but forgot to bring it that day or a student whose inhaler is malfunctioning or empty. There are many examples like these. . Data form the program in Arizona support this , showing that 78% of students who received the stock albuterol inhaler had asthma. Children cannot be diagnosed with asthma until they have had their first asthma flare, commonly called an "asthma attack. We do not have a test that can predict if a child will have asthma. A child is diagnosed with asthma based on their physical exam and any history of asthma symptoms or asthma attacks. This means that they need to have already had symptoms to be diagnosed. We need to make sure our schools are ready to treat theses students, too, if this occurs.

Our advocates are dedicated to the idea of helping students, families, school personnel and school health staff cope with asthma emergencies in school to:

- reduce number of lost days from school,
- reduce number of 911 calls,

- reduce the number of hospitalizations and the length of hospital stay by providing effective and efficient emergency care at the moment of an asthma flare.

We believe that instituting a stock albuterol inhaler program in schools will lead to better health outcomes for school age children and adolescents who suffer from asthma flares in school. In addition, we believe that the reductions listed above will lead to reduction in costs to the school system, the EMS system, families, and the schools.

STATISTICS

In 2010, the US the lifetime prevalence of childhood asthma was ***9.4%. In Maryland it was 16.4%*** (lifetime asthma prevalence in 2010 - approximately 216,000 children). In Baltimore in 2010, the rate of asthma in school-age children was approximately ***20%, with pockets of the city higher than 20%.*** One of the areas of the city with a 20% rate of asthma at the was the community Vivian T Thompson high school saved. Currently 7.6 % of Maryland youth have asthma, with 3,490 children being hospitalized this year.

At the time of the event, there were over 400 students enrolled at Vivien T Thompson. Thus, if 20% of the students had asthma, I should have had a minimum of 80 doctor's orders on file in the health unit. I had none. Yet, I often saw students with inhalers in the school hallways. I contacted students and gave them forms to complete and return. I called parents and asked them to bring in doctor's orders. I did not receive any doctor's orders. I had no authority to require compliance with the requirements.

THE PROBLEM AS I SEE IT

Part of the problem related to asthma inhalers and school health clinics is the complexity of the annual paperwork parents must provide. For example, in Baltimore City, each year the parents of the student with asthma must visit the physician, obtain written doctor's orders, and complete several forms The parents must bring the forms to the school and sign them while the school school witnesses the signature. In addition, unless the doctor writes permission for the student to carry his/her own inhaler, the parent must provide an inhaler to be kept at the school health unit. Thus, the family must obtain at a minimum two inhalers - one for the student to use when not in school and one to be kept at the school. Problems with this system are many —1) Several parents in Baltimore City do not have cars and must use the bus or other transportation to go to the school. 2) Many work more than one job and cannot take time from work to go to the school to deliver paperwork. 3) It is expensive for parents or guardians to have to buy two or more inhalers. 4) Parents whose children have had asthma for several years do not understand why, every year, even though there have not been any changes in their child's asthma nor its treatment, they must provide 8 or more completed forms to the school.

Bottom line. Many parents are non-compliant. Doctors orders are not on file. Yet,, many students carry inhalers. The system is cumbersome and expensive , inconvenient for parents.

Asthma is the most common chronic illness in children. Yet, as a school health nurse I had no emergency medication to treat a student if: 1) their own inhaler was empty or didn't work; 2) they forgot their inhaler; or 3) if, as in my case, their inhaler was inaccessible.

I am a registered nurse. I had access to Maryland's guidelines on how to manage asthma in school age children. I had expertise in recognizing asthma emergencies and treating them. However, without albuterol to use in an asthma emergency, I was handicapped.

I had Narcan for opiate emergencies (which I never used). I had Epipen for allergic reactions (which I never used). Since Epipen is not approved by the FDA for treatment of asthma flares and since there are no written doctor's orders in the school health units for treating asthma with Epipen, I could not use it treat as student with asthma, nor should I have. I was truly at a disadvantage. Albuterol is the gold standard and first line treatment fro asthma.

I am not the only nurse that has experienced using someone else's asthma inhaler to treat a student suffering an asthma flare. Though, I may be one of the few who has reported it. I base this on the results of a study conducted in Pima County, Arizona where school health nurses were asked, anonymously, if they had ever given one student another's inhaler. Many said, "yes." However, they stated that they had not reported it. When asked, "why," they replied, "fear of losing my job."

School health nurses are placed in a position of responsibility without authority. I had no way to enforce the requirement to bring in a doctor's order. I was the only health care professional on site. But I had no emergency medications to administer for asthma exacerbations.

I strongly advocate for passage of SB180 to remedy this problem. Please give nurses and others in the school system a way to cope with a serious life-threatening emergency.

TRAINING NON-MEDICAL SCHOOL PERSONNEL TO ADMINISTER ASTHMA EMERGENCY INHALERS

SB 180 contains provision for training non-medical school personnel to administer an albuterol inhaler during an emergency. This provision is not intended that a non-medical person treat the student if the school health nurse is available. It is intended for times when the school health nurse is not on the premesis - after hours, etc.

Although some have expressed concern over this provision, I believe it is important. First, training non-medical personnel to administer albuterol inhalers is not new to Maryland schools. When I worked as a school nurse, it was routine to train a teacher or a coach to use an albuterol inhaler, if a student with asthma was going on a field trip or to a sporting event off campus. In fact, the Maryland State School Health Services Guideline for Management of Students with Asthma, has specific procedures for training non-medical personnel in administering rescue inhalers when the student is on a field trip. Thus, the concept of non-medical school personnel being trained to administer and, then, possibly, administering a rescue inhaler in an emergency situation, is not new.

Second, medical personnel are not always available. The health clinic closes at the end of the school day. Yet, many children stay after school for extra-curricular activities such as, sports practices and events. It is vital to have a coach trained to administer an albuterol in haler in asa of respiratory distress when the school health nurse is unavailable.

In the case of SB 180, this training would be extended to designated staff. It would focus on recognizing respiratory distress in a child and administering albuterol while calling emergency medical personnel and avoiding adverse outcomes, including worsening asthma and even death. There is precedent for training other personnel to recognize respiratory distress and provide albuterol nationally, as most states with stock albuterol inhaler laws include these provisions Without them, vulnerable children, who do not have a school nurse in attendance, will suffer As you will hear from other advocates, albuterol is essential to treat asthma, yet, is a very safe medication to administer with only few and minor side effects.

We have proposed updating the existing EpiPen legislation, as others have in many states that have successfully passed stock albuterol legislation. It is not because the two drugs are interchangeable for asthma, but because their rationale is similar: they are both used in life-threatening emergency situations that nurses and school personnel can be trained to recognize, they are simple to administer, and they are safe and effective.

COST CONCERNS

As we are all aware, the COVID-19 pandemic has wreaked havoc with budgets. Some have expressed concern about the cost of this program. But, we expect the cost to be minimal for the following reasons.

1) Each school needs only one inhaler per school year.
   Small inhalers hold 60-200 puffs or 30-100 doses (2 puffs per doses). Thus, 30 -100 students could be treated per year with one albuterol sulfate inhaler. Inhalers have a shelf life of one year.
2) Disposable spacers with one-way valves can be attached to the emergency inhaler for each use and then discarded. The one-way valve prevents the inhaler from being contaminated. The inhaler can be safely and effectively used another time.
3) Forms for reporting the use of the inhaler and programs to train for non-medical school personnel in the emergency use of asthma inhalers do not need to add additional cost. For example, the American Lung Association and the University of Arizona have on-line training that is available to us and is that is free and.
4) Total cost of supplies per year: $60.00 per school
   - Average cost of an albuterol inhaler is approximately $40.00.
   - The cost of a package of 25 disposable spacers is approximately$18.95.

In addition, we have included a provision to allow schools to receive donations to successfully administer the emergency bronchodilator program, which has also occurred in other states.

I intend to offer oral testimony as well as this written testimony. I am available for questions. I encourage you to vote yes on SB180. Thank you for your consideration.

Elaine M. Papp, RN MSN COHN-S(R), CM(R) FAAOHN

MSHP Letter of Support_HB86_SB180.pdf
Uploaded by: Farrah Tavakoli
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MARYLAND SOCIETY OF HEALTH-SYSTEM PHARMACY

January 11, 2024

Senator Brian J. Feldman, Chair
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Delegate Vanessa E. Atterbeary, Chair
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Senator Katie Fry Hester
Deputy Majority Whip
Committee on Education, Energy, and the Environment
Public and Nonpublic Schools - Auto-Injectable Epinephrine and Bronchodilators - Use, Availability, Training, and Policies

RE: Support for House Bill 86 and Senate Bill 180, Public and Nonpublic Schools - Auto-Injectable Epinephrine and Bronchodilators - Use, Availability, Training, and Policies

Dear Senator Feldman, Delegate Atterbeary, Delegate Boyce, and Senator Hester and committee members:

Thank you for the opportunity to provide comments on House Bill 86, and Senate Bill 180, Public and Nonpublic Schools - Auto-Injectable Epinephrine and Bronchodilators - Use, Availability, Training, and Policies. The Maryland Society of Health-System Pharmacy (MSHP) strongly supports this bill as originally drafted as it will allow schools in Maryland to provide more immediate access to medications for students with asthma or those suffering from respiratory distress.

MSHP is a heath-system pharmacy organization with a mission to improve patient outcomes in the state of Maryland. House Bill 86 and Senate Bill 180 align with our goals of promoting health care equity and to ensure the safe dispensing of medications to patients in all settings. Now more than ever, MSHP is focused on advocating for mechanisms that improve access to health care across the state to deliver safe, efficient, and affordable healthcare.

House Bill 86 and Senate Bill 180 represents a simple and low-cost solution to a problem that could save childrens lives and the overall cost to the health system. Thus far, 17 states across the nation have passed legislation or have administrative guidelines in place allowing schools to stock asthma medications. Albuterol is a common medication used to provide quick relief of asthma symptoms. Albuterol is safe, effective, easy to administer, and well-tolerated with minimal and mild side effects (transient increased heart rate and jitteriness). While this may or may not surprise you, 80% of children with asthma, do not have their albuterol with them in school. Many children experience their first asthma attack while in school. Without access to albuterol, a life-saving medication, vulnerable children may suffer from severe and sudden asthma attacks. We are deeply concerned about the children in the schools who require

albuterol and do not have access to it. To prevent further delayes to implementing this safe, evidence-based practice in Maryland, we respectfully request your support on House Bill 86 and Senate Bill 180.

The MSHP thanks the Maryland General Assembly for their continued commitment to the health and wellbeing of the residents of Maryland and the desire to protect Maryland students. The MSHP strongly supports House Bill 86 and Senate Bill 180 as drafted and encourages switft action and favorable report to move the bill out of committee and passage by the General Assembly to protect students in schools across Maryland. We look forward to continuing to partner with you to improve the health of Maryland residents.

Sincerely,

Timothy Wu

Timothy Wu, PharmD, MBA
2023-2024 President, Maryland Society of Health-System Pharmacy

Testimony.pdf
Uploaded by: Irada Waldron
Position: FAV

Senate Committee

Education, Energy and the Environment

Written Testimony for SB 180:

"Public and Nonpublic Schools – Bronchodilator Availability and Use – Policy (Bronchodilator Rescue Inhaler Law)."

Prepared by: Irada Waldron, RN, BSN, NCSN

Thank you for the opportunity to provide this written testimony. My name is Irada Waldron, and I work as a school nurse in the Howard County Public School System. I have been working as a school nurse in Howard County since 2018.

In my experience, asthma-related health concerns are among the most common reasons for students' visits to the health room. Asthma is a chronic health condition with frequent flare-ups throughout the school year due to weather conditions, physical activity, air pollution, and airway infections. Students often present to the health room for assistance when symptoms progress to a compromised airway that needs urgent medical attention. Immediate access to bronchodilator medication is crucial to open the airway and improve air circulation. When inhaled rescue medication is not available in the health room, asthma student has an increased risk of life-threatening complications, hospital admissions, and school absences.

Today's healthcare system is complex, and many parents face barriers to accessing needed medications for their children. Often, parents have busy schedules due to working multiple jobs, not having access to transportation regularly, or facing financial hardships, which place challenges in getting access to additional inhaler medication for the school. I have seen many students with asthma diagnoses whose parents do not bring additional inhaler medication to the health room due to the reasons stated above.

As a school nurse, I aim to ensure that each student has access to education and participates in all school activities. Students with an asthma diagnosis and their families often face disruption in their daily lives due to asthma flare-up management. Also, the students with asthma diagnosis have increased school absences. Having access to rescue inhaler medication in each school will save students' lives and will reduce the risk of life-threatening complications due to asthma attacks.

Today, we acknowledge the importance of having Epinephrine injections and Narcan medications in every school to prevent deaths from anaphylaxis and opioid overdose. Providing rescue bronchodilator inhalers in each school will prevent life-threatening asthma complications for students and staff members. It is important to remember that asthma is a chronic health condition when serious flair-ups can happen unexpectedly and require immediate bronchodilator medication administration. I wrote my testimony in favor of SB 180. We can ensure that students and staff diagnosed with asthma remain safe in school by providing rescue bronchodilators in every school for emergencies!

SB 180 - MDH- SWA.pdf
Uploaded by: Jason Caplan
Position: FAV

Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

2024 SESSION
IN-PERSON TESTIMONY WRITTEN SUPPLEMENT

BILL NO.: SB 180
COMMITTEE: Education, Energy, and the Environment
POSITION: Support with Amendments

TITLE: Public and Nonpublic Schools - Auto-Injectable Epinephrine and Bronchodilators - Use, Availability, Training, and Policies - Letter of Support with Amendments

BILL ANALYSIS: Senate Bill (SB) 180 requires county boards of education to update their policies to require school nurses and personnel to complete training to administer auto-injectible epinephrine and to train school personnel to administer bronchodilators to students. The bill also requires the Maryland State Department of Education to develop training for school personnel in identifying respiratory distress in students.

POSITION AND RATIONALE:

The Maryland Department of Health (MDH) supports the intent of this bill to create a stock bronchodilator program in Maryland schools to improve access to potentially life-saving medication for students with asthma. However, MDH respectfully recommends amendments to the bill as written in order to better ensure the safety of Maryland students and decrease the administrative burden on school nurses.

The bill as currently written authorizes unlicensed school personnel to make clinical decisions about whether to administer a bronchodilator or epinephrine to a student in a potentially life-threatening situation. The bill also requires training of unlicensed school personnel to distinguish between anaphylaxis and asthma in order to determine whether a student with respiratory distress without a previous diagnosis should receive a bronchodilator or epinephrine. Even with training, making this distinction requires a level of clinical assessment that is not appropriate for unlicensed school personnel. Additionally, allowing unlicensed school personnel to determine which medication to administer could result in the initial administration of a bronchodilator to a student with anaphylaxis, putting that student at significant risk due to a potential delay in the correct intervention.

Currently, the bill as drafted does not require a student with respiratory symptoms to have a diagnosis of asthma or a prescription in order to receive treatment with a stock bronchodilator. The bill allows for the ongoing administration of a bronchodilator to a student who may be suspected of having asthma, but has not been evaluated by a licensed healthcare provider, who can make a diagnosis and determine appropriate treatment. Other medical conditions can have symptoms similar to those seen in asthma and

delaying appropriate medical evaluation and intervention could have adverse consequences for a student's health. Further, even in a student with asthma, ongoing treatment without a prescription for a bronchodilator is out of the scope of practice of school nurses, is inappropriate clinical practice, and may also be unsafe for students. Maryland's other stock medication statutes (auto-injectable epinephrine and naloxone) are for administration in emergency situations only. As a result, MDH recommends removal of the requirements for training school personnel and designated volunteers to distinguish between asthma and anaphylaxis or respiratory distress. Further, MDH recommends amending the language to authorize only school nurses and school personnel designated by the school nurse to administer a stock bronchodilator only to students experiencing asthma, asthma-related symptoms, or reactive airway disease (another term for asthma-like symptoms) when the school has evidence of the student being prescribed a bronchodilator.

The bill as currently written also requires that school nurses and other health staff record each use of a bronchodilator on a new standardized form and notify the parent of each use of a bronchodilator. According to data from the 2022-23 School Health Services survey, almost 69,000 public school children had a known diagnosis of asthma. Students with asthma may need to use bronchodilators multiple times a day if they are experiencing symptoms. Recording each incident on a standardized form and notifying parents each time will create an undue administrative burden on school health personnel and take time away from addressing other student health needs. There is already a critical shortage of school nurses in Maryland. MDH recommends amending the language to require reporting only when a stock bronchodilator is used in Maryland schools, similar to the reporting requirements for administration of stock epinephrine and naloxone.

MDH is currently working on proposed amendment language and will share it with the committee as soon as it is available.

If you have any further questions, please contact Sarah Case-Herron, Director, Office of Governmental Affairs at sarah.case-herron@maryland.gov.

Sincerely,

Laura Herrera Scott, M.D., M.P.H.
Secretary

K.Babcock written SB180.pdf
Uploaded by: Karen Babcock
Position: FAV

Karen Babcock, B.S., R.R.T.
Baltimore, MD

Testimony for Senate Bill 180
January 16, 2024

Public and Nonpublic Schools – Auto-Injectable Epinephrine and Bronchodilators – Use, Availability, Training, and Policies.

Dear Chair Feldman, Vice-chair Kagan, and members of the Education, Energy, and the Environment Committee:

My name is Karen Babcock, and I am a respiratory therapist at Johns Hopkins Hospital. I am testifying today in support of SB180 concerning the use of stock albuterol in Maryland schools. I submit this testimony as a citizen of Maryland, a health professional with the relevant expertise, and a mother. The views I express here are my own and do not necessarily reflect the views of my employer, Johns Hopkins Hospital.

I have several supervisory responsibilities, along with significant ties to pediatric pulmonary care of patients presently. I spend my time daily educating staff respiratory therapists, physicians, and nurses in all areas of respiratory care. I am a critical resource due to my years of experience and depth of medical knowledge. Throughout my career, I have had diverse experiences as a respiratory therapist on the inpatient and outpatient side of medicine, which includes a lot of time in pediatric pulmonary clinic, and also a significant amount of time caring for hospitalized or in the intensive care unit (ICU). As a respiratory therapist, I take care of children with all types of airway and lung disorders, and asthma is one of the most common diagnoses I see. My colleagues and I take care of children with asthma on a daily basis between pulmonary clinic and the hospital. Unfortunately, children being hospitalized for severe asthma exacerbations is quite common, so we see the full spectrum of disease and are very familiar with it. When there is an asthma emergency in the hospital, they call on me and my colleagues. In addition to having primary responsibility for administering medications like albuterol in the hospital, we also do a lot of teaching about asthma medications in both inpatient and outpatient settings.

For a reactive airway, such as in the case of asthma, when the airway “reacts” and tightens inappropriately to a stimulus such as a virus, an allergen, or an environmental factor (such as cigarette smoke or air pollution), the mainstay of treatment is albuterol. Inhaled albuterol works quickly to relax the muscles around the small airways by stimulating the beta receptors of these airways. Albuterol is one of the safest and most effective medications we use, and side effects are minimal. Typically, if side effects are experienced, they are: nervousness, shakiness, headache, throat or nose irritation, or mild muscle aches. Patients also can experience increased heart rate. In my years of service (22 years this spring), I have never had an incident that resulted in harm or death of patient in regards to albuterol. What I can say, is I’ve given plenty of albuterol to patients who did and did not need it (including those without an asthmatic diagnosis), as well as given to my own child, who does not have asthma. The potential benefit in those moments

outweighed any possible side effects. I also wanted to highlight that albuterol does not mask other conditions besides asthma. For example, if someone was experiencing shortness of breath due to pneumonia, if they got albuterol, if would not reverse or significantly reduce symptoms, unless they happened to have asthma too.

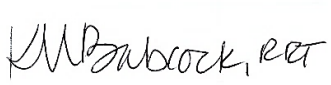
Though there are other medications that exist for asthma, including preventative medications, and even others that can offer rapid relief, albuterol is still the mainstay, and the most effective, first line therapy. It is important that the legislation is written in a general way, for "respiratory distress" because the downsides of giving albuterol to someone who is not having an asthma issue are negligible, and the risk of not giving this medicine to an asthmatic in distress are large. The risk/benefit favors giving the medication. If the law is written only for children with confirmed asthma, too many children will fall through the cracks, including children who have their first serious asthma attack at school and children who have not submitted the proper paperwork documenting their asthma diagnosis. This is where serious deaths have occurred, because their first asthma attack was their last. And is it not just death-many emergency room visits or severe asthma episodes could have been lessened of even avoided if only the child had received albuterol promptly at school when the symptoms first started.

Just like giving an Epi-Pen for a food allergy emergency (it works right away), giving albuterol promptly could drastically change the trajectory of the child's airway issue in an asthma emergency. I have personally witnessed albuterol stop or significantly lessen a severe asthma situation many times. Similarly, delaying albuterol when an asthmatic needs it can also cause an asthma exacerbation to get out of hand very quickly, resulting in increased severity of the exacerbation, which can lead to emergency department admission, hospitalization, or even death. Albuterol is more effective and the safer and more appropriate medication for outpatient care, such as school and home setting. School is a place where kids spend a lot of time, and therefore a place they should have access to albuterol. I spend a lot of my time in pulmonary clinic educating our patients and their families about this. We ask them to always make sure they have access to albuterol, and encourage them to keep their own supply at school. Though this is the ideal, there are too many examples where kids can fall through the cracks and they will not have their medication when an emergency occurs at school. This legislation would provide for a backup method, and it makes a lot of sense.

As the mother of a school age child, I want my child's school and other schools to have the resources they need to help my child and other children in an asthma emergency. We as a medical team always try and identify prevention, education, and intervention for all issues. This is no exception.

Thank you again for the opportunity to testify, and I ask that you please vote in support of SB 180.

Sincerely,



Karen Babcock, B.S., R.R.T.
Pediatric Respiratory Therapist

Connor SB0180 Testimony.pdf
Uploaded by: Kate Connor
Position: FAV

Written Testimony in Favor of SB0180
Submitted by Kate Connor, MD, MSPH
January 16, 2014

My name is Kate Connor. I am a board-certified pediatrician, a school health medical director in Baltimore City, and a member of the faculty in General Pediatrics at the Johns Hopkins University School of Medicine. The views expressed in this testimony are my own and do not necessarily represent the views of the Johns Hopkins University School of Medicine.

I am writing in favor of SB0180 which would permit schools to establish a policy to obtain, administer, and train school personnel to administer bronchodilators to certain students.

Asthma is one of the most common chronic diseases of childhood impacting up to 4 million U.S. children[1]. In 2021 asthma was the cause of more than 270,000 emergency department visits, nearly 30,000 hospitalizations, and 145 deaths in children and adolescents[1]. It is also a major driver of health inequity. Black children and children experiencing poverty are more than twice as likely to have asthma compared to white peers and those not experiencing poverty respectively[1]. Black children are nearly eight times as likely to die from asthma as their white counterparts[2]. Asthma is complex and many factors drive these inequities. At a minimum, access to life-saving, quick-acting bronchodilators like albuterol is needed to prevent hospitalization and death from the disease.

Children and adolescents spend the majority of their time in school. While there are provisions for children with asthma to receive albuterol at school if needed, a clinician order including their signature and a parent/guardian signature as well as a physical is required before the school nurse or other personnel can administer the medication. Even in an emergency, if the order is not signed or the inhaler is not in school, albuterol cannot be given. There are many barriers to obtaining signed paperwork and medications in schools – from healthcare access to conflicting schedules, communication and language barriers and more. In a school with a high prevalence of asthma (or risk of asthma), these barriers leave a significant proportion of students at risk for bad outcomes. I work in a school-based health center where nearly 40% of the school's students have asthma. At our SBHC, a clinician is always onsite. As a result, it is rare that we have to watch a child in respiratory distress get sicker without being able to intervene. In fact, in our first five years of operation we averted more than 300 emergency department visits for students with asthma by providing emergency medications through the SBHC. However, the majority of schools do not have SBHCs and many do not even have nurses. In order to make a true dent in asthma inequities, school health resources must be made available to all students and in the interim we must ensure that caring adults have the resources to save the life of a student experiencing respiratory distress due to asthma.

Bronchodilators are safe medications. They are regularly given to patients in respiratory distress by first responders and earlier administration can improve outcomes and save lives. I ask that you vote in favor of SB0180 to allow schools to develop stock albuterol policies and keep their students safe.

1. Centers for Disease Control and Prevention. Most Recent National Asthma Data. Accessed from: https://www.cdc.gov/asthma/most_recent_national_asthma_data.htm. January 16, 2024.

2. U.S. Department of Health and Human Services, Office of Minority Health. Asthma and African Americans. Accessed from: https://minorityhealth.hhs.gov/asthma-and-african-americans. January 16, 2024.

LCA_ MD_SB0180 Testimony (1).pdf
Uploaded by: Leslie Allsopp
Position: FAV

1/16/2024
Written Testimony: SB0180F
Leslie Allsopp, PhD, MPH, MSN, AE-C
Assistant Professor Pediatric and Women's Health
Principal Investigator: Asthma 411 Initiative in North Texas

The Honorable Senator Kathryn A. (Katie) Fry Hester
Energy, Education, and the Environment Committee
Maryland Senate

Honorable Senator Hester and Committee members:

I am writing today to express support for SB0180F. This bill allows Maryland schools to improve the safety of those who experience respiratory distress at school by improving access to potentially lifesaving bronchodilators.

As a Public Health Professional and Assistant Professor in North Texas, I have recently co-chaired an ad hoc committee that successfully worked to align Texas state policy with national recommendations. I am also the principal investigator for the Asthma 411 initiative in North Texas, a large-scale school asthma program that integrates stock bronchodilators and comprehensive best practices in school asthma services.

The model we use for stock-bronchodilators is Asthma 411, which was developed, implemented, and tested with support from the Centers for Disease Control between 2003-2008. From Asthma 411's inception, it included standing delegation orders for bronchodilators, with asthma education and support to link families to medical resources. The program was found to improve asthma outcomes, and between 2013-2015, Asthma 411 was adapted and piloted on two North Texas schools for two years. The program has continued to expand and today serves over **350 schools with over 250,000 enrolled students**.

<u>The following outcomes support the efficacy and safety of stock bronchodilators:</u>

- **80-85%** of students have safely returned to class following treatment with stock bronchodilators.
- **13-15%** of students have been dismissed early to their families for same-day follow-up.
- **<2%** of students have required emergency medical services.
- **4,800** additional instructional hours are estimated to have been reclaimed for students receiving bronchodilators under the program in 2022-2023.
- There have been ***no*** reported adverse outcomes associated with the program.

The following outcomes are from the 2022-2023 school nurse and health staff survey. (N=259, response rate 73%).

<u>The outcomes demonstrate the satisfaction of school nurses, health staff, and parents with the program.</u>

- **99.6%:** overall satisfaction (79.2% very satisfied, 20.4% somewhat satisfied).

- **91.5%:** program is manageable to implement (83.6% very manageable, 12.9% somewhat manageable).
- **99.3%:** positive parent feedback (80.5% very positive, 18.9% somewhat positive).

In 2019, Texas passed legislation to strengthen liability protection associated with bronchodilators. Unfortunately, the legislation was accompanied by provisions that limited access to this potentially lifesaving medication.

School districts such as those participating in Asthma 411 reported substantial barriers to providing services, and there was limited new adoption of the stock bronchodilators across the state.

Efforts to remove these barriers were initiated for the 2021 Texas legislative session and were unsuccessful. Following that effort, an ad-hoc task force was formed to introduce amendments during the 2023 Texas legislation, focusing on the national recommendations published in 2021. This task force included the Texas School Nurse Organization, the American Lung Association, pediatric pulmonologists, and regional and academic stakeholders from across the state.

Texas legislation passed in 2023:

- *permits* school districts to designate trained personnel to administer albuterol for respiratory distress when a school nurse is unavailable.
- *permits physicians and other authorized prescribers to write orders that align with best practice.*
- *allows* immediate access to this safe and potentially lifesaving medication to anyone experiencing respiratory distress.
- *allows* access to unassigned albuterol at off-campus school events.

We celebrate the alignment of Texas legislation and best practices and are grateful for all who made this possible. At the same time, we recognize there were legal barriers to providing best practices to those who experience respiratory distress at school for **four years**.

I would strongly support the adoption of SB0180F to:

- ***improve*** *the safety of students, faculty, and staff at school and during school events;*
- ***reduce cost*** *and educational disruption of unnecessary EMS calls;*
- ***keeps kids in school****, increasing student attendance and readiness to learn;*
- ***reduces work absences*** *among parents.*

Please let me know if there is any information that I might provide that would be of assistance.

With thanks,

Leslie Allsopp

Leslie Allsopp, PhD, MPH, MSN, AE-C
Assistant Professor Pediatric and Women's Health
Principal Investigator: Asthma 411 Initiative in North Texas

SB180 Written Testimony- Micaela Fritz.pdf
Uploaded by: Micaela Fritz
Position: FAV

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Testimony for Senate Bill 180
January 17, 2024
Public and Nonpublic Schools – Auto-Injectable Epinephrine and Bronchodilators – Use, Availability, Training, and Policies

Thank you for the opportunity to provide this testimony today. My name is Micaela Fritz, and I am a pediatric nurse practitioner at Johns Hopkins Hospital. Prior to my role as a nurse practitioner at Johns Hopkins Children's Center, I was a school nurse for Howard County Public School System in the fall of 2021. I am testifying today in support of this bill to ensure that no student with asthma, diagnosed or undiagnosed, will be without the lifesaving measure they need should they experience respiratory distress in school.

I would like to note that the views expressed here are my own and do not necessarily reflect the policies or positions of my employer, Johns Hopkins Hospital.

In my previous experience as a school nurse, I was responsible for the medical care of over 800 middle school students at a public school. Many of the students I cared for had chronic medical conditions, including asthma. I had an incident in Fall of 2021 where a student who was a known asthmatic needed albuterol. I administered albuterol as prescribed, his cough subsided, and he returned to class. Approximately 4 hours later, he returned with audible wheezing and a violent cough that caused him to vomit continuously. I tried to administer his albuterol inhaler again, however, the pump stopped working. The student had an extra albuterol inhaler in his pocket that his mom had given him that morning. Under the guidelines, I should have confiscated this medication and not allowed him to use it. Instead, he self-administered the albuterol from home and 911 was called. Fortunately- the medicine helped. By the time EMS arrived, his vomiting and wheezing had subsided.

This experience had a profound impact on me professionally and personally. I was thankful that his mother had enough foresight to have him carry another albuterol inhaler just in case, even though he was not supposed to have it. The implications for what would have happened to this student are vast. What would have helped me in this case would be a law like Senate Bill 180. Not only would I have had my own albuterol inhaler supply, but I would also have had permission to use it in emergency situations much like the other medications school's stock.

I strongly urge you to support this bill, which will help to ensure that all children with asthma in Maryland have access to life-saving medication at school in an emergency. Thank you.

Sadreameli SB180 written 1_26_24.pdf
Uploaded by: Sara Christina Sadreameli
Position: FAV

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Testimony for Senate Bill 180
January 16, 2024
Public and Nonpublic Schools – Auto-Injectable Epinephrine and Bronchodilators – Use, Availability, Training, and Policies.

Dear Chair Feldman, Vice-chair Kagan, and members of the Education, Energy, and the Environment Committee:

Thank you for the opportunity to provide this written testimony. My name is Dr. Christy Sadreameli, and I am a pediatric pulmonologist, researcher, and faculty member at Johns Hopkins University in Baltimore City. Asthma is the most common chronic disease in childhood, and I take care of many children with asthma in my clinic and the hospital. I care for children who live all over the state of Maryland and travel to my clinic or my hospital, including many children who live and attend school in Baltimore City. I am testifying today in support of this bill that would provide emergency albuterol in schools. I am here as a pediatrician, and asthma specialist, and a citizen of the State of Maryland.

The prevalence of asthma in Baltimore City in children under 18 is more than twice the national average (20% in Baltimore City compared with 9.4% nationally), and asthma morbidity (including hospitalizations) is very high in Maryland, including Baltimore City. Asthma is a disease of the small airways in the lungs. Acute asthma symptoms, sometimes called asthma attacks, can be life-threatening. Asthma attacks are caused by bronchospasm, or inappropriate tightening of the muscles around the small airways of the lungs, resulting in wheezing, coughing, chest tightness, and difficulty breathing. An asthma attack may be triggered by a respiratory virus, allergens, smoke, poor air quality, certain weather conditions, physical activity, and more. Because asthma attacks can occur suddenly and without warning, children with asthma should always have access to emergency medication that can quickly reverse their symptoms. The gold standard for this is albuterol, supported by all U.S. and international asthma guidelines. Albuterol, a short-acting bronchodilator, is most commonly given by inhaler with an attached spacer, and works right away to relax the smooth muscles around the small airways. This provides quick relief of asthma symptoms and can help prevent the onset of sudden respiratory decompensation. Albuterol is very safe, easy to administer, effective, and well-tolerated-- its side effects are very mild (increased heart rate, jitteriness).

Despite the need for albuterol, 80% of children with asthma do not have it at school. This problem affects all children—whether they are rich or poor, attend private school or public school, and living in urban settings or in rural settings. There are many reasons why a child might not have albuterol at school. They may have run out, may not have turned in the required forms, may have forgotten it (especially relevant with older teens who often have the

responsibility to self-carry albuterol), it may have expired, it may be locked away in a locker or office. Some parents do not realize their child's condition is even called asthma, which is something I commonly encounter in my practice setting. Still other children experience their first-ever asthma attack at school. Under the current system, many children are at risk of life-threatening asthma episodes at school. Without access to albuterol, a life-saving medication, vulnerable children may suffer from severe, sudden asthma attacks and even die at school. In addition to the risk of death, significant delays in treatment increase asthma morbidity. In other words, when children do not have ready access to albuterol, their symptoms can worsen, leading into a more severe asthma exacerbation. In addition to an increased risk of death from asthma and increased suffering for the child, treatment delays such as these lead to increased school absenteeism, missed parent work time, and increased costs to families and to the healthcare system, as EMS transport, ED visits, and hospitalizations become more likely when treatment is delayed.

Despite case management by school personnel (including diligent work by school nurses) the fact remains that many children do not have the proper medication and documentation at school. Using Baltimore City schools as an example, I have spoken with many former and current school nurses and learned that there are schools where less than half of known asthmatics have the required paperwork, and there are schools where zero students have the proper paperwork. This issue affects children from all over the state and the issue is particularly pronounced in schools with fewer resources, including the many schools in Maryland that unfortunately lack a full-time, always-in-person school nurse. Another issue is that because asthma is so common, and particularly uncontrolled asthma is so common in certain parts of our state, including Baltimore City, severe, uncontrolled asthma can be "normalized" and parents and children may not realize that asthma is life-threatening, making it even less likely that they will submit the required forms and medication. Finally, there are many barriers to getting the proper forms and medication, which may require a parent taking off work, making an appointment with the doctor, and going to the pharmacy. Parents may experience many barriers during this process (including those of paperwork, finances, fees associated with forms or additional medication supply (the extra medication, which is not always covered by insurance), comfort navigating the healthcare system, transportation, and discrimination). Children whose parents experience barriers to medical care and paperwork are unfortunately often some of the most at-risk asthmatics. This includes urban minority children, but also to children impacted by poverty and a lack of medical resources anywhere in our state, including rural areas. The differential access to albuterol for children in our state is an equity issue.

It is essential that the law contains language that enables children exhibiting <u>respiratory distress suggestive of an asthma attack</u> to receive emergency albuterol. I strongly recommend that you do not vote for any amendments to narrow the policy to children with a known asthma diagnosis, regardless of how the diagnosis is defined. There are a few reasons for this. <u>First, there is precedent. The Epi-Pen and Narcan bills are written to apply to children who are perceived to be having anaphylaxis or opioid overdose and do not require proof or a pre-existing diagnosis; this bill is written in the same manner</u>. It would be unfair to make the albuterol legislation stricter. This raises the question of why we think children with asthma, who are more likely to be affected by poverty or of a minority group, should be treated differently from children with the other two diagnoses. <u>Second, albuterol is very safe</u>. A child may

occasionally be given albuterol for non-asthma symptoms (e.g., difficulty breathing because of an anxiety attack, or shortness of breath from gym class for non-asthma reasons). However, because albuterol is so safe, it is better to err on the side of giving it rather than miss an opportunity to treat asthma, as delays could lead to a more severe asthma attack, 911 call, or death. It also typically reassures people to know that albuterol cannot "mask" another diagnosis, for example, if albuterol is given for pneumonia, anaphylaxis (a severe food or insect allergy reaction), croup, or anything else that is not asthma. It is straightforward to train staff how to recognize respiratory distress and administer albuterol. Currently, some staff, such as teachers and office staff, already undergo similar training to use albuterol in certain cases (such as for a field trip). Typically, the school nurse confirms this training and ensures the child has the proper medication and paperwork. Third, many children are not classified by the school as having asthma. This could be for the many reasons outlined in a previous paragraph, including a lack of paperwork being filed with the school, lack of parental understanding, or lack of a previous asthma diagnosis, such as in the case of a first asthma attack happening in the school setting. Fourth, requiring a documented asthma diagnosis for children to receive albuterol magnifies health inequities. While we must work as a healthcare system and a society to improve outcomes and reduce disparities for pediatric asthma, it is a massive problem that touches on poverty, housing conditions and other environmental exposures, medical literacy, access to healthcare, the cost of drugs, medication adherence, and much more. We cannot fix all of this with this law, of course, and it is not the job of the schools to fix it either. But we can recognize that children spend most of their weekday in the school setting, and the children most likely to be harmed by lack of access to albuterol in school are the same ones who are often forgotten by society and at greatest risk of asthma morbidity. They are more likely to visit the emergency room, be hospitalized, or die from asthma. Simply acknowledging this and realizing that it would help them, and the school nurses and staff who are with them all day to have access to albuterol, is one small thing we can do as a society to help them. Finally, stock albuterol laws that restrict albuterol to children who are known asthmatics go against national stock albuterol policy guidelines and do not work very well. The most recent example of this is in Texas. Previously, Texas restricted their law to children with a documented diagnosis of asthma. They used a fairly liberal definition, in which parents could self-report the diagnosis rather than relying on paperwork completed by a medical professional. Despite this, they found that the policy too restrictive and was not helping enough children. It was feedback from schools and school nurses that helped encourage the change. In 2023, a new version of their law was signed into law. This law is now in line with national guidelines, as SB180 is, and now allows children with respiratory distress to receive albuterol instead of restricting it to those with a confirmed diagnosis. We should take the advice of national experts who have committed their careers to researching this issue and have written the national guidelines, including Dr. Lynn Gerald, who you will hear spoken testimony from. The recent states who have passed or updated stock albuterol policies, including Iowa, Virginia, Texas (updated), and California have all used broad language and not restricted to diagnosed people. We should also learn from the mistakes that have occurred in other states, such as Texas, and not repeat them in Maryland.

There is no substitute for children with respiratory distress that is better than albuterol, including Epi-Pens. For the past several years, opponents of this bill, led by state-based nursing groups, have suggested that Epi-Pen should be the first line treatment for children without a documented asthma diagnosis. This is not correct. Epi-Pens are very effective for food

allergy (anaphylaxis). The law and the policies covering this are excellent and will remain. It is important to recognize in the rare situation that everyone fears, in which a student is having a very severe episode and the school personnel suspects it could be either from anaphylaxis or asthma, but they are not sure for some reason related to the symptoms they see, the Epi-Pen should always be given, followed by the albuterol. This is because the child falls under the current Epi-Pen law and policy. Otherwise, Epi-Pen should never be viewed as an alternative, a superior tool, or even an equivalent tool to albuterol when the school recognizes respiratory distress consistent with an asthma attack. Albuterol is for asthma, and Epi-Pen is for food allergy. Albuterol is for asthma, and Epi-Pen is for food allergy. Epi-Pen laws exist in all 50 states, so that means all 18 states with stock albuterol laws have Epi-Pen laws and school training too. We know that it works very well, a fact that has been published on and recommended to us. School personnel in Maryland can and should be trained to differentiate between respiratory distress indicative of asthma and anaphylaxis, just as they are in other states. We teach this to our young patients and their parents on a regular basis in my clinic, and it is straightforward. The training that is currently available from the American Lung Association and the state of Arizona address this issue.

SB180 is written in line with best practices and according to national stock albuterol guidelines, as well as recent legislation. The policy statement was published in September 2021 in the *American Journal of Respiratory and Critical Care Medicine* in support of school stock albuterol legislation. The coauthors included expert physicians, including myself, pediatric pulmonologists, general pediatricians, pediatric allergists, school nurses, pharmacists, and parents on behalf of cosponsoring organizations: the American Thoracic Society, the American Lung Association, Allergy & Asthma Network Mothers of Asthmatics, and the National Association of School Nurses. SB180, which you are considering today, contains the essential elements of a successful law that this group of experts recommended, including the general respiratory distress requirement, which was strongly recommended in the policy statement.

Stock albuterol programs are cost effective. Data from a stock inhaler project in the urban Sunnyside Unified School District in Arizona showed that a stock albuterol inhaler was given 222 times to 55 children in 20 schools over one year. This resulted in a 20% reduction in emergency calls and a 40% reduction in ambulance transports in that year (Pappalardo, AA and Gerald LB, *Pediatrics*, 2019). The cost per school was $155, which included albuterol, educational and training materials, and disposable spacers (holding chambers).

I often tell my young patients with asthma (and their parents) that asthma does not have to control their life. However, we must consider the vulnerable children with asthma who are currently at risk for life-threatening asthma events in school. Please consider a favorable report for SB180 this year, which will help to ensure that all children with asthma have access to life-saving medication in school and help protect them so that they can go on to enjoy a happy and healthy future. Thank you again for the opportunity to testify today.

Information sources

1. Baltimore City Health Department **https://health.baltimorecity.gov/node/454**
2. Pappalardo AA, Gerald LB. Let Them Breathe: A Plea to Pediatricians to Advocate for Stock Inhaler Policies at School. Pediatrics. 2019 Jul;144(1).

3. Papp EM, Gerald JK, Sadreameli SC, Gerald LB. Why Every School Should Have a Stock Inhaler: One Nurse's Experience. Am J Public Health. 2019 Nov;109(11):1528-1529
4. Asthma and Allergy Foundation of America. Updated October 2021. Accessed February 7, 2022. https://www.aafa.org/albuterol-in-schools/
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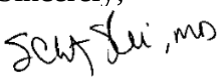
Disclaimer: The views expressed here are my own and do not necessarily reflect the policies or positions of my employer, Johns Hopkins University.

Sincerely,



S. Christy Sadreameli, MD, MHS
Assistant Professor of Pediatrics
Eudowood Division of Pediatric Respiratory Sciences
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Thomas Laudone Letter of Support_HB86_SB180.pdf
Uploaded by: Thomas Laudone
Position: FAV

January 16, 2024

Senator Brian J. Feldman, Chair
Committee on Education, Energy,
and the Environment
2 West
Miller Senate Office Building
Annapolis, Maryland 21401

Delegate Vanessa E. Atterbeary, Chair
Ways and Means Committee
Room 131
House Office Building
Annapolis, Maryland 21401

Delegate Regina T. Boyce, Vice Chair
Environment and Transportation Committee
251 Taylor House Office Building
6 Bladen Street
Annapolis, MD 21401

Senator Katie Fry Hester
Deputy Majority Whip
Committee on Education, Energy, and the
Environment
Public and Nonpublic Schools - Auto-Injectable
Epinephrine and Bronchodilators - Use,
Availability, Training, and Policies

RE: Public and Nonpublic Schools - Auto-Injectable Epinephrine and Bronchodilators - Use, Availability, Training, and Policies

Dear Senator Feldman, Delegate Atterbeary, Delegate Boyce, and Senator Hester and committee members:

Thank you for the opportunity to provide this written testimony. My name is Dr. Thomas Laudone, and I am a pediatric clinical pharmacist in the pediatric emergency department at University of Maryland Medical Center. Asthma is one of the most common chronic disease states in children and accounts for a high volume of emergency department visits among children in Baltimore.

I strongly support House Bill 86 and Senate Bill 180 as originally drafted as it will allow more immediate access to life saving medications for students suffering from an acute asthma exacerbation. Albuterol is a short-acting bronchodilator, given via inhaler with or without an attached spacer, and it works immediately to relax the smooth muscles around the small airways. This medication along with corticosteroids are considered the cornerstone of therapy for acute asthma exacerbations. Albuterol is the first medication administered to patients presenting to the emergency department experiencing respiratory distress secondary to asthma and these patients are typically in severe respiratory distress if they have not received breathing treatments prior to arrival. This group of patients are most at risk of further decompensating and could require higher oxygen support and more invasive interventions such as intubation. I personally have seen numerous patients brought into the emergency department from school via Emergency Medical Services in acute respiratory distress who after receiving intramuscular epinephrine and/or albuterol, improved significantly and did not require admission. Patients who did not receive early administration of albuterol will have a worse prognosis and almost always require admission for ongoing treatment.

House Bill 86 and Senate Bill 180 provide a simple and low-cost solution to treating asthma in children quickly and effectively at school to help prevent overall morbidity and decrease costs to the health system. One of our primary goals is to prevent emergency department revisits and hospital admission and readmission. One way of doing so is ensuring that patients with asthma have an albuterol rescue inhaler available to them at all times. As many as 80% of students with asthma don't have their albuterol inhalers at school. This would help alleviate that issue and make a life-saving medication readily

available for all students with asthma. Additionally, albuterol is safe, effective, easy to administer, and well-tolerated with very minimal side effects including transient increased heart rate and jitteriness. Asthma can be life threatening but if treated quickly and appropriately with albuterol, it is a very reversible disease with very good outcomes for the patient. Not all patients require admission to the hospital as well for an asthma exacerbation which helps decrease overall costs to the entire health care system.

I strongly believe albuterol should be readily available to any and all students with asthma as it very safe/well tolerated, highly effective, and easy to administer. To prevent further delays to implementing this safe, evidence-based practice in Maryland, I strongly support House Bill 86 and Senate Bill 180 and respectfully request your support of these Bills as well. I encourage quick action to move the bill out of committee and passage by the General Assembly to provide students across Maryland access to medication that can improve their overall outcome when experiencing a life-threatening asthma exacerbation at school.

Sincerely,

Thomas Laudone

Thomas Laudone
Thomas Laudone, PharmD, BCPPS
Pediatrics Advanced Practice Pharmacist- Emergency Medicine
Department of Pharmacy Practice and Science
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SB180-AFSCME-FAV.pdf
Uploaded by: Wendy Smith
Position: FAV

Council 3 AFSCME MARYLAND
190 W. Ostend St., #101
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Patrick Moran – President

SB 180 – Public and Nonpublic Schools -Auto-Injectable Epinephrine and Bronchodilators- Use Availability, Training, and Policies
Education, Energy, and the Environment Committee

January 17, 2024

FAVORABLE

Thank you, Chair Fieldman, Madam Vice-Chair Kagan, and members of the Education, Energy and Environment Committee for the opportunity to submit testimony on SB180. My name is Wendy Smith, I have been a registered nurse for 22 years. I'm also the President of AFSCME 3 Local 558 representing registered nurses who work within Baltimore City Public Schools.

As a registered nurse working within the school system, I fully support Senate Bill 180. Baltimore city has a large disproportionate number of students with chronic health conditions. Many of those students are diagnosed with asthma, as well as severe anaphylaxis to certain allergens. I believe that having a standardized quality training program that is provided by professional organizations, such as The American Lung Association and the Asthma and Allergy Foundation of America makes good sense. Due to the shortage of nurses within Maryland's school districts, nurses are assigned to more than one school. Having standardized professional training for school registered nurses, makes the nurse's job easier and saves kids' lives. I also believe as we develop the training that we should solicit input from nurses to ensure the training is realistic and manageable.

I often have parents concerned about the lack in funding for additional Epi-Pens within the schools. As it stands, we are provided one Epi-Pen per school building. The one Epi-Pen provided does not consider the population within that school. It would be reassuring to parents, as well as all stakeholders who are vested in that child's safety, to have additional Epi-Pens and or bronchodilators available for use in easily accessible spaces, such as cafeterias and classrooms.

I thank the sponsors for introducing this bill and I thank the committee for their time and attention to this important matter.

I respectfully ask for your support of SB180.

RT

SB180_MSEA_Lamb_FWA.pdf
Uploaded by: Lauren Lamb
Position: FWA

MARYLAND STATE EDUCATION ASSOCIATION

140 Main Street
Annapolis, MD 21401
800 448 6782
410 263 6600

marylandeducators.org

FAVORABLE WITH AMENDMENTS
Senate Bill 180
Public and Nonpublic Schools – Auto-Injectable Epinephrine and Bronchodilators – Use, Availability, Training, and Policies

Senate Committee on Education, Energy, and the Environment
January 17, 2024

Lauren Lamb
Government Relations

The Maryland State Education Association supports Senate Bill 180 with amendments to return it to the amended form of House Bill 266 (2023) that was passed by the House of Delegate in the 2023 legislative session. As introduced, this bill would require each county board of education and authorize nonpublic schools to update their policies to require school nurses and school personnel to complete certain training before they are authorized to administer auto-injectable epinephrine to certain students and to establish a policy to obtain, administer, and train school personnel to administer bronchodilators to certain students; and requiring the State Department of Education to develop training for school personnel in identification of respiratory distress in students.

MSEA represents 75,000 educators and school employees who work in Maryland's public schools, teaching and preparing our almost 900,000 students so they can pursue their dreams. MSEA also represents 39 local affiliates in every county across the state of Maryland, and our parent affiliate is the 3-million-member National Education Association (NEA).

This legislation seeks to adjust procedures related to the administration of emergency medicines and treatments in schools, including epinephrine and bronchodilators. While we share the goal of keeping all children safe and healthy in school, we must raise our concerns about the consequences of asking non-clinicians such as teachers to make rapid determinations about the appropriate treatment for a student in medical distress. Nurses and other clinical staff are essential to our schools because their specialized medical training allows them to assist students in situations where non-clinical personnel are not equipped to provide treatment.

As written, this bill proposes that non-clinical school personnel could be trained to differentiate between anaphylaxis and asthma or respiratory distress, and from there determine the appropriate treatment. This approach increases health risks for students, places an inordinate burden of diagnosis on nonclinical school personnel,

and is not an appropriate remedy for emergent health situations. Just as teachers train for years in their certification areas, clinical personnel have highly specialized expertise that cannot be replicated in an hours-long training.

Last year, a version of this bill was amended in the House of Delegates to instead establish that students should only be treated with a bronchodilator if it has been prescribed to them. The updated language would better reflect clinical best practice and remedy the issue of non-clinician school personnel determining the source of a student's medical distress. All students and staff should be safe and healthy at school, and the policies required by the amended version of this bill would help protect students from the dangerous effects of asthma, anaphylaxis, and respiratory distress.

We urge the committee to issue a favorable report on an amended version of Senate Bill 180 that is consistent with the version of House Bill 266 (2023) passed by the House in the 2023 legislative session.

SB180_MoCoDHHS_Frey_FWA.pdf
Uploaded by: Leslie Frey
Position: FWA

Montgomery County
Office of Intergovernmental Relations

ROCKVILLE: 240-777-6550 **ANNAPOLIS: 240-777-8270**

SB180 **DATE: January 17, 2024**

SPONSOR: Senator Hester

ASSIGNED TO: Education, Energy, and the Environment

CONTACT PERSON: Leslie Frey **(leslie.frey@montgomerycountymd.gov)**

POSITION: FAVORABLE WITH AMENDMENTS (Department of Health and Human Services)

Public and Nonpublic Schools - Auto-Injectable Epinephrine and Bronchodilators - Use, Availability, Training, and Policies

Among other provisions, Senate Bill 180 requires school nurses and other personnel identified by school nurses to receive a paid professional development training on identifying the symptoms of anaphylaxis, asthma and respiratory distress and distinguishing between anaphylaxis and asthma or respiratory distress. The bill requires each local county board of education to develop a policy for the emergency administration of auto-injectable epinephrine by a school nurse or designated volunteer but does not clarify that the person administering the auto-injectable epinephrine has received the training identified by the bill. The bill further directs each local board of education to establish a policy to authorize school nurses and other school personnel to administer a bronchodilator to a student who is determined by an individual who has undergone the required training that the student has asthma, is experiencing asthma-related symptoms, or is perceived to be in respiratory distress, regardless of whether the student has received a diagnosis of asthma or reactive airway disease from a health care professional or whether the student has been prescribed a bronchodilator by an appropriate health care provider. The provision of the bronchodilator medication is then to be documented and reported to the student's parents or legal guardian and the Maryland State Department of Education.

Montgomery County Department of Health and Human Services (MCDHHS) supports the intent of SB180 to ensure that students have access to life-saving medication when medically necessary. However, the bill presents unfunded mandates on local agencies and places administrative burden on school nurses.

MCDHHS concurs with the Maryland Association of County Health Officers' testimony and requests amendments to remove the requirement to report incidents of bronchodilator usage to parents and MSDE. Additionally MCDHHS respectfully requests that the requirement that school nurses and other personnel receive paid professional development training on the symptoms of anaphylaxis, asthma and respiratory distress be removed. While bronchodilator administration is safe for students, the administration of it under the bill may result in a delay of the administration of lifesaving epinephrine for a student experiencing anaphylaxis if trained staff do not correctly distinguish between anaphylaxis and asthma. Further, students who receive bronchodilator medication who return to the classroom will be monitored by teaching staff who will likely not trained to identify symptoms that may indicate deteriorating health status. Because of the already overburdened status of school health nurses coupled with the impracticality of training every teacher in our schools, the unfunded mandate to only train some school personnel, at a cost to the local health departments, does not resolve the issue of properly administering medication that the bill aims to address. Instead of relying on less experienced proxies to identify anaphylaxis, asthma and related symptoms, efforts should be made to correct the school nurse shortage and improve access to pediatric primary care and in school-based settings. Finally, MCDHHS respectfully requests that the bill be amended to ensure that only students who have been prescribed a bronchodilator by an appropriate health care provider are administered a bronchodilator by school health nurses or school personnel designated by a school health nurse.

SB 180 MD ENA Lisa Tenney written testimony Public
Uploaded by: Lisa Tenney
Position: FWA

EMERGENCY NURSES ASSOCIATION
Maryland State Council
Safe Practice, Safe Care.

To: Maryland Education, Energy, and Environment Committee
Senate Office Building
Annapolis, MD 21401

From: Maryland State Council of the Emergency Nurses Association

Date: January 16, 2024

Re: SB 108 Public and Nonpublic Schools-Bronchodilator and Epinephrine Availability and Use-Policies

Good day Chairman Feldman, Vice Chair Kagan, and Committee members,

The Maryland Emergency Nurses Association (MD ENA) is opposed to SB 180 Public and Nonpublic Schools-Bronchodilator and Epinephrine Availability and Use-Policies, as written, but will support SB 180 if certain amendments are made to the bill for the safety of children in respiratory distress.

This bill advocates for all Maryland schools to maintain a stock of two respiratory distress rescue medications and for them to be administered by nurses, teachers, and other trained school staff.

Physicians, nurses, and paramedics are trained in the assessment and recognition of distinct types of respiratory conditions and their appropriate treatments. They are licensed, trained, and knowledgeable in following doctors' orders for administering emergency medications. They know the indications and contraindications for each medication. This knowledge can make the difference between good outcomes or poor outcomes for children, and even life or death. These licensed healthcare providers know that:

- Epinephrine and bronchodilators are drugs from two different drug classes that are used for varied reasons and at different times during a specific type of respiratory emergency.
- The drug of choice for a patient experiencing anaphylaxis is epinephrine, which stimulates α- and β-adrenergic receptors.
- Epinephrine treats both anaphylactic shock and severe asthma.
- Bronchodilators, such as albuterol, are selective β2 adrenergic receptor agonists, which open the medium and large airways in the lungs. Bronchodilators also relax smooth muscles and prevent bronchospasms in asthmatics.
- Epinephrine relieves low blood pressure in shock and reduces swelling in the upper airway. Bronchodilators do not have these effects and therefore, bronchodilators should never be substituted for Epinephrine.

When a child is in respiratory distress in school, 911 should be called immediately. The on-site licensed healthcare professional should also be called if they are present. The goal is to assure that the child's immediate and long-term medical care needs are addressed. Only licensed health care professionals are trained to recognize and respond to emergencies. They are trained in pharmacology and can safely administer bronchodilators and monitor for side-effects and worsening symptoms. They are equipped to make an assessment and determine which drug should be administered in anaphylaxis vs. asthma vs. airway obstruction vs. another type of respiratory emergency. Teachers or other educational paraprofessionals should not be asked to practice medicine or nursing without a license. MD ENA cannot support unlicensed personnel blindly administering bronchodilators without an order to an undiagnosed child.

Last year the House passed this bill with amendments, and they addressed the above concerns. (In 2023 it was HB 266). The amendments allowed for the creation of a stock of bronchodilators at each school that could be given to a child who was previously diagnosed with asthma and who already had an order for a bronchodilator from a personal physician. The school's bronchodilator stock could be used if the student's own bronchodilator was not available, or if it became contaminated or damaged. The amendments also allow for an enhanced group of school personnel to be trained in the use of epinephrine.

Please know that the Maryland Emergency Nurses Association endorses the current Epinephrine school protocols that allow the use of Epinephrine when a child has an undiagnosed respiratory emergency. (See Education Article 7-426.2). An amendment would allow a child with asthma to receive a previously ordered rescue bronchodilator from the school's stock.

Sincerely,

Lisa Tenney

Lisa Tenney, BSN, RN, CEN, CPHRM, FAEN
Chair, Government Affairs Committee
Maryland State Council Emergency Nurses Association
lctenney@gmail.com
240-731-2736

Resources:
American Heart Association. 2020. Advanced Cardiac Life Support Provider Manual.
American Heart Association. 2020. Advanced Pediatric Life Support Provider Manual.

SB 180 - MDH- SWA.pdf
Uploaded by: Nilesh Kalyanaraman
Position: FWA

Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

2024 SESSION
IN-PERSON TESTIMONY WRITTEN SUPPLEMENT

BILL NO.: SB 180
COMMITTEE: Education, Energy, and the Environment
POSITION: Support with Amendments

TITLE: Public and Nonpublic Schools - Auto-Injectable Epinephrine and Bronchodilators - Use, Availability, Training, and Policies - Letter of Support with Amendments

BILL ANALYSIS: Senate Bill (SB) 180 requires county boards of education to update their policies to require school nurses and personnel to complete training to administer auto-injectible epinephrine and to train school personnel to administer bronchodilators to students. The bill also requires the Maryland State Department of Education to develop training for school personnel in identifying respiratory distress in students.

POSITION AND RATIONALE:

The Maryland Department of Health (MDH) supports the intent of this bill to create a stock bronchodilator program in Maryland schools to improve access to potentially life-saving medication for students with asthma. However, MDH respectfully recommends amendments to the bill as written in order to better ensure the safety of Maryland students and decrease the administrative burden on school nurses.

The bill as currently written authorizes unlicensed school personnel to make clinical decisions about whether to administer a bronchodilator or epinephrine to a student in a potentially life-threatening situation. The bill also requires training of unlicensed school personnel to distinguish between anaphylaxis and asthma in order to determine whether a student with respiratory distress without a previous diagnosis should receive a bronchodilator or epinephrine. Even with training, making this distinction requires a level of clinical assessment that is not appropriate for unlicensed school personnel. Additionally, allowing unlicensed school personnel to determine which medication to administer could result in the initial administration of a bronchodilator to a student with anaphylaxis, putting that student at significant risk due to a potential delay in the correct intervention.

Currently, the bill as drafted does not require a student with respiratory symptoms to have a diagnosis of asthma or a prescription in order to receive treatment with a stock bronchodilator. The bill allows for the ongoing administration of a bronchodilator to a student who may be suspected of having asthma, but has not been evaluated by a licensed healthcare provider, who can make a diagnosis and determine appropriate treatment. Other medical conditions can have symptoms similar to those seen in asthma and

delaying appropriate medical evaluation and intervention could have adverse consequences for a student's health. Further, even in a student with asthma, ongoing treatment without a prescription for a bronchodilator is out of the scope of practice of school nurses, is inappropriate clinical practice, and may also be unsafe for students. Maryland's other stock medication statutes (auto-injectable epinephrine and naloxone) are for administration in emergency situations only. As a result, MDH recommends removal of the requirements for training school personnel and designated volunteers to distinguish between asthma and anaphylaxis or respiratory distress. Further, MDH recommends amending the language to authorize only school nurses and school personnel designated by the school nurse to administer a stock bronchodilator only to students experiencing asthma, asthma-related symptoms, or reactive airway disease (another term for asthma-like symptoms) when the school has evidence of the student being prescribed a bronchodilator.

The bill as currently written also requires that school nurses and other health staff record each use of a bronchodilator on a new standardized form and notify the parent of each use of a bronchodilator. According to data from the 2022-23 School Health Services survey, almost 69,000 public school children had a known diagnosis of asthma. Students with asthma may need to use bronchodilators multiple times a day if they are experiencing symptoms. Recording each incident on a standardized form and notifying parents each time will create an undue administrative burden on school health personnel and take time away from addressing other student health needs. There is already a critical shortage of school nurses in Maryland. MDH recommends amending the language to require reporting only when a stock bronchodilator is used in Maryland schools, similar to the reporting requirements for administration of stock epinephrine and naloxone.

MDH is currently working on proposed amendment language and will share it with the committee as soon as it is available.

If you have any further questions, please contact Sarah Case-Herron, Director, Office of Governmental Affairs at sarah.case-herron@maryland.gov.

Sincerely,

Laura Herrera Scott, M.D., M.P.H.
Secretary

2024 MNA and MASHN SB 180 Side.pdf
Uploaded by: Robyn Elliott
Position: FWA

Committee: **Senate Education, Energy, and the Environment**

Bill Number: **SB 180 – Public and Nonpublic Schools – Auto-Injectable Epinephrine and Bronchodilator – Use, Availability, and Policies**

Hearing Date: **January 17, 2024**

Position: **Support with Amendments**

The Maryland Nurses Association and the Maryland Association of School Health Nurses supports *Senate Bill 180 – Public and Nonpublic Schools – Auto-Injectable Epinephrine and Bronchodilator – Use, Availability, and Policies,* but we request amendments that provide safeguards for when a student is at risk of anaphylaxis. The bill's intent is to safeguard the health of students in respiratory distress, but the bill raises safety concerns in its implementation.

The bill's focus is on strategies to address respiratory distress for children:

- Creation of a stock bronchodilator program to support children with asthma who do not have access to their prescribed bronchodilator. We agree that this strategy is worth serious consideration. It could be accomplished through legislation, although it could also be accomplished through an update to the School Health Guidelines.

- Administration of stock bronchodilator to a child in respiratory distress who has not been diagnosed with asthma and does not have a prescription for a bronchodilator. The bill authorizes either school nurses or trained school staff to

make the determination of when to administer a bronchodilator vs epinephrine. It is this provision that raises concerns as we have detailed below.

Unintentional Risk to Students' Health

We are concerned that this bill will create unintended risk for students, particularly for those at risk of anaphylaxis.

- **Children with Anaphylactic Shock at Heightened Risk:** The core issue is that anaphylactic shock can present itself as respiratory distress with near identical symptoms as asthma. For this reason, school protocols require the use of epinephrine when a child has an undiagnosed respiratory illness.

  This bill relies heavily on school personnel without clinical backgrounds to make a determination about the use of bronchodilators vs epinephrine for students without an asthma diagnosis or bronchodilator prescription. This provision creates significant risk for some students, as students in anaphylactic shock could be given a bronchodilator instead of epinephrine.[i] In these cases, the student could appear to recover temporarily, as the bronchodilator would alleviate respiratory symptoms, but the student's underlying health, or even life, would be at even greater risk because treatment for anaphylactic shock would be delayed[ii].

  The bill proposes that teachers and other non-clinical school personnel be trained to "distinguish between anaphylaxis and asthma or respiratory distress." This is an unsafe responsibility to place on teachers and other nonclinical school personnel. Distinguishing between anaphylaxis and asthma is complicated and should only be done by licensed clinicians and first responders, such as emergency medical technicians and paramedics. [iii] Teachers and other nonclinical school personnel should not bear the responsibility of making a life-altering clinical decision that could jeopardize the health or even the life of a student.

- **Fewer School Personnel Would Be Trained in Use in Epinephrine:** While the bill's main focus is the use of bronchodilators, the bill re-writes the framework for the epinephrine program; and the unintended result is that far fewer school personnel will be trained in the use of epinephrine.

  Under the existing law under Education Article 7–426.2 "Each county board shall establish a policy for public schools within its jurisdiction to authorize the school nurse and other school personnel to administer auto–injectable epinephrine." The bill interjects a new requirement for school personnel to complete a training program on making the determination of when to use bronchodilators vs epinephrine. There may be few school personnel who want to take on that level of responsibility, and they must be approved by the school nurse. School nurses cannot ethically or legally authorize someone to take the training unless they thought they could be truly competent to make emergency clinical assessments.

Conclusion and Recommended Amendments

The House passed a version of this bill last year (HB 266) with amendments that address our concerns. The amendments refocused the bill on creating a stock bronchodilator program for students with bronchodilator prescriptions. The amendments also ensured that a broad number of school personnel could continue to be trained in the use of epinephrine.

We ask that the Senate adopt last year's House amendments. We are aware that there may be other stakeholders who recommend amendments, and we would be very happy to work with other stakeholders to see if there should be any updates to the amendments adopted by the House last year. If we can provide any further information, please contact Robyn Elliott at relliott@policypartners.net.

[i] https://emj.bmj.com/content/emermed/19/5/415.full.pdf
[ii] https://emj.bmj.com/content/emermed/19/5/415.full.pdf
[iii] Ibid

SB180- SEN - EEE - MACHO - LOSWA.doc.pdf
Uploaded by: State of Maryland (MD)
Position: FWA

2024 SESSION
POSITION PAPER

BILL:	**SB 180 - Public and Nonpublic Schools – Auto-Injectable Epinephrine and Bronchodilators – Use, Availability, Training, and Policies**
COMMITTEE:	**Senate – Education, Energy, and Environment Committee**
POSITION:	**Letter of Support With Amendments**
BILL ANALYSIS:	**Senate Bill 180 requires each local board of education to establish a policy for public schools to authorize the school nurse and other school personnel (including personnel with no medical training) to administer auto-injectable epinephrine to students perceived to be in anaphylaxis and bronchodilators to a student who is experiencing asthma-related symptoms or perceived to be in respiratory distress, regardless of whether the student has a diagnosis of asthma or has a prescription for a bronchodilator by an authorized licensed health care practitioner. The bill also requires the policy to include paid professional development training, developed by MSDE for school nurses and other personnel on how to recognize the symptoms of asthma, respiratory distress, and anaphylaxis. The bill requires that a student's parents be notified of the administration of a bronchodilator and records be kept and reported to MSDE. The bill also authorizes each nonpublic school to establish a policy that meets the same requirements.**

POSITION RATIONALE: The Maryland Association of County Health Officers (MACHO) offers support for the overall goals of SB 180 while respectfully requesting the bill be amended after discussions with both primary bill sponsors in the House and Senate. MACHO supports the intent of the bill to improve student access to potentially life-saving medication such as bronchodilator rescue inhalers and auto-injectable epinephrine. More than half (14) of MACHO's member Health Officers run local health departments which operate the school health program in the school systems in their jurisdictions.

As currently written, the bill poses *unfunded* mandates on local agencies and additional administrative burdens on already overtaxed school nurses and other school health staff. MACHO requests amendments to the bill to:

- Remove requirement to notify students' parents and legal guardians of the use of a bronchodilator and report to the Department the number of incidents of bronchodilator use at the school or related events, unless the treatment is administered to a student for whom asthma had not been previously diagnosed:
    - Add to Page 7, Line 32 after "BRONCHODILATOR": "FOR A STUDENT NOT PREVIOUSLY DIAGNOSED WITH ASTHMA"
- Add liability protection for both prescribers of school bronchodilators and any pharmacist or pharmacy filling the prescription:
    - Add to Page 7, line 27 AFTER "CHILD IN DISTRESS": "NOR ANY AUTHORIZED LICENSED PRESCRIBER PROVIDING THE STANDING PROTOCOL OR PRESCRIPTION OF A SCHOOL BRONCHODILATOR AND ANY PHARMACIST OR PHARMACY FILLING THE PRESCRIPTION ARE TO INCUR LIABILITY FOR THE PRESCRIPTION OR ADMINISTRATION OF STOCK BRONCHODILATORS TO STUDENTS WITH ASTHMA OR SUFFERING FROM RESPIRATORY DISTRESS,"

The above changes should be mirrored in Section 7–426.7.

615 North Wolfe Street, Room E 2530 // Baltimore, Maryland 21205 // 410-937-1433

- MACHO also requests that the effective date of the bill be moved from July 1, 2024, to a later date, to give schools and school health staff enough time to implement the trainings required by the bill and secure bronchodilators and auto-injectable epinephrine, as available.

Across the State, there are tens of thousands of students with asthma enrolled in our schools. The tracking and submittal of incident reports each time a bronchodilator is administered to students would be a significant administrative burden on school health personnel and serves no clear objective for students with an established diagnosis of asthma. There is already a critical shortage of school health staff in Maryland. Every minute spent on these thousands of reports takes nurses and other school health staff away from providing healthcare services to students in need.

Lastly, MACHO raises concerns of the intent of the bill to provide treatment access to students who have not received medical care, even a diagnosis, for their chronic asthma symptoms. Management of asthma is complex and requires resources and expertise not available or appropriate in a school health setting, including clinical testing and assessment, daily prevention medication, and teaching on proper medication usage techniques. It is important that the increased access to bronchodilators in schools resulting from this bill not unintentionally divert children away from the appropriate diagnosis and management of chronic asthma by healthcare providers. *MACHO remains very concerned about the school nurse shortage in the state, access to pediatric primary care, and access to pediatric primary care in school-based settings and urges the committee to consider comprehensive policies to ensure that students have access to the appropriate asthma evaluation and medications they need and the appropriate staffing to support these efforts.*

For these reasons, MACHO submits this Letter of Support With Amendments for the Committee's consideration on Senate Bill 180. For more information, please contact Ruth Maiorana, Executive Director, MACHO, at rmaiora1@jhu.edu or 410-937-1433. *This communication reflects the position of MACHO.*

SB 180.Bronchodilator Availability and Use Policy

Uploaded by: John Woolums

Position: UNF

MABE
MARYLAND ASSOCIATION OF BOARDS OF EDUCATION

621 Ridgely Avenue, Suite 300, Annapolis, Maryland 21401
410-841-5414 · 800-841-8197 · Fax: 410-841-6580 · MABE.org

BILL: Senate Bill 180
TITLE: Public and Nonpublic Schools - Bronchodilator and Epinephrine Availability and Use - Policies
DATE: January 17, 2024
POSITION: OPPOSE
COMMITTEE: Education, Energy, and the Environment
CONTACT: John R. Woolums, Esq.

The Maryland Association of Boards of Education (MABE) opposes Senate Bill 180 in favor of maintaining the current law governing the availability and use of auto-injector epinephrine (EpiPens) in schools and current law ensuring that schools meet the health needs of students with asthma, including the availability and use of bronchodilators (inhalers).

MABE shares the objections raised by school nurses about the risks and unintended consequences associated with this legislation, particularly as amended to combine provisions related to the use of EpiPens and inhalers based on decisions made in emergency situations by non-health professionals. This bill would require each local board to establish a policy to authorize not only the school nurse but also other designated personnel to administer an inhaler or EpiPen to a student. Further, the bill would require that these new policies cover instances when a student is determined to have asthma, or is experiencing asthma-related symptoms, or is perceived to be in respiratory distress, regardless of whether the student has been diagnosed with asthma or has a prescription for a bronchodilator.

In contrast to Senate Bill 180, MABE has supported legislation in recent years to ensure that school health guidelines are updated and strengthened, including bills enacted to ensure that school health plans adequately address students with diabetes and students with sickle cell disease. These bills were crafted to ensure a high degree of care and heightened awareness among school personnel regarding the needs of students with diabetes, sickle cell disease, and other health conditions including seizure disorders.

MABE also wants to assure the legislature that local school systems are already operating in accordance with Maryland law that requires specific student health policies and services, including compliance with state guidance on emergency care planning for all students under state law and regulations (Sections 7-401 and 7-426 of the Education Article). Under the law, MSDE and the Maryland Department of Health must provide technical assistance to schools to: implement the adopted guidelines, train school personnel at the local level, and develop a process to monitor the implementation of the guidelines. State law also establishes the office of the school health services program coordinator, who is responsible for implementing State and local health policies in the public schools. Key responsibilities of the school health coordinator include ensuring that public schools adhere to local health services guidelines and communicating State and local health policies to the parents and guardians of public school students.

Local boards of education place a very high priority on student health, by ensuring that schools are operating in accordance with adopted state school health guidelines and local policies and procedures intended to provide a health and safe school environment conducive to student learning. The well-intended policy changes underlying this legislation would be better addressed through updating these separate guidelines regarding the very different issues of anaphylaxis and asthma.

For these reasons, MABE urges an unfavorable report on Senate Bill 180.

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Uploaded by: Laurel Cratsley
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Maryland
STATE DEPARTMENT OF EDUCATION

Carey M. Wright, Ed.D.
Interim State Superintendent of Schools

BILL:	**SB0180 -** Public and Nonpublic Schools – Auto-Injectable Epinephrine and Bronchodilators – Use, Availability, Training, and Policies	**DATE:**	January 17, 2024
SUBJECT:	Letter of Information	**COMMITTEE:**	Senate Education, Energy, and the Environment
POSITION:	Information only		
CONTACT:	Akilah Alleyne, Ph.D. akilah.alleyne@maryland.gov 410-767-0504		

The Maryland State Department of Education (MSDE) provides this information for your consideration of SB0180- *Public and Nonpublic Schools – Auto-Injectable Epinephrine and Bronchodilators – Use, Availability, Training, and Policies.*

Current Practice

In 2023, the Maryland General Assembly enacted Chapter 770 which amended Md. Code Ann., Educ. § 7–426.1 to require each county (LEA) board to adopt and implement guidelines to reduce the risk of exposure to anaphylactic major food allergens in classrooms and common areas. The statute requires the principals of public schools in consultation with a school health professional to implement strategies to monitor and implement the guidelines established by the LEA. Revisions were made to the guidance document, Management of Anaphylaxis in Schools. The guidelines contain recommendations for minimum standards of care and current best practices for students with anaphylactic allergies. MSDE has developed and implemented a form for reporting instances of administration of epinephrine.

In current law, Education Article § 7-426 requires MSDE and the Maryland Department of Health (MDH) to jointly establish guidelines for public schools regarding providing emergency medical care to students with special health needs. Eaach local education agency (LEA) must establish a policy authorizing administration of auto-injectable epinephrine. Education Article § 7-426.3 also states that each nonpublic school in the State may establish a policy authorizing school personnel to administer auto-injectable epinephrine, if available, to a student who is determined to be or perceived to be in anaphylactic shock regardless of whether a student has been identified as having an anaphylactic allergy or has a prescription for epinephrine as prescribed by an authorized licensed health care practitioner.

SB0180

SB 180 adds a requirement that the person administering emergency medical care to students be trained to identify symptoms of asthma and respiratory distress, identify symptoms of anaphylaxis, and distinguish between anaphylaxis and asthma or respiratory distress. The training will be identified or developed by

MSDE, in consultation with MDH, the American Lung Association, and the Asthma and Allergy Foundation of America. The administration of auto-injectable epinephrine can be done by a school nurse or a designated volunteer who has been trained.

SB 180 requires that state guidelines and local polices also address the administration of a bronchodilator to a student who is determined to be experiencing asthma related respiratory distress. This determination will be made by the school nurse of other school personnel who have undergone training. An incident reporting form for use of a bronchodilator will be required.

The required activities for public schools can be carried out within the current scope of work of MSDE using existing resources.

Non-public schools may not have a full-time school nurse on site. Given that SB 180 requires a school nurse to identify those individuals who will receive training, the bill would require nonpublic schools that wish to implement the SB180 to employ a school nurse for this purpose or coordinate supervision with a nurse consultant who is off site. There are currently 882 approved nonpublic schools under COMPAR 13A.09.09. Of these 441 are registered church-exempt schools and 371 are private pay approved schools. There are also 70 publicly funded nonpublic special education schools approved under COMAR 13A.09.10. If a publicly funded nonpublic special education school does not currently employ a school nurse may request a funding increase from MSDE through the Nonpublic Tuition Assistance Program to staff a school nurse position.

Training

SB 180 states that school personnel, designated by the school nurse, participate in "paid professional development training" (proposed 7-426.2 (c)(3)). In school health services, training and professional development are provided by LEAs, MSDE, and other providers. Training and guidance documents cover a wide range of student health care needs, from first aid to specialized health care needs such as asthma. For some issues, training must be provided annually for all staff; in other cases, it is more specialized. Training occurs throughout the school year and typically occurs during the workday (e.g. during after-school all staff meetings, during school year professional development days, or during summer professional development). Training and professional development are considered a part of the job responsibilities of school-based and central office staff. When training or professional development is during the workday, there is no additional payment outside of salary. If training were required outside of the workday, payment would be required but that is not typical and would be costly for the LEAs. It would be a unique circumstance to pay school staff to participate in this type of training, as proposed in SB 180.

Auto-injectable epinephrine

LEAs and nonpublic schools can participate in the national program, EPIPEN4SCHOOLS program, offered by VIATRIS, Inc. The local school health services programs and local school nurses in both public and nonpublic schools may request and receive up to four free EpiPen 0.3 mg and EpiPen Jr. 0.15 mg autoinjectors per school to help improve access to epinephrine in the school setting. LEAs and nonpublic schools may need to budget for extra epinephrine autoinjectors for each school building. The website information for the Free EpiPens for Schools is: https://www.epipen.com/en/hcp/for-health-care-partners/for-school-nurses. The American Academy of Allergy, Asthma & Immunology sponsors a School Stock Inhaler Program with

information available online at https://www.aaaai.org/tools-for-the-public/latest-research-summaries/the-journal-of-allergy-and-clinical-immunology/2021/school-inhaler.

Please contact Dr. Akilah Alleyne at 410-767-0504, akilah.alleyne@maryland.gov, if additional information is needed.

SB 180_MIEMSS Letter of Concern and Information.pd
Uploaded by: Theodore Delbridge
Position: INFO

State of Maryland
Maryland Institute *for* Emergency Medical Services Systems

Wes Moore
Governor

Clay B. Stamp
Chairman, EMS Board

Theodore R. Delbridge, MD, MPH
Executive Director

January 17, 2024

The Honorable Brian J. Feldman
Chair, Senate Education, Energy, and the Environment Committee
Maryland General Assembly
2 Miller Senate Office Building
Annapolis, Maryland 21401

Re: SB 180 – Public and Nonpublic Schools – Auto-Injectable Epinephrine and Bronchodilators – Use, Availability, Training, and Policies – Letter of Information

Dear Chair Feldman:

On behalf of the Maryland Institute for Emergency Medical Services Systems (MIEMSS) and the State Emergency Medical Services (EMS) Board, I am writing to provide information the Committee may find helpful as it considers SB 180.

As you know, MIEMSS is an independent State agency responsible for coordinating Maryland's statewide EMS System. MIEMSS is governed by an 11-member State EMS Board appointed by the Governor. Among other things, the EMS Board is responsible for licensing and certification of all EMS personnel, including Emergency Medical Responders (EMRs), Emergency Medical Technicians (EMTs) and Paramedics. See §§13-516 Education Art., MD Code Ann.

SB 180 requires each local board of education, and authorizes nonpublic schools, to establish a policy to obtain and administer bronchodilator medication to a student experiencing asthma-related symptoms and to obtain and administer auto-injectable epinephrine to a student determined or perceived to be in anaphylaxis. Under the bill, these medications may be administered by school nurses or by other individuals who have undergone training, if available. Since school nurses or certified nursing aides are not available in every school in Maryland, the bill contemplates emergency care being provided by other individuals who have no specified medical training.

In an emergency, recognizing and differentiating between respiratory distress caused by asthma, for which a bronchodilator would be administered, and a severe allergic reaction, for which epinephrine would be administered, is not a simple task for a health care practitioner, let alone a lay person. Treatment of these conditions is not without risk. Neither medication is "over-the-counter," and requires a physician's prescription or order after a sufficient evaluation of the recipient (patient). In the case of epinephrine, decisions about specific dosages are required. For this reason, EMRs may not administer these medications independently, despite being State-certified after completing at least 51 hours of classroom training and passing a psychomotor/ practical exam and a National Registry EMR cognitive exam – far more training than is likely to be provided to individuals under this bill. Other levels of EMS Clinicians (e.g., EMTs and Paramedics) are authorized to administer these medications, following specific protocols or after consultation with an EMS Base Station Physician and after a sufficient physical examination of the patient.

Finally, individuals attempting to differentiate between the asthma and a severe allergic reaction so as to administer the proper medication may delay calling 9-1-1 when, in fact, calling 9-1-1 should be the first response to the emergency situation.

Several years ago, MIEMSS worked with the Maryland State Department of Education and the Maryland Department of Health to develop "Guidelines for Emergency Care in Maryland Schools: Guidelines for helping an ill or injured student when the school nurse is not available." The Guidelines set forth recommended procedures for school staff with minimal training to guide decision making in an actual emergency. The algorithms contained in the Guidelines reflect established first aid and emergency response standards. Developing / updating these Guidelines presents a useful forum within which to consider and recommend treatment for respiratory distress and other emergencies in school children.

I hope you find this information helpful. Please let me know if you have any questions or if I may provide any further information.

Sincerely,

Theodore R. Delbridge, MD, MPH
Executive Director