**SECTION A: GENERAL PEDIATRICS**

**PLEASE NOTE:** Answers to the questions in this section will be used to assess hospital capabilities and performance in one or more specialty areas. The section is called general pediatrics to avoid repeating the questions in individual specialty areas.

**When responding to questions in this section, your hospital must consult with the chief of service (or equivalent) of your Pediatric program to ensure that answers are accurate and consistent with both the care delivered and the intent of the survey.**

**As data are reviewed, U.S. News may have questions about responses to individual questions or about an entire submission. To ensure communication with the appropriate clinical leader, please provide the following information about the chief of service (or equivalent) for your Pediatric program.**

**Full name:**

|  |
| --- |
| **(GP\_DIR\_NAME)** |

**Title:**

|  |
| --- |
| **(GP\_DIR\_TITLE)** |

**Email:**

|  |
| --- |
| **(GP\_DIR\_EMAIL)** |

**Preferred phone:**

|  |
| --- |
| **(GP\_DIR\_PHONE)** |

REQUIRED: IF NAME, TITLE, EMAIL, OR PHONE=BLANK, DISPLAY: “A response is required for [Name/Title/Email/Phone] prior to submitting the survey. Click “OK” to continue with the survey and answer this question later. Click “Cancel” to provide a response to this question now.”

1. **What was the average daily pediatric (including newborns[[1]](#footnote-2) and neonates) inpatient census[[2]](#footnote-3) for the last 2 calendar years****?**

\_\_\_\_\_\_\_\_ a.2023 average daily inpatient census (**GP\_DAILY\_CENSUS\_PREV)**

\_\_\_\_\_\_\_\_ b. 2024 average daily inpatient census (**GP\_DAILY\_CENSUS\_CURR**)

NOTES: A1x should be whole number only. Do not allow decimals.

**A1.2 What was the total number of licensed beds set up and staffed for use**[[3]](#footnote-4) **as of December 31, 2024?**

\_\_\_\_\_\_\_\_ Number of setup and staffed beds **(GP\_BEDS)**

NOTES: A1.2 should be whole number only. Do not allow decimals.

1. **Indicate the number of full-time equivalent (FTE)[[4]](#footnote-5) on-staff RNs in your pediatric program (including the NICU and perioperative nursing staff) who are involved in direct inpatient pediatric care.** [Exclude LVN, LPN, UAP NPs, PAs, ED staff, urgent care staff, and outpatient-only nursing staff. Include all clinical RNs who would normally be replaced if they called in ill. Due to ongoing nursing shortages, contract nurses should be included in your counts of clinical RNs.]

\_\_\_\_\_\_\_\_Number of FTEs **(GP\_FTE\_RNS)**

NOTES: A2 is numeric entry (decimals are allowed).

VALIDATE: If A2 is not numeric: “A2: Please enter a numeric value.”

1. **As of January 1, 2025, was your hospital designated as a Nurse Magnet Facility by the American Nurses Credentialing Center?**

**(GP\_NMF)**

* + Yes
  + No

1. **Does your hospital have at least one of the following specialists available on-site or on-call[[5]](#footnote-6) to provide services or consultation in your pediatric program 24 hours a day, 7 days a week?**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | |  | | | **Yes** | **No** | | |
| a. | | Pediatric anesthesiologists (board certified/board eligible in Pediatric Anesthesiology by the American Board of Anesthesiologists) **(GP\_SPECIALIST\_ANESTHESIA)** | | | **○** | **○** | | |
| b. | | Pediatric critical care specialists (board certified/board eligible[[6]](#footnote-7) by the American Board of Pediatrics with subspecialty certification in pediatric critical care medicine) **(GP\_SPECIALIST\_CRTICARE)** | | | **○** | **○** | | |
| c. | | Pediatric radiologists (board certified/board eligible by the American Board of Radiology or American Osteopathic Board of Radiology with at least 80% of your general pediatric radiologists holding or are eligible for subspeciality certification in pediatric radiology by the American Board of Radiology)  **(GP\_SPECIALIST\_RAD)** | | | **○** | **○** | | |
| d. | | Radiologists specializing in pediatric interventional radiology (board certified/board eligible by the American Board of Radiology or American Osteopathic Board of Radiology and subspeciality certified or eligible in pediatric radiology or interventional radiology by the American Board of Radiology) and practicing more than 50% time in pediatric interventional radiology. **(GP\_SPECIALIST\_INTERVENTRAD)** | | | **○** | **○** | | |
| e. | | Pediatric rheumatologists[[7]](#footnote-8)(board certified/board eligible6 by the American Board of Pediatrics with subspecialty certification in pediatric rheumatology) **(GP\_SPECIALIST\_RHEUM)** | | | **○** | **○** | | |
| f. | | Pediatric infectious disease specialists (board certified/board eligible6 by the American Board of Pediatrics with subspecialty certification in pediatric infectious disease) **(GP\_SPECIALIST\_DISEASE)** | | | **○** | **○** | | |
| g. | | Radiologist specializing in pediatric neuroradiology (board certified/board eligible by the American Board of Radiology or American Osteopathic Board of Radiology and subspecialty certified or eligible in pediatric radiology or neuro radiology by the American Board of Radiology) and practicing more that 50% time in pediatric neuroradiology **(GP\_SPECIALIST\_NEURORAD)** | | | **○** | **○** | | |
| h. | | Pediatric pathologists (board certified/board eligible by the American Board of Pathology with a subspecialty certification in Pediatric Pathology) **GP\_SPECIALIST\_PATHO)** | **○** | | | **○** |

WARNING: IF A4c OR A4d=Yes, GO TO A4.1; ELSE SKIP TO A5.

**A4.1 This question has been removed from the survey.**

1. **Does your hospital have at least one of the following surgeons (board certified/eligible from the appropriate surgical board, with a fellowship training or extensive experience in pediatric surgery) available to your pediatric program?**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Yes** | **No** |
| a. | Pediatric otolaryngology surgeon **(GP\_PED\_SURGEONS\_OTOLARYN)** | **○** | **○** |
| b. | Pediatric cardiothoracic surgeon **(GP\_PED\_SURGEONS\_CARDIO)** | **○** | **○** |
| c. | Pediatric general surgeon **(GP\_PED\_SURGEONS\_GENERAL)** | **○** | **○** |
| d. | Pediatric neurosurgeon **(GP\_PED\_SURGEONS\_NEURO)** | **○** | **○** |
| e. | Pediatric ophthalmology surgeon **(GP\_PED\_SURGEONS\_OPHT)** | **○** | **○** |
| f. | Pediatric orthopaedic surgeon **(GP\_PED\_SURGEONS\_ORTHO)** | **○** | **○** |
| g. | Pediatric urology surgeon **(GP\_PED\_SURGEONS\_URO)** | **○** | **○** |
| h. | Pediatric plastic surgeon **(GP\_PED\_SURGEONS\_PLASTIC)** | **○** | **○** |
| i. | Pediatric hand surgeon **(GP\_PED\_SURGEONS\_HAND)** | **○** | **○** |
| j. | Vascular surgeon with pediatric experience **(GP\_PED\_SURGEONS\_VASCULAR)** | **○** | **○** |
| k. | Pediatric critical care[[8]](#footnote-9) surgeon **(GP\_PEDSURG\_CC)** | **○** | **○** |
| l. | Liver transplant surgeon with pediatric experience **(GP\_PEDSURG\_LIVTRANS)** | **○** | **○** |
| m. | Pediatric and adolescent gynecology (PAG) surgeon **(GP\_PEDSURG\_PAG)** | **○** | **○** |

1. **This question has been removed from the survey**
2. **Does your hospital provide the following pediatric services either on-site or through a formal contractual relationship with another facility?** [Note that for contractual relationships with another facility, the programs must offer these services at a physical location and not simply a virtual service available only through video/teleconference.]

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | | | **Yes** | **No** | |
|  | Neonatal intensive care unit[[9]](#footnote-10) (NICU) **(GP\_PEDSVC\_NICU)** | | | **○** | **○** | |
|  | Pediatric intensive care unit[[10]](#footnote-11) (PICU) **(GP\_PEDSVC\_PICU)** | | | **○** | **○** | |
|  | Patient care rooms with protective environment[[11]](#footnote-12) **(GP\_PEDSVC\_PROTECT)** | | | **○** | **○** | |
|  | Genetic testing/counseling [[12]](#footnote-13) **(GP\_PEDSVC\_GENETIC)** | | | **○** | **○** | |
|  | Palliative care program[[13]](#footnote-14) **(GP\_PEDSVC\_PALLIATIVE)** | | | **○** | **○** | |
|  | Rehabilitation program and consultation service[[14]](#footnote-15) **(GP\_PEDSVC\_REHAB)** | | | **○** | **○** | |
|  | Maternal fetal medicine or fetal treatment program[[15]](#footnote-16) **(GP\_PEDSVC\_FETAL)** | | | **○** | **○** | |
|  | Sport injury prevention program[[16]](#footnote-17) **(GP\_PEDSVC\_SPORT)** | | | **○** | **○** | |
| i. | | Pediatric physiatrist or rehabilitation specialist (board certified/board eligible by the American Board of Physical Medicine and Rehabilitation with subspecialty certification in Pediatric Rehabilitation Medicine) **(GP\_PEDSVC\_REHAB\_CERT)** | **○** | | | **○** | |

1. **Does your hospital provide the following pediatric services on-site which are available *24 hours a day, 7 days a week*?**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Yes** | **No** |
| a. | Pediatric pain management program[[17]](#footnote-18) **(GP\_PAINMGMT)** | ○ | ○ |
| b. | Multidisciplinary pediatric acute pain/sedation service[[18]](#footnote-19) **(GP\_SEDATION)** | ○ | ○ |

1. **Is your ECMO program currently designated as a Center of Excellence by the Extracorporeal Life Support Organization (ELSO)?**

**(GP\_ECMO)**

* Yes
* No
* Not applicable—we do not have an ECMO program

**A9.1 Is your hospital currently designated as a Center of Excellence in Pediatric Sedation[[19]](#footnote-20) by the Society for Pediatric Sedation?**

**(GP\_COEPS)**

* Yes
* No

1. **Does your hospital provide on-site access[[20]](#footnote-21) to the following technologies or services to pediatric patients?**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Yes** | **No** |
| a. | Positron emission tomography[[21]](#footnote-22)/magnetic resonance imaging (PET/MRI) single-console combined scanning unit **(GP\_ACCESS\_TECH\_PETMRI)** | **○** | **○** |
| b. | Positron emission tomography/computed tomography (PET/CT) single-console combined scanning unit[[22]](#footnote-23) **(GP\_ACCESS\_TECH\_PETCT)** | **○** | **○** |
| c. | 3 Tesla magnetic resonance imaging (3T MRI)[[23]](#footnote-24) **(GP\_ACCESS\_TECH\_3TMRI)** | **○** | **○** |
| d. | Image-guided radiation therapy (IGRT)[[24]](#footnote-25) **(GP\_ACCESS\_TECH\_IGRT)** | **○** | **○** |
| e. | Intensity-modulated radiation therapy (IMRT)[[25]](#footnote-26) **(GP\_ACCESS\_TECH\_IMRT)** | **○** | **○** |
| f. | 24/7 in house availability of ultrasound for emergency cases **(GP\_ACCESS\_TECH\_247ULTRA)** | **○** | **○** |
| g. | Dedicated interventional radiology (IR) team (techs and nurses) to support IR procedures **(GP\_ACCESS\_TECH\_IRTEAM)** | **○** | **○** |
| h. | Nuclear medicine integrated SPECT/CT[[26]](#footnote-27) **(GP\_ACCESS\_TECH\_SPECTCT)** | **○** | **○** |
| i. | Contrast-enhanced ultrasound[[27]](#footnote-28) **(GP\_ACCESS\_TECH\_CEULTRA)** | **○** | **○** |

**A10.1 Which of the following does your pediatric program offer to ensure quality and patient safety (e.g., reduce exposure to radiation)?**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Yes** | **No** |
| a. | An MRI safety program compliant with the American College of Radiology (ACR) guidelines **(GP\_REDUCE\_MRI)** | **○** | **○** |
| b. | Participation in the ACR CT dose index registry OR use of dose monitoring software for tracking pediatric patients undergoing CT scans **(GP\_REDUCE\_CT)** | **○** | **○** |
| c. | Dedicated MRI Safety Officer[[28]](#footnote-29) **(GP\_REDUCE\_SAFETY)** | **○** | **○** |

**A10.2 This question has been removed from the survey.**

**A10.3 This question has been removed from the survey.**

**A10.4 This question has been removed from the survey.**

**A10.5 This question has been removed from the survey.**

1. **This question has been removed from the survey.**
2. **Do pediatric patients and their families have direct access to the following providers via a telephone number, paging system, or electronic means such as email rather than first requiring a referral?** [Note that this may include an initial screening or intake system that identifies the need for accessing these services and connects the patient or their family to these services. If you have an existing mechanism in place like this whereby patients can easily access these services, then you should indicate that they provide this access.]

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Yes** | **No** |
| a. | Certified child-life specialists **(GP\_PHONE\_ACCESS\_CHILDLIFE)** | **○** | **○** |
| b. | Family support specialists[[29]](#footnote-30) **(GP\_PHONE\_ACCESS\_FAMILY)** | **○** | **○** |
| c. | Pediatric behavioral health support (psychologists, psychiatrists, licensed clinical social workers, other licensed counselors, etc.) **(GP\_PHONE\_ACCESS\_PSYC)** | **○** | **○** |

**A12.1 Do pediatric patients and their families have direct access to interpreters (with at least 50% certified through the National Board of Certification for Medical Interpreters or the Certification Commission for Healthcare Interpreters) either in-person or through electronic means for medical, imaging and surgical discussions when needed?**

**(GP\_INTERPRETERS)**

* Yes, direct access to both in-person interpreters and interpreters through electronic means
* Yes, direct access to in-person interpreters only
* Yes, direct access to interpreters through electronic means only
* No

1. **Do pediatric patients and their families have direct access to the following inpatient services?**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Yes** | **No** |
| a. | Family resource center[[30]](#footnote-31) **(GP\_DRT\_ACCESS\_FAMILYRES)** | **○** | **○** |
| b. | Sleep areas for family members or guardians (**GP\_DRT\_ACCESS\_SLEEP)** | **○** | **○** |
| c. | School intervention program[[31]](#footnote-32) **(GP\_DRT\_ACCESS\_INTERVENTION)** | **○** | **○** |
| d. | Ronald McDonald House or other residential facility for parents convenient to the hospital **(GP\_DRT\_ACCESS\_MCDONALD)** | **○** | **○** |

1. **Do you have a parent advisory committee that meets at regular intervals?**

**(GP\_ADVCOMMI)**

* Yes – Go to A14.1
* No – Skip to A15

**A14.1 If “yes” to A14, how frequently does your parent advisory committee meet (either in-person or virtually) during the year?** (Please note that we are interested in the number of times you actually meet rather than how often the committee is scheduled to meet during the year.)

**(GP\_FRE\_COMMIA)**

* 1 time
* 2 or 3 times
* 4 or 5 times
* 6 or 7 times
* 8 times or more

1. **Please answer the following questions about parent/family member involvement in your pediatric program.**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Yes** | **No** |
| a. | Does at least one parent or family member of a current or former patient serve as an active voting member on the strategic or facility planning committee for your pediatric program? **(GP\_PAFA\_INVOLVE\_STRATEGIC)** | **○** | **○** |
| b. | Does at least one parent or family member of a current or former patient serve as an active voting member on one or more standing committees (e.g., quality, patient safety, and ethics)? **(GP\_PAFA\_INVOLVE\_COMMITTEE)** | **○** | **○** |
| c. | Can parents or family members participate in clinical care decision making processes such as care conferences in your pediatric program? **(GP\_PAFA\_INVOLVE\_DECISION)** | **○** | **○** |
| d. | Can parents or family members participate in family-centered rounds in all services of your pediatric program? **(GP\_PAFA\_INVOLVE\_ROUNDS)** | **○** | **○** |

**A15.1 If “yes” to any part of A15, please describe what roles parents or family members serve in on committees and clinical decision-making process, and what kind of an impact this has had on your pediatric program in the last calendar year:**

|  |
| --- |
| **(GP\_PAFA\_INVOLVE\_TEXT)** |

1. **Does your pediatric program publicly report performance data on one or more quality metrics by displaying the data on the hospital's or program's website?**

**(GP\_REP\_PERFORM)**

* + Yes
  + No

**A16.1 If “yes” to A16, please describe the data reported, the frequency of updates, and the means by which the information can be accessed by the public:**

|  |
| --- |
| **(GP\_REPORT\_TEXT)** |

1. **Does the hospital sponsor quality improvement activities (projects) that provide credit to physicians for maintenance of certification[[32]](#footnote-33) (MOC) Part IV (Performance in Practice)?** (Check all that apply)

**(GP\_QI\_MOC\_**

* + Yes, the hospital is approved by the ABMS as a multispecialty portfolio program (MSPP) sponsor **\_MSPP)**
  + Yes, the hospital is approved by ABP as a pediatric portfolio sponsor **\_ABPPORTFOLIO)**
  + Yes, the hospital sponsors one or more projects that are approved by the ABP **\_ABPPROJECTS)**
  + No **\_NO)**

1. **This question has been removed from the survey.**

**A18.1 This question has been removed from the survey.**

1. **As of January 1, 2025, was your hospital designated a Level 1 or 2 *Pediatric* Trauma Center by the American College of Surgeons *or* by your state licensing board?**

**(GP\_TRAUMACNT)**

* + Yes, as a Level 1 Pediatric Trauma Center
  + Yes, as a Level 2 Pediatric Trauma Center
  + No

1. **This question has been removed from the survey.**
2. **This question has been removed from the survey.**

**A21.1 This question has been removed from the survey.**

1. **This question has been removed from the survey.**
2. **This question has been removed from the survey.**

**A23.1 This question has been removed from the survey.**

**A23.2 This question has been removed from the survey.**

**A23.3 Which of the following patient engagement features are currently implemented in your pediatric program’s electronic medical record system?**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Yes** | **No** |
| a. | Patients have online access to medical notes or records **(GP\_EMR\_NOTES)** | ○ | ○ |
| b. | Patients may request a revision to medical notes or records online **(GP\_EMR\_REVISION)** | ○ | ○ |
| c. | Patients are able to schedule visits online[[33]](#footnote-34) **(GP\_EMR\_SCHEDULE)** | ○ | ○ |
| d. | Patients can send/receive electronic messages to medical providers **(GP\_EMR\_EMAIL)** | ○ | ○ |

1. **For inpatient care areas (excluding the Emergency Department), does your pediatric program audit hand hygiene compliance rates by electronic monitoring or direct observation[[34]](#footnote-35) (including secret shoppers) using a tool/form that is standard across your institution?**

**(GP\_HANDHYG)**

* + Yes, via direct observation (including secret shoppers) – Go to Question A25
  + Yes, via a hybrid of direct observation and electronic monitoring – Go to Question A25
  + Yes, via electronic monitoring – Go to Question A25
  + No – Skip to Question A26

1. **This question has been removed from the survey.**
2. **Does your pediatric program currently provide financial support (e.g., salary support or contract agreements) for 1 or more pediatric infectious disease specialist physicians to serve as dedicated[[35]](#footnote-36) physician leaders[[36]](#footnote-37) of your infection prevention program (exclude salary support for medical director of antimicrobial stewardship or emergency preparedness programs)?**

**(GP\_FINSUPPORT)**

* + Yes
  + No – Skip to A27

**A26.1 Please provide the cumulative FTE support for pediatric infectious disease specialist physicians who serve as dedicated physician leaders of your infection prevention program.**

**(GP\_FINSUPPORT\_FTE)**

\_\_\_\_\_\_\_ FTE

NOTES: A26.1 is numeric entry (decimals are allowed).

WARNING: IF A26=Yes AND A26.1=0, DISPLAY: “If no financial support is provided, you must answer No to A26.”

VALIDATE: If A26.1 is not numeric: “A26.1 (FTE): Please enter a numeric value.”

1. **How many Infection Prevention (IP[[37]](#footnote-38)) FTEs within your infection prevention program are dedicated to pediatrics?** [Only include FTEs for IPs who only work within the infection prevention program. Do NOT include FTEs for IPs who split time with other hospital programs (e.g., clinical providers)][If none, please enter 0.]

\_\_\_\_\_\_\_\_ IP FTEs **(GP\_PCT\_IPSCERTI)**

NOTES: A27 is numeric entry (decimals are allowed).

VALIDATE: If A27 is not numeric: “A27 (FTE): Please enter a numeric value.”

SKIP LOGIC: IFA27=0, SKIP TO A28

**A27.1. How many of the IPs[[38]](#footnote-39) in your pediatric program are eligible[[39]](#footnote-40) for certification in infection control by the Certification Board in Infection Control (CBIC)? Of those, how many are certified by the CBIC?** [Please report the number of staff and not a percentage or FTE count.] [If none, please enter 0.]

\_\_\_\_\_\_\_\_ a. Number of Eligible IPs (report # of staff, not FTE) **(GP\_CBIC\_ELIG)**

\_\_\_\_\_\_\_\_ b. Number of Certified IPs (report # of staff, not FTE) **(GP\_CBIC)**

NOTES: A27.1x should be whole number only. Do not allow decimals.

1. **For each of the following categories of healthcare personnel, please indicate if seasonal influenza immunization rates are tracked. If rates are tracked, how many healthcare personnel were eligible[[40]](#footnote-41) for seasonal influenza vaccination between October 1, 2023 and March 31, 2024? Of those eligible personnel, how many received seasonal influenza immunization?** [Note that we have updated the categories to match how hospitals report these data to NHSN.]

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Influenza immunization** | **Yes** | **No** |  | **Total Number of Eligible Healthcare Personnel** | | **Number of Healthcare Personnel Who Received Immunization** |
| a. | Employee healthcare personnel (HCP) who are staff on the facility payroll and receive a direct paycheck from your facility regardless of clinical responsibility or patient contact | **○** | **○** |  | \_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_ |
|  | **(GP\_TRCK\_FLU\_** | **EMP)** | | | **\_ELIG)** | **RECEIVED)** | |
| b. | Licensed independent practitioners (physicians and advanced practice providers) who are affiliated with but do not receive a direct paycheck from your hospital regardless of clinical responsibility or patient contact (include post-residency fellows) | **○** | **○** |  | \_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_ |
|  | **(GP\_TRCK\_FLU\_** | **NONEMP)** | | | **\_ELIG)** | **\_RECEIVED)** | |
| c. | Students, trainees, and volunteers[[41]](#footnote-42) that are affiliated with but do not receive a direct paycheck from your hospital regardless of clinical responsibility or patient contact | **○** | **○** |  | \_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_ |
|  | **(GP\_TRCK\_FLU\_** | **NONEMPOTH)** | | | **\_ELIG)** | **RECEIVED)** | |

NOTES: A28x2 and A28x3 should be whole number only. Do not allow decimals.

VALIDATE: IF A28x1=Yes AND A28x2=(BLANK), DISPLAY: “Please provide a value for eligible personnel or answer No to tracking.

IF A28x1=Yes AND A28x3=(BLANK), DISPLAY: “Please provide a value for personnel receiving immunizations or answer No to tracking.

If A28x3 > A28x2, DISPLAY: “A28x: Number of personnel receiving immunizations cannot be greater than total personnel.”

1. **For each of the following categories of healthcare personnel, please indicate if the adult Tdap booster[[42]](#footnote-43) (combined Tetanus, Diphtheria and Pertussis) immunization rates are tracked. If rates are tracked, how many eligible**[[43]](#footnote-44) **healthcare personnel were employed or providing care as of December 31, 2024. Of this group, how many have evidence of Tdap vaccination as of December 31, 2024?**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | **Tdap immunization** | | **Yes** | | **No** | |  | **Total Number of Eligible Healthcare Personnel** | | **Number of Healthcare Personnel Who Had Evidence of Immunization** |
| a. | | Employee healthcare personnel (HCP) who are staff on the facility payroll and receive a direct paycheck from your facility regardless of clinical responsibility or patient contact | | **○** | | **○** | |  | \_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_ |
|  | | **(GP\_TRCK\_TDAP\_** | | **EMP)** | | | | | **ELIG)** | | **RECEIVED)** |
| b. | | Licensed independent practitioners (physicians and advanced practice providers) who are affiliated with but do not receive a direct paycheck from your hospital regardless of clinical responsibility or patient contact (include post-residency fellows) | | **○** | | **○** | |  | \_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_ |
|  | | **(GP\_TRCK\_TDAP\_** | | **NONEMP)** | | | | | **ELIG)** | **RECEIVED)** | |
| c. | Students, trainees, and volunteers[[44]](#footnote-45) that are affiliated with but do not receive a direct paycheck from your hospital regardless of clinical responsibility or patient contact | | **○** | | **○** | |  | | \_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_ |
|  | **(GP\_TRCK\_TDAP\_** | | **NONEMPOTH)** | | | | | | **\_ELIG)** | | **RECEIVED)** |

NOTES: A29x2 and A29x3 should be whole number only. Do not allow decimals.

VALIDATE: IF A29x1=Yes AND A29x2=(BLANK), DISPLAY: “Please provide a value for eligible personnel or answer No to tracking.

IF A29x1=Yes AND A29x3=(BLANK), DISPLAY: “Please provide a value for personnel receiving immunizations or answer No to tracking.”

If A29x3 > A29x2, DISPLAY: “A29x: Number of personnel receiving immunizations cannot be greater than total personnel.”

**A29.1 Between October 1, 2023 and March 31, 2024, did your pediatric program require all volunteers to receive or provide documentation of influenza vaccination?**

**(GP\_VOL\_FLU)**

* + Yes
  + No

**A29.2 Does your pediatric program require all volunteers to receive or provide documentation of Tdap vaccination?**

**(GP\_VOL\_TDAP)**

* + Yes
  + No

**A29.3 Does your pediatric program (or reporting institution) offer an influenza vaccination program for patients’ families/primary caregivers?**

**(GP\_FLU\_FAMILY)**

* + Yes
  + No

**A29.4 Does your pediatric program (or reporting institution) offer an adult Tdap booster program for patients’ families/primary caregivers?**

**(GP\_TDAP\_FAMILY)**

* + Yes
  + No

**A29.5 This question has been removed from the survey.**

**A29.6 This question has been removed from the survey.**

1. **Does your pediatric program participate in each of the following quality and safety programs?**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Yes** | **No** |
| a. | American College of Surgeons (ACS) National Surgical Quality Improvement Program (NSQIP) **(GP\_QUAL\_NSQIP)** | ○ | ○ |
| b. | Children’s Hospitals’ Solutions for Patient Safety network (SPS)[[45]](#footnote-46) **(GP\_QUAL\_CHSPS)** | ○ | ○ |
| c. | American College of Surgeons (ACS) Children’s Surgery Program **(GP\_QUAL\_ACS)** | ○ | ○ |
| d. | Child Health Patient Safety Organization (or other PSO)  **(GP\_QUAL\_PSO)** | ○ | ○ |
| e. | Other national quality and safety collaborative **(GP\_QUAL\_OTHER)** | ○ | ○ |

SKIP LOGIC: IFA30e = “Yes”, GO TO A30.1. ELSE SKIP TO A31

**A30.1 Please list the “other national quality and safety collaborative” that you are currently participating in. For each organization, please identify what the focus of the activities your facility has engaged in with the collaborative over the last year:**

|  |
| --- |
| **(GP\_SAFETY\_COLLABORATIVE)** |

1. **Does your hospital have any of the following elements of an antimicrobial stewardship program (ASP) currently implemented in your pediatric program?**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Yes** | **No** |
| a. | Actively monitoring internal days of therapy (DOT) of antibiotic use per 1,000 patients **(GP\_ASP\_YEARLY)** | **○** | **○** |
| b. | Restriction or pre-authorization of selected antimicrobials **(GP\_ASP\_PHARM)** | **○** | **○** |
| c. | Prospective review and real time intervention regarding antimicrobial use or “handshake stewardship” **(GP\_ASP\_AUDIT)** | **○** | **○** |
| d. | Use of clinical guidelines in prescribing antimicrobials for community acquired pneumonia **(GP\_ASP\_GUIDE)** | **○** | **○** |
| e. | IV to PO conversion program available to ensure correct dosage **(GP\_ASP\_CONVER)** | **○** | **○** |

SKIP LOGIC: IF any items in A31 = “Yes”, GO TO A31.1. ELSE SKIP TO A32

**A31.1**  **This question has been removed from the survey.**

**A31.2 Does your pediatric program have the following full-time equivalent (FTE)[[46]](#footnote-47) staff who provide support of the antimicrobial stewardship program (ASP)?**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Yes** | **No** |
| a. | Dedicated pharmacist, with at least 1.0 cumulative FTE support for hospitals with at least 250 beds or at least 0.5 cumulative FTE support for hospitals with less than 250 beds **(GP\_ASP\_DEDICATED)** | **○** | **○** |
| b. | Medical director, with at least 0.3 cumulative FTE support **(GP\_ASP\_FTE)** | **○** | **○** |
| c. | Dedicated data analyst, with at least 0.2 cumulative FTE support **(GP\_ASP\_ANALYST)** | **○** | **○** |

**Questions A31.3 through A31.5 are being collected for informational purposes only. They will not be factored into the rankings this year.**

**A31.3 Does your hospital’s antimicrobial stewardship program (ASP) cover ambulatory stewardship?**

**(GP\_ASP\_AMBULATORY)**

* + Yes - Go to Question A31.4
  + No - Skip to Question A31.5

**A31.4**  **If “yes” to A31.3, please describe one ongoing initiative.**

**(GP\_ASP\_AMBULATORY\_TEXT)**

**A31.5 Does your hospital’s antimicrobial stewardship program (ASP) report Antimicrobial Use and Resistance (AUR) to NHSN?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Yes, for all categories** | **Yes, for some categories** | **No** |
| a. | Antimicrobial Use (AU)  (**GP\_ASP\_REPORT\_AU)** | **○** | **○** | **○** |
| b. | Antimicrobial Resistance (**GP\_ASP\_REPORT\_AR)** | **○** | **○** | **○** |

1. **Are the following rapid identification systems available for blood culture isolates in your hospital?**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Yes** | **No** |
| a. | Rapid (within 6 hours) identification system for positive blood cultures to enable differentiation of key Gram positive bacterial pathogens by genus and major mechanisms of resistance **(GP\_ASPCDC\_POLICY)** | **○** | **○** |
| b. | Rapid (within 6 hours) identification system for positive blood cultures to enable differentiation of key Gram negative bacterial pathogens by genus and major mechanisms of resistance **(GP\_ASPCDC\_LETTER)** | **○** | **○** |

1. **Does your hospital’s 2024 NHSN report include a** **standardized infection ratio (SIR) for CLABSI in all pediatric ICUs[[47]](#footnote-48) tracked (excluding the NICU)?** [In order to answer “Yes”, your hospital’s NHSN report must list a value for SIR. The value cannot be missing or “N/A”.]

**(GP\_SIR\_REPORT)**

* + Yes – Go to Question A33.1
  + No – Skip to Question A33.2

**A33.1 Please report your NHSN-generated CLABSI standardized infection ratio (SIR), SIR p-value, and 95% confidence intervals (CI) in the last calendar year, 2024, for all pediatric ICUs tracked, excluding the NICU.** This information is readily available for facilities reporting CLABSI data to NHSN. Regenerate datasets in NHSN before running the report in NHSN Analysis. Note that if your organization has intensive care units in different geographic location under different NHSN identification numbers, please report on the location with the largest number of intensive care beds. [Please note that all hospitals wishing to receive credit for this question will be required to upload a screenshot of their NHSN report with the SIR information when submitting their survey.]

\_\_\_\_\_\_\_\_\_ a. Predicted CLABSI events (numPred) **(GP\_CLABSI\_SIR\_EVENTS)**

\_\_\_\_\_\_\_\_\_ b. CLABSI SIR (SIR) **(GP\_CLABSI\_SIR)**

\_\_\_\_\_\_\_\_\_ c. SIR p-value (SIR\_pval) **(GP\_CLABSI\_PVALUE)**

\_\_\_\_\_\_\_\_\_ d. 95% confidence interval lower (sir95ci) **(GP\_CLABSI\_INTERVALL)**

\_\_\_\_\_\_\_\_\_ e. 95% confidence interval upper (sir95ci) **(GP\_CLABSI\_INTERVALU)**

NOTES: A33.1x is numeric entry (decimals are allowed).

VALIDATE: IF A33.1e < A33.1d DISPLAY: “A33.1d & A33.1e: Please check your confidence interval bounds as the upper interval limit should be greater than the lower interval limit.”

IF A33.1b > A33.1e OR A33.1b < A33.1d DISPLAY, “A33.1b: The CLABSI SIR estimate should be between the two confidence interval bounds. Please double check your responses.”

If A33.1x is not numeric: “A33.1x: Please enter a numeric value.”

**A33.2 Please report your central line-associated bloodstream infection (CLABSI) rates in the last calendar year for all pediatric ICUs tracked, excluding the NICU.**[[48]](#footnote-49)**.** [Calculate as follows: (a.) Determine the number of CLABSI events according to current NHSN guidelines.[[49]](#footnote-50) (b.) Determine the total number of central line days[[50]](#footnote-51) in the last calendar year. (c.) Clicking “Save” will calculate the rate by dividing CLABSI events by central line days and multiplying by 1,000. Responses will be rounded to 2 decimals.]

\_\_\_\_\_\_\_\_ a. CLABSI events **(GP\_CLABSI\_EVENTS)**

\_\_\_\_\_\_\_\_ b. Central line days **(GP\_CLABSI \_DAYS)**

\_\_\_\_\_\_\_\_ c. CLABSI rate **(GP\_CLABSI \_RATE)**

NOTES: A33.2a and A33.2b should be whole number only. Do not allow decimals.

A33.2c is autocalculated and should allow decimals.

VALIDATE: IF A33.2a > A33.2b DISPLAY, “A33.2a: The number of CLABSI events cannot be greater than the number of central line days.”

AUTOCALC: A33.2c = [(A33.2a / A33.2b) \*1000]

**A33.3 This question has been removed from the survey.**

1. **This question has been removed from the survey.**

**A34.1 This question has been removed from the survey.**

1. **Does your hospital offer a multidisciplinary Vascular Tumor (or Vascular Anomalies) Program[[51]](#footnote-52) with representation from pediatric hematology, pediatric surgery, dermatology, diagnostic pediatric radiology, pediatric interventional radiology, pediatric neuro interventional radiology and pediatric orthopedics to address vascular non-malignant tumors?**

**(GP\_VASCULAR\_TUMOR)**

* + Yes
  + No

1. **Does your pediatric program have a formal program to prevent hospital-acquired pressure injury (see code list)?**

**(GP\_ULCERS)**

* + Yes
  + No

1. **Does your pediatric program track the rate of hospital-acquired pressure injuries (see code list) for patients seen on an inpatient basis?**

**(GP\_ULCERS\_TRACK)**

* + Yes—Go to Question A38.1
  + No—Skip to Question A39
  + N/A, We treat only NICU patients – Skip to Question A39

**A38.1 This question has been removed from the survey.**

**A38.2 This question has been removed from the survey.**

**A39. This question has been removed from the survey.**

**A39.1 This question has been removed from the survey.**

**A40. This question has been removed from the survey.**

**A41. Does your pediatric program have a physician or nurse serving as a designated Chief Quality Officer and/or a Chief Safety Officer? If yes, how much of their time is designated to cover this role?**

**(GP\_DESIGNATED\_CSO)**

* Yes, > 0.75 FTE
* Yes, 0.50-0.74 FTE
* Yes, 0.25-0.49 FTE
* Yes, < 0.25 FTE
* No

**Health Disparities, Equity, and Inclusion in Children’s Hospitals**

Note that the following questions ask about your children’s hospital or healthcare system. We acknowledge that children’s hospitals engage in Diversity[[52]](#footnote-53), Equity[[53]](#footnote-54), and Inclusion[[54]](#footnote-55) efforts at varying levels within their system of care, including at associated facilities such as an adult hospital, outpatient clinics, community programs and across the broader healthcare system within which the pediatric and adolescent services are provided. When we use the phrase “children’s hospital (or healthcare system)” we are referring to programs that impact your children’s hospital (and associated clinics, programs, etc.) whether or not they are led by the children’s hospital.

**A42. [This item is optional in 2025.] Does your children’s hospital (or healthcare system) directly collect self-reported, or parent/caregiver provided data about the following characteristics of the pediatric and adolescent patients who receive services at your facilities?** [Note these data may be collected via electronic portals or pre-visit questionnaires, at admission, at the first encounter, when receiving outpatient primary or specialty care, inpatient care, or some other type of care within the hospital.]

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | **Yes, for most patients (>75%)[[55]](#footnote-56)** | **Yes, for some patients (25-75%)** | **No, or only for a few patients (< 25% of patients)** | **N/A, unable to collect information due to state laws[[56]](#footnote-57)** |
|  | Race[[57]](#footnote-58) | ○ | ○ | ○ | ○ |
|  | **(GP\_DATA\_PRACE)** |  |  |  |  |
|  | Ethnicity[[58]](#footnote-59) | ○ | ○ | ○ | ○ |
|  | **(GP\_DATA\_PETHNICITY)** |  |  |  |  |
|  | Biological sex (assigned at birth) | ○ | ○ | ○ | ○ |
|  | **(GP\_DATA\_PSEX)** |  |  |  |  |
|  | Gender identity[[59]](#footnote-60) | ○ | ○ | ○ | ○ |
|  | **(GP\_DATA\_PGENDERID)** |  |  |  |  |
|  | Sexual orientation[[60]](#footnote-61) | ○ | ○ | ○ | ○ |
|  | **(GP\_DATA\_PSORIENT)** |  |  |  |  |
|  | Primary language for health care[[61]](#footnote-62) | ○ | ○ | ○ | ○ |
|  | **(GP\_DATA\_PLANG)** |  |  |  |  |
|  |  |  |  |  |  |

**A42.1. [This item is optional in 2025.] Does your hospital currently review patient demographic information collected in A42 against your risk data for hospital acquired conditions, infections, event reports, patient complaints, medical errors, or other indicators to identify disparities and opportunities for quality improvement?**

**(GP\_DIVERSE\_DATA\_REVIEW)**

* + Yes – go to A42.2
  + No – Skip to A43

**A42.2 This question has been removed from the survey.**

**A43. [This item is optional in 2025.] Does your children’s hospital (or healthcare system) collect data directly from patients, parents/caregivers about the following characteristics of parents/caregivers of pediatric and adolescent patients who receive services at your facilities?** [Note these data may be collected via electronic portals or pre-visit questionnaires at admission, at the first encounter, when receiving outpatient primary or specialty care, inpatient care, or some other type of care within the hospital. Please consider your entire patient population when selecting your response.]

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | **Yes, for most parents/caregivers (>75%)** | **Yes, for some parents/caregivers (25-75%)** | **No, or only for a few patients (<25% of patients)** | **N/A, unable to collect information due to state laws[[62]](#footnote-63)** |
|  | Highest level of education of either parent(s)/guardian(s) | ○ | ○ | ○ | ○ |
|  | **(GP\_DATA\_CPARENT\_EDU)** |  |  |  |  |
|  | Financial security/insecurity | ○ | ○ | ○ | ○ |
|  | **(GP\_DATA\_CINCOME)** |  |  |  |  |
| c. | Primary language for health care[[63]](#footnote-64) | ○ | ○ | ○ | ○ |
|  | **(GP\_DATA\_CLANG)** |  |  |  |  |
| d. | Household food security[[64]](#footnote-65) | ○ | ○ | ○ | ○ |
|  | **(GP\_DATA\_CFOOD)** |  |  |  |  |
| e. | Housing security[[65]](#footnote-66) | ○ | ○ | ○ | ○ |
|  | **(GP\_DATA\_CHOUSING)** |  |  |  |  |

**A44. [This item is optional in 2025.] Does your children’s hospital (or healthcare system) review data collected about differences in care (access, quality, safety, or outcomes) with oversight boards[[66]](#footnote-67) as they relate to the following categories/factors?** [Check all that apply.]

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | **Yes, with the primary/ overarching children’s hospital board** | **Yes, with some other oversight board** | **No** | **N/A, unable to collect information due to state laws[[67]](#footnote-68)** |
| a. | Race and Ethnicity | ¨ | ¨ | ¨ | ¨ |
|  | **(GP\_BOARD\_RACETH\_** | **PRIMARY)** | **OTHER)** | **NO)** | **NA)** |
| b. | Sexual orientation and/or gender identity | ¨ | ¨ | ¨ | ¨ |
| **-** | **(GP\_BOARD\_SEXGEND\_** | **PRIMARY)** | **OTHER)** | **NO)** | **NA)** |
| c. | Financial security/insecurity | ¨ | ¨ | ¨ | ¨ |
|  | **(GP\_BOARD\_SES\_** | **PRIMARY)** | **OTHER)** | **NO)** | **NA)** |
| d. | Primary language for health care | ¨ | ¨ | ¨ | ¨ |
|  | **(GP\_BOARD\_PLANG\_** | **PRIMARY)** | **OTHER)** | **NO)** | **NA)** |
| e. | Insurance status (or payer source) | ¨ | ¨ | ¨ | ¨ |
|  | **(GP\_BOARD\_PAYER\_** | **PRIMARY)** | **OTHER)** | **NO)** | **NA)** |
| f. | Food and/or Housing Security/Insecurity | ¨ | ¨ | ¨ | ¨ |
|  | **(GP\_BOARD\_SECURITY\_** | **PRIMARY)** | **OTHER)** | **NO)** | **NA)** |

NOTES: Allow multiple “yes” responses, but “no” and “NA” should be mutually exclusive (i.e., cannot be selected with any other responses.)

**A45. [This item is optional in 2025.] For what percent of patients and families/caregivers are screening data for one or more of the following social drivers (determinants) of health (such as economic stability, education, community/social context, health and health care access/quality, neighborhood/physical environment)[[68]](#footnote-69) recorded in your children’s hospital (or healthcare system) electronic medical record (EMR)?** [Please include patient care from inpatient, specialty clinic, primary care, emergency department, and urgent care visits.]

**(GP\_SDOH)**

* + 50% or more of patients
  + 25-49% of patients
  + Less than 25% of patients

**A46. [This item is optional in 2025.] Has your children’s hospital (or healthcare system) implemented any quality improvement projects designed to address a specific known health disparity (for characteristics covered in question A42 and A43), with your patient population or community?**

**(GP\_QUALITY\_PROJECTS)**

* + Yes – Go to A46.1
  + No – Skip to A47

**A46.1 This question has been removed from the survey.**

**A47. [This item is optional in 2025.] Which of the following elements of a diversity, equity, and inclusion (DEI) program are currently present at your children’s hospital[[69]](#footnote-70) (or healthcare system)?**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Yes** | **No** |
|  | Have established a formal DEI program dedicated to your children’s hospital(s) | ○ | ○ |
|  | **(GP\_DEI\_PROG\_EST)** |  |  |
|  | Have a designated leader for DEI (such as a Health Equity Officer) in a senior leadership position dedicated to your children’s hospital(s) | ○ | ○ |
|  | **(GP\_DEI\_PROG\_DESIG)** |  |  |
|  | Provide at least 0.75 FTE support for DEI leadership position(s)[[70]](#footnote-71) dedicated to your children’s hospital(s) | ○ | ○ |
|  | **(GP\_DEI\_PROG\_DFTE)** |  |  |
|  | DEI program is provided with at least 0.5 FTEs of administrative support staff (e.g., administrative assistant, program coordinator, etc.) dedicated to your children’s hospital(s) | ○ | ○ |
|  | **(GP\_DEI\_PROG\_AFTE)** |  |  |
|  | Your DEI program has a separate budget from other activities at your children’s hospital or healthcare system | ○ | ○ |
|  | **(GP\_DEI\_PROG\_BUDGET)** |  |  |
|  | Your DEI program works across your children’s hospital or healthcare system to collaborate with other departments or programs that have related objectives (e.g., community outreach, human resources, faculty affairs) | ○ | ○ |
|  | **(GP\_DEI\_PROG\_COLLAB)** |  |  |

**A48. [This item is optional in 2025.] Has your children’s hospital (or healthcare system) established strategic objectives[[71]](#footnote-72) to increase the number and inclusion/participation of individuals from groups historically underrepresented in medicine (URiM)**[[72]](#footnote-73) **in your clinical providers who provide direct patient care (e.g., physicians, physician assistants, nurse practitioners, nurses, psychologists, and social workers)?**

**(GP\_DIVERSE\_FACULTY\_OBJECTIVES)**

* + Yes – Go to Question A49
  + No – Skip to Question A50

**A49. This question has been removed from the survey.**

**A50. [This item is optional in 2025.] Has your children’s hospital (or healthcare system) established strategic objectives to improve the representation of your senior leadership team (e.g., chief medical officer, chief nursing officer, chief legal officer, chief executive officer, or department chair, etc.)?**

**(GP\_DIVERSE\_LEAD\_OBJECTIVES)**

* + Yes
  + No

**A51. [This item is optional in 2025.] Does your children’s hospital (or healthcare system) currently offer trainings[[73]](#footnote-74) on the following topics for providers (physicians, physician assistants, and nurse practitioners) and other bedside staff (nurses, psychologists, social workers, physical therapists, occupational therapists, etc.) to participate in?**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Physicians, Physician Assistants, and Nurse Practitioners** | | | | | **Nurses and other bedside staff** | | |
| **The importance/significance of the following on care delivery to patients and their families:** | |  | **Yes, offered** | | **No** | |  | **Yes, offered** | **No** |
| a. | Foundations of Diversity, Equity, and Inclusion[[74]](#footnote-75) |  | | ○ | | ○ |  | ○ | ○ |
|  | **(GP\_TRAINING\_DIVERSELEAD** |  | | **\_CLINICAL)** | | |  | **\_BEDSIDE)** | |
| b. | Effective communication[[75]](#footnote-76), including language diversity |  | | ○ | | ○ |  | ○ | ○ |
|  | **(GP\_TRAINING\_COMM** |  | | **\_CLINICAL)** | | |  | **\_BEDSIDE)** | |
| c. | Gender identity[[76]](#footnote-77) |  | | ○ | | ○ |  | ○ | ○ |
|  | **(GP\_TRAINING\_GENDERID** |  | | **\_CLINICAL)** | | |  | **\_BEDSIDE)** | |
| d. | Inclusive hiring[[77]](#footnote-78) |  | | ○ | | ○ |  | ○ | ○ |
|  | **(GP\_TRAINING\_GENDEREQ** |  | | **\_CLINICAL)** | | |  | **\_BEDSIDE)** | |
| e. | Sexual orientation[[78]](#footnote-79) |  | | ○ | | ○ |  | ○ | ○ |
|  | **(GP\_TRAINING\_SORIENT** |  | | **\_CLINICAL)** | | |  | **\_BEDSIDE)** | |
| f. | Cultural responsiveness/cultural humility[[79]](#footnote-80) |  | | ○ | | ○ |  | ○ | ○ |
|  | **(GP\_TRAINING\_CULTURE** |  | | **\_CLINICAL)** | | |  | **\_BEDSIDE)** | |
| g. | Human trafficking[[80]](#footnote-81) |  | | ○ | | ○ |  | ○ | ○ |
|  | **(GP\_TRAINING\_TRAFFIC** |  | | **\_CLINICAL)** | | |  | **\_BEDSIDE)** | |
| h. | Principles of trauma-informed care[[81]](#footnote-82) |  | | ○ | | ○ |  | ○ | ○ |
|  | **(GP\_TRAINING\_TRAUMA** |  | | **\_CLINICAL)** | | |  | **\_BEDSIDE)** | |
| i. | Child abuse/neglect[[82]](#footnote-83) |  | | ○ | | ○ |  | ○ | ○ |
|  | **(GP\_TRAINING\_ABUSE** |  | | **\_CLINICAL)** | | |  | **\_BEDSIDE)** | |
| j. | Impact of the social drivers (determinants) of health[[83]](#footnote-84) |  | | ○ | | ○ |  | ○ | ○ |
|  | **(GP\_TRAINING\_DRIVE** |  | | **\_CLINICAL)** | | |  | **\_BEDSIDE)** | |

**A52. Does your hospital display data on your hospital website for each of the following quality metrics?**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Yes** | **No** |
| a. | CLABSI | ○ | ○ |
|  | **(GP\_QIDATA\_CLABSI**) |  |  |
| b. | Hand hygiene compliance | ○ | ○ |
|  | **(GP\_QIDATA\_HANDHYG)** |  |  |
| c. | Patient experience | ○ | ○ |
|  | **(GP\_QIDATA\_PATEXP**) |  |  |
| d. | Surgical site infection after specified procedures | ○ | ○ |
|  | **(GP\_QIDATA\_SSI)** |  |  |
| e. | Other quality metric | ○ | ○ |
|  | **(GP\_QIDATA\_OTHER)** |  |  |

**A53. Does your pediatric program currently provide financial support (e.g., salary support or contract agreements) for 1 or more physicians to serve as dedicated physician leaders[[84]](#footnote-85) of your outbreak response/incident management/emergency preparedness program (exclude salary support for medical director of your infection prevention and antimicrobial stewardship programs)?**

**(GP\_OUTBREAK\_PHYS\_DEDICATED)**

* + Yes – go to A53.1
  + No – Skip to A54

**A53.1 Please provide the cumulative FTE support for physicians who serve as dedicated physician leaders of your outbreak response/incident management/emergency preparedness program?**

\_\_\_\_\_\_\_ FTE **(GP\_OUTBREAK\_SUPPORT\_FTE)**

NOTES: A53.1 is numeric entry (decimals are allowed).

VALIDATE: If A53.1 is not numeric: “A53.1: Please enter a numeric value.”

**The following are being collected for information purposes only. They will not be factored into the rankings this year.**

**A54. This question has been removed from the survey.**

**A54.1. This question has been removed from the survey.**

**A55. Does your hospital have the following programs or resources devoted to creating a positive work environment and encouraging physician wellness?**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Yes** | **No** |
| a. | Physician peer-to-peer counseling program to ensure physician wellness when physicians experience a workplace event (i.e. surgical complication, safety event, warning signs of burn out, etc.) | ○ | ○ |
|  | **(GP\_WELLNESS\_COUNSELING**) |  |  |
| b. | Chief Wellness Officer with dedicated resources and budget | ○ | ○ |
|  | **(GP\_WELLNESS\_OFFICER** |  |  |
| c. | A program to ensure physician retention and reduce physician turnover | ○ | ○ |
|  | **(GP\_WELLNESS\_RETENTION**) |  |  |
| d. | A program to track physician work hours or EMR use outside of clinical hours | ○ | ○ |
|  | **(GP\_ADMIN\_HOURS**) |  |  |

**A56. Does your hospital take the following measures to reduce administrative burden?**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Yes** | **No** |
| a. | Provide a mechanism for non-physician team members (other than nurse practitioners and physician assistants) to place orders on behalf of physicians | ○ | ○ |
|  | **(GP\_ADMIN\_ORDERS)** |  |  |
| b. | Provide ‘Scribes’ or ‘Speech Recognition Software’ to aid with clinical documentation | ○ | ○ |
|  | **(GP\_ADMIN\_SCRIBES**) |  |  |

**A57. This question has been removed from the survey.**

**A58.**  **This question has been removed from the survey.**

**A59. Does your hospital’s 2024 NHSN report include a standardized infection ratio (SIR) for all pediatric inpatients (i.e., “whole house” CLABSI rate)?** [In order to answer “Yes”, your hospital’s NHSN report must list a value for SIR. The value cannot be missing or “N/A”.]

**(GP\_INPAT\_SIR\_REPORT)**

* + Yes – Go to Question A59.1
  + No – Skip to Question A59.2

**A59.1. This question has been removed from the survey.**

**A59.2. This question has been removed from the survey.**

**A60. This question has been removed from the survey.**

**A60.1. This question has been removed from the survey.**

**A60.2 This question has been removed from the survey.**

**A60.3 This question has been removed from the survey.**

**COMMENTS FOR SECTION A:**

If needed, you may provide clarifications to the responses you provided to the questions asked in this section only. All other comments, suggestions or questions should be sent to [PediatricHospSurvey@rti.org](mailto:PediatricHospSurvey@rti.org).

|  |
| --- |
| **(GP\_COMMENTS)** |

1. For hospitals with labor and delivery services, only include newborns that were admitted to the pediatric program for care in the NICU, PICU, or one of the inpatient pediatric specialty units (pulmonology, neurology, oncology, etc.). [↑](#footnote-ref-2)
2. Inpatient days divided by the number of days that the hospital was open (e.g., 365). Please include all patients admitted to the hospital, including short stays and observation stays. [↑](#footnote-ref-3)
3. Please report only operating beds, not constructed bed capacity that is not currently in use. Include all bed facilities that are set up and staffed for use by pediatric inpatient care, including NICU beds. Exclude beds that have been newly constructed but are not yet in use and all temporary beds such as post anesthesia, postoperative recovery room beds, psychiatric holding beds, and beds that are used only as holding facilities for patient prior to a transfer to another hospital. [↑](#footnote-ref-4)
4. Calculate FTEs based on total paid hours for the period of review divided by 2080. Note that 2080 must be used for this calculation even if your hospital typically uses a different value for the total hours annually for an FTE. [↑](#footnote-ref-5)
5. On-call staff must be available to attend patients on-site if required. [↑](#footnote-ref-6)
6. Note that board eligible is now defined by the American Board of Pediatrics as a care provider out of training <7 years; beyond this window, all physicians being counted in this question must be board certified to be included. If a provider does not meet the board eligible or board-certified criteria, then they may not be counted. [↑](#footnote-ref-7)
7. May count if available 7 days a week, but not 24 hours a day. [↑](#footnote-ref-8)
8. Critical care surgeons are surgeons board certified or board eligible in both pediatric general survey and surgery critical care. [↑](#footnote-ref-9)
9. A NICU provides mechanical ventilation, neonatal surgery, and special care for the sickest infants, including those with the lowest birth weights (below 1,500 grams), who are born in the hospital or transferred from another institution. The NICU is separate from the newborn nursery. A full-time neonatologist serves as director. [↑](#footnote-ref-10)
10. A PICU is staffed with specially trained personnel and has monitoring and specialized support equipment for treating pediatric patients who, because of shock, trauma, or other life-threatening conditions, require intensified, comprehensive observation and care. [↑](#footnote-ref-11)
11. The Protective Environment incorporates the following: air exchanges > 12 per hour; central or point-of-use high-efficiency particulate (HEPA) filters, consistent positive air pressure differentials between the patient’s room and hallway and continuous monitoring of pressure differentials. [↑](#footnote-ref-12)
12. A genetic testing/counseling service is equipped with the appropriate laboratory facilities and is directed by a physician qualified to advise parents and prospective parents on potential problems in cases of genetic defects. A genetic test is the analysis of human DNA, RNA, chromosomes, proteins, and certain metabolites in order to detect heritable disease-related genotypes, mutations, phenotypes, or karyotypes for clinical purposes. Genetic tests can have diverse purposes, including the diagnosis of genetic diseases in newborns, children, and adults; the identification of future health risks; the prediction of drug responses; and the assessment of risks to future children. [↑](#footnote-ref-13)
13. A palliative care program is organized and staffed for children nearing the end of life or living with lifespan-limiting conditions. The program’s purpose is to minimize pain and discomfort, provide emotional and spiritual support for children and their families, assist with financial guidance and social services, and support decision making. Programs must include at least one physician providing direct patient care; a nurse coordinator; and a social worker, certified child-life specialist, or pastoral counselor. All program staff must have training in palliative care. [↑](#footnote-ref-14)
14. This program provides either a rehabilitation unit and/or a consultation service within the pediatric program for patients requiring rehabilitation. The program must include a pediatric physiatrist (board certified/board eligible pediatric rehabilitation physician) as the director. [↑](#footnote-ref-15)
15. This program should focus on managing health concerns of the mother and fetus prior to, during, and shortly after pregnancy. [↑](#footnote-ref-16)
16. This program works with schools, leagues, and youth athletic organizations to encourage best practices to reduce the likelihood of injuries during training, games, and other activities. [↑](#footnote-ref-17)
17. Administered by specially trained physicians and other clinicians, this is a recognized clinical service or program providing specialized medical care, drugs, or therapies for the management of acute or chronic pain and other distressing symptoms among children suffering from an acute illness of diverse causes. To say “yes” to this item, the program must include outpatient pain management services available to cancer patients. [↑](#footnote-ref-18)
18. This service provides monitored anesthesia care and sedation within the hospital (but not within an operating room or PICU), as well as emergency airway management and acute and chronic pain management for neonates and pediatric patients on a 24-hour basis. A qualified program must have at least an identified medical director (e.g., general pediatrician, pediatric subspecialist, or anesthesiologist) with documented education in pediatric sedation (e.g., minimal sedation, moderate sedation/analgesia, deep sedation, and general anesthesia) and an RN coordinator (or pain management clinical nurse specialist). [↑](#footnote-ref-19)
19. https://pedsedation.org/resources/quality-safety/center-of-excellence/ [↑](#footnote-ref-20)
20. For purposes of this question, these technologies would need to be available within the pediatric facility, a physically connected medical center, or an affiliated medical center within the same city. If available at another location beyond this, hospitals should answer no to this question. [↑](#footnote-ref-21)
21. PET scanning is a computerized nuclear medicine imaging technology that uses radioactive (positron-emitting) isotopes created in a cyclotron or generator to produce composite images of the brain and heart activity. The scans are sectional images depicting metabolic activity or blood flow rather than anatomy. [↑](#footnote-ref-22)
22. PET/CT combines the capabilities of PET and CT scanning into a single integrated device, which provides metabolic functional information for monitoring chemotherapy, radiotherapy, and surgical planning. [↑](#footnote-ref-23)
23. 3T MRI is a higher-powered version of MRI that offers improved morphological and functional studies of the brain compared with the more common field strength of 1.5T. [↑](#footnote-ref-24)
24. IGRT is an automated system that produces high-resolution x-ray images to pinpoint tumor sites, adjust patient positioning, and generally make treatment more effective and efficient. [↑](#footnote-ref-25)
25. IMRT is a three-dimensional radiation therapy that improves the targeting of treatment delivery in a way that is likely to decrease damage to normal tissues and allows for varying intensities. [↑](#footnote-ref-26)
26. This version of nuclear medicine superimposes images obtained from the exposure to small amounts of radioactive materials with integrated single photon emission computed tomography/computed tomography (SPECT/CT) or [computed tomography](https://www.radiologyinfo.org/en/glossary/glossary.cfm?gid=22) (CT) to produce image fusion or co-registration images for the diagnosis of a variety of medical disorders and conditions. [↑](#footnote-ref-27)
27. Contrast-enhanced ultrasound involves the administration of IV or intracavitary (e.g., intravesical) contrast agents containing [microbubbles](https://radiopaedia.org/articles/microbubbles) of of perflutren, octafluoropropane, or sulfur hexafluoride gas. The technique has the advantage over fluoroscopy, contrast-enhanced MRI and CT in children as it eliminates the need of radiation exposure, sedation or anesthesia, and can be administered in those with reduced renal function as well as being conducive for repeated administration. [↑](#footnote-ref-28)
28. MRI Safety Officer is a member of your medical staff who is required to review and ensure safety standards are being followed. Standards can be found at the ACR website at: https://www.acr.org/Clinical-Resources/Radiology-Safety/MR-Safety. [↑](#footnote-ref-29)
29. Family support specialists help families meet practical needs (e.g., school coordination, transportation, lodging, etc.), information needs (e.g., family resource center, access information, etc.), and in some cases making appropriate connections back to their child's clinical treatment team. The primary goal of the family support specialist is to facilitate meeting the practical and information needs of families of patients being seen for care at your hospital. Note that hospitals may use a variety of different types of staff (e.g., social workers, case managers) to facilitate the role described above; if this function/role is covered by your staff, a hospital may say yes to this question. [↑](#footnote-ref-30)
30. Family resource centers should provide patients and families access to a wide variety of information about child and maternal health and well-being. To receive credit, a hospital must have paid staff that are designated to run and support the center. [↑](#footnote-ref-31)
31. A school intervention program works with the patient, the family, and the school to sensitize schools to the needs of the patient. The school intervention program must include a) a provision for providing education services during prolonged hospitalizations, and b) transition services for return to school after change in medical, functional, or cognitive status. [↑](#footnote-ref-32)
32. Certification of quality improvement programs and projects by the American Board of Pediatrics requires a detailed submission of plans that meet criteria for planning, data collection, measurement and follow-up on quality projects. See: https://www.abp.org/content/maintenance-certification-moc [↑](#footnote-ref-33)
33. This may include both direct scheduling by patients (or their families) online or by requesting an appointment using scheduling tool online with review by clinical staff to ensure correct specialists are scheduled. [↑](#footnote-ref-34)
34. Direct observers (including secret shoppers) are individuals who are trained hand hygiene monitors. This should not include patient or family observations. [↑](#footnote-ref-35)
35. Here, “dedicated” is intended to mean that medical staff have specific clinic time on the calendar each month devoted to this program at the exclusion of other responsibilities. [↑](#footnote-ref-36)
36. Includes financial support for the medical director or healthcare epidemiologist serving as the overall leader and additional roles such as associate/assistant medical director or associate/assistant hospital epidemiologist but does not include financial support specifically for antimicrobial stewardship or outbreak response/incident management/emergency preparedness. [↑](#footnote-ref-37)
37. IPs are typically nurses, medical technologists or epidemiologist who play specific roles in hospital infection prevention. Include all IPs, not just those eligible to sit for certification. The intent of the question is to examine the certification rate of everyone doing the work, not just those who are eligible. [↑](#footnote-ref-38)
38. IPs are typically nurses, medical technologists or epidemiologist who play specific roles in hospital infection prevention. Include all IPs, not just those eligible to sit for certification. The intent of the question is to examine the certification rate of everyone doing the work, not just those who are eligible. [↑](#footnote-ref-39)
39. In order to be eligible to take the initial certification exam, a candidate must meet all of the requirements defined by the CBIC (<https://www>.cbic.org/CBIC/Candidate-Handbook/Eligibility-Requirements/Updated-CIC-Eligibility-Requirements.htm) at the time of application. [↑](#footnote-ref-40)
40. Eligible” healthcare personnel, as defined by NHSN, includes all personnel who have worked at the facility for at least 1 working day between October 1, 2023 and March 31, 2024 during the reporting period, regardless of clinical responsibility or patient contact. This includes healthcare personnel who joined after October 1, 2023 or left before March 31, 2024 or who were on extended leave during part of the reporting period. Working for any number of hours a day counts as one working day. Personnel should be counted as individuals rather than full-time equivalents. Licensed practitioners including those who receive and do not receive a direct paycheck from the reporting facility, or who are owners of the reporting facility, should be counted as employees; note that this means that other physicians who are not employed by the hospital or are owners do not need to be counted. Include staff who refuse immunizations for personal reasons as eligible healthcare personnel. For more information see NHSN guidelines: <https://www.cdc.gov/nhsn/pdfs/hps-manual/vaccination/hps-flu-vaccine-protocol-508.pdf> [↑](#footnote-ref-41)
41. Include medical, nursing, or other health professional students, interns, medical residents, or volunteers aged 18 or older. [↑](#footnote-ref-42)
42. The adult Tdap booster refers to the vaccine that has been available since 2005 and does not refer to childhood immunization. For more information see NHSN guidelines: <https://www.cdc.gov/vaccines/hcp/vis/vis-statements/tdap.html> [↑](#footnote-ref-43)
43. “Eligible” healthcare personnel include all personnel who have worked at the facility for at least 1 working day as of December 31, 2024, regardless of clinical responsibility or patient contact. This includes healthcare personnel who joined after October 1 or left before December 31, or who were on extended leave during part of the reporting period. Working for any number of hours a day counts as one working day. Personnel should be counted as individuals rather than full-time equivalents. Licensed practitioners including those who receive and do not receive a direct paycheck from the reporting facility, or who are owners of the reporting facility, should be counted as employees; note that this means that other physicians who are not employed by the hospital or are owners do not need to be counted. Include staff who refuse immunizations for personal reasons as eligible healthcare personnel. For more information see NHSN guidelines: <https://www.cdc.gov/nhsn/pdfs/hps-manual/vaccination/hps-flu-vaccine-protocol-508.pdf> [↑](#footnote-ref-44)
44. Include medical, nursing, or other health professional students, interns, medical residents, or volunteers aged 18 or older. [↑](#footnote-ref-45)
45. This program was previously known as the Ohio Children’s Hospital Solutions for Patient Safety learning network (OCHSPS). The program focuses on an array of hospital quality measures and is available to hospitals nationally. [↑](#footnote-ref-46)
46. Calculate FTEs based on total paid hours for the period of review divided by 2080. [↑](#footnote-ref-47)
47. Please consider requesting from the NHSN a custom report if your hospital is reporting for a PICU, NICU, SICU or other ICU on the survey from more than one location. For additional guidance on joint submissions please contact the Best Children’s Hospitals Project at PediatricHospSurvey@rti.org. [↑](#footnote-ref-48)
48. Exclude numbers from NICU, oncology ICUs, and non-PICU stem cell transplant units. [↑](#footnote-ref-49)
49. For the most recent NHSN definition of CLABSI, see the following: <https://www.cdc.gov/nhsn/pdfs/pscmanual/pcsmanual_current.pdf>. As per these instructions, only include lab-confirmed CLABSI cases (do not include clinical sepsis) and exclude MBI-CLABSI. [↑](#footnote-ref-50)
50. According to NHSN guidelines, a patient with one or more central lines on a given day equals 1 central line day. [↑](#footnote-ref-51)
51. This program brings together a multidisciplinary team of specialists to diagnose and ensure the most effective treatment for optimal functioning and quality of life for children with vascular anomalies (tumors or malformations). To be eligible, a program must have at least three of the following: pediatric physicians in Dermatology, Hematology, Diagnostic Radiology, Interventional Radiology, Pediatric Surgery, Pediatric Neuro-interventional Radiology and Pediatric Orthopedics, to diagnose and provide optimal treatment for pediatric patients with vascular malformations. The program must also include a nursing clinical coordinator and a medical director. [↑](#footnote-ref-52)
52. The presence of different and multiple characteristics that make up individual and collective identities, including race, gender, age, religion, sexual orientation, ethnicity, national origin, socioeconomic status, language, and physical ability. In the context of healthcare delivery of healthcare, diversity applies to both having a wide mix of patients that represent the community and providers that reflect the community of patients being seen. This concept also plays a role in the leadership of healthcare organizations, seeking to include people from a wide variety of backgrounds and characteristics in roles across the organization. [↑](#footnote-ref-53)
53. The process of identifying and removing the barriers that create disparities in the access to resources and means, and the achievement of fair treatment and equal opportunities to thrive. In the context of health these means working so that everyone has a fair and just (equitable) chance to reach their best health. In the context of healthcare this means that we work to ensure equitable access, experience, and outcomes for every patient. [↑](#footnote-ref-54)
54. Efforts made by organizations to create environments in which any individual or group can be and feel welcomed, respected, supported, and valued to participate fully. Note that belonging is often a concept associated with efforts to increase inclusion and equity. It is the sense that individuals and groups have that they are not only included but that they valued and belong in their community and where they receive services such as healthcare. [↑](#footnote-ref-55)
55. This includes all patients receiving care services—both inpatient and outpatient—at your children’s hospital. [↑](#footnote-ref-56)
56. We are aware that there are a number of state laws and regulations that are either in effect or will be in the future that may restrict the collection and use of certain patient information. Please refer to the current laws and regulations for your state when responding to this question. [↑](#footnote-ref-57)
57. Race is a social construct used to categorize people into distinct social groups based on phenotypical, social, and cultural characteristics. [↑](#footnote-ref-58)
58. Ethnicity is a social construct used to categorize people into groups based on their unique set of cultural characteristics such as language, diet, dress, and value systems or religions. [↑](#footnote-ref-59)
59. Gender is a social construct used to categorize people into socially defined groups based on the shared attitudes and behaviors of each group’s members (e.g., masculine, feminine, nonbinary). Gender identity cannot be determined by their biological sex as defined on medical records such as a birth certificate; hospitals that only maintain records for sex at birth and do not ask or record self-identified gender identity information should respond “no.” This question only applies to patients 13 years of age or older, or documentation if the patient or parent/caregiver offers this information at any age. [↑](#footnote-ref-60)
60. Sexual orientation is a social construct used to categorizes people into distinct groups based on their emotional and sexual preferences, relationships and/or lifestyles. This question only applies to patients 13 years of age or older, or documentation if the patient or parent/caregiver offers this information at any age. [↑](#footnote-ref-61)
61. This is the language requested for spoken or written communication in healthcare. [↑](#footnote-ref-62)
62. We are aware that there are a number of state laws and regulations that are either in effect or will be in the future that may restrict the collection and use of certain patient information. Please refer to the current laws and regulations for your state when responding to this question. [↑](#footnote-ref-63)
63. This is the language requested for spoken or written communication in healthcare. [↑](#footnote-ref-64)
64. Food security refers to the status of a patient, and/or their family’s, physical, social, and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life. [↑](#footnote-ref-65)
65. Housing security refers to a patient, and/or their family’s, access to stable, affordable, uncrowded and safe housing to ensure their shelter needs. [↑](#footnote-ref-66)
66. Examples of oversight boards are the overall hospital board, a foundation board, or the pediatric program board. Note that these boards need to have a governance responsibility for the hospital. [↑](#footnote-ref-67)
67. We are aware that there are a number of state laws and regulations that are either in effect or will be in the future that may restrict the collection and use of certain patient information. Please refer to the current laws and regulations for your state when responding to this question. [↑](#footnote-ref-68)
68. Social determinants of health are conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. For a list of common factors consider those described by the CDC here: <https://www.cdc.gov/socialdeterminants/about.html>. [↑](#footnote-ref-69)
69. We recognize that for some hospitals, the DEI program may be located at the system level rather than at the children’s hospital. Note that we are interested in the resources that are dedicated to your children’s hospital. [↑](#footnote-ref-70)
70. Note that this may involve more than one leader but must be protected time set aside to address DEI issues. [↑](#footnote-ref-71)
71. This would include written policies and procedures related to expanded recruitment, hiring practices, training search committees related to implicit bias, etc. This does not involve setting percentages or numbers of a specific group, but efforts to ensure that hospital staff to reflect the community and the population that they serve. [↑](#footnote-ref-72)
72. <https://www.aamc.org/what-we-do/diversity-inclusion/underrepresented-in-medicine> [↑](#footnote-ref-73)
73. These courses do not need to be taken every year, however, ongoing training would certainly count. [↑](#footnote-ref-74)
74. Refers to practical training on how to implement diversity, equity, and inclusion principles in a health care setting. This training may include a wide variety of different types of training including implicit bias, microaggressions, anti-racism training. [↑](#footnote-ref-75)
75. Refers to improving communication with patients, families, and colleagues in the delivery of care. [↑](#footnote-ref-76)
76. Refers to understanding self-identified gender identity (rather than sex at birth) and how to appropriately address patients, families, and colleagues in the delivery of care. [↑](#footnote-ref-77)
77. Refers to promoting fair treatment, access, and opportunity while identifying and eliminating barriers that have prevented the full participation of all groups. [↑](#footnote-ref-78)
78. Refers to understanding differences in emotional and sexual preferences, relationships and/or lifestyles that exist and how to appropriately address patients, families, and colleagues in the delivery of care. [↑](#footnote-ref-79)
79. Refers to understanding differences in culture between people of different backgrounds and learning how to appropriately address patients, families, and colleagues in the delivery of care. [↑](#footnote-ref-80)
80. Refers to being aware of, recognizing the signs of, and being able to intervene to stop or address the impact of human trafficking on patients, families, and colleagues in the delivery of care. [↑](#footnote-ref-81)
81. Refers to awareness of the impact of trauma on patients, families, and colleagues and how that manifest in care delivery settings. [↑](#footnote-ref-82)
82. Refers to awareness of actions or the failure to act by parents or caregivers that may result in death, serious physical or emotional harm, sexual abuse, or exploitation of children and adolescents and how this may impact patients, families, and colleagues in care delivery settings. [↑](#footnote-ref-83)
83. Refers to awareness of the impact of major social drivers (determinants) of health on patients, families, and colleagues and how that manifest in care delivery settings. [↑](#footnote-ref-84)
84. Includes financial support for the director or overall leader and additional roles such as associate/assistant director but does not include financial support specifically for infection prevention or antimicrobial stewardship. Physicians may be from a variety of disciplines including pediatric infectious diseases, critical care, hospital medicine and/or emergency medicine. Children’s hospitals that are hospitals within hospitals or a part of a larger system should report the FTE for physicians specifically responsible for pediatric populations. [↑](#footnote-ref-85)