

The world’s preeminent diabetes clinic and research center

|  |  |
| --- | --- |
|  Elvira Isganaitis, MD, MPH Assistant Professor of Pediatrics One Joslin Place Boston, MA 02215 | Elvira.Isganaitis@joslin.harvard.edu Tel. 617-309-4554 Fax. 617-309-2451 |
|  |  |

February 13, 2025

Department of Public Health

250 Washington Street

Boston, MA 02108-4619

Submitted via email at Reg.Testimony@mass.gov

RE: 105 CRM 210.000: The Administration of Prescription Medications in Public and Private Schools

Dear Department of Public Health Reviewers:

I am providing this written statement both as a concerned resident of Massachusetts and as an Attending Pediatric Endocrinologist and Associate Director of the Pediatric, Adolescent, and Young Adult Unit at the Joslin Diabetes Center, an affiliate of Harvard Medical School. I have been practicing pediatric endocrinology since 2010, and I currently provide direct clinical care for several hundred school-aged children with Type 1 diabetes (T1D), and medical oversight for the approximately 2000 children with T1D followed at our center. As such, I would like to express my **enthusiastic support for including glucagon as an emergency medication that can be administered by non-medically licensed, trained staff in school-related settings**. This position is widely accepted by my pediatric endocrinology colleagues and by our professional organizations, including the American Diabetes Association and The Endocrine Society.

Allowing glucagon to be administered by trained, non-healthcare personnel in the school setting would improve the safety of pediatric patients with type 1 diabetes, and may save lives. Indeed, severe hypoglycemia requires urgent treatment, as it can lead to loss of consciousness, seizure, neurological disability, and death. Prompt administration of glucagon can quickly and safely reverse severe hypoglycemia. I have personally known a child who was left with permanent neurological impairment, and a teenager who died, because they did not receive glucagon to treat a hypoglycemia episode in time. **Limiting glucagon administration to health care personnel may delay its administration, and expose students to undue risk**. Pediatric endocrinologists, diabetes educators, and other diabetes providers work together with families to ensure that anyone who is in contact with a child with diabetes (e.g., parents, grandparents, babysitters, teachers, coaches) knows how to recognize signs of hypoglycemia, and is trained and ready to give emergency glucagon if needed. Thus, the notion that glucagon administration in a school setting should be restricted to medically licensed personnel runs counter to the way glucagon is administered outside of the school setting. Moreover, glucagon administration by trained, non-medically licensed school staff is the norm in most other U.S. states, in Canada, in the U.K. and in the European Union.

Injectable glucagon has been available by prescription since the 1960’s, and has accumulated an extremely robust track record of safety. In fact, the safety profile of glucagon is superior, with fewer side effects than epinephrine, which is currently approved for administration by trained non-healthcare school personnel in Massachusetts. Traditional glucagon emergency kits require mixing of a powder with a saline diluent before intramuscular or subcutaneous injection; these kits are intended for use by non-healthcare professionals, after they have received some training. Newer formulations of glucagon are now available using very simple, single-use intranasal devices (Baqsimi) and as pre-mixed injectable devices similar to Epi-Pen (G-Voke Hypo-Pen); these newer formulations are extremely easy to use and require minimal training. As a health care professional, I feel that glucagon and epinephrine are comparable in that they both have life-saving potential, both need to be given in a time-sensitive manner, their mode of administration, and their excellent safety (with glucagon having fewer adverse effects). Thus, in my professional opinion, glucagon and epinephrine administration by non-healthcare personnel in a school setting should be approached in a similar manner. I am supportive of revising 210.04 to state that “The administration of parenteral medications may not be delegated or administered by training, with the exception of epinephrine, glucagon, and emergency rescue medications…” It is important that the revised language be inclusive of the many glucagon formulations that are currently available on the market, and not be limited to intranasal devices. Health insurance benefits can vary dramatically, such that it may not always be possible or affordable for my patients to obtain a specific type of glucagon formulation or device. As such I would recommend that the revised language be inclusive of all glucagon forms and modes of administration.

In summary, I strongly support changes to 105 CRM 210.000: The Administration of Prescription Medications in Public and Private Schools to allow for trained, non-medical personnel to administer any glucagon preparation within school settings in Massachusetts. I am grateful for this opportunity to share my perspective with the Department of Public Health. Please feel free to contact me if you have any questions.

Sincerely yours,



Elvira Isganaitis, MD, MPH

1, Joslin Place, Room 655A

Boston, MA 02215

Elvira.Isganaitis@joslin.harvard.edu