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State Models:
1. Many of our state’s pediatricians are connected through social network and mass electronic messaging through the AAP Chapter (MIAAP) and this is a natural touch point for educating front line providers (who will, in turn, educate families and community partners such as daycares/schools). The Michigan Health Alert Network (MiHAN) is also a communication tool that could include a wider catchment of providers, such as emergency medicine and family medicine doctors. The AAP could leverage the breadth of the MiHAN to keep pediatric practices up to date.
2. Michigan has a nearly fully developed burn surge plan that has a model for supporting the non-specialist in a community hospital without specialized burn services to care for patients through web-based educational modules. A pediatric expert group is working with the state to develop (nearly complete) a pediatric preparedness toolkit that includes materials for all mass events (CBRNE or pandemic) modeled on the New York Department of Health toolkit (with permission), which will support hospital and system preparedness.
3. There has been great success with the Michigan Care Improvement Registry (MCIR) as a repository for immunization information. One of our team members, a pediatrician and Local Public Health (LPH) professional, praised MCIR as a model (one of the first and best in class). It was utilized heavily for H1N1 as a powerful tool for PCPs for both inventory of vaccines and logging of doses administered. It is already in place and available for other providers to use, such as emergency departments. MCIR has enhancements planned for high risk children that could be used and tracked. This platform is state-owned and its director is supportive of expanded utility. Michigan AAP Chapter Members are supportive of MCIR as a platform. Greater than 90% of primary care physicians who immunize children input the data. We would propose that this platform could be a tool to:
   A. Gather data for optimal resource allocation of vaccines
   B. Communicate high risk status of individuals whose data is contained in the MCIR
   C. Improve and leverage MCIR access by schools and daycare providers
   D. Use this popular tool as a messaging platform for providers about children’s risk status

We propose that the Michigan Chapter and our Team Members engage the Michigan Department of Community Health to discuss potential enhancements now that funding retained for the program.

Key Challenges:
1. Educating and reaching all the stakeholders who would care for children in a mass medical event (MME) is challenging (parents, medical providers, schools and daycares, prehospital and hospital providers who are not pediatric-focused), both before (no urgency) and during (panic and chaos) the event. This includes ensuring that these caregivers and providers have access to the latest information about accessing medications/treatments and positioning stockpiles to match pediatric needs. Childcare providers may have difficulty interpreting expert advice aimed at medical personnel (CDC website, e.g.) and, during H1N1, were sometimes overwhelmed with quantities of changing content. A central
source of interpretation for our state is necessary that meets the needs of providers; recognizing that
keeping such a resource up to date would be difficult.

2. There is a paucity of pediatric expertise in rural or underserved areas of our state; we need to include
these medical providers in planning for pediatric MME and provide opportunities for them to receive
planned or just-in-time information or training in pediatric care. AAP mass communications and
MiHAN messaging may not be available to rural family medicine practices, which would be providing
care to that area’s children. It is also unclear if federally qualified health centers are all receiving these
alerts.

3. Children with special healthcare needs or who have high risk conditions could be at significant risk in
a MME because their specialty providers and centers may be overwhelmed, as well as their primary
provider. The definition of “high risk” among the pediatric population is often nonstandard, creating
confusion about prioritizing for vaccines or medications and cohorting during that care delivery. Also,
physicians caring for these children may not be on AAP social messaging or MiHAN lists, especially
if they are rural and not pediatricians. Specialty providers often work closely with the medical home,
but this coordination can be difficult in MME. There are structures in the state that ensure that all
Child with Special Health Needs enrollees have a public health nurse.

Action Steps:
3 to 5 steps to improve pediatric preparedness (can be focused on influenza preparedness, pandemic
preparedness, or pediatric preparedness in general). These should be steps that team members can take
given available resources.

Consider focusing steps on communication, pediatric involvement in decision-making, and resources to
prioritize within high risk groups.

1. Use existing preparedness infrastructure (federal/state/regional/local) to advocate for and educate
about pediatric needs in an MME, ensuring that all educational events or products include a pediatric
component. Leverage findings of National Commission on Children and Disasters to create urgency
around this issue within these groups and “lobby up” thought leaders at state/national ASPR
organizations to increase focus on pediatrics. Michigan’s Office of Public Health Preparedness should
have enhanced involvement by the pediatric provider community, and hopefully information about
these opportunities can be promulgated through the Chapter.

2. See the discussion about MCIR in the section about “State Models” above; this platform has
significant support among providers who care for children and should be prioritized for further
enhancement as discussed.

3. Create appropriate educational products for the non-pediatric focused providers, who will surely care
for children in an MME, that can be deployed proactively before an event, or in a just-in-time fashion
during events. Web-based modules, telemedicine relationships with pediatric experts, “pediatric surge
education centers” are options. Teachers/Childcare providers are hungry for education around
preparedness planning and are also an excellent source of information dissemination to parents. If
these providers could participate in targeted educational opportunities and receive educational credit
valued in their particular discipline, buy-in is likely to be very high. Medical and daycare providers
could be incented by having AAP and family or emergency medicine organizations endorse and offer
continuing medical (or other professional) education credits for completion of these modules. Existing
research indicates that childcare centers, like schools, could be useful “sentinel centers” for reporting
to LPH at the start of pandemic and this could be an adjunct monitoring opportunity.

4. Create safety net for high risk children by enhancing their emergency care plans to include
contingencies for local care, home care during MME. The AAP Policy recommending Emergency
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Information Forms (EIFs) can be leveraged to recommend that daycare/schools require these forms and mandate regular updates. The use of this tool for children in all their care settings should be stressed, along with the concept of the medical home for these children. Could high risk children in a region be identified in a registry that allows resource allocation (such as ensuring the providers who care for them receive vaccines)? There are structures in the state that all Child with Special Health Needs enrollees have a public health nurse. Telemedicine is being deployed in select cases with more opportunities for reimbursement, but full utilization still faces challenges. There are challenges beyond getting care and vaccines for the child with special needs; must ensure that their critical caregivers are healthy. EIF should be on disc or waterproof sheet and, ideally, accessible from a web-based repository accessible by practices and emergency departments in any location.

5. School-based opportunities to deliver vaccines, with streamlined consent process. Reaching the 0-5 year old population is challenging and potential for partnership with LPH/medical community/daycare providers could increase immunization opportunities for this group. The 0 to 5 age group frequently attends daycare and Child Care Providers (CCPs) are beginning to interface with medical professionals (example: Great Start Network) to improve understanding of the needs and challenges of caring for that age group. Messaging to CCPs should be enhanced so they can assist parents in pandemic or MME. Delivering vaccines needs provider buy-in as it was revealed during the pandemic that many providers deferred vaccine delivery to LPH to avoid the “hassle” of consent and administration.

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