

## **MCHB/EMSC Webcast**

### **Introduction to Interfacility**

### **Transfer agreements and Guidelines**

February 13, 2008

DAN KAVANAUGH: Welcome to this afternoon's webcast, "When Minutes count: Making Transfers Work for Critically Ill and Injured Children." And before we move on to the webcast and I introduce our speaker I just wanted to provide some technical information about today's webcast.

The slides will appear in the central window and they should advance automatically. The 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 delay control at the top of the messaging window.

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At this time I would like to introduce our speaker for this afternoon's webcast. Diana Fendya is the speaker, a trauma acute care specialist for the emergency medical services for Children National Resource Center. She's been part of the staff there for seven years. She's a licensed pediatric clinic nurse specialist well versed in pediatric trauma care and system development. She is both an undergraduate and graduate degree in nursing of children and families. Prior to joining the National Resource Center, Diana was the pediatric trauma nurse specialist and trauma program manager at Cardinal Glenn and Children's Hospital in St. Louis, Missouri, a level one pediatric trauma care center and Diana was there for 12 years. She's been an EMSC grantee herself having assisted in the development and coordination of projects on four EMSC grants within the State of Missouri. At this point I would like to go ahead and turn the webcast over to Diana for her presentation. Diana.

DIANA FENDYA: Hi, Dan. Thank you very much for inviting me to participate in this webcast. I would like to say good afternoon and thank each of the participants who are joining us today as well. Could I please have my first slide up? The EMSC program continues to work with states through our grantees, professional organizations, families

and others interested in children to improve and better integrate the emergency care needs of children in state emergency and healthcare systems for over some 20 plus years now. Most of us participating on this call today are well aware that the 2005 EMSC performance measures were an effort to provide both direction to states and to ensure accountability of states in assuring that essential pediatric emergency care needs of kids were met nationwide. Experts in pediatric emergency care helped in the development of these measures and now three years later these measures continue to be refined and enhanced. EMSC grantees and their advisory committees in all 50 states and the territories are continuing their efforts to facilitate performance measure implementation and improvements in pediatric emergency care. This afternoon, I was asked to address two of the measures which focus upon components of the emergency care system that are often not quickly identified as being part of the emergency continuum of care.

Historically many of the extraordinary efforts of EMSC grantees in the EMSC community have focused upon the pre-hospital care of children. As important as it is to assure that EMS providers have the resources including training, equipment and protocols to care for children, it is equally important to insure that the emergency departments that receive these children are also prepared. And yet knowing that not all hospitals are alike, transfer agreements and transfer guidelines become an essential step in the emergency care of many children to assure access to needed resources.

Next slide, please. During this next hour, we'll discuss the need for interfacility transfer. We'll review performance measure 66D which deals with interfacility transfer guidelines, and performance measure 66E which refers to interfacility transfer agreements. And we'll identify components of interfacility transfer guidelines and the role that they play in assuring timely and safe transfer of pediatric patients. We'll discuss implications of transfer

guidelines to clinical outcomes for children as well. Next slide, please. The Institute of Medicine's recent study the future of emergency care in the United States and the pediatric component of that report shares with us the magnitude of the emergency care visits and the composition of those visits in regard to children.

Next slide, please. To be an emergency department prepared to meet the needs of all patients is no easy feat but 2000-2003 public information and education spearheaded by EMSC was an effort to raise the public awareness of pediatric emergencies while helping organizations, communities and states comply with accepted standards of pediatric emergency care. In looking at pediatric emergency visits, it is apparent that emergency departments must be prepared for both pediatric trauma and medical emergencies and that the very patient that raises the anxieties of most emergency care providers, those young children under the age of three, are also the very patients that most often turn to the emergency care system for care.

Next slide, please. And as we consider those children who turn to emergency departments for care, we would be amiss if we disregarded those children with special healthcare needs who frequently find it necessary to access emergency departments and for whom many emergency departments are not adequately prepared. Next slide, please. A doctor from the University of California has done a very nice job doing a study looking at the emergency care departments and their preparedness for providing care for our children. And I would like to take some time to talk about that in just a few minutes but I think the important piece to see here is that 89% of pediatric emergency care visits are actually occur in rural or remote facilities. And I think before -- if we could have the next slide, please, I think before we go on to discuss some of the studies that have some relevancy to this talk, the recent studies, I think it's important for us to once again review the

emergency for service children's mission. The mission of the EMSC program is to ensure state-of-the-art emergency medical care for the ill or injured child and adolescent, to ensure that pediatric services are well integrated into an emergency medical services system and backed by optimal resources and that the entire spectrum of emergency services, acute care and rehabilitation is provided to children and adolescents as well as adults. Next slide, please. In a nutshell, the EMSC program strives for state-of-the-art pediatric emergency medical care that is well integrated into the EMS system, backed with optimal resources inclusive of the entire spectrum of emergency services.

Next slide, please. Hospitals are a critical component of the spectrum of emergency care. If we're to fulfill our EMSC mission we must reach beyond EMS providers and proceed through the doors of emergency departments to assure that hospitals, too, are prepared and have appropriate resources to provide care for children, including advanced preparation for transfer if needed. As a lead-in to our discussion regarding transfer agreements and guidelines I would like to share some information from the two studies that I referred to earlier that emphasize the need for advanced preparation in the establishment of transfer agreements and guidelines.

Next slide, please. The first study looks at hospital variation and this was a study that was published in 2006 by the U.S. Department of Health and Human Services. The CDC study was done by Middleton and Burt and presents an estimate of the pediatric services and supplies for treating pediatric emergencies in U.S. hospitals. The author's results from a self-administered questionnaire supplement that was a component of the 2003 national hospital ambulatory medical care survey. For those of you who are unfamiliar with the national ambulatory medical care survey it is samples, non-federal short stay in general hospitals in the United States. The emergency pediatric services and equipment

supplement survey that was attached to the national ambulatory medical care survey was based on the 2001 joint AAP/ACEP guidelines for pediatric services, medical expertise, small size supplies and equipment for emergency departments. We'll be coming back to that pediatric emergency preparedness survey in a few moments. As we look at the slide it becomes apparent that less than 5% of all hospitals in the United States are recognized as pediatric or Children's Hospitals. If only 5% of hospitals are Children's Hospital, we know most children do not receive their emergency care in facilities fully prepared for pediatric patients and one can anticipate the specialty needs of the pediatric patient may often require transfer. 52% of the hospitals admit children but they do not have necessarily a separate pediatric ward or department. And 10% of hospitals have a pediatric intensive care unit. If only 10% of hospitals surveyed have an actual PICU then one must anticipate that most of the critically ill and injured children will be being transferred to facilities that do and therefore agreements and guidelines for transfer should be or need to be in place. As one can see from the slide, there is much variation in hospital ability or preparation to provide care for children.

Next slide, please. This slide continues talking about hospital variation. The good news is that 51% of hospitals without pediatric intensive care units do, in fact, have transfer agreements with facilities that do have pediatric critical care units. The bad news is, though, that 49% do not have those agreements in place. So the next question we need to look at is at these facilities without pediatric intensive care units and without agreements, are these children being admitted to adult ICUs or are the caregivers in those emergency departments scrambling when a critical child arrives through their doors and are they trying to locate a pediatric ICU somewhere within their community or nearby and make transfer arrangements while at the same time trying to, perhaps, provide life-saving measures and care to the child. At this time one is uncertain. In either situation is the

question that needs exploration to assure that children are getting timely and appropriate care. It is interesting, though, that the majority of injured children are being moved to another appropriate facility and that agreements do, in fact, exist for the injured child. This is good news for those of us who are interested in pediatric trauma care. It is an indication that trauma system development is helping to get injured kids to the right places and the right resources. Next slide, please. A second study done by a doctor from the University of California that I talked about earlier was published in November of last year. It's pretty much hot off the press. The name of the study was pediatric preparedness of U.S. emergency departments, a 2003 survey. The objective of this study was to evaluate the compliance with the AAP/ACEP preparedness guidelines among U.S. emergency departments. This actually was the first survey done to gather data on pediatric preparedness of all EDs in the U.S. The survey was mailed out to 5,000 emergency department medical and nursing directors. The investigators received back over 1,500 of the surveys out of which 1,489 were usable. The next few slides will share some of the findings from this very important study. Next slide, please. There is a variety of emergency department configurations. 4% of non-Children's Hospitals surveyed have a separate area in which to see children. This may be a separate emergency department within a general E.D. with pediatric providers or it may only be a designated pediatric emergency room or rooms. But typically those hospitals that have identified or developed separate areas to see emergency pediatric patients typically have a higher volume of children being seen in their emergency departments. Other findings that came out of this study is that 64% of emergency departments have board certified emergency physicians available 24 hours a day. 18% of emergency departments surveyed had actual pediatric emergency medical sub specialists available to provide care for children and that only 6% of those emergency departments surveyed had all of the recommended pediatric supplies. It is important to realize that more than 1/3 of hospital emergency departments do not have staffing that

includes a physician trained in emergency medicine and therefore children coming to these emergency departments will be needing transfer more than likely in order to get the care that they deserve.

Next slide, please. The joint AAP/ACEP department guidelines identify critical policies that should be in existence as well. On the slide you'll see there are 13 recommended policies that the guidelines identify. Transfers for definitive care can be found bolded on the right-hand side of your slide list. Only 26% of those surveyed had all 13 policies in place. So obviously this is an area where hospitals, emergency departments needs to put forth some effort. Most often the policies that were cited as being available included those for child maltreatment. Unfortunately the policy most often missing was the one dealing with family issues or family presence in the emergency department. This is an area that is clearly wide open for our EMSC advisories committees and representatives to assist hospitals in making a difference for children and families. It is an important reason why we have requested and we actually ensure that every EMSC program has a family rep on their advisory committee.

Next slide, please. A separate question on the survey dealt with the recommended plans for transfer of pediatric emergency department patients for subspecialty care. The subspecialty care that is building recommended that transfers be in place for would be for trauma, medical or surgical incenseive care. Reimplantation care for those suffering traumatic amputation, burn care, psych at trick care. Next slide, please. When one discusses transferring patients there are usually concerns related to -- this webcast is not trying to talk about Impala in depth but provide an overview. It's a federal statute that dictates when a patient can refuse treatment or transferred from one hospital to another. It implies to only participating hospitals with provider agreements under which they'll accept

payment from the Department of Health and Human Services and Medicaid services under the Medicare program. For services provided to beneficiaries of that program. It was originally designed as an anti-dump statute to avoid having patients transferred due to the inability to pay. According to the regulations, once the patient is admitted and stabilized the obligation ends. Thus once the patient is admitted and stabilized in the emergency department, the obligation can be ended and the patient transferred if definitive care is further needed. Therefore compliance with this section does not really relate to performance measure 66D and E.

Next slide, please. As grantees and advisory committee members work with hospitals in the development of transfer guidelines and ensuring that agreements are in place, it would be very helpful to be aware of the joint AAP/ACEP position policy on guidelines for emergency department preparedness. Mary Anne findings, even though the guidelines were and are supported by 17 professional organizations and have been published in two professional journals, she identified that only 59% of emergency department managers were knowledgeable about them. The question I would pose to participants of this webcast and are EMSC grantees, are you aware of these guidelines and are you able to help educate these ED managers who are not knowledgeable about them? This in itself will be a huge step in helping to improve the emergency care of children in hospitals.

Next slide, please. I have listed the reference information for the emergency guidelines on this particular slide for your reference. And I hope that for those of you who are unfamiliar with them, that you will come back and pick up the reference information and obtain a copy of these guidelines. We have reviewed the variability that exists in hospital emergency departments and the reality is that most children requiring emergency care will continue to initially seek that care in their own communities and then require transfer to

specialty services at other facilities. I would now like to move on to performance measure 66D and 66E. Next slide, please. By this time and point most of our grantees and our advisory committees are well familiar with the fact that performance measure 66D refers to the percentage of hospitals that have written pediatric interfacility transfer guidelines and that performance measure 66E refers to the percentage of hospitals that have written pediatric interfacility transfer agreements.

Next slide, please. Critically ill and injured children will often be moved to other facilities with more resources and transfer agreements and guidelines will help in assuring these processes are done both in a timely and safe manner. They are important because without effective interfacility transfer agreements and guidelines, the timely and appropriate transfer of patients to the right level of emergency care might be delayed or it may not even occur. And these delays could result in very negative patient outcomes.

Next slide, please. Evidence has shown the best outcomes for critically ill and injured children are achieved when treated at facilities most prepared to address their needs. Hospitals should have interfacility transfer agreements, a written formalized arrangements in place for critically ill and injured patients. Hospitals need to identify those resources for which they do not have available and establish legal agreements in advance. Many trauma centers don't have their own rehab facilities and yet they have agreements in place with rehab centers once they can participate in the last step of recovery. Keep in mind the transfer agreements are not new concepts but they are, in fact, readily recognized for perinatal centers and other types of subspecialty care. Care has become much too complex and expensive for all hospitals to have all resources to do both the diagnostic workups and manage the care for all patients regardless of age and diagnosis. Vermont has worked hard with their hospital association to establish one formal agreement that all

14 of their hospitals have signed onto and agree to accept patients from one another when the need arises. This model might want to be explored by other states that have just a few hospitals within the state. The next step, though, for Vermont is to assure timely and appropriate transfer would be to identify the specialty resources available in each of these hospitals so the new nurse, which I very well could be if I decided to move to Vermont and work in their emergency department, would readily know where the best place might be for a specific medical diagnosis. Several states are now in the process of developing a guideline template that all hospitals will agree to follow. We'll discuss transfer guidelines specifics in a few moments.

Next slide, please. Agreements to facilitate planning and assist hospitals in considering the management of patients needing transport to care in advance of such a situation rather than forcing providers to cope with these issues during the incident. There is nothing worse than being a provider in a busy emergency department and knowing that a patient needs to be moved to get better care such as the instance of the burn patient and not knowing where burn patients are to be transferred to.

Next slide, please. An example I would like to share comes from my own home state in Missouri before I move on to mass casualty. Missouri as a state requires all hospitals to have transfer agreements in place for those services and resources which they cannot provide. Several years ago, there was an incident in which an 18 wheeler truck brakes went out and he was unable to stop at a stoplight and unfortunately ran into the back of a school bus which was stopped at the back -- which was stopped at the light. The impact of the truck hitting the bus killed two children in the back of the bus and threw several more children forward in the bus. One of those children who was thrown forward in the bus was thrown into the back of one of the bus seats. This was an older bus being used and the

back seat had one of those steel supports exposed across the back of the bus. The result was a severe open skull fracture with brain tissue extruding. The young patient was picked up by the local ALS squad who took him to the closest hospital which didn't have a pediatric neurosurgeon. The EMS provider called to the local emergency department for medical direction and facilitate preparation for their arrival. The emergency department staff knew they had an agreement with a level one pediatric trauma facility who agreed to accept the patient. The level one trauma center was contacted by the emergency department staff with the patient still being en route. An initial treatment plan was defined for the referring facilities which including stabilizing the child's airway, getting shock control in place with I.V. fluids and dressing and an immediate transfer via helicopter. The young patient arrived and the emergency department physician and staff escorted the patient and the EMS provider to the helipad where the helicopter was already waiting at the request of the referring physician. On the helipad the child's airway and fluid resuscitation to addressed to assure safe transport. Upon arrival at the receiving facility, the child was taken immediately to the operating room where the neurosurgeon was waiting. This child had no extra time to spare. The pre-planning had been done in advance and the process worked as it should. Because of the type of injury, though, that the child sustained, the receiving hospital would later need to transfer the child to a rehab facility and again, the agreement was in place to facilitate such. So now we can move on and look at another reason for interfacility transfer agreements and guidelines. Interfacility agreements and guidelines can also be essential when resources are limited or exhausted and alternate care sites must be considered. This would be especially true when there is a need to increase surge capacity and deal with mass casualty incidents. State grantees can, in conjunction or partnership with their state bioterrorism or hospital preparedness programs, find a viable option in establishing both agreements and guidelines for transfers. Such agreements assure that hospitals have a process in place to transfer patients to facilitate

surge capacity for more critically ill and/or injured patients. This is a different process than a formal mutual aid agreement than hospitals sign onto. Mutual aid agreements are typically activated when an emergency occurs within a community. A good mutual aid agreement can lay the ground work and be built upon for emergency transfer between emergency facilities day-to-day. Alaska has shared a nice example of an agreement and knowing that hospitals have willingly signed onto the agreement and are willing to work with one another on providing aid in transfer of patients in the event of a mass casualty event. One would think a normal agreement much like what Vermont has already established may be entirely feasible. Alaska needs to consider building upon their mutual aid agreements to develop an actual statewide agreement to facilitate agreements between all hospitals for all emergencies. Next slide, please. For children, this pre-planning for transfers and transfer agreements does and can make a difference in their outcomes. Next slide, please. A transfer guideline is basically a decision-making process for identifying those patients needing transfer as well as the critical steps to be implemented in the actual safe transfer of the patient to a specified facility. These steps are a critical piece of the transfer process for unfortunately the many pieces involved with often not intuitive to all providers. The clearer the steps are defined, the smoother the transfer will occur. Minutes can and will be saved and minutes for children can and do make a difference.

Next slide, please. Performance measure 66D clearly details the critical elements of transfer guidelines. I would like to take a few moments to discuss each of these elements and their importance to the child and actually the caregiver trying to arrange transfer of a pediatric patient. The first of these elements is a process for initiation of transfer. This includes identifying those who need to be transferred. Identifying those needing to be transferred basically is a list of those patients whom the caregiver should consider for

transfer such as the child with the open head fracture. Child with a compromised airway who will require pediatric critical care. Washington State has been working hard on this measure with their advisory committee and actually has done a very nice job creating an algorithm of criteria to be considered in children for transfer. The example might be helpful to others as you work with your advisory committees to develop the transfer process in your states. Part of this initiation of transfer also, though, needs to be defining the roles and responsibilities of the referring and referral facilities. In the example of the young boy and the school bus incident the referring or sending facility knew who their agreement was with for pediatric neurological surgical care. They need to link them with the guidelines. Many hospitals will have multiple agreements in place and it's not fair to expect staff to remember the process for initiating the transfer with numerous hospitals. If a state decides to develop a transfer guideline template for hospitals to use, it must be sure to allow for the individuality of the processes that are employed at the receiving institutions. For example, on the slide you will see three hospitals. Hospital A is the receiving hospital that receives the patient first. Hospital B and C both have transfer agreements with hospital A. Hospital B, if you call them to see if they would be willing to accept a patient, you merely call their emergency department and speak with the emergency department attending who will assist you in making those arrangements. Hospital C also receives critically ill and injured children but because they are a more involved, more developed teaching institution, all transfers must be accepted by the chief resident who is on call in the facility. Therefore, hospital A would need to contact the chief resident at hospital C. If you were transferring a patient to some other hospitals, you may, in fact, actually contact a specific nursing supervisor or someone in that capacity to assure that an open bed is available. So acceptance of the transfer process of the transferring patient may differ from hospital to hospital.

Next slide, please. This slide deals with the second element of the guideline, a process for selecting the appropriate care facility. If a hospital has multiple agreements to send patients for resources which they cannot provide, it is helpful to have the transfer guideline to note where the referring facility would like the patient to go for specific resource needs. The staff will not necessarily know in all instances the referring facility preferences unless it's spelled out in the guidelines. On this slide we have two hospitals, both of which are level one pediatric trauma centers and both do a great job taking care of children who are injured and their families. Hospital B also has a burn program for children and hospital C does not. It only makes sense that the referring facility clearly have in their guidelines that all burn patient go to hospital B. Keep in mind that guidelines are available to help the staff move patients quickly and safely and for new staff or unfamiliar staff who happen to be working in ED that day when a child needs to be transferred. This information is not intuitive and therefore needs to be clearly spelled out to facilitate movement of the child.

Next slide, please. A third element of the guideline needs to include the process for selecting the appropriately-staffed transport service to match the patient's acuity level. In other words, the level of care required by the patient, the response time required and the equipment needed to transport the patient. Can the child go by BLS or does he need the skills of an ALS provider for maybe even a pediatric transport team. Can he or she go by ground or is time critical and air transport required? Sometimes the closeness of two facilities may be impeded if it's in a heavy traffic area and it just so happens to be rush hour and therefore would require air transport. These discussions should take place between the referring and the receiving facilities. Many of you have been working on performance measure 66D and may have tackled this process already. Again, Washington State has a very nice algorithm and example set up to facilitate this decision-making process and again you may want to contact Scott to preview it.

Next slide, please. The fourth critical element of a guideline is a process of preparation for patient transfer which includes obtaining informed consent. But it also includes patient stabilization needs, diagnostic tests that need to be completed or not completed, essential supplies that need to accompany the patient en route and, of course, the appropriate documentation that needs to be provided to the receiving facility. Part of the conversation for acceptance of transfer should be information to facilitate stabilization and immediate treatment needs prior to transfer. Hospitals want to do the right thing for all patients and want to make sure they're working -- that they're working patients up correctly prior to transfer. Many of them are very, very nervous about working up children. One of the things that I found when I was working in the hospital is that many of the hospitals, when a child came in with head injury, knew one of the diagnostic tests was a head CT. A child with a head injury that needs a head CT needs a head CT that does much finer cuts and is much more specific to a child's brain than what a CT scanner in most general hospitals might have available. Therefore, to take time out to do a head CT on a child in a general hospital where that specificity cannot be visualized is more or less a waste of time. Therefore, we had to do a huge education campaign in my particular area to help hospitals realize that it was not essential to get that head CT at their hospital but rather we would prefer that they package the patient and transfer he or she more expeditiously. In the case of the child with the open skull fracture, time was of essence and a head CT would have done nothing to have helped the neurosurgeon who was waiting in the OR ready to operate on this child. A head CT under those situations would have again taken time and may very well have led to a delay that would have impacted the child's survivability. So part of the initial conversation should be getting care guidelines from the receiving institution. Find out what kinds of diagnostic tests they would like to have done at the referring institution, if any. And what are the essential care requirements to assure

safe transport to the receiving institution. In this instance, the child with the open skull fracture it was airway stability and fluid resuscitation. Can we go on to the next slide, please? A fifth element is planned for transfer of the patient information, personal belongings of the patient and the provision of directions to the referring institution and information to the families. Keep in mind that parents are very overwhelmed with the emergency situation itself and that if their child needs to be moved to another facility for more specialized care, their alarms go up immediately. That sense of fear and anxiety do not make that drive an easy one for them and therefore making sure that they have a set of very clear directions to guide them to the receiving facility is an important piece of care. Many receiving facilities have already pre-printed directions available that they're willing to provide to referral institutions so that they're readily available in emergency departments. A critical piece that many of the states are beginning to embark on or consider as they consider transport guidelines is a transfer checklist. This can be very helpful for transferring institutions and assuring that all specifics are being covered prior to moving the patient and that the patient is being transferred appropriately and safely. You may want to consider developing a template tool for hospitals to utilize in your state and if you need examples of states that are embarking on that process, please contact the NRC.

Next slide, please. The sixth element is perhaps the one element that many of the states who have already contacted us are struggling with. This is a process for return transfer and follow-up communications on the pediatric patient who has been transferred. Keep in mind the community hospitals want to do what is right for all patients but especially for children. But they are also in the business to make money and to assure that their doors stay open for all the individuals within their communities. So they will transfer patients to places with higher expertise and more resources. And in return, though, they need and they expect follow-up phone calls regarding the patients' condition. They deserve praise

when they do things well and they need assistance in making improvements when problems are identified. These problems need to be shared with the performance improvement team and fortunately when conditions warrant it is nice when the patient is stabilized if he or she can actually be transferred back to the referring facility. This does not always happen but in an ideal world it allows families to be reunited with the rest of their support structures and it allows parents to resume work often and it allows that referring facility to get to know that patient once more. This is especially important if that patient is one of those children with special healthcare needs who may be coming back to their emergency department at a later date for care. Next slide, please. Performance measure 66D and 66E are all about getting children to the right care at the right time and assuring that hospitals have prepared in advance a process to assist in the transfer of children. I thank you very much for your attention. My contact information is up there on the slide. Should you want to contact me with questions regarding transfer agreements and guidelines as you work on them in your states, and I'm going to turn this back over to Dan at this time.

>> Thank you, Dinah. Thank you very much. I would like to throw one question back at you that came up during the course of the webcast. One person had asked, what about for those states that don't have a pediatric specialty or Children's Hospital? How should they address transfer agreements or who should they be with?

>> I do realize that there are some states that do not have pediatric specialty hospitals available. And most of those states, more than likely, have transfer patterns that have already developed with neighboring states where there are pediatric specific resources available. And under those circumstances, those guidelines need to be developed as multi-states. I think we have the same issue with the territories as well. Agreements do

need to be in place and I would strongly encourage that for those states that don't have a pediatric specialty hospital, that they begin to focus in on those AAP/ACEP guidelines for emergency department preparedness to make sure their departments are as best prepared as they can be and when children are being transferred across state lines to pediatric specialty units, that optimal care has been provided to them prior to the transfer.

>> Okay. Thank you. At this time I would like to thank everybody for their attention to this webcast. It will be archived on [mchcom.com](http://mchcom.com) and if you have questions that you might think about, you know, after the webcast that you wanted to ask but didn't think about at the time, feel free to email Diana, as she mentioned, at [when her website](http://www.hersite.com). This concludes our webcast and thank you very much.