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Testimony for House Bill 226
February 8, 2023
Public and Nonpublic Schools - Bronchodilator and Epinephrine Availability and Use – Policies.

Dear Chair Atterbeary, Vice-chair Wilkins, and members of the Ways and Means Committee:

My name is Karen Babcock, and I am a respiratory therapist at Johns Hopkins Hospital. I am testifying today in support of HB266 concerning the use of stock albuterol in Maryland schools. I submit this testimony as a citizen of Maryland, a health professional with the relevant expertise, and a mother. The views I express here are my own and do not necessarily reflect the views of my employer, Johns Hopkins Hospital.

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

For a reactive airway, such as in the case of asthma, when the airway “reacts” and tightens inappropriately to a stimulus such as a virus, an allergen, or an environmental factor (such as cigarette smoke or air pollution), the mainstay of treatment is albuterol. Inhaled albuterol works quickly to relax the muscles around the small airways by stimulating the beta receptors of these airways. Albuterol is one of the safest and most effective medications we use, and side effects are minimal. Typically, if side effects are experienced, they are: nervousness, shakiness, headache, throat or nose irritation, or mild muscle aches. Patients also can experience increased heart rate. In my years of service (21 years this spring), I have never had an incident that resulted in harm or death of patient in regards to albuterol. What I can say, is I’ve given plenty of albuterol to patients who did and did not need it (including those without an asthmatic diagnosis), as well as given to my own child, who does not have asthma. The potential benefit in those moments outweighed any possible side effects. I also wanted to highlight that albuterol does not mask other conditions besides asthma. For example, if someone was experiencing shortness of breath

due to pneumonia, if they got albuterol, if would not reverse or significantly reduce symptoms, unless they happened to have asthma too.

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

Just like giving an Epi-Pen for a food allergy emergency (it works right away), giving albuterol promptly could drastically change the trajectory of the child's airway issue in an asthma emergency. I have personally witnessed albuterol stop or significantly lessen a severe asthma situation many times. Similarly, delaying albuterol when an asthmatic needs it can also cause an asthma exacerbation to get out of hand very quickly, resulting in increased severity of the exacerbation, which can lead to emergency department admission, hospitalization, or even death. 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 266.

Sincerely,

KNBabcock, RRT

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Pediatric Respiratory Therapist