

MCHB/EMSC Webcast

Improving EMS Medical Direction for Pediatric Patients,

An Internet

August 22, 2006

DAN KAVANAUGH: Good afternoon. My name is Dan Kavanaugh, the senior program manager for the emergency medical services for children program, and with me today is Dr. Kathleen Brown and Dr. Joseph Wright from the Children's National Medical Center, and the talk is on improving EMS medical direction for pediatric patients. I want to go through a few general information first about the webcast. Slides will appear in the central window and they should advance automatically. Slide changes are synchronized with the speaker's presentations. You do not need to do anything to advance the slides. You may need to adjust the timing of the slide changes to match the audio by using the slide control at the top of the messaging window.

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from. The questions will be relayed on to the speakers periodically throughout the

broadcast. If we don't have the opportunity to respond during the broadcast, we will email

you afterwards, collect the questions and email them out on the listserv afterwards. On the

left of the interface is the video window. You can adjust the volume of the audio using the volume control slider. You can adjust by clicking on the loud speaker icon.

Those of you who selected accessibility features, when you registered will see text captioning. Please take a couple minutes to fill out the online evaluation. Your responses will help you to work on future broadcasts in the series and provide technical support. Next slide, please. Just wanted to mention accreditation for continuing medical education, Indian Health Service is accredited to sponsor continuing education for physicians, and this is up to one hour of category one credit to the physicians recognition award and each should only claim one hour that you spend in the activity. And it's accepted by the American Academy of Physician Assistants and Nurse Midwives. It's a provider of the nursing education by the Credentialed Center Commission and designates 1.2 contact hours for nursing.

Next slide, please. Disclosure statement, Doctors Wright and Brown have no significant financial relationship with any product or commercial manufacturer that would constitute a conflict of interest.

Next slide, please. And now to discuss our program performance measures. The performance measures were to improve pediatric emergency care. With the implementation of the government results act, public sector agencies are increasingly being held accountable for achieving outcomes. It focuses on a results-oriented approach which requires federal agencies to have performance measures that inform and guide

organizational decisions and communicate to a broad constituency about the success. They are obligated to provide information to Congress on the effectiveness of the programs, such as the emergency medical services for children program. And the grantees are required to report annually on three measures that have been developed which have numbers of 66, 67 and 68 in the partnership guidance and applications.

Next slide, please. In terms of how these measures were developed, the development of these measures involve the participation of representatives from national organizations, such as the national association of EMS directors, officials, current grantees, partners at the national highway traffic safety administration and federal officials. And during that process we reviewed relevant documentation to identify when the possible universe of measures might be. We narrowed this down to a working set of 50 measures. EMSC consensus group meetings to identify three core measures was convened where we brought all the stakeholders together I just mentioned. That's where this occurred. And we convened follow-up conference calls with various members of the group to refine the three measures. Appear -- and then beta tested with three of the grantees, Colorado, Illinois, and New Hampshire.

The next slide, please. I'm going to go through each of the performance measures and also they have submeasures to them. The first one number 66, degree t which the state or territory has ensured to provide pediatric emergency care. Operational capacity is defined by the five submeasures.

Next slide, please. Submeasure A is the percentage of prehospital provider agencies in the state or territory that have online and offline pediatric medical direction at the scene of an emergency or basic life support providers and advanced life support providers.

Next slide. Performance submeasure B is a percentage of prehospital provider agencies in the state or territory that have the essential equipment or supplies as outlined in the American academy of pediatric, and others. Next slide, please. C is the existence of a statewide, territorial or regional standardized system that recognizes hospitals that are able to stabilize and/or manage pediatric emergencies. D is the percentage of hospitals in the state or territory that have written inter-facility agreements, and E is where they have written guidelines.

Next slide, please. Performance measure 67 is the adoption of requirements by the state, territory or pediatric emergency education for the recertification of paramedics. What this refers to, the state or territory has the formal process, has formal written recommendations and/or guidelines for pediatric emergency care education as part of the recertification for paramedics. Recommended training curricula and/or course things may include but not limited to pediatric education, advanced pediatric life support, and advanced life support courses.

Next slide, please. Performance measure 68 is the degree to which the state, territory has established permanence in the system, and this is comprised of four submeasures.

Next slide. The first submeasure is the establishments of an advisory committee in the state or territory. Incorporation of pediatric representation on the state, territory EMS board. Next slide, please. Establishment of one full-time equivalent EMSC manager, and the integration of the priorities into existing EMS or hospital health care facilities statutes and regulations. What I have shown is a thumbnail sketch of the measures. Each of the grantees has been provided with an implementation guide that goes to more detail to get the data from in order to meet the measures and what type of data the program is looking for. So again, this has been just a rough, a thumbnail sketch of what the measures actually are. All the information behind them, each of the grantees has through their implementation guide that they were provided with upon awarding of the state partnership grant.

The next slide, please. At this point I'm going to turn it over to Doctors Wright and Brown.

JOSEPH WRIGHT: Good afternoon. My name is Joseph Wright. And I'm a pediatric emergency medicine physician at children's national medical center in the District of Columbia and a grantee in the state partnership category. The last ten years, served as a pediatric EMS medical director within the Maryland emergency medical services system, and from that perspective is where we will be talking this afternoon about measure 66A. Measure 66A as Dan has already alluded to speaks to a goal that by 2011, 90% of pre-ops will provide the agencies in the state or territory, will have online and offline pediatric medical directions for emergency or basic life support and ALS providers. And this in turn is understanding that measure with a little bit more detail. It's important to design the

components of the measure. When we talk about prehospital provider agencies, we are talking about license, certified or designated agencies with the primary requirement of delivering care to pedestrian truck -- pediatric patients during an emergency, and transporting them. Air ambulance is excluded from the definition. In terms of what constitutes the group, persons up to 18 years old.

Next slide, please. The other aspect of the definition I think is important is that does not appear in the guidance, is online and offline. It was at the recent grantees' meeting, online is realtime medical direction, and offline we are talking about protocols. With that I will turn it over to my colleague Dr. Brown who will talk about protocols.

KATHLEEN BROWN: Good afternoon, I am Kathleen Brown and an emergency medical physician, and I work with Dr. Wright. In the past I've been involved with the New York EMSC advisory and EMS advisory committee, and also function currently as the chairperson for the national association of EMS physicians. In the webcast today we hope to be able to help you with developing or meeting guidelines performance measure 66A, and as part of that developing protocols, online and offline, and medical direction for your region or state.

Can we have the next slide, please? The one resource for that, I hope some of you are familiar with this. A document that was developed by the national association of EMS physicians pediatric committee, first published in 2000. [Inaudible] it was revised and republished again in 2003.

One of the controversies, should they be separate, stand alone, or more useful to have protocol that could be integrated into the general protocols for your state or region. If you would like to see those protocols, they were available on the web site until just about a month ago when they changed their web site. Currently they are not, but we are working on getting them back up there. You could find them in the original published version, and again the revised version in 2003.

Next slide, please. So other resources that may be helpful in developing protocols, the center for pediatric emergency medicine located in New York City at Bellevue hospital. They have a resource called TRIPS, contains other protocols for pediatrics, and also teaching guides how to implement them. And the life support guidelines, these are often the I -- [inaudible] if there are issues that cause controversy when you are developing your protocols, it's a resource to go to to find more information about particular topics. Also the ENSC national resource center has the model protocols. One example is the state of Illinois. Get more information on through the national resource center web site.

Next slide, please. Again, more resources, both the American college and AAP might be able to help you find people to develop your protocols, or in helping to provide standards for online pediatric medical direction. And children's hospitals in your state may be a place you can find such people. Not only children's hospital. In New York State, we didn't have a Children's Hospital in upstate New York, so I and other people who I worked with were

able to help with regional protocols and have them put into the state protocols also. Next slide.

JOSEPH WRIGHT: Okay. So how can you assist your grant program? Well, EMSC has done an excellent job of dissemination. And in fact, all 50 states and six territory have that present, and some of which have been mentioned by Dr. Brown and Dan earlier. I think it's important to direct the resources through the web site, it's a good place to go to provide assistance and access to resources and products, and resources that perhaps the jurisdictional folks might not be aware of. So I think that in your role as EMS leadership, and your state or territory before, beware of the pediatric resources that are available and can assist in the process of protocol development.

Next slide. And to that end, these resources actually provide detailed language about protocol development. Template language, for instance, the model protocol, one such product that Dr. Brown mentioned, and in fact, in the District of Columbia where they we have been involved in protocol development from the standpoint of Children's Hospitals, the first place we went to develop pediatric protocol language was to the model protocol. Also mentioned the training resource for [inaudible] both ELS and ALS language that can be utilized and the whole objective of these products is to be able to take them and customize them to your system. And I think this is a good way to engage either regional or jurisdictional people who are interested in pediatrics to get involved, be able to have some baseline language from which you can build your pediatric protocols.

Next slide, please. So, how can you further assist your EMSC grant program? First of all, you need to know where your grand program is. There are a variety of variations on the theme across the country, as to where your EMSC program exists. Right here at the table we have, you know, in the same region two different variations on that theme, and the District of Columbia where Dr. Brown and I practice, the partnership grant is held at the Children's Hospital. And the state of Maryland, neighboring jurisdiction where I work in the EMS system, the state EMS office is the holder of the partnership grant. So it's important in order to be able to assist those in the system who will be responsible for pediatric protocol development to know where the resources are, where the expertise is, and specifically when we talk about protocol development and the buy-in, if you will, it's important to know who your, your medical resources are, who will your champions, if you will, with regard to pediatrics, medical direction. In the state of Maryland, we, on an annual basis, have what we call an annual medical director's forum, where all of the medical director, come together for updates around the country in regards to EMS. So again, I believe it's important to be able to identify what your resources are, particularly those that are available in the public domain through the EMSC program. And also be able to identify who your resources are with regard to pediatric expertise in your state or territory. That may be [inaudible] may be at the children's hospital, or pediatric expertise at general emergency departments that have a pediatric -- where you can assist the grantees is knowing where they are, and who represents -- [inaudible].

KATHLEEN BROWN: Next slide, please. One other way that you can assist the grant program is participate in the state advisory committee. This is obviously going to vary from

state to state as Joe mentioned. Where it's housed in your state may be variable. I know in New York there was regional protocols that then went to a state EMSC -- EMS advisory committee that had members on it. So we would review the protocols for each region and approve those. In other places where Joe works now, in Maryland, the EMS -- the protocols are statewide. So there's one set of protocols that all the agencies in the state utilize. And so his position as the advisor for the state enables him to have direct input on the protocols. Next slide. So another thing that would need to be done in a way that you can assist your grant programs, is to monitor the individual agency accountability. So again, in many states there are multiple agencies and many states, each of them have their own protocols. Not every state has statewide protocols. So these need to be continuously monitored to make sure that they include each one of them include pediatric components. And again, as what happened in New York, often they will be submitted to a central -- [inaudible] and monitored in that way. Another thing again is that you need to make sure the topic is integrated and remains on the EMS board agenda. So it's not a one-time thing where you write a protocol and let it go like other EMS protocol, you need to continuously revise. So whenever there is a revision process going on with the general protocols, you may be helped to provide the pediatric protocols. Again, they need to be continuously, changes need to be incorporated and be kept up to date with the other protocol. Next slide.

JOSEPH WRIGHT: Next slide, please. Okay. What we are going to do now is go into an exercise of looking at the different ways that you can approach protocol development, and as was mentioned earlier by Dr. Brown, we both here represent two different approaches

to pediatric protocol development. An integrated approach which is what you utilize in the state of Maryland, where it's a part of a statewide protocol development, or a process of a separate pediatric protocol development, and over the course of the next several slides as we wrap up the normal part of the webcast we would like to weigh the pros and cons and the benefits and challenges of each approach. So I'll start and we'll talk about the methodology utilized in the Maryland institute for emergency systems which is an integrated approach. And it's important to have identified a champion, someone who is going to move the process along to bring the issue to the table, and to research the issue. We tried to be as evidence-based as possible in EMS, and so therefore, it's important that there is one individual who reviews the literature, looks at what is available in other EMS jurisdictions, and brings that to the table. So in the Maryland system, the three aspects are required before a protocol is considered. Also within the system, the state of Maryland system, we also utilize the data that we have from our own experience so that the, for instance, we recently developed a protocol on a life-threatening event, it's a specific issue, and wanted to have some idea of what the experience was like for our providers and were able to drill down into our own data in a confidential manner to learn what we needed to develop in the protocol so that we would not miss the children and they would be appropriately identified.

Finally, this process flows up to a pediatric advisory committee which we call the pediatric emergency medical advisory committee, where the protocol -- a consensus is reached in that group. Next slide, please. At that point, once the pediatric group reaches consensus, the pediatric advisory body reaches consensus, the recommendation is then made to the

larger protocol review committee. This is where the integration takes place. There is [inaudible] the small group of pediatric experts, but the final recommendation blows through -- flows through the review committee, and in Maryland the board is the final voting body on changes relative to protocol. Each spring there is a roll-out of what's new in the protocol, so the instructors at the jurisdictional level will know what's coming up and our publication date is typically July 1 of each year for a new set of protocols. And I think the one feature that we have added to this process, particularly within the pediatric advisory group, is that we recognize that just because a protocol appears in the book and on paper, there's an educational process that goes along introducing a new protocol and procedure, at the provider level and as such we have implemented what we think needs to be at least a two or three-year educational process to support new protocols as they are introduced. So we will build into our pediatric continuing education as soon as we know there is a new protocol that will be published, we introduce it to the regional and statewide continuing ed conferences and keep the new protocols on the agenda for these conferences for at least a two, or three-year period.

Next slide, please. So this is an example of the new protocol I talk about, a pair of life-threatening events. This was new in 2005, and I wanted to point out on this slide that in terms of what appears on paper for the provider, use the icon, the universal image, if you will, to represent pediatrics, and in many EMS protocol, and this particular bear, I don't know if you can see it, I think has a Maryland flag on his chest. But when the provider sees this in the protocol book or his or her pocket protocols, they know it's either a pediatric-specific protocol or this is a pediatric approach to a general protocol. Next slide,

next. This is what the providers are presented with each -- each year with the update or, of the protocol. You see the larger notebook there. You have the ability to include new pages to the protocol. I mention the pocket protocol, the smaller book that providers -- a smaller book that they can take with them or keep in their pocket, it's a smaller version of the larger book.

So what are the benefits of this approach? As I mention, pediatrics has an identified seat at the table. There is an incorporated expectation that pediatrics will be participating in the process, and it is understood that there will be input from pediatric group. In terms of education and training, we believe it's less intimidating for providers to have pediatric, new things in pediatric interviews in the context of overall -- as opposed to something focused just on kids, which can be intimidating for providers who don't see a whole lot of kids. And it cannot get lost. It's always incorporated in the protocol updates and it is difficult to overlook what improvements or advances are happening in pediatrics when it's built into the improvements and advancements in the EMS protocol updates overall. What are the challenges? Well, as I went through that process, you probably recognize that there were a lot of steps, and there is bureaucracy. There is the need to weave yourself in as the pediatric representative to the larger group. And with that comes the need to be able to play nice in the sand box with everyone, and to be able to work with them. Overall bureaucracy of the particular state, region or territory. And it may be a struggle in that process to be heard. There was competitive with other constituents. For instance, there may be concerns about what do we do with the geriatric population. All that they may encounter. Able to make a convincing argument with what is important for kids and for the

argument to be heard. And finally there is the constant need to remind people of the unique needs of children. There have been lots of advances, if anyone has paid attention to the most recent recommendation and guidelines, there have been some pretty important advances with regard to the approach to resuscitation and ALS care and other care of children, and so there is the need constantly to remind folks that you need -- you need them -- requires a place at the table. Next slide.

KATHLEEN BROWN: I'm going to talk a little bit about an example of separate pediatric protocols, and this is in the District of Columbia where Joe and I currently practice. The partnership grant in 2000 with a grantee, this is before I was living and working in D.C., specifically is [inaudible] protocols, pediatric protocols for the District of Columbia.

Through Dr. Wright and his team was able to on their own create the protocols by reviewing the literature, using some of the sources of information we have discussed in the past. And again, created these protocols. One of those things they used as a resource were the model protocols referenced up there, the two publications on the slides.

Next slide, please. So by doing this, they were then able to present this through the existing regulatory bodies in the District of Columbia and get them approved, the single agency provider in the District of Columbia. And those have been the pediatric protocols used by the fire and EMS.

So next slide, please. So what are the benefits of this type of process of having separate protocols? One is the flexibility of autonomy, rather than having to deal with a large

bureaucracy, Dr. Wright was able to use the expertise and the resources they were aware of to create these protocols, did not have to go to numerous meetings and argue particular points in the protocols with other parts of the EMS bureaucracy. So that made -- that was an advantage. Also again, having a separate pediatric protocol emphasizes to use in children. It shows this is a special population that requires different approaches for a particular emergency and again, emphasizes that providers and I think through the EMS agencies themselves. And then finally, in this type of approach I think that pediatric expertise is valued. When you are part of the group that utilizes and reviews these protocols, you are looked to as the person that is an expert, and able to give an opinion and a final word often about what the protocol will look like. Again, I think it's a little late for the autonomy that we discussed earlier.

Next slide. So what are the challenges of this type of approach? One is the very feel here they may get lost. If they are in a separate book, they may get overlooked because they are not used as often as the general protocols. We know that kids represent a minority of the transports that that EMS does. So it may not be the place that they can easily access it. A little story in D.C., there's a, medical control subcommittee functions as the EMS advisory committee for D.C. at the moment, and when they wanted to find out what the pediatric protocols said about a particular issue recently they didn't know where they were. And had to come to Joe and the people at Children's to find a copy of that and exactly what was located in the protocols. So this is an example of the protocols being separate that said they were lost. Training issues, again, protocols are separate and you are doing refreshers or training, initial training on EMS providers, the pediatric issues may be

separated so that that they are lost, and I think Joe mentioned that keeping pediatrics separate may be more intimidating for providers. It can be an intimidating issue by EMS providers by separating it out really emphasizes the difference there. And again, ownership, I just gave an example of how the protocol in D.C. was not really owned by D.C. fire, that they looked to our group to keep track of those. One thing Joe mentioned again, the guidelines for children have not changed in the way that will really affect when they are adopted the care by EMS providers. Basically it has not changed and needs to be revised. And so we will be looked on to do this, even though D.C. fire at this moment may not be looking to advise their general protocols, clearly there is a need to revise the pediatric protocols. So it may happen at different times because the issues may be different between the care of children and adults.

Next slide. So we both discussed examples of how the protocols have been developed and how they function in our system. But both of these systems are really urban systems. In Joe's case, there's a unifying agency. So obviously if you work in a state that has multiple agencies with different levels of providers, you know, you may have a [inaudible] many more challenges that we don't face in our particular system. And again, the same is for rural and remote areas. May be much harder to locate to get the expertise in such places as there are other issues that will need to be addressed. And finally the bottom line is there does need to be a pediatric presence whenever these issues are addressed. So always -- needs to be whichever way you choose to do it, whether you integrate them or have them separate, some pediatric presence in the development of the protocols or guidelines for online medical direction.

DAN KAVANAUGH: We do have a couple questions that I'm going to provide to the, to Dr. Wright and talk to Dr. Brawn. I want to talk about the performance measures and the grantees are doing on this one. One of the things is that the program, you know, doesn't expect that the grantees are going to do everything in the first year of their grant, regarding either this performance measure or the other two performance measures that have been developed. For example, this performance measure regarding medical, regarding online and offline pediatric medical direction has a time frame of from 2006 through 2011. And by 2011, the goal is that 90% of the -- 90% of prehospital provider agencies in the state or territory will have online and offline pediatric medical direction at the scene of an emergency for the providers. And the grantees have also been given suggestions where over the course of from now until 2011, that data can be collected. Primarily one is through surveys, surveys of either prehospital or provider agencies or regional coordinators in the state or territory. The second one is ambulance inspection reports, another thing, that sometimes states are already collecting that information through the ambulance inspection reports. A couple of the questions that came through, one of them was the question is are these protocols nationally registered or recognized?

KATHLEEN BROWN: The [inaudible] what you are referring to, they are not I don't think registered in any way. They are recognized in that they are utilized by many throughout the country. They were developed by [inaudible] but then again, that is through many other national organizations, provider organizations and physician organizations.

JOSEPH WRIGHT: And I'll just add that the protocols, the model protocols are evidence-based and always striving to build what we do in EMS on sound evidence. And the process that Kathleen and others are involved in developing the model protocols is based on I think very reliable and sound evidence, and folks can feel confident in using -- that the use of these protocols represents what's current and what is up to date in the medical care of children. Now, part of the problem with, I think the question asks, are they registered or recognized. It's kind of difficult to have a one protocol fits all approach. Because systems differ across the country. Kathleen mentioned the challenges of rural or frontier system, and obviously protocols that might make sense for urban or small jurisdictions are not going to make sense for a jurisdiction that's largely rural. So I think that we have to be careful about how prescriptive any set of model protocols can really be. Ultimately all the protocols need to be customized to be a specific system in which they are applied.

DAN KAVANAUGH: And there is actually a comment, and also a question from Dr. Romig in Florida. He commented that not to forget, or to do some outreach, actually, with rangers and lifeguards. Many of these providers are often BLS-based and do not have pediatric input for online or offline direction. So just a comment to include them in the area. And the question, do we have a feeling of which format of pediatric protocols by providers, integrated with adult protocols or a separate set. And mentioned in South Florida the general practice is for integrated protocols.

KATHLEEN BROWN: You know, I would like to know the answer to that question, too. Because as we are revising the model protocols, we are deciding now about the format,

and the question is whether to go along with the larger group that is developing model protocols for all age patient, or whether to keep with the separate protocols and provide, you know, revise them as separate protocols. So I don't know the answer. I do know that the model protocols that exist have been pretty well accepted by the medical directors and have been downloaded by the websites and used. [Inaudible]

JOSEPH WRIGHT: And actually that's a great question, and I appreciate you bringing it forward. When we looked at this a couple years ago for a presentation at a conference, I think 75% of pediatric protocols in the country are actually integrated. But that's not based on any knowledge of provider preference. I agree with Kathleen, we don't know what the providers prefer. But the state doesn't state, if you will, most part pediatric protocols are integrated and across the country, in larger EMS protocols.

DAN KAVANAUGH: And a follow-up from Dr. Romig, should we work toward a survey of the providers themselves as to which format they prefer, and she says I think I have a way to do this.

KATHLEEN BROWN: Sure. Sounds like a great targeted issue.

KATHLEEN BROWN: I would love to know the answer to that.

DAN KAVANAUGH: At this point, I would like to ask if our speakers have any additional final thoughts that they would like to share with our audience.

KATHLEEN BROWN: Again, if there are -- if there are people out there with opinions or who have experience with the protocols, I would love any feedback that you can give me as we are trying to find how to revise those, and what would be most useful out there for people who really use them.

JOSEPH WRIGHT: And I'll just add again, I think there is not just a need to develop protocols, but also to monitor their utility in the field, and how they are being received by providers. Often centrally there is the development of protocols, in which there may not be full representation of the provider community at the table, but it's often the reality, and I think it's important for leadership and EMS to monitor utility of protocols and the -- how protocols are actually applied in the field and how they are being received in the field after [inaudible] and so it goes beyond just development. But I think there's a [inaudible] responsibility as well.

DAN KAVANAUGH: Sounds like the comments here as we are wrapping up has prompted another question. Do these integrated protocols meet national standards?

JOSEPH WRIGHT: I see here that the provider of the question is capitalizing national, and I just want to be clear if we are referring to sort of national -- I'm not sure what the metric is for national standards, but again, I think the answer to the question is no, we did not have universal EMS protocols that meet anybody's "standards or certification." There are protocols that are based on the available evidence, and a pretty meticulous -- [inaudible] I

don't know if we will ever be able to get to a universal set of protocols nationally because we have such a different approach [inaudible] great. Thank you. The question comes across, yes, reference to national standards is in reference to national registry. And again, there is not a formal certification by anyone and there's not a formal certification by anyone. --crosswalk, if you will, of the protocols of national registry. So the answer to the question is no. But I want to emphasize that a great deal of ground work has gone into the development of the model protocols and are moving forward. This is not a status product. But it's in the process of being revised. We would like input as to the best way to do that.

KATHLEEN BROWN: I want to add that this is an issue for EMS if there are any on the national standards protocol among other things. I think that there are people who are working towards developing them, but that's a very ambitious project and it's probably going to take years to complete. I know that there's talk of federal funding, but again, it's something that is not going to be available until you probably are in the grant cycle because it's a very ambitious project.

JOSEPH WRIGHT: I see here the questioner has sent a follow-up, St. Thomas in the Virgin Islands writes solely on these standards. Let me assure everyone that I think you can, all of us can have total confidence that the model protocols represent sound approach to care for children in the field. These have been signed off on by all the key hospital and emergency care professional relations in the country, and as Kathleen said, until there is a central oversight and direction for EMS in this country, there really will not be the ability to develop universal approaches to EMS care when there is such [inaudible]

DAN KAVANAUGH: Well, I would like to thank our presenters and also thank you, our participants, and this webcast will be archived. You should be seeing the slide at www.mchcom.com. And this will be archived within the next five days, so that you can, you know, pass it along to others you think might be interested in viewing this webcast. And again, I would like to thank all our EMSC grantees for the great work that they are doing. I know many are here on the webcast. And I would like to thank the medical directors who are attending this also and for the work that you do with our EMS grantees for supporting them. This concludes the webcast. Please fill out the evaluation after the webcast. The instructions for doing that are on your screen. Thank you very much.