I am Chris Martinez, CEO of Asthma & Allergy Foundation of America - Mid States.

AAFA Mid States has implemented statewide stock inhaler programs in both Missouri and Illinois. Missouri was the first state in the nation to pass stock inhaler legislation in 2012. We have been implementing the program in St. Louis since that time and, it has been so successful that our state legislature has recently provided funding to support statewide implementation. Stock inhaler legislation was passed in Illinois in 2018 and has also recently received funding from the state legislature for near statewide implementation. Both states require reporting and we have had no problems with medication administration.

The 2012 legislation in Missouri never restricted use of stock albuterol to children who had a documented diagnosis of asthma. Many children experience their first episodes of respiratory distress at school and both can and do benefit from stock inhalers, even though they don't have a diagnosis of asthma. Other children have a diagnosis, but the school is unaware of this diagnosis as it has not been reported by the parent or the proper documentation is not on file. Even if a child has a diagnosis on file, treatment for respiratory distress is time sensitive and making a school staff member check for that diagnosis wastes valuable time when a child cannot breathe.

Additionally, we know that the vast majority of children who have access to these medications in school are able to return to class. This saves them both the health emergency of visiting an ER in an ambulance along with the cost. Many children with asthma are on Medicaid or CHIP. Meaning, that a portion of these expense are also the responsibility of the state and its taxpayers. With proper legislation and implementation states like Maryland can preserve time in class and save both student lives and tax payer dollars.

I would also like to address the concept of using fast acting epinephrine as a first line treatment for asthma. To my knowledge, this is not best medical practice and is not in line with national guidelines. School staff in both Missouri and Illinois have been trained to distinguish between the symptoms of respiratory distress and anaphylaxis and are choosing the correct medication as well as looking for a logical progression in the administration of the appropriate drug when necessary. Many children have both asthma and allergies that could lead to anaphylaxis. Both the child and their parent can choose the correct medication for their symptoms and again nurses can be trained to identify when to elevate their intervention to an epinephrin injection. We have had no documented problems ti my knowledge in either Missouri or Illinois with administration of albuterol to children for respiratory distress.

The groups advocating for epi first have used the AAFA website as evidence that epi pens can be used to treat respiratory distress (https://community.aafa.org/db/ask-the-allergist/record/can-i-use-an-epipen-for-a-severe-asthma-attack). Here is the quoted question that was asked by a patient and answered by one of our physicians in May of 2022.

QUESTION
I had a doctor in the past tell me to use an epi-pen for a severe asthma attack if my Albuterol inhaler wasn't working. He's retired and my new pulmonologist told me to just go straight to the hospital. Is it unsafe to use the epi-pen for an asthma attack?

ANSWER

In the past, injectable epinephrine was used in the emergency room as a treatment for acute asthma attacks or exacerbations that were not responding to standard treatments. Today, there are many new quick relief and controller medicines available to manage asthma symptoms.

In situations where typical asthma treatments are not working to control symptoms, epinephrine may help patients with severe asthma exacerbations. This would be a unique situation. This would typically be done in the emergency room while the patient is monitored.

***If no other treatments are working to control asthma symptoms** and an Epi-Pen is available, it **could** be administered. 9-1-1 should be called to activate Emergency medical services. The patient will need to be evaluated and managed in an emergency room.*

Finally, there are some patients who have a history of anaphylaxis (e.g. due to a food, venom, or medication) and asthma. It would be fine for these patients to use epinephrine first and then appropriate asthma medications if the patient is not sure if their symptoms are due to an anaphylactic reaction, asthma, or both. Again, the patient would need to be evaluated in the emergency room after these treatments.

John M. James, MD, is a board-certified allergist. He is also President of Food Allergy Consulting and Education Services, LLC. He has worked as a medical specialist in the field of allergy, asthma, and immunology for over 30 years. Dr. James received his bachelor's degree from the University of Arkansas and his Doctor of Medicine degree from the University of Tennessee. He is board certified by the American Board of Allergy and Immunology.

As you can see, our expert physician is not *advocating* for use of an epi pen first. He says that it *can* be done as a last resort and is usually not done outside of a medical facility where monitoring is available. This use of an epi-pen is usually not covered by stock epi laws.

I respectfully encourage you to support HB86. Thank you for the opportunity to serve the school children of Maryland and present this testimony.