Children's Surgery Verification
American College of Surgeons

Optimal Resources for Children's Surgical Care (2021 Standards)
Frequently Asked Questions

General Questions

Where can I find references for the new standards?

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?

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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 children's surgery program. It is the individual who helped ensure the written commitment to the surgical program was implemented to provide optimal multidisciplinary surgical care. This role could be fulfilled by the Surgeon-in-Chief or the Division Director of Pediatric Surgery if an academic institution or the MDCS. If the Surgeon-in-Chief is also the MDCS, this will meet the requirement as this individual serves a dual role.

(1.2) If a surgical program is funded by different departments and not a single budget, how should it be documented in the PRQ?

Please provide a narrative of how each position is supported.

Chapter 2: Program Scope and Governance

(2.2) What is the definition of a surgical case?

A surgical procedure is defined as a case requiring general anesthesia or in which an anesthetic/procedure record is generated. Examples in addition to cases performed in an operative suite would include cardiac catheterization, bronchoscopy, and endoscopy if done in a separate location in the hospital.

(2.5) Do ambulatory surgery centers under a different LLC or CMS number from the applicant center need to be included in the center's application for CSV?

Ambulatory surgery centers with different provider numbers are not required to be included in a center's application for CSV. The intent of standard 2.5 is for freestanding ambulatory surgery centers that are owned and operated by an applicant center to be fully integrated with the applicant center, and that the ambulatory surgical care in any ambulatory component of the main hospital is included in the application. Ambulatory surgery centers that patients and the community view as extensions or a part of the children's surgery center should be included in an application for CSV.

(2.9; 2.12) Can the MDCS also be the NSQIP Pediatric Surgeon Champion?

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 to be effective in the role. For a Level I center, the role requires a minimum of one full time equivalent (FTE) and must not be additive to the job of the OR Director or other individual with responsibilities outside of the program. In Level II or III centers, the time commitment of the CSPM, with administrative oversight, must be demonstrably adequate for the institutional patient volume.

(2.11) What is the definition of "relevant clinical experience" for the role of CSPM?

An individual with healthcare quality improvement and healthcare management experience will meet the requirement for "relevant clinical experience." The CSPM does not need to be a registered nurse or to have bedside nursing experience.

(2.11) Can the CSPM be a fully remote position?

No. The CSPM must play an active role in directing quality implementation and oversight of the CSV and NSQIP Pediatric (if applicable) programs. The CSPM assumes day-to-day responsibility for process and performance improvement activities as they relate to nursing and ancillary personnel and assists the MDCS in carrying out the same functions for physicians. The CSPM must attend the PIPS Committee meetings and have a working relationship with the MDCS so that they function as a team. As such, the CSPM must be present on-site to effectively perform these duties, and to personally interact with the rest of the quality and safety leadership team in the hospital, in addition to the other qualifications and activities outlined in the table for standard 2.11.

It is not the intent of the CSV program to dictate work schedules, however, the institution will need to demonstrate that the work is being performed effectively if or when the CSPM works in a semi-remote capacity during times when this is mandated or necessary for personal reasons.

Chapter 3: Facilities and Equipment Resources

(3.1) Are Level II centers required to have a Neonatal Intensive Care Unit if the center excludes neonates from its scope of practice?

A Level II center may prospectively define its scope of practice to exclude neonatal patients. These centers would not be associated with a birthing center or take neonates in transfer. Typically, these centers would be part of system with a Level I center that is admitting neonates born within or transferred to the system. If the Level II center does not care for neonates, a NICU is not required but the center must have a PICU and all relevant medical and surgical specialties.

(3.1) How does my surgery center determine what is our NICU's designated level?

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 heart disease?

To meet Standard 4.1, a Level I center must have a congenital cardiology program that is able to comprehensively diagnose and medically manage complex congenital heart disease. Surgical treatment of complex congenital heart disease may be provided by transfer to another center that is integrated into the system of care. These transfers must be supported by written transfer agreements and prospectively defined plans to assure well-coordinated continuity of care. Additionally, Level I centers must be able to perform cardiopulmonary bypass to support comprehensive surgical services in patients with other problems such as tumor resections or trauma.

(4.1) Is attending surgeon involvement required to be demonstrable in the medical record for cardiac surgery?

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 (pediatric orthopedic surgery, pediatric neurosurgery, congenital heart surgery, pediatric plastic surgery, pediatric ophthalmology, pediatric otolaryngology, and pediatric urology) if cases for that specialty are performed at the Level II center. Otherwise, a transfer agreement must be in place to a Level I center for services not offered at the applicant Level II center.

(4.1) Will board certification in complex pediatric otolaryngology (CPO) be required for pediatric otolaryngologists?

Pediatric otolaryngologists are defined by the CSV program as CPO board certified, eligible for the CPO board exam, or pediatric fellowship trained. Pediatric otolaryngologists will not be expected to obtain sub-certification in complex pediatric otolaryngology until after 2030 when the practice option closes by the board.

Centers will still need to have prospectively defined scope of service and pediatric back-up call schedules for providers who do not have additional pediatric qualifications (either CPO board certified, CPO board eligible, or pediatric fellowship trained) when providing call. Please refer to standard 4.12 for Call Coverage requirements.

(4.1) What are the acceptable pathways for a surgeon to be considered a children's surgical specialist?

For the purpose of the CSV program, the following pathways will be recognized as pediatric sub-specialty certification: pediatric sub-specialty board certification by an ABMS member board, completion of an ACGME-approved pediatric fellowship training program, pediatric sub-specialty board certification by a non-ABMS board, or completion of a pediatric fellowship defined by a specialty society. Informal fellowships that are not part of a specialty-wide educational paradigm will require individual evaluation.

(4.2) Are attending pediatric anesthesiologists required to be on-site 24 hours a day?

Pediatric anesthesia services must be immediately available on-site 24 hours a day. Providers utilized to meet this requirement must be credentialed by their institution to initiate surgical anesthesia independently in emergent situations in consultation with the on-call pediatric anesthesiologists. Attending pediatric anesthesiologists are not required to be on site 24 hours a day. This requirement may be fulfilled by on-site

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-threatening surgical needs and cannot be delayed for transport should receive initial stabilization and necessary care at the site of presentation.

(4.5; 4.6) What is the definition of a major operative procedure?

An operative procedure or major operative procedure is any case performed at the bedside requiring general anesthesia for which a separate anesthetic record is generated OR any operative procedure that requires the use of an OR team. Any intracavity procedure is considered a major operative procedure (except placement of drains).

This includes procedures outside of the operating room (e.g., NICU, PICU, CICU) where either anesthesia or an OR team provide staffing for the case on site. This does not include procedures that fall under the umbrella of sedation services unless an anesthetic record is generated.

(4.9) Do pediatricians who staff the ED and who have not completed an ACGME-approved or equivalent pediatric emergency medicine fellowship training program need to follow the alternative pathway?

Pediatricians at Level I centers who are not certified in pediatric emergency medicine should be on the alternative pathway if they staff the ED. At least one pediatric emergency medicine physician must always be present in the ED.

(4.12) Can multiple disciplines share call coverage for pediatric surgical pathologies?

There are circumstances where two or more disciplines may overlap in terms of pediatric training, expertise, credentials, and practice at individual institutions. One such example is that of airway management in infants and children. Pediatric otolaryngologists and pediatric surgeons may share call for neonatal airway management, foreign bodies, and other specialized pediatric problems. The expectation of the ACS Verification Committee in these circumstances is that all of those who provide care to infants and children must have appropriate pediatric training and expertise, ongoing relevant pediatric experience, and specific pediatric privileges at the institution. Furthermore, the expectation is that a pediatric specialist be available either as the primary call responder or by published back-up call schedule 24/7/365. In the circumstance where a primary call schedule includes a non-pediatric specialist in conjunction with a back-up pediatric specialist call schedule, there must be prospectively defined circumstances which determine the threshold for the primary call provider to call in the pediatric specialist. The PIPS process must systematically monitor compliance and outcomes. At the site visit, chart reviews will include these specific areas and relevant patients.

(4.12) When are pediatric back-up call schedules required?

Pediatric back-up call schedules and specific scope of practice are required when call coverage is provided by physicians or surgeons without pediatric certification or without specific pediatric credentials.

(4.12) Which surgical specialties are required to have a scope of practice and back-up call schedules if call coverage is provided by physicians or surgeons without pediatric certification or without specific pediatric credentials?

Pediatric medical and surgical specialists are defined as individuals who are either eligible for certification by, or are board certified by, the appropriate Board of the American Board of Medical Specialties (ABMS) or equivalent and who have obtained, or are eligible for, the pediatric certificate of added qualification or equivalent when offered, or who have obtained ACGME pediatric postgraduate fellowship training (or equivalent) when a certificate of added qualification is not offered in the discipline; and who are specifically credentialed to provide children's specialty care in the discipline. If there are non-pediatric certified providers taking call within any required surgical specialties, then the specialty would need a scope of practice document and back-up call schedule to indicate the circumstances that would require the call-in of a pediatric provider.

(4.12) Is a back-up call plan required when children's surgical specialists provide call coverage for multiple locations?

A written policy or process must be in place to ensure coverage for pediatric surgical emergencies when children's surgical specialists are providing care at another location or otherwise encumbered while on call. Centers are expected to monitor compliance with this policy through PIPS. This standard can be met by a written plan to include a back-up call schedule, an alternate service to cover the call, and/or a transfer plan to another center that can provide the care. An example would be a patient with testicular torsion and the backup call could be met by the adult urology or pediatric surgery service.

The pediatric general and thoracic surgeons and pediatric anesthesiologists on call must be dedicated to the center while on call. If the surgeon or anesthesiologist provides any clinical services in another location while on call, a back-up call schedule must be available.

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(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 resources? Does this mean adult versus pediatric?

This question is not about adult versus pediatric. 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 (Standard 4.17). This question is intended to determine if your site is compliant with this standard.

(4.19) Do all nutrition assessments in the NICU and PICU need to be completed by a registered dietician within 48 hours?

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 by uploading a guideline or protocol in the PRQ.

(4.24) What are the minimum requirements for pediatric pathology in a Level I center?

An anatomic pathologist with appropriate pediatric expertise is defined as either a board- certified pediatric pathologist or one who has completed a pediatric pathology fellowship and is in the examination process. A pathologist with specific expertise in an area that bridges the gaps between child and adult may qualify. For example, a pathologist who specializes in central nervous system tumors at any age of patient would have pediatric expertise.

If the center is not staffed with Board Certified Pediatric Pathologists who are available for call 24/7, there will need to be a way to establish who responds when there is an emergent need for a pediatric pathologist off hours and how this service is covered.

Chapter 5: Patient Care: Expectations and Protocols

(5.1) What is the standard for call team coverage in cardiac catheterization and electrophysiology labs?

The cardiac catheterization and electrophysiology labs are considered an extension of the operating room. These labs should have call schedules to ensure the availability of appropriate pediatric specialty personnel 24/7/365 including anesthesia. The timeliness of starting procedures in these labs should be monitored by PIPS

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 of the Perioperative Risk Assessment Program and in the perioperative period.

Chapter 6: Data Surveillance and Systems

(6.1) Is the ACS NSQIP Pediatric the only data collection tool needed?

Sites applying for Level I, Level I Specialty Musculoskeletal, or Level II verification are required to participate in ACS NSQIP Pediatric. Additionally, all three levels are also required to collect the safety data in Appendix 1. This will be provided through a table in the online application.

Chapter 7: Quality Improvement

(7.2) If my site has monthly PIPS meetings, can attendance compliance be calculated based on the minimum quarterly denominator?

If your site has monthly meetings, the attendance for required specialties will be calculated based on monthly attendance.

(7.4) Are sites expected to review mortalities that occur within 30 days of a procedure, but outside of the hospital?

Yes. If the medical team is made aware of a death that occurred outside of the hospital within 30 days of a procedure, it should be categorized and reviewed by the PIPS committee or subcommittee. There may be extenuating factors that contributed to the death (e.g., if a NICU baby went home and did not have the correct equipment or supplies). If it was a coroner's case, the autopsy results might be helpful.

Patient mortalities that occur during the 30-day postoperative period and within the hospital stay are considered Appendix I events. Patient mortalities that occur during the 30-day postoperative period and outside of hospital are NOT considered Appendix I events.

(7.7) Is the children's surgery PIPS program required to review transfers to an affiliated center for procedures or diagnostic studies for performance improvement?

Yes. The PIPS Committee must review all interhospital transfers for appropriateness, timeliness, and outcome. Any quality or safety issues related to interhospital transfers/transports must be reviewed by the PIPS committee or a multidisciplinary subcommittee thereof. The intent is to ensure all transfers are safe and communicated effectively without delay of care. For Specialty hospitals, this would also include any interhospital transfers to neighboring institutions for services not available at the applicant institution.

(7.7) When our facility receives a transfer for a surgical patient, we call the child's primary physician to notify them of the admission and then send a discharge summary upon discharge. Is this sufficient?

For those patients received from other hospitals, calling the child's primary physician to notify them of the admission and then sending a discharge summary discharge is helpful, however, a description of the review and transfer process in more detail is preferred. Additional information for both internal transfers between units, inter institutional transfers, and inter hospital transfers to a higher level of care will also be needed. How do you communicate with the hospitals from which you receive patients? What are your transfer agreement details? What is the process improvement and communication system for these transfers?

Chapters 8 and 9: Educational: Professional and Community Outreach & Research

(8.1) What positions should be included on the Graduate Medical Education Table?

Grouped by specialty, please outline all positions for GME trainees who participate in the management of children, including whether the training program is a residency or fellowship and whether it is or is not ACGME-accredited.

Appendix I: Children's Surgery Safety Report

When are we required to start using the new definitions to capture safety events (now Appendix I)?

You can start collecting the new data points immediately. Ideally, you should have at least one year of the new Appendix I data prior to opening a PRQ under the new standards. If this is not possible for your reporting period, please contact the Children's Surgery team for guidance.

Are we required to continue collecting all the Appendix II safety events that are not included in Appendix I (such as Hemorrhage, etc.)?

No. Once you begin collecting the Appendix I (v2021) data, you no longer need to collect the data points from Appendix II (v1) that were removed.

What specific events must be tracked for the Appendix I event "death within 30 days"?

This event includes any death in the operating room and any death within 30 days from the operative procedure IF the patient is in the hospital, continuously since the operation or because of readmission. This does not include patients discharged from the hospital prior to death within 30 days and occurring outside the hospital.

If the quality and safety program of the hospital receives information about the death of a child at home or in another hospital, from the parent or other medical provider, and it is in 30-day proximity to the operation, this should prompt at least a phone call to understand why the child died. Although not technically mandatory, this type of review provides an opportunity to look at discharge planning and care coordination with the patient's medical home to make sure there were no factors that might have contributed to the child's death. There may also be involvement by the medical examiner or autopsy results that may be helpful in understanding the death.

Can you please clarify the new event "Loss or mishandling of an irreplaceable biological specimen"?

This event is defined as the loss or mishandling of a biological specimen that results in an additional intervention or an inability to diagnose. This would include procedural-related specimens i.e., biopsies, interoperative cultures, spinal taps, etc.

Do the Appendix I events that are captured in the NSQIP Pediatric registry need to be collected in both the NSQIP Pediatric registry and the Children's Surgery Safety Report table in the PRQ?

Yes. The three Appendix I events that are captured in the NSQIP Pediatric registry (CPR during operation, unplanned extubation, and cerebral vascular accident/stroke or intracranial hemorrhage) must be tracked in both the NSQIP Pediatric registry and on the Children's Surgery Safety Report table for standard 6.2 in the PRQ. This is because all Appendix I events require 100% capture and NSQIP does not include all surgical patients. These events can be tracked in the NSQIP Pediatric registry via the CSV Safety Report.

Level III centers are not required to participate in NSQIP Pediatric. Level III centers that do not participate in NSQIP Pediatric must capture all Appendix I events within the Children's Surgery Safety Report table for standard 6.2 in the PRQ.

Appendix II: Alternative Pathway

Must pediatric anesthesiologists qualifying by way of the alternative pathway include neonates in their practice for criterion 5?

Pediatric anesthesiologists qualifying by way of the alternative pathway are not required to care for neonates. Evidence of care for patients less than 2 years of age is adequate. Neonates must be cared for by anesthesiologists qualified to care for neonates (board certified or board eligible pediatric anesthesiologists or pediatric anesthesiologists on the alternative pathway). If the anesthesiologist in question does not have experience with neonates, the institution must demonstrate that coverage for neonates is provided 24/7 by a pediatric anesthesiologist with ongoing neonatal experience. A back-up call schedule for the last 3 months must be provided to ensure children of all ages, including neonates, are cared for by an appropriately trained provider. A mechanism must be in place to ensure that the appropriate provider is at the bedside to care for neonates.

Do anesthesiologists who are not pediatric specialty board certified but have decades of experience practicing only pediatric anesthesia need to be placed on the alternative pathway?

Yes, any anesthesiologists who do not meet the definition of a pediatric anesthesiologist and care for patients less than two years of age must follow the alternative pathway. A pediatric anesthesiologist is defined as an

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.