

Optimal Resources for Children's Surgical Care

Frequently Asked Questions

General Questions

What specific time period does "preceding 12 months" and "past 3 years" refer to regarding documentation of care of surgical infants and children and average annual CME requirements?

The reporting year(s) should preferably be the 12 months or 3 years prior to receiving the PRQ. The last fiscal reporting year(s) are 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 a site. We may need to schedule the visit outside of this range due to surveyor 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 purpose of 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).

Chapter 2

How is a pediatric surgeon defined?

A pediatric surgeon is defined as an individual certified or eligible for certification in pediatric surgery by the Pediatric Surgery Board of the American Board of Surgery or an equivalent body.

How is a pediatric anesthesiologist defined?

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 3 of the Optimal Resources for Children's Surgical Care v.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].
How is a neonatologist defined?	A neonatologist is defined as an individual who is either sub-board eligible or certified by the American Board of Pediatrics in neonatal-perinatal medicine or equivalent.
How is a pediatric radiologist defined?	A pediatric radiologist is defined as an individual certified by the American Board of Radiology or equivalent body, in addition to being certified or eligible for certification in pediatric radiology by the American Board of Radiology or equivalent body. An individual may qualify as a pediatric radiologist by demonstrating equivalent training and experience as detailed in the pediatric radiology alternative pathway delineated in Appendix 3 of the Optimal Resources for Children's Surgical Care v.1.
How is a pediatric emergency physician defined?	A pediatric emergency physician is an individual who is board certified or eligible to be certified either in Pediatrics or Emergency Medicine, and who has completed an Accreditation Council for Graduate Medical Education (ACGME)-approved or equivalent pediatric emergency medicine fellowship training program. An individual may qualify as a pediatric emergency medicine provider by demonstrating equivalent training and experience, as detailed in the pediatric emergency medicine alternative pathway delineated in Appendix 3 of the Optimal Resources for Children's Surgical Care v.1.
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 are pediatric medical and surgical specialists defined?	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.
(CD 2-5) Surgeons and anesthesiologists must be physically present for procedures for which they are the primary responsible provider. What are the differences and duties of anesthesiologists supervising versus differences and duties of primary anesthesiologists providing the patient care? What does "physically present" entail?	When an attending anesthesiologist is "physically present" for a procedure, he/she must be on site, immediately available to respond to OR events and serve as the anesthesiologist of record for the patient, but this does not mean he/she has to be physically in the OR for the entire time if a resident, fellow, CRNA or CRNA student is also caring for a pediatric patient. Most institutions require that the attending anesthesiologist is in the OR for induction and wake up of all patients. A pediatric anesthesiologist assigned elsewhere in the hospital, or at home, or off campus does not meet the standard.
(CD 2-11) A pediatric anesthesiologist must serve as the primary anesthesiologist for all children two years or younger. What is the definition of "two years or younger"?	"Two years or younger" is defined as 24 months of age or younger. An anesthesiologist with pediatric expertise must demonstrate continuous experience with children age 24 months or younger. A pediatric anesthesiologist must serve as the primary anesthesiologist for all children age 24 months or younger. If a patient is 24 months and 1 day, they are over 2 years of age.

(CD 2-11) What is considered an alternative equivalent body (board certification) for pediatric anesthesiologists?	<p>Certifying bodies in the UK and Canada are considered equivalent to the American Board of Anesthesiology. Their credentials are accepted without further review and the physicians do not need to follow the alternative pathway.</p> <p>Board certification processes of other countries and jurisdictions are currently under investigation to further assess their equivalence. If the applicant center designates a provider as having an “equivalent” pediatric board certification, the provider is required to be added to the Explanation of Non-Traditional Certification Table with additional detail provided in the last column. The provider’s CV must also be uploaded within the PRQ with the Explanation of Non-Traditional Certification Table. The CSV committee will review the CV to determine if the credentials of the provider in question are accepted as equivalent or if the provider must go on the alternative pathway. If the alternative pathway is required, ACS staff will assist the center in submitting alternative pathway documentation prior to the site visit or at the time of site visit, if necessary.</p>
(CD 2-11) Is osteopathic board certification (American Osteopathic Association) considered equivalent pediatric board certification?	<p>If an anesthesiologist is a doctor of osteopathy, completed an ACGME pediatric fellowship program, and is certified by the American Board of Anesthesiology in pediatric anesthesiology, then the individual is considered to hold equivalent pediatric certification and is not required to follow the alternative pathway. Anesthesiologists who are AOA board certified and completed non-ACGME training will be reviewed on an individual basis.</p>
(CD 2-12; CD 5-2) How specific should delineation of privileges be?	<p>Credentials for privileges for operative procedures to be performed specifically in children must be age-based. Generic credentials such as “patients of all ages” or “all children age 18 years and younger” will not suffice. A plan to change delineation of privileges within the credentialing process as physicians are recertified is acceptable if approved by the appropriate boards at the site and implemented by the time of site visit. Information regarding the approved plan and implementation strategy should be provided in the PRQ.</p>
(CD 2-16) Is it specifically required to have an in-house surgical residency program?	<p>It is not required to have an in-house surgical residency program.</p>
(CD 2-17) 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?	<p>You would assign the NICU level that is consistent with the 2012 AAP document. In this case, it would be a Level IV NICU.</p>
(CD 2-17) Is it required for a Level I center to offer Extracorporeal Membrane Oxygenation (ECMO)?	<p>In general, Level I centers should be able to provide treatment for most complex pediatric conditions. However, there are treatments that are so infrequent and complex that concentration of these patients into fewer centers may improve quality. ECMO is a treatment that may be best concentrated in centers with higher volumes.</p> <p>CSV Program does not intend to cause the proliferation of low volume ECMO centers. Therefore, it is not required that a Level I center physically house an ECMO program, but the program must be able to promptly and safely transfer appropriate patients to an ECMO center. These transfers must be supported by written transfer agreements and prospectively defined plans to assure well-coordinated continuity of care.</p>

(CD 2-18) For the sub-specialties, what does 24/7 access mean? Does 24/7 access refer to a consult?	Yes, it means 24/7 to be seen by (consultation) or have services available from these specialties.
(CD 2-21) Are pharmacists with pediatric training and experience required to be available 24 hours/day for all requests?	No, pharmacists with pediatric training and experience are not required to be available 24 hours/day for all requests. The question on this topic in the PRQ is information seeking to determine how CD 2-21 is demonstrated at a site and the availability of nursing, respiratory therapy, pharmacy, and other support staff.
(CD 2-30) When are pediatric back-up call schedules required?	<p>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. There must be prospectively defined scope of pediatric practice documents for specialties in which adult providers cover call for pediatric patients indicating the adult providers' pediatric training and ability to care for children.</p> <p>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.</p>
(CD 2-35) 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.
(CD 2-40) Can Level II centers care for patients with an ASA score over 3?	<p>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 one or more pediatric anesthesiologists on the medical staff (CD 2-39), 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, as for Level I centers (CD 2-40).</p> <p>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 or by way of the pediatric anesthesia alternative pathway delineated in Appendix 3.</p> <p>If a true emergency exists and pediatric anesthesia is unavailable the center must be able to promptly and safely transfer the patient to a center with the capability of providing the resources the patient needs. These transfers must be supported by written transfer agreements and prospectively defined plans to assure well-coordinated continuity of care.</p>

(CD 2-65) 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?

How is "ambulatory" defined?

An ambulatory center must be demonstrably integrated within the larger parent system, and the on-site ambulatory surgery care team must possess pediatric-specific training and experience consistent with the requirements delineated for the relevant level of center verification. Ambulatory surgery in infants born before 37 weeks' gestation may be safely performed after 50 weeks' postmenstrual age as long as there is no anemia, prior apnea, or coexisting disease. Institutional guidelines generally require full-term infants younger than 4 weeks or preterm infants less than 50 postmenstrual weeks to be monitored for at least 12 hours postoperatively. The intent of this question is to determine whether or not full-term infants less than 4 weeks of age and preterm infants younger than 50 weeks postmenstrual age are operated upon as ambulatory outpatients.

(CD 2-66-CD 2-74) Are these standards all related to the ambulatory setting?

Yes, standards CD 2-66 — CD 2-74 all relate to the ambulatory setting.

(CD 2-66-CD 2-74) The PRQ references a freestanding ambulatory center. Should these standards be completed if an organization is including a freestanding ambulatory center, separate from the hospital physical structure, as part of the parent center verification process?

Yes, a hospital's ambulatory surgical center can be included in the center application if they are fully integrated with the parent center, share the same staff, and can meet all the same requirements for whichever level of verification is being sought. The ambulatory surgical center must meet all the resource standards for children delineated, and the on-site ambulatory care team must possess pediatric training and experience consistent with the level of verification.

Is the inclusion of ambulatory center(s), as part of verification, optional?

The applicant center may decide to include or exclude off site ambulatory surgery center(s), however, it is highly encouraged to include any ambulatory surgery center(s) as part of the application. Any included ambulatory center will need to meet the standards consistent with the level of verification the center is pursuing. Excluded ambulatory sites will not be considered part of verified center.

Chapter 3

(CD 3-1) Does the applicant center have a means for effective communication between referring and receiving center? Aside from documenting in EHR system, what does this mean?

This question in the PRQ is asking how your site receives information and provides feedback for children with surgical needs prior to transfer, communication during transport, and your policy/procedures for ensuring a safe handoff. A PIPS review and related communication are required.

(CD 3-5) Can you provide clarification on what mechanism for feedback to referring institutions must be in place?

A mechanism to provide feedback to referring institutions must be established. A process should be in place to screen surgical transport activities for any quality or safety issues. Any issues that are identified that are unique to the patient or transferring institution should have feedback provided by the Director of Transport Services or his/her designee. Any quality or safety issues that represent a trend or system issue should be escalated to the PIPS committee for review. Feedback from the PIPS discussion should be provided to the Director of Transport Services and to the referring institution.

There are a few PRQ standards related to facility transfer agreements that an organization has on file. Is there a need to update all the transfer agreements that an individual organization has on file?

Existing transfer agreements do not need to be revised. The agreement in the standards document is an example. These standards will be met if there is a formal agreement between the institutions on the subject of who the patients are, and how transfers will be completed and there is a PI process that includes these patients.

Chapter 4

Does the ACS have published job descriptions for the Medical Director or Surgical Director and other key positions required in this process?

The ACS does not have published jobs descriptions for the MDCS, MDCA, or CSPM. Minimal qualifications are outlined in the standards document.

(CD 4-19-CD 4-20) Does the Children's Surgery Program Manager have to be a full-time employee (FTE), or can this person be someone who is already employed through the hospital on a part-time basis and just adds the Program Manager as a new job responsibility?

There are not specific FTE requirements for the CSPM, but the institution will need to demonstrate that the work is performed effectively and for Level I center applicants in particular, less than 1.0 FTE will be scrutinized carefully. The tasks required here cannot simply be added on, for example, to the OR Director or other individual who was previously a 1.0 FTE. The time commitment of the CSPM must be demonstrably adequate for the institutional patient volume.

(CD 4-3) 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.

Are Children's Surgery Program Managers (CSPMs) required to provide evidence of educational preparation via a required number of continuing education credits per year?

While CSPMs are encouraged to obtain continuing education credits, they are not required to provide evidence of a particular number of credits per year in the current *Optimal Resources for Children's Surgical Care, 2015*. The number of continuing education credits will be mandatory for CSPMs in future versions of the standards manual.

Chapter 6

(CD 6-2) Can Certified Anesthesiologist Assistants (C-AAs) be used to fulfill the anesthesia immediate availability requirement (available on-site 24 hours/day) in Level I and Level II centers?

No, practitioners that are allowed to fulfill the anesthesia immediate availability requirement must be able to initiate surgical anesthesia independently in emergent situations in consultation with the on-call pediatric anesthesiologists. Though each state has different regulations, C-AA's generally must practice under the direct supervision of an anesthesiologist. The immediate availability requirement may be fulfilled by on-site anesthesiology residents in their final year of training, pediatric anesthesiology fellows, CRNAs, or board-certified anesthesiologists who are capable of assessing emergency situations in children and of providing any indicated treatment, including airway management and initiation of surgical anesthesia. We are unaware of any state that currently allows for independent practice by C-AA's, but will evaluate this on a case-by-case basis should state regulations change.

(CD 6-14) Why does the PRQ ask what are the institutional criteria for utilization of pediatric PACU personnel and resources? Does this mean adult versus pediatric?

The question for CD 6-14 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 (CD 6-14). This question is intended to determine if your site is compliant with this standard.

(CD 6-20) 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?

One pediatric radiologist is required to be involved as liaison to the children's surgical program and involved 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 (CD 6-20).

(CD 6-26) Why does the PRQ ask if the ongoing attending surgeon involvement with all perioperative children is verifiable in the medical record regardless of physical location of the patient?

For all levels of verification, ongoing attending surgeon involvement must be documented in the medical record for all perioperative and other surgical patients regardless of physical location (CD 6-26). This is required regardless of the physical location of the patient.

(CD 6-28) Must a Level I children's surgical center be able to provide surgical treatment of complex congenital heart disease?

In general, Level I centers should be able to provide treatment for most complex pediatric conditions. However, there are diseases with sufficient complexity and rarity that concentration of care into fewer centers may improve quality. Complex congenital heart disease is a particular example of this volume: outcome relationship. Given the demonstrable differences between centers, it is not the intent of CSV to encourage the proliferation of low-volume congenital cardiac surgery programs. Therefore, it is not required that a Level I center physically house a complex congenital heart surgery program.

In order to meet CD-6-28, a Level I center must have a congenital cardiology program that it 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.

Chapter 7

Is the ACS NSQIP Pediatric the only data collection tool needed?	Sites applying for Level I or II verification are required to participate in ACS NSQIP Pediatric. Additionally, all three levels are also required to collect the safety data in Appendix 2. This will be provided through a table in the online application.
Is there a data dictionary for ACS NSQIP Pediatric?	Yes. The data dictionary is available to sites when they join the program and attend training. This is available to Surgeon Champions and SCRs via the online workstation.
How long should our facility be collecting data in ACS NSQIP Pediatric and participating in process improvement work prior to requesting a site survey for ACS Children’s Surgery verification?	Sites need to collect enough ACS NSQIP Pediatric data to demonstrate a process improvement project. For example, the case details report will have sufficient data after six months of data collection for an internal research project, but generally twelve months of data collection will be necessary.

Chapter 8

If our hospital currently has a specialized system in place for reviewing certain criteria (i.e. transport team operations, interhospital transport, assessment for over/under triage), then is it sufficient to describe our current system or must we create an alternative internal review system for these elements through PIPS?	This committee will suffice. The PIPS committee does not need to be called PIPS. The standards will be met as there is a committee which is reviewing and monitoring the required information (required for PIPS). The PIPS process is a higher-level multidisciplinary review, which incorporates all relevant surgical and medical specialties for the scope of service. Level I and II centers will also need to have a stand-alone Children’s OR committee or equivalent to review staffing, equipment, etc. and address children’s surgical program operational issues.
(CD 8-6) What medical procedural specialists are required to be representatives of the PIPS committee?	Representatives from critical care medicine and emergency medicine are required to participate on the PIPS committee and must attend at least 50% of the PIPS meetings. Representatives from pulmonology, gastroenterology, and hematology/oncology are required on an ad hoc basis. They must be present at PIPS meetings in which cases from their respective specialties are to be discussed.
(CD 8-12) All deaths of infants and children occurring within 30 days of an operative procedure must be systematically reviewed and categorized through a peer review process as unanticipated mortality with opportunity for improvement, mortality without opportunity for improvement, or anticipated mortality with opportunity for improvement. Should unanticipated and anticipated mortalities without opportunity for improvement be reviewed and categorized separately?	Unanticipated and anticipated mortalities without improvement can be reviewed and categorized separately, but it is not required.
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 percent of effort contributed to the PIPS committee. Please include the percent 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.

Chapter 10

(CD 10-2) What are some examples of how the center provides means to facilitate referral and access to children's surgical center resources?

Sites have demonstrated various strategies, including: call center, referral hotline, telemedicine links, transport team, various outreach programs, various NICU or PICU networks among them, etc.

(CD 10-4) What types of programs qualify as external CME?

Programs given by visiting professors and invited external speakers, as well as teaching done by children's surgeons elsewhere, are considered external CME.

(CD 10-4, 10-5) 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 surgical technique is the same whether or not 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.

(CD 10-5) How can members of children's surgical specialties who take call meet the requirement of demonstrating current knowledge in the care of children with surgical needs?

All members of children's surgical specialties who take call must be knowledgeable and current in the care of children with surgical needs. This requirement is met by maintaining current board certification of their respective specialty board. Physicians/surgeons who are currently board-eligible (recent graduates) and those who have life-time (grandfathered) board certification, meet the CME requirement. Physicians/surgeons who are not board certified can meet this requirement by documenting the acquisition of 12 hours of relevant CME per year on average, or by demonstrating similar participation in an internal educational process conducted by the children's surgical program and the specialty liaison based on the principles of practice-based learning and the PIPS.

In completing the PRQ tables for ongoing competency among individuals requiring an average of 12 hours annually or 36 hours in three years of related Category 1 CME, should the total number of accrued hours be reported?

Yes, the total number of Category 1 CME hours accrued over the past 3 years should be reported for such individuals regardless of if the total is above the 36 hours.

PRQ Appendix A

Is there a detailed data dictionary available that includes inclusion/exclusion criteria and refined definitions of each Appendix 2 event (i.e. pressure injuries, all or select stages of surgically-related pressure injuries)?

Appendix 2 definitions will be available in your Children's Surgery Portal which you will receive access to upon approval of your pre-application.

In the Appendix 2 – Safety Data Table, should events be captured according to the timeframe indicated in the heading (within 48 hours of operation) or according to timeframes provided in the event definitions of the Appendix 2 Reference Guide?

All events under the first heading (Intraoperative events or those occurring within 48 hours of operation) should be captured within 48 hours despite other timeframes listed in the Appendix 2 Reference Guide. The definitions in the Reference Guide are referenced from other quality reporting systems. All events under the second heading (Intraoperative or perioperative events occurring as delineated) should be captured within the timeframes indicated on the Appendix 2 – Safety Data Table.

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.

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. Such individuals should be added to the Explanation of Nontraditional Certification Table with information regarding their board eligibility provided in the last column.

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

Please list all residency or fellowship programs that include trainees who rotate through pediatrics. Residency and fellowship programs can be through an affiliate university, etc. if they occur at the applicant center.

Standards Appendix 3

For pediatric anesthesiologists qualifying by way of the alternative pathway, can a fellowship certificate from an ACGME accredited fellowship be submitted in lieu of a residency letter for criterion 1?

Yes, a fellowship certificate from an ACGME accredited fellowship can be submitted in lieu of a residency letter for pediatric anesthesiologists qualifying by way of the 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 3.

Is documentation of 36 hours of children's related CME during the past 3 years required to meet the CME criteria for qualification by way of alternative pathway as pediatric anesthesiologist, pediatric emergency medicine provider, or pediatric radiologist?

Yes, all 7 criteria must be fulfilled for an anesthesiologist, emergency medicine provider, or pediatric radiologist to be approved by the alternative pathway. A list of the 36 hours of children's specialty (anesthesia, radiology, or emergency medicine)-related continuing medical education during the past 3 years is required for the alternative pathway.

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

The list of 36 hours of children's specialty-related CME during the past 3 years must be submitted to the ACS Children's Surgery Verification Committee office at least 1 month in advance of the on-site visit. Evidence that such hours are pediatric-specific must be readily available at the site visit.

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 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 time 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 who is board eligible for certification in pediatric anesthesiology by the American Board of Anesthesiology or equivalent body need to be placed on the alternative pathway?

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

Do pediatric anesthesiologists qualifying by way of the alternative pathway who specialize in CV or neurosurgery anesthesiology need to devote their clinical practice primarily to pediatric patients for the last 2 years or at least 30% of their clinical practice averaged over the last 5 years to pediatric patients?

Adult providers that specialize in cardiac or neurosurgery anesthesiology are required to meet the pediatric 30% clinical practice requirement outlined in Appendix 3. Experience, training, and regular practice in caring for infants and children with significant comorbidities is essential in providing optimal pediatric cardiac and neurosurgical anesthetic care and is required in the ACS CSV program. Recent studies have shown that infants and children undergoing cardiac and neurosurgical procedures have the highest risk of perioperative cardiac arrest. All children greater than or equal to 2 years of age must be cared for by a Board certified or Board eligible pediatric anesthesiologist or an anesthesiologist who meets the qualifications via the alternative pathway. Children less than or equal to 5 years or with an ASA greater than or equal to 3 should be cared for by an anesthesiologist with similar qualifications.