Pediatric Regionalized Systems of Care
Special Considerations Toolbox

More than 31 million children and adolescents access the emergency care system every year, many of whom are 3 years of age or younger. Children enter the emergency care system for very different reasons than adults. They have different diseases, injuries, and unique physiologic and emotional responses to illness and injury. Many of them have special health care needs or chronic illnesses. They require different kinds and sizes of equipment, medication dosing processes, and often need pediatric specialists to treat their illness and injuries. Unfortunately, these resources and staffing, though recognized as important in providing optimal care for children, are not always readily available where children live, play, and attend school.

A regionalized approach to care can mitigate these health care challenges. Regionalization provides opportunities for health care providers and facilities to organize and share resources, within a given geographic area. Pediatric regionalization specifically facilitates the matching of appropriate resources to a child’s health care needs, increases access to health care specialists, and helps control health care costs and improve quality of care across a population.

The need for regionalized systems of care, in particular for pediatric specialty care, has been highlighted and supported by the National Academies of Sciences, Engineering, and Medicine (NASEM, formerly known as IOM) as well as several national organizations, such as the American College of Critical Care Medicine, the Society of Critical Care Medicine, the Pediatric Section of the American Academy of Pediatrics, the Committee on Pediatric Emergency Medicine, and the National Association of State EMS Officials (NASEMSO).

This toolbox features resources for three special considerations in the development and implementation of pediatric regionalized systems of care: telemedicine applications, working across jurisdictional boundaries, and tribal sovereignty. Readers are encouraged to explore this toolbox in its entirety, as there is a great deal of overlap among these special considerations.

Telemedicine

Telemedicine has emerged as a promising tool for increasing access to pediatric specialty care across geographical distances, improving the quality of initial emergency care, and achieving maximum efficiencies within regionalized systems of care. The following sections provide resources related to telemedicine systems in terms of its utility, development and implementation, and common barriers and challenges.
Healthcare Provider Resources

American Telehealth Association (ATA)

- American Telemedicine Association is the leading international resource and advocate promoting the use of advanced remote medical technologies. ATA and its diverse membership work to fully integrate telemedicine into transformed healthcare systems to improve quality, equity and affordability of healthcare throughout the world.

  The mission of ATA is to promote professional, ethical and equitable improvement in health care delivery through telecommunications and information technology. This will be achieved through the following means:
  - Educating and engaging government, payers and the public about telemedicine
  - Providing a clearinghouse of information and services for both newcomers and experienced professionals
  - Fostering networking and collaboration among allied interests in medicine and technology
  - Promoting research, innovation and education
  - Developing and disseminating policies and standards
  - Ensuring a strong financial basis for the association to support operations
  - Creating consumer awareness and support

American Academy of Pediatrics (AAP)

- Section on Telehealth Care. The mission of the Section on Telehealth Care (SOTC) is to improve the provision of in-person and remote care through the use of telehealth technology in a medical home. To accomplish this mission, SOTC will develop guidance and education on telehealth care and advocate for those who receive and provide it.

- Telemedicine: Pediatric Applications [Technical Report]. This report chronicles the use of telemedicine by pediatricians and pediatric medical and surgical specialists to deliver inpatient and outpatient care, educate physicians and patients, and conduct medical research. It also describes the importance of telemedicine in responding to emergencies and disasters and providing access to pediatric care to remote and underserved populations. Barriers to telemedicine expansion are explained, such as legal issues, inadequate payment for services, technology costs and sustainability, and the lack of technology infrastructure on a national scale.

- The Use of Telemedicine to Address Access and Physician Workforce Shortages [Policy Statement]. This policy statement describes the expected and potential impact that telemedicine will have on pediatric physicians’ efforts to improve access and physician workforce shortages. The policy statement also describes how the American Academy of Pediatrics can advocate for its members and their patients to
best use telemedicine technologies to improve access to care, provide more patient- and family-centered care, increase efficiencies in practice, enhance the quality of care, and address projected shortages in the clinical workforce.

**American Board of Pediatrics**

- **2015-2016 Workforce Data.** The American Board of Pediatrics (ABP) collects and continually updates workforce data from a number of reliable sources. These data indicate current shortages in the pediatric sub-specialty workforce.

**American College of Emergency Physicians**

- **Telehealth in Emergency Medicine: A Primer.** This paper provides an overview of the definition of telehealth, its history, current technology, practical uses, cost and reimbursement, quality improvement measures integrated with telehealth, as well as potential risks and opportunities to its use.

**Children’s Health Fund**

- **15 Million Kids in Health Care Deserts: Can Telehealth Make a Difference?** This is the second in a series of white papers on technology and child health by the Samsung Innovation Center at Children’s Health Fund. This paper features EMSC State Partnership Regionalization of Care grantees Drs. James Marcin from UC Davis Children’s Hospital and Robert Sapién from the University of New Mexico Health Science Center. (See **EMSC State Partnership Regionalization of Care Program** below).

**Federation of State Medical Boards**

- **The Interstate Medical Licensure Compact** This compact offers a new, voluntary expedited pathway to licensure for qualified physicians who wish to practice in multiple states, increasing access to health care for patients in underserved or rural areas and allowing them to more easily connect with medical experts through the use of telemedicine technologies. (April 2016)

- **Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine.** This 2014 policy document provides guidance to state medical boards for regulating the use of telemedicine technologies in the practice of medicine and educates licensees as to the appropriate standards of care in the delivery of medical services directly to patients via telemedicine technologies. (April 2016)

**Institute of Medicine**
The Role of Telehealth in an Evolving Health Care Environment [Workshop Summary] (2012). With support from the Health Resources and Services Administration (HRSA), the IOM held a workshop in Washington, DC, on August 8-9, 2012, to examine how the use of telehealth technology can fit into the U.S. health care system. HRSA asked the IOM to focus on the potential for telehealth to serve geographically isolated individuals and extend the reach of scarce resources while also emphasizing the quality and value in the delivery of health care services. This workshop summary discusses the evolution of telehealth since 1996, including the increasing role of the private sector, policies that have promoted or delayed the use of telehealth, and consumer acceptance of telehealth. The Role of Telehealth in an Evolving Health Care Environment: Workshop Summary discusses the current evidence base for telehealth, including available data and gaps in data; and discusses how technological developments, including mobile telehealth, electronic intensive care units, remote monitoring, social networking, and wearable devices, in conjunction with the push for electronic health records, is changing the delivery of health care in rural and urban environments. This report also summarizes actions that the U.S. Department of Health and Human Services (HHS) can undertake to further the use of telehealth to improve health care outcomes while controlling costs in the current health care environment. (May 2016)

Learninghealth.org

Things to Consider when Developing a Credentialing and Privileging Process for Telehealth. This archived webinar was presented by Joe Tracy, VP Telehealth Services, Lehigh Valley Health Network on Thursday, May 21, 2015. It provides a history of credentialing and privileging for telehealth and discusses a model used in one large telehealth hub site.

National Advisory Committee on Rural Health and Human Services

Telehealth in Rural America: Policy Brief March 2015. During its Fall 2014 meeting in Sioux Falls, South Dakota, the National Advisory Committee on Rural Health and Human Services discussed the use of telehealth in rural areas and how this technology aligns with the emerging focus on value in health care. The Committee met with rural health research experts, health care providers, and patients. The Health Subcommittees held meetings with stakeholders at the Pipestone County Medical Center and Family Clinic Avera and at the Good Samaritan Society – Pipestone, both in Pipestone, Minnesota, and with stakeholders at the Howard Community Health Center in Howard, South Dakota. There they learned about the utilization of telehealth services in a Critical Access Hospital, a long term care facility, and a Federally-Qualified Health Center. This policy brief continues the Committee’s examination of the rural American health care system under the ACA and offers recommendations to the Secretary of the U.S. Department of Health and Human Services (HHS) for improving access to health care through telehealth in a value-focused future.
National Public Safety Telecommunications Council (NPSTC)

- EMS Telemedicine Report: Prehospital Use of Video Technologies [Report] (2016). This report describes an effort to assess the question of whether the ability to use emergency medical services telemedicine (EMST) adds value to the new EMS. It is based on the results of a comprehensive nationwide questionnaire involving more than 670 respondents representing prehospital EMS providers, hospital emergency department directors, trauma center directors, EMS medical directors, and online EMS medical control physicians. While 77% of all respondents favored the use of EMST over a series of patient care scenarios, this report identifies a number of important issues and barriers that must be addressed. (May 2016)

U.S. Department of Health and Human Services, Federal Office of Rural Health Policy

- Telehealth Programs. The Office for the Advancement of Telehealth (OAT) in the Federal Office of Rural Health Policy (FORHP) promotes the use of telehealth technologies for health care delivery, education, and health information services. This webpage provides information on OAT resources and funding programs to improve telehealth services in rural areas, including the Telehealth Network Grant Program (TNGP), Telehealth Resource Center Grant Program (TRC), Evidence-based Tele-Emergency Network Program (EB TNGP), Rural Veterans health Access Program (RVHAP), Licensure Portability Grant Program (LPGP), and Rural Child Poverty Telehealth Network Grant Program (RCTNGP).

- Telehealth Resource Centers (TRCs). Established to provide assistance, education and information to organizations and individuals who are actively providing or interested in providing medical care at a distance. The simple charter from the Office for Advancement of Telehealth is to assist in expanding the availability of health care to underserved populations. And because it is federally funded, the assistance provided is generally free of charge.

TRCs are funded by the U.S. Department of Health and Human Services’ Health Resources and Services Administration (HRSA) Office for the Advancement of Telehealth, which is part of the Office of Rural Health Policy.

U.S. Department of Health and Human Services, Indian Health Service

- Resources Requirement Methodology: Telemedicine. The Indian Health Service (IHS) Resources Requirements Methodology (RRM) is a system designed to project the staffing needs for a specific facility or primary service area. It is available in a computer spread sheet program to assist with the preparation of staffing estimates. The goal of RRM is to help insure that IHS provides appropriate, reasonable and consistent staffing information to Congress and Tribes. The RRM Telemedicine staffing module estimates the requirements for telemedicine staff to enhance care in various clinical disciplines. Telemedicine can facilitate expanded regional service
delivery. Many clinicians already traveling to regional hospitals/clinics can supplement in-person clinics with telemedicine clinic/consultation services.

Example Practices: Model Programs

**California UC Davis Pediatric Telemedicine Program**

UC Davis’ pediatric telemedicine program, the first of its kind in the United States, provides physicians and patients real-time remote consultation and evaluation though interactive, high-definition video and audio communication. This enhanced video technology allows UC Davis to offer 24/7 expertise to remote health-care providers, without the need to transfer a patient to UC Davis Children’s Hospital. Through the program, UC Davis emergency medicine physicians, neonatologists and critical care specialists connect directly to remote hospital emergency departments, newborn nurseries and inpatient wards to provide care and consultation for infants, children and adolescents who experience traumatic injuries, life-threatening infectious diseases or other critical illnesses.

**Children’s Hospital of Pittsburg, University of Pittsburg Medical Center**

**Pediatric Emergency Telemedicine: A Primer.** In this Children’s Telemedicine video, Dr. Jeremy Kahn describes pediatric emergency telemedicine. Questions posed include: Why use telemedicine for pediatric patients? What evidence exists for the benefits of telemedicine? What is the future of pediatric emergency telemedicine?

Educational objectives:

- Explain rationale for adopting pediatric telemedicine in western Pennsylvania
- List the potential benefits of pediatric telemedicine consultation

**EMSC State Partnership Grant Program**

**Pacific Islands EMSC Region: All Roads Lead to Collaboration.** In 2010, the EMSC State Partnership Programs in American Samoa, Guam, CNMI, Republic of Palau, Republic of the Marshall Islands, Federated States of Micronesia, and Hawaii formed the Pacific Islands EMSC Region (PIER). PIER works in collaboration to enhance individual program endeavors by sharing technical resources, allying program partnerships/business associates, and working in concert toward education and training. This PIER presentation highlights this regions program developments and the launching of some very exciting initiatives, including telehealth.

**EMSC State Partnership Regionalization of Care Program**

**2012 – 2016**

**Regents of the University of California, Office of Research, Sponsored Programs.** The North Coast EMS Agency, the UC Davis Medical Center, the United Indian Health Service, and the North Coast Clinics Network worked in collaboration to develop a regionalized,
standardized health care delivery system that integrates at both the local and regional levels to ensure evidence-based emergency medical services - either by transport or telemedicine - and that increases access to ongoing education and quality care to remote, rural, and underserved areas within the state.

University of New Mexico Health Sciences Center, Department of Emergency Medicine, Child Ready Virtual Pediatric Emergency Department. At the University of New Mexico, the Virtual Pediatric Emergency Department Telehealth Network program connects hospitals, providers, and patients. This program uses robust technology to connect UNM Hospital providers with clinicians from rural hospitals around the state offering consults for the acutely ill or injured child to help improve the health and wellness of rural and tribal children. The program helps children stay in their own communities, thus decreasing the need for parents to drive long distances for their child’s medical care. (April 2016)

2016 – 2020

Regents of the University of California, Transport of Acutely Ill and Injured Children to Institutions of Higher Care from Allied Localities (TACTICAL). TACTICAL continues to expand pediatric quality improvement, telemedicine, the Emergency Department Approved for Pediatrics readiness recognition program, and a standardized data collection program. For more information, contact Dr. Marcin at jpmarcin@ucdavis.edu.

State of Montana, EMS & Trauma Systems Section, Montana Department of Health and Human Services, Child Ready Montana (MT) Project. Child Ready MT continues implementation of a regionalized system of healthcare for children across the state. Key components of this initiative include: an assessment of existing services and skills of health care providers, the provision of education/training opportunities, and validating hospital pediatric care capabilities through a formal facility recognition program which includes a telemedicine component. For more information contact Jim DeTienne at JDetienne@mt.gov.

University of New Mexico Health Sciences Center, Department of Emergency Medicine, Child Ready: Expanding A Novel Community Self-Assessment Approach to Regionalization. Child Ready New Mexico engages tribal and rural communities, leaders of health care facilities and systems, and health care providers in the revision, expansion, and dissemination of the Child Ready program to include systems of regionalized pediatric emergency care. Simultaneously, the team will work on improving the pediatric readiness of the Child Ready Virtual Pediatric Emergency Department (CR-VPedED) Telehealth Network, as well as the overall scores for the state's National Pediatric Readiness Initiative. For more information contact Dr. Sapién at rsapien@salud.unm.edu.

EMSC Targeted Issues Grants

2005 – 2008
Regents of University of California, Improving the Care of Acutely Ill and Injured Children in Rural Emergency Departments with Telemedicine. Rural emergency departments (EDs) often lack pediatric expertise and pediatric emergency services. As a consequence, critically ill children cared for in rural EDs often receive delayed or substandard care. The goals of this project were to (1) develop and test a new instrument for measuring quality of care provided to pediatric patients presenting to EDs; (2) determine baseline measurements of quality of care and medication errors that acutely ill and injured children experience in a sample of EDs; (3) determine differences in quality of care and medication errors between ED settings and physician training; (4) improve the quality of care provided to acutely ill and injured children presenting to rural EDs using telemedicine; and (5) improve parent/guardian satisfaction and diagnostic and therapeutic advice provided to acutely ill and injured children in rural EDs when telemedicine is used compared to telephone consultations.

Kansas Health Institute

Specialist in South Dakota Use Telehealth to Give ER Care in Kansas. This 2014 article highlights a telehealth program linking eight states with real-time support for emergency rooms. (May 2016)

Family and Caregiver Resources

American Telemedicine Association (ATA)

- What Is Telemedicine? This webpage describes telemedicine and telehealth services, what types of services can be provided using telemedicine, how it is delivered, and what the benefits are for patients and families.

International Journal of Telemedicine and Applications

- Connecting Hospitalized Patients with Their Families: Case Series and Commentary. The overall aim of this project was to ascertain the utilization of a custom-designed telemedicine service for patients to maintain close contact (via videoconference) with family and friends during hospitalization. The organization conducted a retrospective chart review of hospitalized patients (primarily children) with extended hospital length of stays. Telecommunication equipment was used to provide videoconference links from the patient’s bedside to friends and family in the community. Thirty-six cases were managed during a five-year period (2006 to 2010). The most common reasons for using Family-Link were related to the logistical challenges of traveling to and from the hospital—principally due to distance, time, family commitments, and/or personal cost. The staff concludes that videoconferencing provides a solution to some barriers that may limit family presence and participation in care for hospitalized patients, and as a patient-centered innovation is likely to enhance patient and family satisfaction.

Lucile Packard Foundation for Children’s Health
Realizing the Promise of Telehealth for Children with Special Health Care Needs. Families of children with special health care needs are painfully acquainted with the frequent difficulty of gaining access to specialty care, especially in rural areas. One emerging solution is the use of telehealth technology to allow for remote appointments. A new report highlights telehealth successes for children with special needs, the barriers to its use, and possible policy solutions. The authors suggest providing comprehensive telehealth information to providers; educating families on its use; expanding billing codes and the locations and modalities that can be billed; convening a stakeholder group to identify policy barriers and solutions; and implementing pilot programs for children served by the California Children's Services program. (May 2016)

News Medical Life Sciences and Medicine

Telemedicine Makes Diagnosis and Treatment More Easy, Cost-effective for ASD Patients and Families. This article highlights a new University of Iowa study, published recently in the journal Pediatrics, that shows that parents with children on the autism spectrum are able to have a specialist address challenging behavior in these children by interacting over the computer, and at less than half of the cost of receiving similar care in person.

Database Searches

Working Across Organizational and Jurisdictional Boundaries

Regionalized pediatric systems of care are designed to match appropriate resources to healthcare needs, increase access to specialists and pediatric specialty centers, and improve the quality and efficiency of care within a given geographical area. The primary goal is to assure that the right care is available to every child when they need it regardless of where they live, travel, or attend school. However, the seamless delivery of care across organizational and geographical boundaries is often impeded or completely prohibited by jurisdictional policy or regulation, resource allocation and restrictions on use of assets, and healthcare reimbursement constraints. Varying rules for licensing and credentialing of hospitals, EMS agencies, and healthcare professionals makes crossing borders difficult or impossible and imposes restrictions on the use of telemedicine. Additionally, public and private insurance reimbursement policies for out-of-network or out of state emergency care present significant challenges. This section provides resources related to barriers associated with the development and implementation of regionalized pediatric systems of care across organizational and jurisdictional boundaries.

Healthcare Provider Resources

American Academy of Pediatrics
- **Interstate Medical Licensure Compact: Advocacy Action Guide for AAP Chapters.** This document contains information for AAP state chapters interested in advocating for adoption of the Interstate Medical Licensure Compact by state legislatures. The advocacy guide provides readers with background information and a concise overview of the Compact and its importance to AAP.

**Council of State Governments**

- **Health Care Without Borders.** This resource addresses disparities among access to care in underserved, rural communities. License portability is one solution to overcoming such barriers and increasing access to care. This article focuses on the successes of existing interstate compacts in health care and how they can be used to expand health care access across borders. (May 2016)

- **Recognizing EMS Personnel Across State Lines.** This 2014 article highlighted the Recognition of EMS Personnel Licensure Compact, or REPLICA, including history, current status, and next steps.

- **Resolution in Support of the Recognition of EMS Personnel Licensure Compact (REPLICA).** A resolution by the Council of State Governments supporting the establishment of the Recognition of EMS Personnel Licensure Compact (REPLICA) and encouraging its member jurisdictions to consider the new interstate agreement as an innovative policy solution to the challenge of interstate EMS personnel emergency and life-saving operations.

- **Top 5 Issues in 2016: Interstate Compacts.** In this Issue Brief, Colmon Elridge, Director of CSG's National Center for Interstate Compacts, discusses key legislation for state legislators to consider in 2016. (June 2016)

**EMSC State Partnership Regionalization of Care Program**

- **Evaluating Systems of Pediatric Care in Remote and Frontier Alaska: Defining Next Steps for Improvement.** More than 31 million children and adolescents access the emergency care system every year. Unfortunately, pediatric resources to provide optimal care for children are not always readily available where children live, play, and attend school. This is especially true in Alaska. With 75% of Alaskan communities not connected by roads to a hospital, travel is often expensive necessitating creative alternatives to assure access to essential pediatric services when an emergency occurs. Julie Rabeau, RN, EMSC State Partnership Regionalization of Care (SPROC) grantee, and Matthew Hirschfeld MD, PhD, medical director, Maternal Child Health Services at Alaska Native Medical Center, discussed challenges encountered in providing emergency care to children in frontier and remote areas of Alaska. A quality improvement initiative implemented through the SPROC grant focused on evaluating the continuum of care and identifying opportunities for improving the care of severely injured children was also
highlighted. In addition, innovative approaches to improving aeromedical resource availability, as well as educational opportunities were shared. (March 16, 2016)

**Federation of State Medical Boards**

- **Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine**. This 2014 policy document provides guidance to state medical boards for regulating the use of telemedicine technologies in the practice of medicine and educates licensees as to the appropriate standards of care in the delivery of medical services directly to patients via telemedicine technologies. (April 2016)

- **Report of the Ad Hoc Committee on Telemedicine: A Model Act to Regulate the Practice of Medicine Across State Lines**. The Federation of State Medical Boards developed the Ad Hoc Committee on Telemedicine to evaluate the practice of medicine across state lines and develop a model act to provide regulatory recommendations to state medical boards. This report describes the rationale behind each section of the model act.

**HealthIT.gov**

- **Are There State Licensing Issues Related to Telehealth?** This question falls under the Rural Health, Telehealth FAQs section and provides additional resources to learn more about state licensure and telehealth.

**Interstate Medical Licensure Compact Commission**

- **Notice of Interstate Medical Licensure Compact Commission Executive Committee Meeting**. This is a notice of public meeting for the Interstate Licensure Compact Commission Executive Committee Meeting. The meeting was held via teleconference on June 6, 2016 at 3:00 pm (EST). Teleconferencing information and an overview of the meeting agenda are provided.

**Journal of Health and Life Sciences Law**

- **Medical Control of Emergency Medical Services**. This article, published in the February 2011 edition of the *Journal of Health and Life Sciences Law*, discusses medical oversight and the legal framework of emergency medical services systems.

**Journal of the American Academy of Psychiatry and the Law**

- **Boundary Violation**. Regulation of the interstate practice of medicine represents a challenge to state medical boards. Although laws prohibiting the unlicensed practice of medicine were originally enacted to protect the public from unqualified practitioners, they could be invoked in a whole host of common clinical situations such as calling in prescriptions to a patient in another state, giving expert testimony in another jurisdiction, or reviewing radiology films on the internet, with potentially serious criminal ramifications. In this article a recent case describing a physician’s
being prosecuted for the illegal practice of medicine across state lines is presented
and followed by a discussion of the numerous ways in which contemporary
practitioners are likely to engage in such acts. The function of state medical
legislation is explored as it relates to prohibitions on interstate practice. It is
suggested that states, and possibly the federal government, should devise legislative
solutions to allow for the good faith intermittent practice of interstate medicine.

Example Practices: Model Programs

**EMSC State Partnership Regionalization of Care (SPROC) Demonstration Projects**

**ALASKA** – Department of Health and Social Services, Trauma Program. The Alaska
EMSC SPROC Program investigated solutions to overcome the challenges of promptly
delivering specialized pediatric care to children in rural, frontier, and wilderness
communities of the state, and the indigenous Alaska Native and American Indians. The
primary goals of the project were to: increase statewide pediatric-specific training in
disaster preparedness; integrate pediatric components in disaster response planning;
provide training to stakeholders and providers, establish a regionalization of pediatric care
program, and integrate pediatric components with the current trauma designation,
consultative, or educational processes.

**ARIZONA** – Department of Health Services, Maternal and Child Health, Injury
Prevention. The primary goal of the Arizona EMSC SPROC Program was to expand its
Pediatric Prepared Emergency Care (PPEC) program into more rural and tribal
communities within the state and to integrate evidence-based guidelines into clinical
decision-making for all participating facilities. Implemented in 2011 by the Arizona EMSC
program and the Arizona Chapter of the American Academy of Pediatrics, PPEC is a three-
tiered voluntary pediatric emergency care facility program that recognizing hospitals
prepared to stabilize and/or manage pediatric medical emergencies.

**CALIFORNIA** – Regents of the University of California, Office of Research, Sponsored
Programs. The North Coast EMS Agency, the UC Davis Medical Center, the United Indian
Health Service, and the North Coast Clinics Network worked in collaboration to develop a
regionalized, standardized health care delivery system that integrates at both the local and
regional levels to ensure evidence-based emergency medical services - either by transport
or telemedicine - and that increases access to ongoing education and quality care to
remote, rural, and underserved areas within the state.

**MONTANA** – Department of Health and Human Services, Office of Research,
Sponsored Programs. The purpose of the Montana EMSC SPROC grant was to implement
the Montana Inclusive Model of Pediatric Emergent Care, a replicable, regionalized system
of healthcare to optimize the sharing of resources; facilitate the management and
treatment of acutely ill and severely injured children; expedite processes to provide
pediatric specialty services for children requiring access to a higher level of service; and
improve access to and retrieval of clinical data to provide safe, timelier, efficient, effective,
equitable, and patient-centered care.
NEW MEXICO – University of New Mexico, Health Science Center, Department of Emergency Medicine. The University of New Mexico (UNM) Division of Pediatric Emergency Medicine and the UNM Center for Native American Health designed, developed, and disseminated a **Child Ready** system of regionalized pediatric emergency care in New Mexico and the border regions of Arizona, Colorado, Texas, and Mexico. Additional components of this system include providing guidance to facilities to help them arrive at a level of readiness to manage pediatric emergencies; assist providers caring for acutely ill or injured children; and conduct injury prevention activities in communities. The primary populations of focus for this initiative are children and families in tribal and rural areas of New Mexico.

PENNSYLVANIA – University of Pittsburgh, Office of Research, Office of the Provost. Through an innovative collaboration between the Children’s Hospital of Pittsburgh; the University of Pittsburgh, School of Medicine; and the Pennsylvania Department of Health and Public Welfare, this project developed and implemented a regionalized system of pediatric emergency care in rural western Pennsylvania. The program built off existing collaborations between rural community health providers and a major academic referral center, leading to both improved emergency care access in the region and knowledge on how to improve pediatric emergency care nationwide.

South Carolina Health Information Exchange (SCHIEx)

**Georgia and SC Launch State-to-State Exchange of Health Information.** SCHIEx is an innovative statewide information highway that allows participating health care providers to view a patient's medical history, including medications, diagnoses and procedures. On November 11, 2014, the Georgia Health Information Network (GaHIN) and SCHIEx announced the launch of a successful information interchange between the two networks that allows for the exchange of secure, real-time patient health information among hospitals, physicians, and clinicians across state lines. This is a major step forward for assuring regional access to immediate life-saving care and appropriate follow-up and opens the door for further development of pediatric regionalized systems of care.

Family and Caregiver Resources

Capital Public Radio News

- [California Border Residents Grapple with Out-of-State Health Insurance Restrictions](#). Capital Public Radio’s Health Reporter Pauline Bartolone traveled to the town of Quincy, California, where major insurers Anthem Blue Cross and Blue Shield of California are not covering routine out-of-state care.

HealthyChildren.org

- [AAP Issues Recommendations on Telemedicine in Pediatric Health Care](#). In July 2015, the AAP published a policy statement, “The Use of Telemedicine to Address Access and Physician Workforce Shortages,” which provides recommendations for
reducing barriers and increasing access to care for children through the use of telemedicine. (May 2016)

Mayo Clinic

- **Borders Challenge Emergency Care.** This article highlights challenges of providing appropriate and timely emergency care across international and interstate borders. For international transfer, obstacles due to customs regulations, passports, and insurance portability are discussed. Licensure and the inability to share data are the focus of interstate emergency transports. (June 2016)

U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health, EMSC Program

- **Regionalization of Care for the Pediatric Patient.** Pediatric regionalization assures that children receive the care they need while ensuring that care is both coordinated and accountable. Available medical resources, across the continuum of care (i.e. 911 through rehabilitation) within a specific geographic area/region are matched to the child’s needs; thus maximizing health benefits and outcomes while minimizing cost and resource utilization over time. As regionalized systems of care evolve for children, these geographic locals may cross county boundaries, state borders, and even oceans as they strive to match resources to the pediatric patient’s health care needs. The features of each individual region may vary as a result of local capabilities and capacity. The core concept being a system of care in each region that assures all children have access to the care they need. As both accountable and organized, care delivery for the child and family becomes seamless in these systems.

Database Searches


Tribal Sovereignty

The EMSC Program’s mission is to ensure all children and adolescents regardless of where they live, attend school or travel receive appropriate emergency health care when it is needed. This mission transcends geographical boundaries, political constraints, and financial barriers that frequently influence and complicate the delivery of health care for children.

Many children in the United States fall under the classification of "Native Americans” or “Indians.” Native American or Indian populations include the Eskimos and Aleuts of Alaska and the North American Indians. The 2014 census reported that approximately 2.4% (5.4 million) of the total American population are American Indian or Alaska Natives alone or in combination with other races. There are 566 federally-recognized Indian tribes. Indian tribes are defined as a body of Indians of the same or similar race living in a geographic
area or territory. They are united under tribal leadership or government. The EMSC mission extends to all children, including those living, traveling, or attending school in sovereign tribal nations. This section provides information and resources related to tribal sovereignty, access and delivery of care within tribal communities, and the implementation of regionalized systems of pediatric emergency care across borders.

Overview of Tribal Sovereignty

The United States Constitution grants ultimate authority with regard to matters affecting the Indian tribes to the United States. The U.S. Constitution recognized tribal governments and, starting with Thomas Jefferson, America's founding fathers pledged that their sovereignty was to be protected. An Indian tribe recognized by the United States government Bureau of Indian Affairs usually possesses Tribal sovereignty. Tribal sovereignty, is similar to that of a state in some situations, and that of a nation in others. The degree of self-government and sovereignty varies from one tribal nation to another as dictated by the historical circumstances of recognition. Indigenous tribes have the power to govern themselves within the borders of the United States of America. Tribal governments are the oldest governments in existence in the Western Hemisphere.

A number of laws have been established by the United States government to assist in clarifying the relationship between federal, state, and tribal governments. Tribes have the power to determine their own form of government, as well as the power to interpret their own laws and ordinances; such interpretations are ordinarily followed by the courts and other government agencies. Many tribes also try to conform to the current practices in state, local, and federal governments. An Indian tribe may tax its own members and non-members doing business within the reservation. Numerous federal statutes dealing with Indian rights and governance exist, such as the Indian Reorganization Act and the Indian Civil Rights Act (also known as the Indian Bill of Rights). 28 U.S.C. § 1360 deals with state civil jurisdiction in actions in which Indians are parties.

It should be noted that some states have recognized tribes for varying purposes. State recognition confers limited benefits under federal law but often provides some protection for tribal autonomy for those tribes not federally recognized. State recognition is based on established criteria defined by the state in collaboration with Native American representatives, and may or may not be based on federal criteria. State-recognized tribal members are still subject to state law and government, and the tribe does not have sovereign control over its affairs. To date 14 states recognize tribes at the state level.

There are also tribes that have neither been recognized by the federal government or state governments. These groups claim to be historically, culturally or genetically related to historic Native American Indian tribes, but are not officially recognized as indigenous nations by the United States federal government.

Where are the tribes?
States with 100,000 or more American Indians or Alaska Native residents as identified in the 2014 census included:

- California
- Oklahoma
- Arizona
- Texas
- New York
- New Mexico
- Washington
- North Carolina
- Florida
- Michigan
- Alaska
- Oregon
- Colorado
- Pennsylvania
- Minnesota

Healthcare Provider Resources

Native American Caucus of the California Democratic Party

- [Tribal Sovereignty: History and the Law](#). This document provides a brief historical look at tribal government, sovereignty, constitutional law and legal precedent related to the relationships between Indian tribes and the federal government. (May 2016)

National Indian Health Board

- [About NIHB](#). The National Indian Health Board (NIHB) represents Tribal governments—both those that operate their own health care delivery systems through contracting and compacting, and those receiving health care directly from the Indian Health Service (IHS). The NIHB mission is “One voice affirming and empowering American Indian and Alaska Native Peoples to protect and improve health and reduce health disparities.” (May 2016)

University of Utah School of Medicine, Department of Pediatrics and U.S. Department of Health and Human Services Indian Health Service Emergency Services

- [An Assessment of Indian Health Service Affiliated Tribal EMS Agencies in the United States](#). This poster was presented at the American Public Health Association 139th Annual Meeting and Exposition October 29 – November 2, 2011. It reported results of a 2007 survey of 75 HIS EMS agencies. The results indicated that in some areas, tribal EMS agencies were prepared to care for children including carrying most
prehospital pediatric equipment, collecting and submitting patient care data and integration with the state EMS system. However, severe deficiencies remained including lack of medical direction and capacity to care for children during a mass causality. (May 2016)

**U.S. Department of Health and Human Services, Maternal and Child Health, EMSC**

- [Providing Culturally Sensitive Care to Children and Families](#). This webinar focused on the importance of cultural sensitivity in the provision of care to American Indian children and families, the cultural difference in providing care to Native American reservation and urban children and families, as well as barriers to implementing culturally sensitive strategies.

**U.S. Department of Health and Human Services, Indian Health Service**

- [Indian Health Manual](#). The Indian Health Manual (IHM) is the reference for IHS employees regarding IHS-specific policy and procedural instructions. The Parts and Chapters section includes permanent policies, procedures, and operating standards specific and unique to IHS administrative and program operations are maintained in the nine Parts of the IHM. This includes general operational policies and procedures as well as professional services and standards including emergency medical services and medical credentialing and more. (June 2016)

**U.S. Department of the Interior Indian Affairs**

- [Frequently Asked Questions](#). This online publication provides valuable information about American Indian and Alaskan Native tribes and their relationship with the federal government. Topics include:
  - Why Tribes Exist Today in the United States
  - The Nature of Federal-Tribal and State-Tribal Relations
  - Tribal Governments: Powers, Rights, and Authorities
  - Our Nation’s American Indian and Alaska Native Citizens
  - The Assistant Secretary—Indian Affairs, the BIA, and the BIE

(May 2016)

**Example Practices: Model Programs**

**U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, Emergency Medical Services for Children (EMSC) State Partnership Regionalization of Care (SPROC) Program**

**Alaska Department of Health and Social Services Trauma Program**

[EMSC State Partnership Regionalization of Care](#). The Alaska EMSC SPROC Program investigated solutions to overcome the challenges of promptly delivering specialized pediatric care to children in rural, frontier, and wilderness communities of the state, and the indigenous Alaska Native and American Indians. The primary goals of the project were
to: increase statewide pediatric-specific training in disaster preparedness; integrate pediatric components in disaster response planning; provide training to stakeholders and providers, establish a regionalization of pediatric care program, and integrate pediatric components with the current trauma designation, consultative, or educational processes.

Evaluating Systems of Pediatric Care in Remote and Frontier Alaska: Defining Next Steps for Improvement. More than 31 million children and adolescents access the emergency care system every year. Unfortunately, pediatric resources to provide optimal care for children are not always readily available where children live, play, and attend school. This is especially true in Alaska. With 75% of Alaskan communities not connected by roads to a hospital, travel is often expensive necessitating creative alternatives to assure access to essential pediatric services when an emergency occurs. Julie Rabeau, RN, EMSC State Partnership Regionalization of Care (SPROC) grantee, and Matthew Hirschfeld MD, PhD, medical director, Maternal Child Health Services at Alaska Native Medical Center, discussed challenges encountered in providing emergency care to children in frontier and remote areas of Alaska. A quality improvement initiative implemented through the SPROC grant focused on evaluating the continuum of care and identifying opportunities for improving the care of severely injured children was also highlighted. In addition, innovative approaches to improving aeromedical resource availability, as well as educational opportunities were shared.


EMSC State Partnership Regionalization of Care. The primary goal of the Arizona EMSC SPROC Program was to expand its Pediatric Prepared Emergency Care (PPEC) program into more rural and tribal communities within the state and to integrate evidence-based guidelines into clinical decision-making for all participating facilities. Implemented in 2011 by the Arizona EMSC program and the Arizona Chapter of the American Academy of Pediatrics, PPEC is a three-tiered voluntary pediatric emergency care facility program that recognizing hospitals prepared to stabilize and/or manage pediatric medical emergencies.

University of New Mexico, Health Science Center, Department of Emergency Medicine.

EMSC State Partnership Regionalization of Care. The University of New Mexico (UNM) Division of Pediatric Emergency Medicine and the UNM Center for Native American Health worked to design, develop, and disseminate a Child Ready system of regionalized pediatric emergency care in New Mexico and the border regions of Arizona, Colorado, Texas, and Mexico. Additional components of the system included providing guidance to facilities to help them arrive at a level of readiness to manage pediatric emergencies; assisting providers caring for acutely ill or injured children; and conducting injury prevention activities in communities. The primary populations of focus for this initiative were children and families in tribal and rural areas of New Mexico.
Family and Caregiver Resources

Family Voices

- **Growing your Capacity to Engage Diverse Communities by Working With Community Liaisons and Cultural Brokers.** Family Voices National Center for Family Professional Partnerships (NCFPP) partnered with the National Center for Cultural Competence’s Children and Youth with Special Health Care Needs Project (NCCCYSHCN) to develop this guide to provide valuable information about working with community liaisons and cultural brokers to help engage diverse families and communities. The ultimate goal is that all children with special needs and disabilities will have access to the information and support they need to ensure the highest quality care for their family. (May 2016)

U.S. Department of Health and Human Services, Indian Health Service

- **Find Health Care.** This is an interactive map that can be used to find an Indian Health Service, Tribal, or Urban Indian Health Program facility. It can be used to zoom in to find a facility in a general location within a region, enter a location to identify available facilities, or searching for the location of a facility by name. The map includes IHS affiliated hospitals, dental clinics, behavioral health facilities, and health centers.

Database Searches


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6. 2014 Census Bureau