ALA_MD_Senate_Asthma Testimony - HB 384 - 4-5-22.p
Uploaded by: Aleks Casper
Position: FAV

American Lung Association Testimony House Bill 384
Senate Education, Health and Environmental Affairs Committee
April 5, 2022
Support

Chair Pinsky and Members of the Committee:

Thank you for the opportunity to provide comments on House Bill 384, Bronchodilator Rescue Inhaler Law sponsored by Delegate Boyce. 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 6.1 million children have asthma. In Maryland, just over 129,000 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 and an initiative the Lung Association would be happy to support at this time, 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.

HB 384 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.

That is why HB 384 is so 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, 16 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 HB 384. 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*** House Bill 384 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,

Aleks Casper
Director of Advocacy, Maryland
202-719-2810
aleks.casper@lung.org

Bronchodilator Availability

Uploaded by: Charmayne Anderson
Position: FAV

8229 Boone Boulevard, Suite 260, Vienna VA 22182 • 800.878.4403 • *AllergyAsthmaNetwork.org*

Testimony
Senate Committee on Education, Health, and Environmental Affairs
on
Public and Nonpublic Schools - Bronchodilator Availability and Use - Policy (HB384)
Maryland General Assembly
April 5, 2022

Allergy & Asthma Network ("Network"), the leading national nonprofit dedicated to ending needless death and suffering due to asthma, allergies and related conditions **supports bill HB384 *Public and Nonpublic Schools – Bronchodilator Availability and Use***. This legislation authorizes schools in the state of Maryland to purchase, acquire, and possess albuterol inhalers and disposable spacers for use by a trained employee or agent in an emergency for a student experiencing symptoms of respiratory distress. This legislation will help any student who either does not have their own medication available or experiences respiratory distress for the first time.

With more than 24 million Americans living with asthma, including six million children, asthma remains one of the most serious chronic diseases. Asthma is the number one reason that children and youth are absent from school. Approximately 3,600 Americans die each year from asthma and this chronic condition costs the U.S. healthcare system $80 billion annually in direct healthcare expenditures (emergency department visits and hospitalizations) and indirect costs from lost productivity (missed school days and work days).

The U.S. Department of Education and the U.S. Department of Health and Human Services recommend that schools develop and maintain comprehensive management plans to support children with lower airway disorders, such as asthma, and help control their disorders while in school. Most schools, unfortunately, do not maintain such plans and are ill-prepared for emergencies. This type of preparation and management in schools will not only improve a child's health, but also ensure students are able to focus on learning while in school.

When the *Asthmatic Schoolchildren's Treatment and Health Management Act* was signed into law in 2004, it led to legislation in all 50 states ensuring schoolchildren with asthma had the right to self-carry and administer their quick-relief bronchodilator inhaler at school. There is a movement in states across the country to pass laws or guidelines that standardize asthma management plans in schools and permit schools to stock emergency supplies of albuterol inhalers with a prescription and administer to a student believed to be in respiratory distress. Currently 16 states (Arizona, Arkansas, Georgia, Illinois, Indiana, Kentucky, Missouri, Nebraska, New Hampshire, New Mexico, New York, Ohio, Oklahoma, Texas, Utah, and Virginia) have laws or guidelines in place.

At the federal level, the *School-Based Allergies and Asthma Management Program Act* sponsored by House Majority Leader Steny Hoyer (Maryland) became law in January 2021 to encourage more schools around the country to put comprehensive asthma and allergy management programs in place by increasing federal grant preferences to states. The grant incentive comes by way of the Centers for Disease Control and Prevention's ("CDC") National Asthma Control Program ("NACP") which supports efforts in the states to track asthma prevalence, promote asthma control and prevention and build capacity in state and local health programs. Maryland was a CDC NACP grant recipient in 2013 and was approved for funding in 2014 but along with 12 other states including DC, it was not funded. Prior to 2013, 40 states were funded. Currently only 23 states including the City of Houston, TX and Puerto Rico are funded. Together with other national asthma stakeholders, Allergy and Asthma Network is seeking increased funding in fiscal year (FY) 2023 for the NACP. With increased funding, the CDC hopes to expand the NACP to ultimately reach all U.S. states and territories. If this bill (HB384) becomes law, it will help position the state of Maryland for NACP funds in future grant rounds.

In closing, Allergy & Asthma Network commends Maryland Delegate Regina Boyce for her leadership on this issue. We appreciate your consideration and hope this legislation becomes law. Thank you.

Bronchodilator Rescue Inhaler Law

Uploaded by: Delegate Boyce Delegate Boyce
Position: FAV

Regina T. Boyce
Legislative District 43
Baltimore City

Environment and
Transportation Committee

Subcommittees
Environment
Motor Vehicle and Transportation

THE MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

Annapolis Office
The Maryland House of Delegates
6 Bladen Street, Room 316
Annapolis, Maryland 21401
410-841-3476 · 301-858-3476
800-492-7122 *Ext.* 3476
Fax 410-841-3295 · 301-858-3295
Regina.Boyce@house.state.md.us

April 5, 2022

RE: Testimony HB384, Public and Non-Public Schools – Bronchodilator Availability and Use Policy (Bronchodilator Rescue Inhaler Law)

Education, Health and Environmental Affairs Vice Chair, and Committee Members,

For the record, I am Delegate Regina T. Boyce testifying today on **HB384 Public and Non-Public Schools – Bronchodilator Availability and Use Policy (Bronchodilator Rescue Inhaler Law).**

HB384 quires public schools in the state, and authorizes nonpublic schools**, to establish a policy to stock inhalers (albuterol) in schools for emergency purposes (recue inhaler),** requiring select school personnel to be trained to administer the inhaler in the absence of a school nurse and removes personal liability of nurse and personnel.

According to the Asthma and Allergy Network, **7.6% of Maryland Children,** have been diagnosed with asthma, **56% of children with asthma do not have an asthma plan** on file at their school, and it is reported that **19.2% of parents with asthmatic children** report that their children missed 1-2 days of school because of their asthma. Asthma is one of the leading causes of school absenteeism in the country alone. Add to those stats the number of individuals who haven't been diagnosed with asthmas and the growing shortage of school nurses, we have a risk management dilemma. In the U.S., asthma is responsible for 10 deaths a day. Given these stats and risks, states are considering stock albuterol (rescue inhalers) in policy and guidelines. Currently, **14 states** (Arizona, Arkansas, Georgia, Illinois, Indiana, Kentucky, Missouri, New Hampshire, New Jersey, New Mexico, Ohio, Oklahoma, Utah, and Virginia) have stock albuterol laws, and 2 states (New York and Nebraska) have stock albuterol guidelines. At the federal level, Congressman Steny Hoyer introduced and passed HR2468 **"School Based Allergies and Asthma Management Program Act", December 2020.** The bill amends the Public Health Service Act to increase the preference given in awarding certain allergy and asthma related grants to states that require certain public schools to have allergy and asthma management programs. This federal act allows states to create and implement programs as needed with financial assistance.

What I've learned about Asthma is that you cannot diagnoses it without first having an incident, or an asthma attack. **Unfortunately for some, an asthmatic incident or attack is the first and last sign of a respiratory condition.**

An inhaler is as important and lifesaving as an EpiPen, and Naloxone (Narcan). It must be available in our schools, and it must be added as a stock item to the lifesaving tool box for our schools and school professionals.

Thank you for your time and consideration of HB384. I ask for a favorable report.

Regina T. Boyce

Written Testimony HB384.pdf
Uploaded by: Elaine Papp
Position: FAV

Written Testimony for House Bill 0384
"Public and Nonpublic Schools – Bronchodilator and Epinephrine Availability and Use (Bronchodilator Rescue Inhaler Law)."
Prepared by: Elaine M. Papp RN MSN COHN-S(R), CM(R) FAAOHN

Dear members of the Senate Education, Health and Environmental Affairs Committee,

Thank you for the opportunity to provide written testimony on this bill. 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, and our rationale. I also include my perspective as a nurse advocate about 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 it was locked in the gym teacher's desk and the gym teacher was not in the building. Although 911 was called, they were very delayed in responding. I assessed the situation quickly, as I have been trained to do. I didn't know the student. I didn't have medication for her. And, I had no doctor's order for an inhaler for her in the school health clinic, even though she had a prescribed albuterol inhaler on the school premises..

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 quickly becoming 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. I requested that the principal find me any student's rescue inhaler (albuterol inhaler).

Albuterol Inhalers are universally used as rescue inhalers for people with asthma. In fact, albuterol inhalers are the first line therapy for emergency relief of bronchospasm and are given in a standard dose. The student in crisis had an albuterol inhaler that was provided by her physician. It was inaccessible. Using another student's albuterol for this student was the best choice at the time. The other student's inhaler contained the same medication as had been prescribed for the distressed student. Thus, I gave the unconscious student another student's albuterol inhaler.

Within a few minutes of administering the albuterol, her respiratory rate lessened, and her heart rate came down. Her mother arrived, and I told her what I had done. She was grateful. Soon, the student regained consciousness. 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 and The American Lung Association. Our ad hoc group also worked with a school-age asthma researcher from the University of Arizona. 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 HB 0384. We are in the forefront of an important movement.

OUR RATIONALE

Children cannot be diagnosed with asthma until they have had their first asthma flare, commonly called an “asthma attack.”As Dr. Ben Wormser at Johns Hopkins (previous ad hoc group member) states, “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. Since children spend the majority of their awake time at school, it is very likely that this first asthma attack will occur during the school day. We need to make sure our schools are ready to treat them when 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.

THE PROBLEM AS I SEE IT

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 am not the only nurse that has experienced this, 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 had an EpiPen for allergic reactions. I had Narcan for opiate overdoses. Yet, I did not have a medication to administer for the most common life-threatening illness among Maryland’s children.

I strongly advocate for passage of this bill HB 384 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

HR0384 contains provision for training non-medical school personnel to administer an albuterol inhaler during an emergency. 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 fro 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 HB0384, 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. 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, because the two drugs are so similar: they are both used in life-threatening emergency situations, simple to administer, 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 puffs or 30 doses (2 puffs per doses). Thus, 30 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. In fact, many hospitals carry “universal inhalers” in their pharmacy department for unexpected asthma flares.
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 in a one-time start-up cost. Similar resources exist in other states and have been shared with us.
4) Total cost of supplies per year: $60.00 per school
   - Average cost of an albuterol inhaler is $40.00.
   - The cost of a package of 25 disposable spacers is $18.95.
   - I suspect that bulk ordering through the school purchasing plan may reduce the cost per package.

In addition, we have included a provision to allow schools to receive donations to successfully administer the emergency bronchodilator program. I intend to offer oral testimony as well as this written testimony. I am available for questions. I encourage you to vote yes on HB 384 . Thank you for your consideration.

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

K. Babcock written testimony HB384 2_8_22.pdf
Uploaded by: Karen Babcock
Position: FAV

Karen Babcock, B.S., R.R.T.
Pediatric Respiratory Clinical Coordinator
Johns Hopkins Hospital
200 North Wolfe Street
Baltimore, Maryland 21287-2533
(410) 955-2035
(410) 955-1030 (fax)

Testimony for House Bill 384
April 4, 2022
Public and Nonpublic Schools – Bronchodilator Availability and Use – Policy (Bronchodilator Rescue Inhaler Law)

Dear Chair Pinsky, Vice-chair Kagan, and members of the Education, Health, and Environmental Affairs Committee:

My name is Karen Babcock, and I am a respiratory therapist at Johns Hopkins. I am testifying today in support of HB384 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 run the pulmonary function lab associated with the main pediatric pulmonary clinic at our Baltimore location and also have supervisory responsibilities for other respiratory therapists at my institution. 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. 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

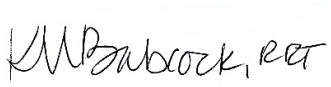
"respiratory distress" because the downsides of giving albuterol to someone who is not having an asthma issue are negligible, and the risk of not giving this medicine to an asthmatic in distress are large. The risk/benefit favors giving the medication. If the law is written only for children with confirmed 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.

Similar to giving Epi-Pen for a food allergy emergency, 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. 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 HB 384.

Sincerely,



Karen Babcock, B.S., R.R.T.
Pediatric Respiratory Clinical Coordinator

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

Micaela Fritz
Nurse Practitioner
Johns Hopkins Hospital
Department of Pediatrics- Pediatric Complex Care
1800 Orleans Street
Baltimore, Maryland 21287
(410) 955-5000

Testimony for House Bill 0384
April 4, 2022
Public and Nonpublic Schools – Bronchodilator Availability and Use – Policy
(Bronchodilator Rescue Inhaler Law)

Dear Chair Pinsky, Vice-chair Kagan, and members of the Education, Health, and Environmental Affairs Committee:

Thank you for the opportunity to provide this testimony. 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 through December 2021. I am testifying today in support of this bill that would provide emergency albuterol in schools.

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. Parents were required to submit an emergency preparedness form and any medications a student may require at the beginning of the school year. However, oftentimes parents would either forget to submit this information or more often, simply send their child to school with their medication in their backpack without providing the school with medication or submitting the proper paperwork for the school to be able to provide the medication.

If a student was caught with a medication (such as albuterol) that did not have appropriate documentation, the medication would be confiscated and held until the parent came to pick the student up. Even if the student had an asthma attack, I would not be allowed to administer the medication they had on hand. Instead, I would be required to dial 911 and expected to wait. This would lead to a delay in care, exacerbation of symptoms and without treatment with albuterol, even death may occur.

I had an incident this past fall where a student who was a known asthmatic needed albuterol. He was sent to the health room for a cough and was noted to have bilateral wheezing on exam- there was no question that this was an asthma attack. 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 (which was not empty), stopped working. There seemed to be something wrong with the device. 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 this one. Not only would I have had my own albuterol inhaler supply, I would have had permission to use it in emergency situations. Some nurses in my shoes who have done something similar have lost their jobs. Fortunately, I did not, and medically, I know it was the right thing to do. Now imagine a scenario where the child didn't have a backup inhaler in his pocket- I am not sure what would have happened, but the situation could have been dire, even life-threatening to the student. This is actually quite a scary thing to consider for this child, who could have had a bad outcome, and for healthcare professionals like myself, working in a school environment and knowing they may not have access to a common lifesaving drug when we need to use it.

I strongly urge you to consider supporting this bill, which will help to ensure that all children with asthma have access to life-saving medication at school. Thank you.

Senate; MD HB384 bronchodilator written testimony
Uploaded by: Sara Choi
Position: FAV

Testimony for House Bill 384

April 5th 2022

HB 384 Public and Nonpublic Schools – Bronchodilator and Epinephrine Availability and Use

Dear Senate Education, Health, Environmental Affairs committee members and others:

Thank you for allowing me to provide my testimony in support of this bill which would provide albuterol in emergency situations within the Maryland schools. My name is Sara Choi, and I am a pediatric pharmacist at the Johns Hopkins Pediatric Emergency Department. As a health care provider who sees first hand many children presenting to the emergency department due to respiratory distress, I am testifying today to the safety and efficacy of albuterol inhalers and to the necessity of this legislation.

In the event of an asthma attack, inflammation and constriction of the small, microscopic airways in the lungs can lead to difficulty breathing, wheezing, and respiratory distress. Albuterol is a medication that works quickly to relax the smooth muscles in these small airways, which opens them up and makes it easier for a person to breathe. Patients with asthma refer to this medication as their "rescue inhaler," and it is an essential medication for them to have access to at all times. Immediate interventions are necessary in anyone presenting with severe respiratory distress because, if untreated, an asthma attack can lead to cardiorespiratory arrest and potentially death. Albuterol was first approved by the FDA in 1981**,** so it is a familiar medication to the health care community and the general population[1]. It is effective and also one of the safest medications we use. Albuterol has a quick onset of action of less than 5 minutes and has minor adverse effects including tremor, increased heart rate (tachycardia), and nervousness. The only contraindication to administering albuterol is a previous anaphylactic reaction to albuterol, which is extremely rare.

Interventions for a child in respiratory distress from asthma is time sensitive, vital, and directly impacts medical outcomes. Although albuterol will be most effective if the breathing emergency is due to asthma, it is important that the law is written in a way that any child presenting with respiratory distress can be treated with albuterol. Fortunately, the Bronchodilator Rescue Inhaler Law is written this way, and this is for several reasons. First, some children have undiagnosed asthma. They may have their first asthma attack at school or perhaps they have had them before, but it has not yet been recognized as asthma, and the child has not received the appropriate diagnosis by a healthcare provider. Another example is that the child is known to have asthma by someone such as their primary care provider or their parent, but for some reason, the school is not aware. A diverse number of other examples can be imagined, but the bottom line is that the vast majority of children exhibiting respiratory distress at school will be having these symptoms due to asthma.

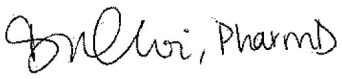
The benefit of administering albuterol in a child presenting with respiratory distress outweighs any potential risk of albuterol as this can be a matter of life and death. In the event that the child has respiratory distress for another reason such as pneumonia, administering albuterol, regardless of asthma diagnosis, would not cause patient harm or death. It would simply not help very much in this situation. Providing albuterol in a child who presents with respiratory distress, but does not have asthma, may cause some mild, short-term tachycardia which can last for about four hours[2]**.** On the other hand, administering albuterol in a child who presents with respiratory distress with undiagnosed asthma, but actually has asthma, will save this child's life. The low risk of increased heart rate is incomparable to saving a child's life and is definitely worth providing albuterol in any acute respiratory

distress. Furthermore, the administration of an albuterol inhaler through a spacer is straightforward and easy, allowing school administration staff to safely administer to students in need.

Working in the pediatric emergency department, I frequently see children presenting with difficulty breathing throughout all seasons of the year. Sometimes these children are not yet diagnosed with asthma but present with the typical symptoms of asthma including, but not limited to, wheezing, coughing, shortness of breath, and/or chest tightness. Some children, whether they are known asthmatics or newly diagnosed with asthma, present in extreme respiratory distress leading to intubation and mechanical ventilator use due to the severity of the asthma exacerbation. Thankfully, the pediatric emergency department is a well-equipped environment and has the abundant resources a child needs to receive necessary treatment as well as physicians and nurses who are able to appropriately prescribe and administer therapy. Although a school environment has minimal resources, the provision to administer albuterol can be a life-saving treatment when a physician assessment is delayed. Additionally, in a school setting, there are multiple factors that can further delay the medical care for a child such as the wait for an ambulance to arrive and the transportation time to the hospital. The time between when a child shows respiratory distress and to when the child arrives to a hospital are critical moments that must be taken advantage of.

Thank you again for the opportunity to testify in support of this bill. I urge you as a pediatric pharmacist and a healthcare advocate for children, to please be in favor of this legislation in order to provide a safe medical plan in schools for our vulnerable pediatric population. Albuterol is a safe, effective, and necessary tool for our children to have access to in schools.

Sincerely,



Sara Choi, PharmD
Pediatric Emergency Medicine Clinical Pharmacy Specialist
The Johns Hopkins Hospital
Department of Pharmacy
1800 Orleans St., Bloomberg 7234
Baltimore, MD 21287

Disclosure: The views expressed in this testimony are my own and do not necessarily reflect the policies or positions of my employer, Johns Hopkins Hospital.

References:

1. Accessdata.fda.gov. 2022. Drugs@FDA: FDA-Approved Drugs. [online] Available at: https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=reportsSearch.process&rptName=1&reportSelectMonth=5&reportSelectYear=1981&nav. Accessed 6 February 2022.
2. Albuterol. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Available at: http://online.lexi.com. Accessed 6 February 2022.

Senate MD HB384 stock albuterol written 4_4_22.pdf
Uploaded by: Sara Christina Sadreameli
Position: FAV

S. Christy Sadreameli, MD, MHS
Assistant Professor of Pediatrics
Johns Hopkins University
Eudowood Division of Pediatric Respiratory Sciences
200 North Wolfe Street
Baltimore, Maryland 21287-2533
(410) 955-2035
(410) 955-1030 (fax)

Testimony for House Bill 384
April 4, 2022
Public and Nonpublic Schools – Bronchodilator Availability and Use – Policy
(Bronchodilator Rescue Inhaler Law)

Dear Chair Pinsky, Vice-chair Kagan, and members of the Education, Health, and Environmental Affairs 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. Many of the young patients with asthma I care for attend school in Baltimore City and many other places around our state. I am testifying today in support of this bill that would provide emergency albuterol in schools. I am here as a pediatrician and as 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 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, poor air quality, certain weather conditions, pollution, 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 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, and still other children experience their first-ever asthma attack at school. 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. As one example, one public school in Baltimore City with excellent and above-average health staff resources cites that approximately *half* of its known asthmatics have the medication and documentation at school. The situation can be much worse in other schools in Baltimore City and around the state. Another issue is that because asthma is so common, and particularly uncontrolled asthma is so common in certain parts of our state such as 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 (which may require a parent taking off work, going to the pharmacy, making an appointment with a doctor, etc.). These barriers (of paperwork, finances, and comfort navigating the healthcare system) mean that the current system disadvantages children who are already at risk. Children whose parents have financial, transportation, or other barriers to medical care are often those who do not have the proper paperwork and medication on file with the school. Unfortunately, these are often some of the most at-risk asthmatics. Under the current system, many children are at risk of life-threatening asthma at school. Without access to albuterol, a life-saving medication, vulnerable children may suffer from severe, sudden asthma attacks and even die at school.

It is important that the law contains language that enables children exhibiting respiratory distress suggestive of an asthma attack to receive emergency albuterol, even if they do not have proper documentation of asthma diagnosis. Though this will occasionally result in a child without asthma being given albuterol for non-asthma symptoms (e.g., a child that is having difficulty breathing because of an anxiety attack, or a child with pneumonia), the risk of adverse consequences from albuterol given in a situation like this are minimal. If the underlying condition is not asthma, albuterol will not be effective; i.e., giving albuterol will not "mask" another diagnosis like pneumonia because it does not treat pneumonia. The risk of *not* giving this medication to children with an asthma attack is much higher, as it can result in ambulance transfer, serious illness, and even death. It is not difficult 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). In order to have the greatest impact, and because the risk of adverse consequences of albuterol is so low, I recommend that you do not limit this legislation to children with a documented diagnosis of asthma. There is also no current policy or law that will cover these children. For example, the Epi-Pen legislation and implementation policies are meant to cover severe food allergy (anaphylaxis) and cannot, and should not, be viewed as an alternative to this legislation. Rather, this bronchodilator (albuterol) legislation should co-exist with the existing Epi-Pen legislation, as each covers a different situation. School personnel can and should be trained to differentiate between respiratory distress indicative of asthma and anaphylaxis.

In September of 2021, a group of stakeholders, including myself, published a joint policy statement in the *American Journal of Respiratory and Critical Care Medicine* in support of school stock albuterol legislation. The coauthors included physicians, 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. These organizations came together because of this important cause. HB 384, 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 by this group of experts.

Stock albuterol programs have been found to be effective at preventing adverse asthma events at school and 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).

Sixteen states have already passed laws or have guidelines providing stock emergency albuterol inhalers at school. Many existing laws were created by amending the existing EpiPen legislation. The rationale is similar, as EpiPens and albuterol are both life-saving medications that must be given quickly in an emergency situation to halt rapid decompensation. Just as for the EpiPen law, where staff training includes recognition of a life-threatening food allergic reaction (and does not require a documented food allergy diagnosis), this law should not be restricted to those with a documented asthma diagnosis. It also should not restrict access to albuterol, a life-saving medication, whether or not a health professional is physically present during an emergency situation to give it. This bill is meant to be pragmatic and to work in the current situation, even when a school nurse is not present (which is, unfortunately, often the case in our schools today).

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 supporting HB 384, 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. We were pleased with the unanimous support in the House of Delegates and look forward to your favorable report of the bill. 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/
5. Volerman A, Lowe AA, Pappalardo AA, Anderson CMC, Blake KV, Bryant-Stephens T, Carr T, Carter H, Cicutto L, Gerald JK, Miller T, Moore NS, Phan H, **Sadreameli SC**, Tanner A, Winders TA, Gerald LB. Ensuring Access to Albuterol in Schools: From

Policy to Implementation. An Official ATS/AANMA/ALA/NASN Policy Statement. Am J Respir Crit Care Med. 2021 Sep 1;204(5):508-522.

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
Johns Hopkins University
Baltimore, MD, USA
Office: (410) 955-2035
Fax: (410) 955-1030
Email: ssadrea1@jhmi.edu

2c - HB 384 - EHEA - MACHO - LOSWA.pdf
Uploaded by: Maryland State of
Position: FWA

2022 SESSION
POSITION PAPER

BILL: **HB 384 - Public and Nonpublic Schools – Bronchodilator and Epinephrine Availability and Use – Policies**

COMMITTEE: **Senate – Education, Health and Environment Committee**

POSITION: **Letter of Support With Amendments**

BILL ANALYSIS: **House Bill 384 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 a bronchodilator to a student who is experiencing asthma-related symptoms or perceived to be in respiratory distress. 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.**

POSITION RATIONALE: The Maryland Association of County Health Officers (MACHO) offers support for overall goals of HB 384 while respectfully requesting the bill be amended. 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 of MACHO's members run local health departments who are responsible for hiring and overseeing the nurses that work in the school systems in their jurisdictions.

As currently amended, the bill poses *unfunded* mandates on local agencies and additional administrative burdens on already overtaxed school nurses. MACHO requests amendments to the bill to **remove the requirements to:**

- Train ancillary school personnel on how to recognize the symptoms of asthma and respiratory distress, which will place a significant demand on the time of school health nurses, taking them away from other student health needs.
    - Strike Page 3, Line 4 starting with "AND" through line 7.
    - Strike Page 6, Line 35 starting with "AND" through Page 7, Line 2.
- Allow personnel other than health professionals to administer a bronchodilator.
    - Strike Page 6, Lines 10-14.
    - Strike Page 6, Line 17 "AND OTHER SCHOOL PERSONNEL".
    - Amend Page 6, Line 21: Strike "OR" and replace with "AND".
    - Strike Page 7, Line 11 "OR DESIGNATED VOLUNTEER".
    - Strike Page 7, Line 23 "OR DESIGNATED VOLUNTEER".

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

- 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 8, Line 7 after "BRONCHODILATOR": "FOR A STUDENT NOT PREVIOUSLY DIAGNOSED WITH ASTHMA"

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

- MACHO also requests that the effective date of the bill be moved to July 1, 2023 to a later date, to give schools and school health nurses enough time to implement the training 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 submission 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 school nursing shortage in Maryland. Every minute spent on these thousands of reports take nurses away from providing healthcare services to other students in need.

MACHO has concerns that the bill allows non-medical personnel to make clinical judgments in potentially life-threatening situations. Expecting non-medical volunteers to distinguish anaphylaxis from severe asthma based on course material with no clinical training has the potential to result in improper treatment and dangerous side effects such as cardiac arrhythmias. *We caution against minimizing the need for healthcare expertise that can only be gained through proper medical training. This is a potential slippery slope*. **Efforts should be made to correct the shortage of school nurses and not to rely on poorly qualified proxies.**

Finally, MACHO raises concerns that one possible intent of the bill is to provide treatment access to students who have not received medical care for their chronic asthma symptoms. Management of asthma is complex and requires resources and expertise not available from school health personnel. *We urge the committee to consider other more effective policies to ensure students have access to the asthma evaluation and medications they need*.

For these reasons, MACHO urges the Committee to adopt the above amendments and issue a favorable report on House Bill 384. 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.*

HB 384.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: House Bill 384
TITLE: Public and Nonpublic Schools - Bronchodilator and Epinephrine Availability and Use - Policies
DATE: April 5, 2022
POSITION: OPPOSE
COMMITTEE: Education, Health, and Environmental Affairs
CONTACT: John R. Woolums, Esq.

The Maryland Association of Boards of Education (MABE) opposes House Bill 384 in favor of maintaining the current law governing the availability and use of epinephrine in schools and current law ensuring that schools meet the health needs of students with asthma, including the availability and use of bronchodilators.

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 epinephrine and bronchodilators 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 a bronchodilator or epi pen 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.

By contrast to House Bill 384, 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 provides for emergency care planning for all students under the Code of Maryland Regulations 7-401 and 7-426. 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 guidelines.

For these reasons, MABE urges an unfavorable report on House Bill 384.

MAJ Position Paper -- HB 384 -- Inhalers Epi-pens

Uploaded by: Josh Howe

Position: UNF

MARYLAND ASSOCIATION FOR JUSTICE

10440 Little Patuxent Parkway, Suite 250, Columbia, MD 21044
(410) 872-0990 • FAX (410) 872-0993
info@mdforjustice.com

HB 384: Public and Nonpublic Schools – Bronchodilator and Epinephrine Availability and Use – Policies

UNFAVORABLE

HB 384 directs county boards of education to establish training programs for certain school nurses and other personnel, in order to administer bronchodilators to students who are perceived to be suffering symptoms of asthma or other respiratory distress, or to administer auto-injectable epinephrine to students who are perceived to be suffering symptoms of anaphylaxis.

While MAJ supports the concept of keeping schoolchildren safe, MAJ has significant concerns about the manner in which HB 384 would authorize "school personnel" – including personnel with no nursing or other health-care training – to administer ***potentially dangerous and/or expired pharmaceuticals*** to sick children, thereby needlessly delaying calls to 9-1-1 or other life-saving emergency assistance.

A nationwide lobbying strategy implemented by pharmaceutical giants has greatly expanded the market for auto-injectable epinephrine, and increased market share, which in turn allowed the manufacturer of "Epi-pens," Mylan Pharmaceuticals, to increase prices astronomically, resulting in multi-billion dollar corporate profits.[1] In response, the General Assembly has restricted immunity for administering auto-injectable epinephrine to individuals suspected of suffering anaphylaxis, to ensure ***both*** that proper standards and procedures for storage and administration are followed (epinephrine must never be refrigerated) ***and*** that the medication is not administered beyond the expiration date (epinephrine can expire in as little as one year). *See* Md. Health-Gen. § 13-7A-07 (2018).

Not only does HB 384 include ***none*** of these vitally important safeguards – thereby exposing Maryland schoolchildren to potentially unsafe or expired medicines – HB 384 encourages schools [at page 5, lines 18-27] to collect donations of unused medicine for use in schoolchildren ***without regard*** to whether the medications were properly stored or retain their potency. Of course, needlessly administering expired or spoiled medications to a child will delay the administration of necessary, safe, and effective healthcare.

Even worse, HB 384 grants immunity [at page 4 lines 1-4] to school personnel who administer expired or spoiled medications. School boards of education already enjoy substantial limitations on their liability to students under Maryland law. Boards of education must not be permitted to escape liability ***altogether*** if their improper handling or storage of medications, or improper training of school personnel, caused a sick child to suffer the consequences of a delay in obtaining the proper care. Similarly, non-public schools should not enjoy immunity from liability when their unsafe medication storage or handling practices, or their unsafe training programs, cause harm to students.

Finally, HB 384 fails to define the term "school personnel" for the purposes of administering medication to children in public schools [page 2 line 8 through page 4 line 9], thereby exposing school children to the danger that untrained school personnel would choose to act incorrectly, thereby delaying a call for trained emergency assistance.

Indeed, the definition of "school personnel" applicable to nonpublic schools [page 4 lines 17-20] makes it clear that "school personnel" includes everybody. MAJ respectfully submits that, when everybody has immunity from liability, nobody is safe from harm.

The Maryland Association for Justice respectfully urges an UNFAVORABLE Report on HB 384.

[1] C. Koons, "How Markteing Turned the EpiPed into a Billion-Dollar Business," Bloomberg Business (Sept. 23, 2015), http://www.bloomberg.com/news/articles/2015-09-23/how-marketing-turned-the-epipen-into-a-billion-dollar-business. This article describes Mylan's strategy for increasing demand and market share for EpiPens through "public entity legislation." A chart from that article is attached.

HB 384-Kari Keaton-Unfavorable.pdf
Uploaded by: Kari Keaton
Position: UNF

Statement of Kari Keaton
Senate Education, Health, and Environmental Affairs Committee
April 5, 2022
Position: **UNFAVORABLE HB 384**

Dear Chair Pinsky and members of the Education, Health, and Environmental Affairs Committee:

I live in Rockville, Maryland, and I am a parent of two sons with asthma and life threatening (anaphylactic) food allergies. I am here to voice opposition to House Bill 384 as it is written. My sons are now 29 and 24 years-old, so they are long past their days in Montgomery County Public Schools. I stay in touch with these issues because for the past 23 years I have been the facilitator for the Metro DC Food Allergy Support Group. Our members deal with multiple atopic conditions in addition to food allergies, including many with asthma.

I have two major concerns about stocking bronchodilators in schools to be used for children with or without diagnosed asthma. My first concern is that diagnosing respiratory distress in a child is often not easy. One of my son's first anaphylactic reactions to peanuts began with respiratory distress (no hives or swelling right away). If I had chosen to use a bronchodilator instead of epinephrine, the anaphylactic reaction might not have subsided so quickly. I could have used a bronchodilator and waited to see if it worked, but delaying the administration of epinephrine can have very serious, potentially fatal consequences.

Because both of my sons also have asthma, there are times that the bronchodilator is necessary, and all they need to use to alleviate their asthma symptoms. However, I have always told them that in case their bronchodilator inhaler doesn't seem to alleviate their symptoms, they should not hesitate to use their epinephrine. Epinephrine will also act as a powerful bronchodilator.

My second concern with stock bronchodilators is that the administration of an inhaler is not always easy (especially with a child that has never used an inhaler). It is critical that the medication is inhaled deeply to get into the lungs--that is why for very young children or anyone being treated in a hospital with a bronchodilator, nebulizers are used--the medication is aerosolized and breathed in through a mask covering the nose and mouth. I understand the bill calls for spacers to be used and while they are helpful, I still feel a child who has never used an inhaler, and is possibly very stressed by their breathing difficulties might not get the full benefit of the bronchodilator.

I believe that the Maryland State Department of Education and the Maryland Department of Health should collaborate on updating the guidelines for treating asthma in schools and address the potential of adding stock bronchodilators as part of a comprehensive review of the asthma treatment protocols. I am hopeful that you will not pass on this bill with a favorable report.

HB384X_MSEA_Lamb_UNF.pdf
Uploaded by: Lauren Lamb
Position: UNF

MARYLAND STATE EDUCATION ASSOCIATION

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

marylandeducators.org

Testimony in Opposition to House Bill 384
Public and Nonpublic Schools - Bronchodilator and Epinephrine Availability and Use – Policies

Education, Health, and Environmental Affairs
Tuesday, April 5th, 2022
1:00 p.m.

Lauren Lamb
Government Relations

The Maryland State Education Association opposes House Bill 384, which would require each county board of education and authorize nonpublic schools in the State to establish a policy to obtain, administer, and train certain school personnel to administer in emergency situations bronchodilators to a student who is determined to have asthma, is experiencing asthma-related symptoms, or is perceived to be in respiratory distress. It would also require the Department of Education to develop training for school personnel in identification of respiratory distress in students.

MSEA represents 76,000 educators and school employees who work in Maryland's public schools, teaching and preparing our almost 900,000 students for the careers and jobs of the future. 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 urgent 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. 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 on non-clinical 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.

We urge the committee to issue an Unfavorable Report on House Bill 384.

2022 MNA HB 384 Senate Side.docx.pdf
Uploaded by: Robyn Elliott
Position: UNF

Committee:	**Senate Education, Health, and Environmental Affairs Committee**
Bill Number:	**House Bill 384 – Public and Nonpublic Schools – Bronchodilator and Epinephrine Availability and Use - Policies**
Hearing Date:	**April 5, 2022**
Position:	**Oppose**

The Maryland Nurses Association opposes *House Bill 384 – Public and Nonpublic Schools – Bronchodilator and Epinephrine Availability and Use – Policies.* The bill's intent is to safeguard the health of students in respiratory distress, but the bill raises serious safety concerns. **The bill jeopardizes the health and safety who are in respiratory distress because of anaphylactic shock. We recommend that the Committee ask the Maryland State Department of Education and the Maryland Department of Health, in collaboration with the the Maryland Institute for Emergency Medical Services Systems and other stakeholders, review the issues raised by the bill over the interim and address by updating school health guidelines.**

<u>Core Safety Issues</u>

The bill raises some core safety issues:

- **Puts Students in Anaphylactic Shock at Risk:** Under current school health policies, students in respiratory distress should be given epinephrine, as anaphylactic shock often manifests itself with symptom similar to asthma.[i] The exceptions are students who have an asthma diagnosis and a prescription for a bronchodilator. In those cases, the school nurse or school-nurse's designee can administer a bronchodilator – either the student's own medication or a stock bronchodilator.[ii,iii]

This bill would allow for non-clinicians to make decisions about the administration 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.[iv] 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[v].

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 unfair, unrealistic, and 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. [vi] 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. School nurses could not legally or ethically delegate this responsibilities to non-clinicians.

Even school nurses cannot administer medications to students without a prescription, as it would violate Title 8 of the Health Occupations Article. There is legal mechanism to address this through a standing order, but the bill does not contemplate standing orders for school nurses.

- **Rewrites Existing Epinephrine Law:** Maryland's epinephrine program in schools has been working safely and effectively. For reasons that are unclear, the House amended the underlying epinephrine law and created potential problems for the epinephrine program.

  Under current law, a health care professional, such as a physician or nurse practitioners, prescribes epinephrine under a standing order and provides the prescription to the school nurse. The school nurse then has the responsibility for storing the epinephrine and arranging for designated school personnel to have access to the epinephrine in an emergency. In the amended bill on page 3 in lines 22-24, prescribers could give epinephrine to nonclinical school personnel directly. This change has significant safety

and policy implications, raising questions about the legal responsibility and liability of the non-clinicians, including teachers, in storing and administer epinephrine.

Conclusion and Recommendation

We ask for an unfavorable report. Instead of moving forward with the bill, we recommend that the Committee request that the Maryland State Department of Education, Maryland Department of Health, and examine and evaluate current school health guidelines regarding asthma and other forms of respiratory distress as part of the school health guidelines process. The state agencies could consult with interested stakeholders and report back to the Committee.

If we can provide any further information, please contact Robyn Elliott at relliott@policypartners.net.

[i] https://www.aafa.org/anaphylaxis-severe-allergic-reaction/
[ii] https://www.lung.org/getmedia/92bd8d3f-c5ca-46c0-9063-9d5719ec690b/model-policy-for-school.pdf.pdf
[iii] https://www.lung.org/getmedia/872c9b6a-5379-4321-8913-102d53182e29/improving-access-to-asthma.pdf.pdf
[iv] https://emj.bmj.com/content/emermed/19/5/415.full.pdf
[v] https://emj.bmj.com/content/emermed/19/5/415.full.pdf
[vi] Ibid

2022 MASBHC HB 384 Senate Side.pdf
Uploaded by: Scott Tiffin
Position: UNF

masbhc
MARYLAND ASSEMBLY ON
SCHOOL-BASED HEALTH CARE
education+health=success

PO Box 716
Baltimore, MD 21233
202.669.0031 phone

Oppose

House Bill 384 – Public and Nonpublic Schools - Bronchodilator and Epinephrine Availability and Use - Policies

Education, Health, and Environmental Affairs Committee

April 4, 2022

The Maryland Assembly on School-Based Health Care (MASBHC) opposes House Bill 386 – *Public and Nonpublic Schools - Bronchodilator and Epinephrine Availability and Use - Policies*. This bill seeks to improve care for children with asthma, but as drafted, it could result in serious unintended consequences.

As introduced, this bill sought to allow school staff to administer stock bronchodilators to children who could not access their prescribed bronchodilator and to children in respiratory distress who had never received an asthma diagnosis. Although we agree that there may be ways for properly trained staff to administer stock bronchodilators when a prescribed bronchodilator is missing, we have serious concerns about non-clinicians providing bronchodilator to children with no diagnosis. We believe that allowing stock bronchodilators to be administered to children experiencing respiratory distress with no known cause increases the risk of delayed treatment for fatal anaphylactic shock. A bronchodilator will do nothing to treat anaphylaxis but can mask the symptoms. There are examples of children dying because an anaphylactic event was miss-identified as an asthma attack[i] and the American Lung Association's model stock bronchodilator policy does not recommend bronchodilators for children without an asthma diagnosis.[ii]

To attempt to address the concerns raised about administering bronchodilators to children without an asthma diagnosis, the House modified the state's stock epinephrine statute to include a requirement that school staff be taught how to differentiate between anaphylaxis and asthma. Differentiating between anaphylaxis and asthma can be difficult for trained clinicians, and we do not feel it is fair to put this level of differential diagnosis on non-clinical school staff. When a student is experiencing respiratory distress of unknown cause, we believe that school staff should immediately contact 9-1-1, provide general first aid, and administer and EpiPen—if it appears the child in in anaphylactic shock and if trained to do so.

Although we have serious concerns about this bill, we agree with the proponents that there are many issues related to asthma health disparities and underdiagnosis. This is why we

have consistently supported efforts to improve access to student health services. We also recommend that the General Assembly request MSDE and MDH to update school health guidelines on asthma. MSDE and MDH have the ability to do much of what is included in this bill, and there may be other things that could be improved in how our schools support students with asthma.

Thank you for your consideration of our testimony, and we urge an unfavorable report, but encourage the General Assembly to request an update to the school health guidelines for asthma. If we can provide any further information, please contact Scott Tiffin at stiffin@policypartners.net or (443) 350-1325.

---

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

[ii] https://www.lung.org/getmedia/96873d5c-3a30-4be6-9a3c-445a2dafdd7b/Model-Policy-On-Stock-Bronchodilators.pdf

Statement from Chris Van Order_VA med tech.pdf
Uploaded by: Scott Tiffin
Position: UNF

Statement from Chris Van Order:

Here is my statement: As a volunteer firefighter for Fairfax Fire and rescue department for 7 years and an EMT with DC Fire &EMS department I've treated many allergic reactions and many asthmatics. The protocol we have in the schools for asthmatics in respiratory distress is not going to work. The protocol states a student in distress gets 8 puffs from the inhaler with a minute or two in between each puff. When someone is in respiratory distress there is inadequate breathing which means that person cannot inhale the medication properly to get it deep into the lungs where it is needed. In the last 10 years all fire departments have gone to training their people at the national level with the national registry. This makes it so there is a common medical treatment standard within the fire departments. The medical protocol for an asthmatic in distress is Epi.

HB0384 Howard Co BOE Testimony 040522 for EHEA - B

Uploaded by: Staff Howard County

Position: UNF

Board of Education of Howard County

Vicky Cutroneo, *Chair*

Antonia Watts, *Vice Chair*

Christina Delmont-Small

Yun Lu, Ph.D.

Jennifer Swickard Mallo

Jolene Mosley

Chao Wu, Ph.D.

Peter J. Banyas
Student Member

Michael J. Martirano, Ed.D.
Superintendent
Secretary/Treasurer

Board of Education of Howard County
Testimony Submitted to the Maryland Senate,
Education, Health, and Environmental Affairs Committee
April 5, 2022

HB0384: UNFAVORABLE
Public and Nonpublic Schools - Bronchodilator and Epinephrine Availability and Use – Policies

The Board of Education of Howard County (the Board) opposes **HB0384 Public and Nonpublic Schools - Bronchodilator and Epinephrine Availability and Use - Policies** as an unfunded mandate that should be left to health experts to determine necessary actions.

HB0384 requires county boards to establish a policy for schools to authorize school nurses or other personnel to administer a bronchodilator, if available, to a student who is determined to have asthma, is experiencing asthma-related symptoms or in respiratory distress regardless of whether the student has been diagnosed or has a prescription (unless they are a PreKindergarten student). The policy must include training for nurses and school personnel on recognizing signs and symptoms, procedures for emergency administration, authorization for school nurses to obtain and store at schools, and a requirement for each public school to develop and implement a method for notifying parents of the policy at the start of each school year. Schools may accept donated bronchodilators from licensed pharmacies or manufacturers or obtain grants. Staff using the equipment in good faith cannot be held personally liable for any act or omission. Schools must notify parents of each use, make a record of the incident, and submit a report to MSDE on the number of uses.

The provisions of HB0384 that call for administration regardless of prescription are concerning to Howard County Public School System (HCPSS) Health staff. Medication should only be administered with a physician order, especially for a steroid like a bronchodilator to someone that is “perceived” to be in distress. In schools where a health assistant is utilized, moreover a non-medical school staff volunteer as called for in the amended version of the bill, there would be a concern with conducting assessments, which include evaluation of breathing in the case of respiratory distress. As a measure of the significance of this, a certification for health assistants does not include the ability to assess lung sounds. HCPSS health provisions already direct staff to administer EPi in the case of asthma-related complications and to further call 911.

Additionally, while the bill calls for use of a bronchodilator if available, the required policy that includes training for all schools implies they will be available for use at all

schools. Maintaining these in all HCPSS schools would be costly as they are not interchangeable for multiple uses.

For these reasons, we urge a UNFAVORABLE report of HB0384 from this Committee.

2b - HB 384 - EHEA - MBON - LOC.pdf
Uploaded by: State of Maryland (MD)
Position: UNF

Maryland

Board of Nursing

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

Gary Hicks, Board President | Karen Evans, Executive Director
4140 Patterson Ave, Baltimore, MD 21215

April 5, 2022

The Honorable Paul G. Pinsky
Chair, Senate Education, Health, and Environmental Affairs Committee
2 West Miller Senate Office Building
Annapolis, MD 21401-1991

RE: HB 384 – Public and Nonpublic Schools – Bronchodilator and Epinephrine Availability and Use – Policies – Letter of Concern

Dear Chair Pinsky and Committee Members:

The Maryland Board of Nursing (the Board) respectfully submits this letter of concern for House Bill (HB) 384 – Public and Nonpublic Schools – Bronchodilator and Epinephrine Availability and Use – Policies. This bill requires each county Board of Education and authorizes nonpublic schools to establish a policy to obtain, administer, and train certain school personnel to administer in emergency situations bronchodilators to a student who is determined to have asthma and experiences asthma-related symptoms or is perceived to be in respiratory distress; requires each county board of education and authorizes nonpublic schools to update their policies to require certain school personnel to complete training before they are authorized to administer auto-injectable epinephrine to a student who is determined to be, or perceived to be, in anaphylaxis; and requires the State Department of Education to identify or develop training for certain school personnel to identify symptoms of anaphylaxis, asthma, or respiratory distress in students.

The Board is in favor of increasing school readiness by addressing student health conditions related to asthma, respiratory distress, and anaphylaxis. The Board supports efforts to ensure schools have the ability to stock bronchodilators and authorizes the school nurse to identify personnel who are competent to administer bronchodilators to a student in an emergency situation. The Board has great concern, however, with legislating clinical practice and disregarding current school health guideline processes for medical conditions.

The Maryland State Department of Education's (MSDE) School Health Services is responsible for developing standards and guidelines related to the safe practice and training of school nurses, the administration of medications, and the delegation of tasks to unlicensed assistive personnel. MSDE has published protocols related to the training and administration of naloxone, anaphylactic reactions, epinephrine, medical cannabis, and management of diabetes, asthma, and sickle cell disease[1] in the school setting. The training and administration of bronchodilators should follow similar processes that are currently instituted by MSDE. This would ensure

[1] School Health Services Guidelines – Table of Contents. Maryland State Department of Education.

---

consistency and uniformity by allowing a stakeholder workgroup to convene and discuss best practices for bronchodilator administration, safety measures for symptomatology and contraindications, and next steps to be taken by either the school nurse or school administrator. The Board finds it inappropriate to bypass current processes that have been found to be both thorough and effective.

The Board is additionally concerned with the provisions that allow the school nurse or other personnel to administer a bronchodilator regardless of whether a student has been diagnosed with asthma or reactive airway disease or has been prescribed a bronchodilator by a licensed healthcare practitioner. Registered Nurses (RN) and Licensed Practical Nurses (LPN) are not legally authorized to administer medications, such as bronchodilators, to an individual who has not received a prescription from an authorized practitioner, unless a standing order has been appropriately issued. The bill, however, remains silent on the matter of standing orders. As a result, nurses and other school personnel would need to defer to current emergency protocols for students exhibiting asthma-related symptoms or respiratory distress.

For the reasons discussed above, the Maryland Board of Nursing respectfully submits this letter of concern for HB 384.

I hope this information is useful. For more information, please contact Iman Farid, Health Policy Analyst, at (410) 585 – 1536 (iman.farid@maryland.gov) or Rhonda Scott, Deputy Director, at (410) 585 – 1953 (rhonda.scott2@maryland.gov).

Sincerely,

Gary N. Hicks
Board President

The opinion of the Board expressed in this document does not necessarily reflect that of the Department of Health or the Administration.

2a - HB 384 - EHEA - MDH - LOI.pdf
Uploaded by: Heather Shek
Position: INFO

Maryland
DEPARTMENT OF HEALTH

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

April 5, 2022

The Honorable Paul G. Pinsky
Chair, Senate Education, Health and Environmental Affairs Committee
2 West, Miller Senate Office Building
Annapolis, MD, 21401

RE: HB 384 - Public and Nonpublic Schools - Bronchodilator and Epinephrine Availability and Use - Policies - Letter of Information

Dear Chair Pinksy and Committee Members:

The Maryland Department of Health (MDH) is submitting this letter of information for House Bill (HB) 384 - Public and Nonpublic Schools - Bronchodilator and Epinephrine Availability and Use - Policies.

HB 384 requires each county board to establish a policy for public schools within its jurisdiction to authorize the school nurse and other school personnel to administer a bronchodilator to a student who is perceived to be in respiratory distress, regardless of whether the student has a formal diagnosis of asthma. The bill also allows nonpublic schools to establish the same policy. MDH notes that students who are in respiratory distress and who do not have a known asthma diagnosis should be administered auto-injectable epinephrine as the course of first treatment. Many of the symptoms of a severe allergic reaction or a severe asthma attack may seem similar. Thus, the respiratory symptoms that the student is experiencing could be a component of anaphylaxis (not asthma) and delays in treating anaphylaxis (i.e. administering a bronchodilator in lieu of auto-injectable epinephrine) can be life-threatening. Clinical guidance recommends using an epinephrine auto-injector first (it treats both anaphylaxis and asthma) if it is unclear whether the respiratory distress is caused by asthma or anaphylaxis.[1]

The bill as amended also requires training, for school nurses and "voluntary school personnel who are designated by a school nurse, and in the clinical judgment of the school nurse, are appropriate recipients of the training", to identify the symptoms of asthma and respiratory distress, the symptoms of anaphylaxis, and how to distinguish between them. After receiving the training, they will be eligible to administer a bronchodilator as established above. Distinguishing between anaphylaxis and asthma or respiratory distress requires a level of clinical assessment that is not appropriate for non-registered nurse school personnel who may not have any formal health education, experience, or licensure.

[1] Asthma and Allergy Foundation of America, https://www.aafa.org/anaphylaxis-severe-allergic-reaction/

The amendments also require county boards and nonpublic schools to develop policies that authorize "school nurses" and trained volunteers "designated by a school nurse" to administer emergency medications (auto-injectable epinephrine and bronchodilators) to students when they have symptoms. This is more restrictive than the language in current statute[2] for auto-injectable epinephrine which permits each nonpublic school to 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 anaphylaxis. Nonpublic schools that do not have a school nurse will be unable to designate any personnel to administer these emergency medications; some fill this clinical role with a physician consultant..

Lastly, HB 384 as amended now requires the training of public school nurses and designated volunteers in asthma, respiratory distress and anaphylaxis symptoms be a paid "professional development training" which typically requires continuing education units (CEU) to be given. This training is to be identified or developed by the Maryland State Department of Education in consultation with MDH, the American Lung Association, and the Asthma and Allergy Foundation of America. According to data from the 2018-19 School Health Services Survey completed by each of the 24 local public school systems/local health departments, there were approximately 1,950 school health personnel[3] across the state who would be required to take this training. There will be an unfunded cost in order to develop the training program to meet this criteria or pay the costs of providing the CEUs to each of the aforementioned school health personnel.

If you would like to discuss this further, please contact Heather Shek, Director, Office of Governmental Affairs at 410-767-5282 or heather.shek@maryland.gov.

Sincerely,

Dennis R. Schrader
Secretary

[2] MD Code, Education, § 7-426.3
[3] This figure does not include staffing figures for nurses or other school health personnel at nonpublic schools.

HB 384_Schools_Bronchodilators & Epinephrine_MIEMS
Uploaded by: Theodore Delbridge
Position: INFO

State of Maryland

Maryland Institute for Emergency Medical Services Systems

653 West Pratt Street
Baltimore, Maryland
21201-1536

Larry Hogan
Governor

Clay B. Stamp, NRP
Chairman
Emergency Medical Services Board

Theodore R. Delbridge, MD, MPH
Executive Director

410-706-5074
FAX 410-706-4768

April 4, 2022

The Honorable Paul G. Pinsky
Chairman
Senate Education, Health & Environmental Affairs Committee
2 West Miller Senate Office Building
Annapolis, Maryland 21401

Re: HB 384 – Public and Nonpublic Schools – Bronchodilator and Epinephrine Availability and Use – Policies – Letter of Information

Dear Chairman Pinsky:

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 HB 384.

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.

HB 384 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

Cc: Timothy Chizmar, MD, State EMS Medical Director
Patricia Gainer, JD, MPA, Deputy Director