All references are listed in the Resources section of individual standards.

What is the PRQ reporting period?

The reporting year(s) should preferably be the 12 months prior to receiving the PRQ. The last fiscal reporting year is also acceptable.

For what reporting period should charts be made available for on-site review during the site visit?

Surgical patient medical records indicated on the CSV Site Visit Agenda should be available for all patients at the time of the site visit for this reporting period. This reporting period is defined as the 12 months preceding submission of the PRQ.

How is the site visit date determined?

We will work to schedule the site visit based on the preferred dates provided by the site. We may need to schedule the visit outside of this range due to reviewer availability, however we will work with you to ensure an agreeable date. We will not schedule the visit during your blackout dates.

How are the following personnel required to be available for individual interviews at the site visit defined: Nursing Director, Administrative Director, and Medical Staff Director?

The specific titles of the personnel required to be available for individual interviews will vary by site. For the interviews, the Nursing Director is characterized as the individual who oversees nursing activities and credentialing (i.e., CNO). The Administrative Director is defined as the senior administrator responsible for surgical operations and services. He/she likely partners with physician(s) to perform this role. The Medical Staff Director is defined as the individual responsible for the entire portfolio of patient care providers for the institution - medical and surgical staff. He/she will likely oversee credentialing and quality for the site (i.e., Hospital Medical Director or CMO).

How should the PRQ tables be completed for providers who are eligible for board certification in their respective specialties?

The response to the PRQ tables questions regarding current primary board certification for physicians/surgeons that are eligible for board certification should be no. An explanation of such providers' board eligibility should be provided in the "comments on non-traditional pediatric certification" column.

The Surgical Program Leadership and PIPS Committee Table asks for the % FTE for the various members. What if some of these roles do not have FTE commitment and/or do not receive funding from the Children's Surgical Center, but instead serve as volunteers on the PIPS committee?

This does not pertain to employment status, only to the percentage of effort contributed to the PIPS committee. Please include the percentage of time devoted to the PIPS committee. For example, this may include time devoted to monthly PIPS committee meetings, reporting, research, analysis, or any other PIPS related activities.

Should dentists be included on the Surgeon Table?

If dental care is within the scope of service provided at the site, dentists may, but are not required to be included on the Surgeon Table. Dental cases should be listed in the Surgical Case Volume Table if the procedures meet the criteria indicated in the table instructions.

Chapter 1: Institutional Administrative Commitment

(1.2) What is the definition of the surgical administrator required to comprise the administrative structure of the hospital?

The surgical administrator is the individual who worked with the site's medical director to establish and maintain the components of the d(S-5.9 (s9(d(S-5.9 (1(t)-4.8 (s) (e)-6b..041 5[o)-9.6 (m)- -T0.00428.576S9.7 (f1 Tf-0.001.6 (r t)7.9 (o)-6.

The CSV Program recommends that the MDCS and NSQIP Pediatric Surgeon Champion roles be served by two distinct individuals who actively communicate with each other. Further, it is considered best practice for these leaders to collaborate to make sure that at least some QI projects focus on metrics that fall below standard on the semi-annual NSQIP Pediatric report.

(2.11) Does the Children's Surgery Program Manager have to be a full-time employee (FTE), or can this person be employed through the hospital on a part-time basis and add the Program Manager as a new job responsibility?

The CSPM must have adequate FTE / TT02e.CTE 7TT02vTE (7e aie F(rt)-3 (ri()9-6),6 at)4 3 (s)c 20 Tw 918.076 0-3 67( ) 1

NICU designations are consistent with those delineated by current American Academy of Pediatrics' recommendations. [American Academy of Pediatrics. Levels of neonatal care: Committee on Fetus and Newborn. Pediatrics. 2012;130(3):587-597. Reaffirmed 2015.]

(3.1) Our hospital has a Level III NICU designation, which is the highest designation that can be achieved in our state. Level IV designation has not been implemented by the state; however, we do meet Level IV criteria by AAP Guidelines. Would this impact our application in any way?

You would assign the NICU level that is consistent with the 2012 AAP document. In this case, it would be a Level IV NICU. [American Academy of Pediatrics. Levels of neonatal care: Committee on Fetus and Newborn. Pediatrics. 2012;130(3):587-597. Reaffirmed 2015.]

(3.6) Are sites required to have a physically separate Pediatric PACU?

A designated PACU or other unit with specific pediatric personnel and functional capacity, including qualified pediatric nurses, must be available 24 hours per day to provide care for the pediatric patient if needed during the recovery phase. The environment of care should be definitively focused on being child and parent friendly. This would not require structural changes but rather a scheduling commitment and plan to cohort children to specific pediatric ready (this includes pediatric emergency equipment) areas.

(3.9) How is "surgical engagement" defined for this standard?

Surgeons must be a part of the leadership of this program to assure well-coordinated care. Collaborative leadership of the ECMO program, including neonatologists and pediatric intensivists, is encouraged, but surgeons must be actively engaged in quality improvement efforts and protocol development. Engagement includes actively participating in ECMO conferences, developing protocols, and bidirectional knowledge sharing with the ECMO leadership and other surgeons within the department.

Chapter 4: Personnel and Services Resources

(4.1) For the sub-specialties, what does 24/7 access mean? Does 24/7 access refer to a consult?

Yes, it means surgical consultation or services are available from these specialties 24 hours a day, 7 days a week.

(4.1) Must a Level I children's surgical center be able to provide surgical treatment of complex congenital

Yes. Documentation of daily involvement of attending surgeons is required for all surgical services, including cardiac surgery. A process to document the continued involvement of the attending cardiac surgeon for at least the immediate perioperative period is necessary. This does not require a separate note by the attending. Presence of the attending surgeon can be demonstrated by the surgeon attesting to one of the notes by other team members if the attestation states that the surgeon was physically present. Alternatively, a multidisciplinary note or note by an advanced practitioner that states that the surgeon participated in rounds will meet this requirement. This should mention the surgeon by name.

There will be routine targeted review assessing surgeon involvement and documentation as part of chart review during the site visit.

(4.1) What pediatric surgical specialists are required for Level II centers?

At a minimum, Level II centers must include pediatric general and thoracic surgery. Additional pediatric surgical specialists must match the scope of services offered – this means the Level II center must have a particular pediatric surgical specialist (pe

anesthesiology residents in their final year of training, pediatric anesthesiology fellows, CRNAs, or board-certified anesthesiologists who can assess emergency situations in children and of providing any indicated treatment, including airway management and initiation of surgical anesthesia. Providers utilized to meet this requirement must be able to initiate surgical anesthesia independently in emergent situations in consultation with the on-call pediatric anesthesiologists. When anesthesiology chief residents, pediatric fellows, CRNAs, or board-certified anesthesiologists are used to fulfill immediate availability requirements, as described above, the staff pediatric anesthesiologist on call must be advised of clinical activities, be able to respond to the bedside within 60 minutes and be physically present for all operations for which he or she is the responsible anesthesiologist. A pediatric anesthesiologist must serve as the primary anesthesiologist for all children 2 years or younger. A pediatric anesthesiologist must be available to respond to the bedside and provide service within 60 minutes 24/7 when required. Local criteria must be established to define conditions requiring the attending anesthesiologist's physical presence, and a PIPS program must verify compliance.

(4.2) Can Level II centers care for patients with an ASA score over 3?

Yes, a Level II children's surgical center can care for patients with an ASA score over 3. A Level II children's surgical center must have two or more pediatric anesthesiologists on the medical staff, who must be available within 60 minutes 24/7. This individual must serve as the primary pediatric anesthesiologist for all children 2 years or younger, and the individual should serve as the primary anesthesiologist for all children 5 years or younger or with an ASA of 3 or higher. Emergent procedures in some patients of ASA > 3 may be appropriate in neonatal patients, such as those with necrotizing enterocolitis. Infants and children who have emergent or life--n5 lr1oie

(4.13) Who is required to submit pediatric specific CME?

Providers (emergency medicine providers, radiologists, and anesthesiologists) on the alternative pathway; international pediatric specialty graduates who do not maintain certification in their country of origin; physicians and surgeons who are not board certified or participating in continuous certification; and in Level III centers, a general surgeon or anesthesiologist with pediatric expertise must complete 12 or more pediatric AMA PRA Category 1 Credits™ credit hours annually.

General surgical specialists who are board certified in their specialty and have a defined limited scope of service are not required to submit pediatric specific CME.

(4.13, Alternative Pathway) Some CME events that surgeons attend do not have the word pediatric within the title, but the content within the CME event would apply to both the pediatric and adult surgical patient. For example: if I attend a CME event on central line placement. This is the same whether it is performed on a pediatric or adult patient. Do CME events need to be definitively categorized as pediatric?

CME events will not be scrutinized to this level. If the surgeon attests that the CME is relevant to children's surgery, then this will be applied to the standard.

(4.14) In relation to the pediatric rapid response and/or resuscitation team, is this question in the PRQ seeking the number of times in a 12-month period the team is activated?

Yes, please answer with how many times the rapid response and/or resuscitation team was called upon.

(4.14) Which members of the perioperative team should be notified when the rapid response team is activated for a pediatric surgical patient?

The surgical or surgical specialty team should be notified if the patient is on the surgical service. If the patient is on the pediatric service, and the patient needs a rapid response within 24 hours of surgery, the perioperative team including anesthesia and the surgical service that operated on the patient should be contacted as need for the rapid response could be related to anesthesia or the procedure itself.

Rapid response activations should be reviewed for opportunities and the rapid response report should be presented at PIPS on a regular schedule.

(4.17) Why does the PRQ ask what are the institutional criteria for utilization of pediatric PACU personnel and

Surgical patients in the NICU and PICU must undergo a nutritional assessment within 48 hours unless the patient's stay is less than 48 hours. The initial nutritional screening assessment does not need to be completed by a registered dietician, however, a valid nutritional screening tool should be used by the team and documented in the patient's chart within 48 hours of admission. The screening tool must be developed by a registered dietician and evidence based. A dedicated registered dietician must be available and must facilitate further nutrition assessment, optimal nutrient delivery and appropriate adjustments when needed for the patient. During the site visit, the reviewer team will evaluate the site's NICU and PICU nutrition assessment policies and staff members involved in each step of the process

(4.23) Are Level I Specialty Oncology centers required to have a dedicated child protective or child maltreatment (NAT) team available 24/7?

Level IS Oncology centers are not required to have a dedicated child protective or child maltreatment team available 24/7/365 for consultation. While a child maltreatment team is recommended, transfer agreements are acceptable to provide those services when not available.

A process and policy must be in place to screen for abuse or suspected abuse of a child. The process and policy must follow state guidelines for reporting suspected child abuse.

(4.23) Do states in which healthcare providers are mandated reporters and screen all patients for suspected abuse/neglect meet the requirement of implementing a valid screening tool to identify child maltreatment?

Yes, such states meet this requirement as a screening population is defined (all pediatric patients) and targeted via a screening tool to identify child maltreatment. You will define the screening population and methodology r-8.3 (2.7 (10.6

and appropriate measures must be implemented as required to ensure appropriate response times for emergencies and high quality of care.

(5.2) Why does the PRQ ask if at least one pediatric radiologist is involved as liaison to the children's surgical program and in protocol development and trend analysis that relates to diagnostic imaging?

For Level I and II centers, at a minimum, a pediatric radiologist must be involved in the development of protocols and analysis of trends that relate to diagnostic imaging (Standard 5.2). This role may be satisfied by a radiologist with pediatric expertise in a Level III center.

(5.7) Can a Child Life Specialist be utilized to meet the requirement of having a behavioral health clinician available to assist in patient and family counseling and preparation for surgical procedures when needed?

A child life specialist would not meet this requirement alone. A behavioral health clinician is defined as a psychiatrist, psychologist, or licensed social worker. These individuals are specifically trained to evaluate and assist with psychosocial issues that can impact both preoperative and postoperative care, including perioperative behavioral medicine support. These professionals should be available when needed as part oo(o)-6.6 ()13.1 (s)

(7.7) Is the children's surgery PIPS

If the quality and safety program of the hospital receives information about the death of a child at home or in

individual certified or eligible for certification in pediatric anesthesiology by the American Board of Anesthesiology or equivalent body, or who is similarly qualified by demonstrable experience and training by way of the pediatric anesthesia alternative pathway delineated in Appendix 2.

Can care provided by pediatric anesthesiologists outside the site (at centers not applying for verification) be included in total case volume count if a list of said patients and procedures is unavailable due to contractual/HIPAA reasons?

To document provision of care outside your site, individual pediatric anesthesiologists should write and sign a letter attesting to their compliance with case volume criteria. Such letters should be readily available at the on-site visit.

Would resident certificates, in lieu of a letter from the program director, suffice for evidence that a pediatric anesthesiologist/EM provider/radiologist successfully completed a residency training program with the period consistent with the years of training in the US?

Certificates will not be accepted in lieu of a letter. While a letter from the program director or proxy is preferable, a statement from the individual applicant outlining his/her residency training will suffice if such documentation is unavailable.

Does a pediatric anesthesiologist/EM provider/radiologist who is board eligible for pediatric certification need to be placed on the alternative pathway?

No, such individuals do not need to be placed on the alternative pathway. Pediatric anesthesiologists/emergency medicine providers/radiologists who are board eligible for certification have met the qualifications to sit for pediatric certification.

How should percent clinical practice in Appendix 2 criterion number 7 (physician's clinical practice devoted primarily to specialty for the last 2 years, or at least 30% of the clinical practice over the last 5 years) be calculated for pediatric anesthesiologists, emergency medicine providers, and radiologists qualifying by way of the alternative pathway?

Percent clinical practice can be calculated by the number of pediatric patients seen divided by total patient volume or the number of pediatric shifts divided by total shifts. In either calculation, percent clinical practice must be clearly demonstrated.

Can emergency physicians use nonemergency pediatric sedation patients in their numbers of patients treated when applying for alternative pathway?

Sedation services for children that are part of an emergency physician's practice can be counted to qualify via the alternative pathway.

How detailed does the list of specialty-related CME need to be?

Verifiable evidence of completion is required. Example: A copy of the CME certificate.