



Pediatric Safety Net

Operational Coordination Tabletop

Findings Report

Session held August 4, 2026

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Table of Contents

Executive Summary.....	3
Background.....	4
About the Session	5
The Scenarios in Brief.....	6
Findings	8
Reading the Situation.....	8
What Constrains the Response	9
Coordination, Authority, and Crisis Governance.....	11
Data and Signals the Group Wants.....	12
Recommendations.....	15
Action Items.....	16
Open Questions	17
Looking Ahead	17
Participating Organizations	19

Executive Summary

On August 4, 2026, the group reconvened for its third working session of the Pediatric Safety Net initiative. This was the first session to move the framework off the page and into live decision making. Teams from hospitals, health systems, EMS, public health, and state partners spent the day working a series of escalating scenarios. They used hospital data sheets to decide for themselves where the pediatric system stood on a scale of watch, active coordination, and crisis.

The day was built around one question, asked over and over as the pressure rose: where is the pediatric system right now, and what should that tell us to do. Rather than being handed a level, each table acted as a coordination call, read the data in front of it, and diagnosed the level on its own. The goal was to test whether the framework helps a room of busy people agree on where they are and what comes next. The tables were not asked to place every patient or solve the scenario.

The first finding is that the model works. Teams read the data sheets and landed on a level, and the levels they chose matched the profiles the facilitators had built during our previous discussions. The places teams disagreed were just as valuable, because they marked where the group does not yet share a definition. Those splits were treated as useful information rather than as something to smooth over.

The clearest theme of the day was that the numbers alone do not tell the story. A bed count says nothing about how sick the waiting children are or what a hospital can still do internally, and teams repeatedly asked for that context before committing to a level. Clinical leaders offered a useful counterweight: acuity is fairly stable across pediatric centers over time, so the group should anchor on an objective, documentable trigger rather than trying to chase a feeling.

The scenarios also exposed where the current model reaches its limits. When the situations got hard, the response was broken by staffing and transport. Physical beds were rarely the limiting factor. The clearest sign that the system had moved past watch was an access failure: a child who could not be placed. Weather and geography repeatedly reordered the picture, so in a storm the closest appropriate bed mattered more than the usual referral pattern.

Underneath all of it sat one structural finding. The coordination structure the group has designed can convene and align hospitals, but it owns no beds, so its influence depends entirely on hospitals choosing to accept the process. That makes the authority to act the central open question, and the hardest next step. The crisis end of the model, including scarce resource rules, de-escalation, and the role of legal and ethics, is still only sketched. The overarching shift the initiative asks for is a move from self protection, where each hospital guards its own beds and community first, toward acting as one statewide system when it counts.

The remainder of this report describes how the session was run, walks through the scenarios, and then organizes the findings into three areas: how the group reads the situation, what constrains the response, and where coordination and governance still need to be built. It closes with the data and signals the group asked for, a set of recommendations and concrete action items, and the questions left open.

Background

The Pediatric Safety Net did not begin with a grant or a working session. It grew out of a decade of Michigan hospitals trying to answer one recurring question: what do we do when a child needs a pediatric bed or a pediatric resource that the hospital in front of them cannot provide.

A Decade of Informal Groundwork

For years, the state's children's hospitals and pediatric capable centers have worked to solve this together in the moment. A shared bed availability dashboard and a standing weekly call, running most Mondays for the better part of a decade, gave the group a way to see one another and move patients when they had to. That same group and that same dashboard carried the state through the pediatric strain of COVID. Roughly eight or nine hospitals who accept pediatric inpatients, and a dozen or so hospitals who primarily admit only adults, came to rely on these habits of coordination, even though none of it was formalized.

The Surge That Made the Case

About three years ago, a severe RSV surge pushed the informal system past its limits. The group was meeting twice a week and working the dashboard, and still found itself sending children to Ohio and calling hospitals in Illinois, in one of the largest states in the country. Leaders tried to distribute pediatric patients across the state's ICUs on the fly, in the middle of the disaster, and it did not work. The lesson was that a plan improvised in the middle of a crisis comes too late. The group decided to wait until the surge passed, sit down together, and design something deliberate for the next time.

Phase One: Designing the Framework

That decision became the first formal phase of the Pediatric Safety Net. In the spring of 2025, more than fifty professionals from hospitals, EMS, public health, emergency management, and state government gathered for a two day working session, convened by Region V for Kids, the Pediatric Disaster Center of Excellence, with support from an ASPR grant. Participants split into three working groups, each taking on a piece of the problem: a standardized pediatric data set and dashboard, a tiered and trigger based activation framework, and a redesigned pediatric critical care distribution model. Their work produced the concepts this initiative has been refining ever since, including standardized data elements, activation triggers, a distribution model built around an air traffic control style coordination hub, and early thinking on governance and transport. The activation framework from that session is what has since been expressed as the three levels used today: watch, active coordination, and crisis.

Phase Two: Validating and Operationalizing

The second phase set out to test whether those concepts hold up in practice. A virtual tabletop in July 2026 validated the data set and the triggers and confirmed that the framework made sense on paper. It also surfaced the gap this session was designed to close. The group had strong agreement on what data to collect and what the triggers were, but had not yet worked through what those triggers should change about operations, what help each hospital would need, and how the group would actually coordinate. The August 4, 2026 operational coordination tabletop, the subject of this report, was built to answer exactly those questions by putting the framework to work in live decision making.

This work is also being watched beyond Michigan. Similar conversations are happening at large centers across the country, but few if any are doing it at the state level with health systems, public health, the

hospital association, and national partners in the same room. That is the context in which the findings that follow should be read. They mark the point where a decade of informal coordination is being turned into a system that can be documented, governed, and repeated.

About the Session

The session was built for hands-on participation. There were no long presentations. Teams sat as small groups, each acting as a pediatric coordination call, and moved through scenarios that grew more difficult over the course of the day. The format built on the standing Monday calls and on the coordination calls designed during our previous discussions.

How the Tabletop Worked

Each table received a data sheet for every participating organization, roughly eight to nine in all. Where an organization was not represented in person, someone at the table played that role so the call reflected the whole system rather than only the people present. The data was built to be adjusted, and teams were told to change anything that did not match their reality rather than treat the sheet as fixed.

The task at each table was to read the data, decide what level the system was in, and then report out on four things: where they landed, what worked, what would break in a real event, and what they would change. Teams were not required to reach a single answer. Where a table split between two levels, it was asked to document the split and the reasoning behind it. Three scenarios were run during the session, each building on the last, with a fourth left for teams to work through on their own. Groups were mixed after lunch so the later scenarios got a fresh set of perspectives.

The Level Scale

The scale had been renamed during our previous discussions from a numbered structure to three plain terms: watch, active coordination, and crisis. Watch borrows the intuition of a tornado watch, a state where something is developing and everyone is paying attention but no one is acting yet. Active coordination is the state where hospitals are actively helping one another move patients and resources. Crisis is the state where the system needs active, coordinated participation to keep children safe. The facilitators built each scenario off a specific level profile, which is what allowed the room to test whether teams would independently arrive at the intended level.

Guiding Questions

To keep the tables consistent, facilitators anchored each scenario in the same set of questions:

- Where are we on the scale of watch, active coordination, and crisis, and is that the right call?
- Do we need to escalate, and what would tell us it is time?
- What operational changes, help, or resources would we actually need right now?
- Are the triggers we would use based on data, or are they operational judgments?
- How can we help each other during this kind of event?

The Scenarios in Brief

The four scenarios moved from a routine seasonal rise to a full statewide crisis. Summarizing them here gives context for the findings that follow, since many of the same lessons surfaced first as reactions to a specific situation on the table.

Scenario One: A Seasonal Rise

The first scenario presented a familiar early season picture, with respiratory volume climbing and a community hospital reporting local strain. Most tables landed on watch, with several sitting on the line between watch and active coordination and one calling it watch plus. The reasoning was consistent: hospitals still had internal strategies to manage their own census, the big centers were already meeting weekly, and nothing yet required active coordination. What teams wanted before moving up was a better read on whether community hospitals were having to make far more calls than usual to place children, and whether the seasonal trend matched what the region normally sees. This is also where the day's loudest theme first appeared, that the numbers on the sheet did not tell them enough about how sick the patients were.

Scenario Two: A Winter Storm and a Child Who Cannot Move

The second scenario put a winter storm across the state, with an intubated infant at Other Hospital who had already called three centers with no bed, a second child worsening, and a shrinking window to move anyone. Statewide, pediatric ICU capacity was effectively full, one critical care transport crew was committed, air was out of service, and roads were degrading. This scenario produced the reframing that reset the room: set occupancy aside, because a child who cannot be placed after calling three centers has already told you the system is no longer in watch. Teams moved to active coordination and crisis, and the conversation shifted from bed counts to the order in which children should move and which site was closest and safe given the weather.

Scenario Three: Coordinating Across the Region

The third scenario deepened the coordination problem. Teams landed on active coordination and spent their time on how the group should actually work together: balancing admissions across the region, running a daily call with every key stakeholder present, and giving regional sites one place to call instead of working down a list of transfer centers on hold. This is where the fairness of elective surgery came to the front, along with the recognition that any real expectation to pause electives would have to come from the state level. Teams also began reaching toward the crisis end of the model, raising the idea of a statewide triage or command function and, tentatively, scarce resource rules.

Afternoon Scenario: Statewide Crisis and Scarce Resources

The afternoon scenario left no ambiguity. Across the state there were no available pediatric or ICU beds, no available ventilators, and every ECMO circuit in use, with out of state options in Toledo, Cincinnati, and Indianapolis, and the Upper Peninsula effectively dependent on Wisconsin. An intubated infant had been in an emergency department for eight hours and was deteriorating. The room agreed almost immediately that this was crisis. The value of the scenario was in what it forced the group to admit it did not yet have: a coordination center with plans already in place, a defined way to triage a set of children across the whole state quickly, a clear owner for the decision, and, most of all, a way to know when to stand back down.

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Findings

01 Reading the Situation

- 1 The model works, and the splits are useful.** Teams read the data sheets and landed on a level without being told, and the levels matched the profiles the facilitators had built. Scenario one came in around watch, the middle scenarios at active coordination, and the last firmly at crisis. Where a table split, for example reading the system as watch overall while one hospital looked like active coordination, that split marked a point the group has not yet defined together. Those disagreements are worth keeping and working through rather than smoothing over, because they show precisely where a shared definition is missing.
- 2 The numbers do not tell the story.** This came up at nearly every table and became the theme of the day. A bed count says nothing about how sick the waiting children are or what a hospital can still do internally, and teams found themselves filling in blanks and telling themselves a story to reach a level. They wanted whoever reports out to describe how sick the boarded and waiting children are, along with their number. One thread proposed capturing this in a composite score, built from several data points such as an acuity or surge score, an emergency department overcrowding score, or points earned for opening a unit, going to semi private rooms, or pulling in staff. One way to picture that is as a single line, a red line of trouble, that rises as inputs like bed availability and EMS strain climb, with escalation triggered when the line crosses a defined threshold rather than when any one number does. Clinical leaders pushed back usefully, noting that acuity is statistically stable across pediatric centers unless something truly abnormal is happening, so the group should build those assumptions in and anchor on an objective, documentable trigger rather than on feel.
- 3 Capacity means different things at different hospitals.** The group cannot align on a level until it agrees on what capacity means, and today it does not. One hospital never boards because it can flex inpatient space, while another boards routinely but cannot expand, so emergency department boarding on its own is a misleading signal of distress. Some hospitals count a bed as staffed the moment they have the physical room because they will find a way to staff it, while others do not. The shared bed availability system only shows available staffed beds and cannot exceed one hundred percent, which hides surge capacity in one direction and, in the other, makes a stressed hospital look better on paper the moment it opens beds and its occupancy percentage falls. If pediatric ICU capacity becomes the trigger, the group has to state plainly whether that percentage is measured against licensed beds or against real time staffed beds on a given morning.

- 4 An access failure is the clearest trigger.** A child who has called three centers with no bed is telling you the system is past watch, whatever the percentages say. The most reliable early signal is the lived experience of a community hospital working seven or eight calls down a referral list, spending hours, and being told to call around and check back if it gets bad enough. That happens every respiratory season, and it is exactly what prompts the bigger centers to start changing what they do. Capturing that pattern, and educating community and regional hospitals on how to read the dashboard and who to call, is one of the most concrete opportunities the session surfaced.

Taken together, these four points describe a group that can already diagnose the system when the data is good, but that lacks a shared language for capacity and acuity, and that has been reading the wrong signal. The most useful early warning is the sound of a hospital that cannot place a child.

02 What Constrains the Response

- 1 Staffing and transport are the binding limits.** Across the harder scenarios the constraint was nursing ratios, the availability of critical care transport, and weather. Physical space was rarely the problem. Beds sat closed for lack of staff, and in the crisis scenarios the system was down to a single committed critical care transport crew, with air out of service and ground routes degraded. When several children need to move at once and only one crew is available, the order in which they move becomes the real decision, described in the room with the shorthand of choosing the best and closest place for each child.
- 2 Transport is invisible on the calls today.** The sharpest observation of the day came from a transport perspective: no one is ever asked how transport is doing on the coordination calls, even though it is run every day and is the thing that fails first in bad weather. Transport status, meaning ground and air crews available, committed, or out of service, expected waits, and the effect of weather and road conditions, should be a standing item on every call, reported and tracked the same way beds are.
- 3 Weather and geography redraw the map.** In a storm the closest appropriate bed matters more than the usual referral relationship, and keeping care in region becomes the priority. Geography also sets hard limits at the edges of the state, where the Upper Peninsula depends heavily on Wisconsin for transport through the winter and long distances stretch every move. When roads and air both degrade, the choice narrows to whatever destination is actually reachable.
- 4 Hospitals have real internal levers that never show on the sheet.** Teams repeatedly noted that a hospital can open overflow units, move to semi private rooms, double up beds outside the ICU, step patients down out of the ICU to free critical beds, and up staff through incentive pay or agency support. Real examples came up, including calling a bed briefing when two patients had nowhere to go, and housing staff on site overnight when weather threatens their ability to get to work. None of this is visible in a bed count, which is why teams asked that these levers be shared on the calls so the group understands both how stretched a hospital is and what it can still do.

- 5 Level loading belongs in active coordination.** The group should be balancing pediatric ICU admissions across the region before a crisis forces it, so a heavy day at one center does not sit next to an empty one elsewhere. Beginning those conversations early, while the system is only in active coordination, also means the group already knows what it would do once a crisis arrives rather than improvising in the moment.

The pattern across this section is that staffing and transport decide the response, and beds are rarely the true limit. A plan that tracks only beds will keep missing the two things that actually decide outcomes in a surge: whether there is staff to open the bed, and whether there is a way to get the child to it.

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03 Coordination, Authority, and Crisis Governance

- 1 The group can coordinate but owns no beds.** This was said plainly in the room. The structure the group is designing can convene and align hospitals, but its influence rests entirely on hospitals choosing to accept the process. It cannot compel a hospital to open a bed, staff a unit, or take a patient. What the session pointed toward is authority that scales with the level. At watch, coordination runs on goodwill. At active coordination, the coordinating body takes on an advisory role, actively helping hospitals move patients and resources. At crisis, the commitment has to be binding, backed by agreements the organizations have signed in advance. Resolving that ladder, and reserving a formal memorandum of understanding for the crisis level, is the hardest and most important next step, and the rest of the work depends on it.
- 2 Callers need one number and one voice for the state.** Regional sites want a single place to call that knows where beds are and can route them, rather than working a list of transfer centers alone and landing on hold. Today the first call goes to whoever a site always calls, and the value is in being guided to where capacity actually is. The group also wants a coordinator who can get out of state centers onto a conference call and speak for Michigan as a whole, saying in effect that the state has these children who need placement, rather than leaving each hospital to negotiate on its own. Transfer center coordinators and administrators on duty do versions of this now, but they sit somewhat apart from the pediatric leaders who would need to be involved, and not everyone is in the loop at the same time. Making this work at active coordination means giving the call real structure: a named liaison from each participating organization, a standing agenda, and clear report-out roles so everyone is speaking the same language.
- 3 Elective surgery is the fairness test for one system thinking.** It is not fair for one health system to keep performing elective cases that could safely wait while another cannot place a critically ill child. Because systems hold different cultures about what they will pause, any real expectation around elective surgery in a crisis has to come from the state level, at the governor and health department level, and has to be set proactively rather than improvised during an event. The group has already begun widening the circle of influence, bringing in the hospital association and national partners, on the premise that this engagement has to happen well before a crisis.
- 4 Self protection is the default the model has to overcome.** Under strain, the honest instinct is to protect your own beds and your own community first. Teams named this directly, including the reality that the people with the best real time picture, such as charge nurses, also carry their own preferences about which patients they will take. The coordination model exists precisely to move the group past that instinct when it matters, which is only possible if the authority and the trust are established ahead of time.

- 5 Crisis governance is only sketched.** Once pediatric ICU beds became a genuinely scarce resource, the group started reaching for tools it has not yet built. Scarce resource allocation rules and crisis standards of care came up but do not exist yet, and participants noted that in practice people do the right thing in the moment and sort out reimbursement afterward, which becomes complicated and contentious across systems and across state lines. Two gaps stood out. The first is de escalation, meaning how and when the system stands back down from crisis and surge to routine operations, which the group called the most critical and least defined decision in the whole model. The second is legal and ethics, the seat currently missing from the table and needed for the final phase as the work moves toward health systems and toward state and federal leaders.

This section is where the initiative graduates from a good idea to a governed system. The group has strong agreement on what a coordinating body should do, and honest clarity that it currently has no authority to do it. Closing that gap, and deciding who holds the decision in a crisis, is the work that makes the model dependable in a real crisis.

Data and Signals the Group Wants

A recurring request through the day was to bring more than a bed count to the calls. The items below collect the data points and signals participants raised, grouped by how they would be used. At least one participant offered a fuller list to build from, and these should be treated as a starting point for that work rather than a final specification.

Dashboard Data and Meeting Data

The group drew a useful line between two kinds of data. Dashboard data is what the shared system can show on its own, ideally automated and current, such as available beds and equipment on hand. Meeting data is what only surfaces on the call, such as how a hospital is really doing, what it can still flex, and what it needs. A working coordination call depends on both, which also means the group has to define who reports out for each organization and what the standing agenda covers.

What Data Defines Each Level

The data can also be organized by the level it signals. The mapping below reflects where that thinking stands and should be refined as the triggers are finalized.

Watch

- Available beds, counted separately for ICU, med/surg, and ED.
- Equipment on hand, such as ECMO and ventilators.
- Whether each hospital is currently accepting transfers.
- Whether any hospital is already operating at a contingency level of care, surfaced on the dashboard.

Active Coordination

- Patients accepting, pending, and deferred.
- Alternate spaces in use or opened, as a percentage across med/surg, ICU, NICU, and ED.
- Whether current levels are normal for the season or worse, read against a baseline.

Crisis

- Reductions or modifications to services, such as scaling back scheduled or specialty care.
- Staffing, and the changes being driven by staffing.
- Scarce equipment such as ECMO circuits.

Context to Bring Beyond the Bed Count

- Patient acuity: how sick the boarded and waiting children are, alongside their number.
- Internal surge levers currently available, such as overflow units, semi private rooms, doubling outside the ICU, step downs, and up staffing.
- Staffing status, including nurse to patient ratios, call ins, incentive or agency options, and whether staff can reach work in the weather.
- Transport status, including ground and air crews available, committed, or out of service, expected waits, and road and air conditions.
- Time of day and day of week, since a picture that looks tight in the morning may ease by midday, especially heading into a weekend.
- Whether a hospital is holding patients despite open beds, and the reason, since that gap often reflects staffing or acuity rather than space.

Signals That Suggest Escalation

- Community and regional hospitals making many calls to place a child, with long hold times as they work down the list.
- A child who cannot be placed after calling multiple centers, treated as an access failure.
- Declining transfers becoming common, since decline behavior can say more about true capacity than a percentage.
- Canceling or deferring elective surgeries at one or more centers.
- Beds closed for staffing rather than for lack of space.
- Critical care transport unavailable or badly delayed.

Forecast and Context Signals

- Viral activity projections and regional trends for RSV, flu, and similar illnesses, and which side of the state is rising.
- Weather, road, and air conditions that will affect transport and staffing.
- Mass casualty or single event reports that could send a sudden wave of pediatric patients.

Every finding points the same direction. The instinct under strain is self protection, holding your own beds and caring for your own community first, and that instinct is reasonable at the level of a single hospital. The purpose of the safety net is to move the group toward acting as one statewide system when it counts, while respecting that each hospital still carries real constraints on staff, space, and transport. The recommendations and action items that follow all serve that shift, from a set of hospitals that coordinate when they can to a system that knows how to act together when it must.

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Recommendations

- 1 Resolve the authority to act.** Define the commitment at each level, from goodwill at watch, to advisory support at active coordination, to a binding agreement at crisis, and move toward a formal memorandum of understanding for the crisis level that gives the coordination structure real standing. Nearly every other recommendation depends on this being settled first.
- 2 Define the capacity trigger and standardize terms.** Decide whether pediatric ICU capacity is measured against licensed beds or real time staffed beds, and write down shared definitions so the same number means the same thing at every hospital. Pair the objective trigger with the acuity assumptions clinical leaders described so the group is not rebuilding acuity from scratch on every call.
- 3 Enrich the data brought to the calls.** Add the operational context the room asked for, including internal surge levers, staffing status, and transport status, and incorporate the fuller list a participant offered. The goal is a call that reflects what a bed count cannot.
- 4 Design the coordinator and command function.** The non pediatric hospitals want a single point of contact to place a pediatric patient. The clearest form of that is a single phone number, built by the state or by regions and staffed by people who can see the dashboard and, in crisis mode, triage beds across the system. Outside crisis, the sending facility would have direct access to the dashboard and could still call that same number, with a simple menu to reach the hospital it needs. Above all, community hospitals are asking for one number to call. Name that single point of contact, define what the role is empowered to do, and specify when a statewide triage function activates and who staffs it. In the interim, it could be run by bed placement teams across organizations using existing tools.
- 5 Write the escalation and de-escalation playbook.** Tie watch, active coordination, and crisis to specific, pre agreed actions, and give equal attention to de escalation: how and when the system stands back down to routine operations. The group named this as its least defined decision.
- 6 Convene a hospital leadership tabletop.** Run the same kind of exercise the operational teams completed with the leaders who can commit their systems. Include the Michigan Health & Hospital Association, the American Hospital Association, the Health Resources and Services Administration, and the chief executives of both the pediatric and the non pediatric hospitals. Use it to work through the decisions those leaders would face, such as pausing elective activity and allocating scarce resources, and to bring legal and ethics into questions of scarce resource allocation and crisis standards of care before a crisis makes them urgent.

Action Items

The following concrete steps carry the recommendations into work that can be assigned and tracked.

- **Establish the authority to act.**
 - Define the commitment at each level: goodwill at watch, advisory support at active coordination, and a binding agreement at crisis.
 - Draft a memorandum of understanding for the crisis level among participating organizations.
 - Clarify how decisions hold across independent hospital systems.
- **Define the capacity trigger and terminology.**
 - Choose a licensed or real time staffed measure for pediatric ICU capacity.
 - Publish shared definitions so a number means the same thing everywhere.
- **Enrich the coordination call.**
 - Add internal surge levers, staffing, and transport status as standing items.
 - Incorporate the additional data points a participant offered to provide.
- **Stand up the coordinator and command function.**
 - Name the single point of contact and define its authority.
 - Establish one number for community and regional hospitals to call.
 - Specify when a statewide triage function activates and who staffs it.
- **Write the escalation and de-escalation playbook.**
 - Map watch, active coordination, and crisis to specific actions.
 - Define how and when the system returns to routine operations.
- **Engage legal, ethics, and senior leadership.**
 - Convene a legal and ethics work group for scarce resource questions.
 - Brief C suite leaders through the hospital association and partners before a crisis.
- **Convene a senior leadership tabletop.** Bring the executives who can commit their systems into the same kind of exercise the operational teams have now run, so the hardest choices, such as pausing elective activity and allocating scarce resources, are rehearsed before a crisis forces them. Intended participants include:
 - Chief executives of both the pediatric and the non pediatric hospitals, together with their chief medical officers.
 - Michigan Health & Hospital Association (MHA).
 - American Hospital Association (AHA).
 - Health Resources and Services Administration (HRSA).
 - Michigan Department of Health & Human Services (MDHHS).
 - The president of the state's rural health programs.
- **Share the work and build the evidence base.**
 - Develop a research paper documenting the model and what the sessions produced.

- Engage The Joint Commission and pediatric readiness programs.
- Continue presenting the work at conferences and to national partners.

Open Questions

- 1 Does the model cover a mass casualty incident?** A sudden bolus of patients from a single event came up in more than one scenario, and the group did not settle whether the current approach handles it or whether it needs its own method. This should be resolved deliberately rather than assumed.
- 2 What trigger set balances simplicity and signal?** The acuity score idea (derived from the EHR) and the argument that acuity is stable both have merit. The group needs to reconcile them into one defensible, documentable trigger rather than leaving two competing philosophies in play.
- 3 How do community and regional hospitals plug in?** Much of the early warning and much of the strain lives with these hospitals, yet they are the least connected to the dashboard and the coordination structure. The group needs a practical way to bring them in that they will actually use during a season.

Looking Ahead

Beyond the operational build, the group named voices and perspectives the next phase should bring in, so the model is shaped by them rather than adjusted for them after the fact.

- **Pediatric champions.** Re-engage the named champion at each participating organization. This program already exists, and its role is to carry the work locally and keep it moving between sessions.
- **Rural health.** Rural and community health leadership at the table, so the realities of the parts of the state with the least access shape the model directly.
- **Families.** The family and community perspective, which the provider side of the framework does not yet capture. This is the focus of a planned family focus group, and its findings should be folded back into the model.

Taken together, these are the inputs the group flagged to add as the work moves from a provider coordination framework toward a fuller picture of pediatric readiness across the state.

Participating Organizations

Bronson Children's Hospital
Children's Hospital of Michigan
Corewell Health Children's Hospitals
Covenant HealthCare
Henry Ford Health
Hurley Medical Center
Michigan Department of Health & Human Services
Michigan Health & Hospital Association
Michigan Medicine (C.S. Mott Children's Hospital)
Munson Healthcare
Region V for Kids
Sparrow Health
Trinity Health
Upper Peninsula Health System