**Supplemental File 2. Voting Table**

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|  | **VOTING TABLE** |  |  |
| **Statement**  **Focus** | **Refined Statements** | **Choices** | **Response %** |
| **Admission-Based Levels of Care** | | | |
| **Levels of Care** | Patients who are appropriately triaged according to level of illness and services provided in community/tertiary/quaternary or specialized PICU facilities will have comparable outcomes and quality of care. | Agree Disagree Abstain | 97%  03%  0% |
| **Skills** | Expertise in the care of the critically ill child is required in community/tertiary/quaternary or specialized based PICUs. | Agree Disagree Abstain | 100%  0%  0% |
| **Population & Skills** | Patient volume in the PICU setting has a positive impact on outcomes. | Agree Disagree  Abstain | 79%  18%  03% |
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| **Population & Levels of Care** | Pediatric patients requiring specialized service interventions, such as cardiac, neurological, or trauma-related surgery, etc., have better/improved outcomes when cared for in a quaternary or specialized/tertiary PICU. | Agree Disagree Abstain | 100%  0%  0% |
| **Populations & Levels of Care** | Pediatric patients requiring specialized service interventions, such as cardiac,  neurological, or trauma-related surgery, etc., have better/improved outcomes when cared for in a tertiary PICU. | Agree  Disagree  Abstain | 82%  18%  0% |
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| **Populations,**  **Levels of Care & Skills** | Surgical volume (cardiothoracic, neurosurgery, trauma) has a positive impact on patient outcomes. | Agree  Disagree  Abstain | 82%  15% 03% |
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| **Populations & Levels of Care** | Congenital heart surgery should only be performed in a hospital that has a PICU with a dedicated pediatric cardiac intensive care team, including but not restricted to: pediatric intensivists and nurses with expertise in cardiac intensive care, pediatric perfusionists, pediatric cardiologists with catherization and imaging experience, pediatric cardiac anesthesiologists, and advanced practice providers, including intensivists and bedside nurses. | Agree Disagree Abstain | 88%  12%  0% |
| **Skills, Equipment & Technology** | The number of patients requiring respiratory support (invasive and non-invasive) in PICU has an impact on patient outcomes. The minimum number of patients requiring respiratory assistance per year including both invasive and noninvasive ventilation including BiPAP, HFNC, CPAP: choose optimal case number per year. | 50-75 cases/year  76-100 cases/year  101-150 cases/year  >151 cases/year | 18%  23%  23%  36% |
| **Skills** | Expertise and excellence in the care of the critically ill child and infant must be present in a community-based PICU. | Agree Disagree Abstain | 100%  0%  0% |
| **Admission Criteria** | | | |
| **Levels of Care** | Developing admission criteria assists in the placement of a critically ill child in an | Agree | 100% |
|  | appropriate PICU level of care. | Disagree  Abstain | 0%  0% |
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| **Education & Skills** | All critically ill children admitted to any PICU should be cared for by a pediatric intensivist either board eligible, board certified, or undergoing maintenance of certification as primary provider or in consultation (in person or otherwise) while in the ICU setting. | Agree  Disagree Abstain | 88%  12%  0% |
| **Outcomes** | Multidisciplinary team: The ICU structure/care delivery model components having the greatest impact on patient outcomes include the following:   * In-house Intensivist overage 65% * Experienced PICU Nursing 100% * Dedicated Clinical Pharmacist 94% * Multidisciplinary Rounds 88% * Social Workers 65% * Child Life Specialists 56% * Chaplain/Clergy 47% * Palliative Care Specialists 50% * PICU Experienced Respiratory Therapists 97% | | |
| **Populations Diseases & Admissions** | The following technologic or monitoring capabilities are required for a community level PICU.   * Noninvasive and Invasive Ventilation Support: Agree 100%; Disagree 0%; Abstain 0% * Continuous EEG Monitoring: Agree 35%; Disagree 65%; Abstain 0% * Central Line Access or Monitoring: Agree 91%; Disagree 09%; Abstain 0% * Initiation of Chemotherapy with Anticipated Tumor Lysis Syndrome: Agree 29%; Disagree 71%; Abstain 0% * Renal Replacement Therapy: CVVH, HD, PD, Plasmapheresis: Agree 12%; Disagree 88%; Abstain 0% * Exchange Transfusion: Agree 35%; Disagree 62%; Abstain 3% | | |
| **Levels of Care** | Specialty care (quaternary) ICUs must have an in-house post graduate pediatric level 3 or higher physician with training and experience in the designated specialty. | Agree Disagree  Abstain | 71%  29%  0% |
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| **Quality & Safety** | A qualified medical provider, who is able to [can] respond within 5 minutes to all emergency patient issues (such as airway management, cardiopulmonary resuscitation) is necessary for optimal patient outcomes in all levels of PICUs. | Agree Disagree Abstain | 100%  0%  0% |
| **Coverage, Quality & Safety** | Night coverage response requirement for pediatric intensivists, who are not in house, includes being readily available by telephone and present in the PICU within 30 minutes of request. | Agree Disagree Abstain | 85%  15%  0% |
| **Multi- Disciplinary Providers** | The use of medical providers in the PICU including hospitalists, nurse practitioners, or physician assistants may improve patient outcomes. | Agree Disagree Abstain | 79%  15%  06% |
| **Support &** | All PICUs should have access to an on-site pediatric pharmacist who is available for daily | Agree | 94% |
| **Education** | rounds, pharmacy support and on-going educational activities. | Disagree | 06% |
|  |  | Abstain | 0% |
| **Education, Skills & Training** | All levels of PICUs should participate in academic pursuits.  Clinical Trials………………………………Agree 21%; Disagree 80%; Abstain 0%  Basic Research……………………………Agree 09%; Disagree 91%; Abstain 0%  Scholarly Pursuits……………………….Agree 53%; Disagree 44% Abstain 03% | | |
| **Education and Training** | | | |
| **Quality &** | Pediatric hospitalists, nurse practitioners, and physician assistants who provide first-line | Agree | 85% |
| **Safety** | night coverage in PICUs must be skilled in advanced airway, line placement, and | Disagree | 15% |
|  | ventilator management. | Abstain | 0% |
| **Education &** | All levels of PICUs should be involved in providing peer community outreach education, | Agree | 76% |
| **Training** | such as educational conferences, technical skills competencies, stabilization, and | Disagree | 24% |
|  | resuscitation. | Abstain | 0% |

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| **Education & Training** | Which levels of PICUs should be affiliated with a training program that has at least medical students and residents.  Quaternary Tertiary Community  Agree 39% 52% 09%  Disagree 0% 17% 83%  Abstain 67% 0% 33% | | |
| **PICU Admissions Based on Resources and Advanced Technology** | | | |
| **Technology & Skills** | Renal replacement therapies (peritoneal dialysis, continuous hemofiltration and hemodialysis, intermittent hemodialysis) may be safely performed in a community-based PICU with appropriately trained support personnel, which includes a pediatric  Nephrologist. | Agree Disagree Abstain | 65%  35%  0% |
| **Technology** | All levels of PICUs should have access to the following inhalation gases:  Heliox Nitric Oxide Anesthesia  - Agree 100% 62% 45%  - Disagree 13% 61% 78%  - Abstain 0% 0% 0% | | |
| **Quality & Safety** | PICUs should have access to a transfer and transport program that can ensure the safe and timely movement of a critically ill child from a community hospital to the institution with a PICU. | Agree Disagree Abstain | 100%  0%  0% |
| **Training & Skills** | PICUs may outsource some if not all of their critical care transport activities; however, the transport service utilized must have training in pediatric critical/emergency care. | Agree Disagree  Abstain | 100%  0%  0% |
| **Quality & Safety** | PICUs should have a transfer plan with PICUs that can provide a higher level of specialized care when needed. | Agree Disagree  Abstain | 97%  03%  0% |
| **Quality & Safety** | PICUs should have a transfer plan in place that assists in the referral to a specialized facility (i.e. burn center, transplant center, rehab facility). | Agree Disagree  Abstain | 97%  03%  0%  0% |
| **Quality & Safety** | PICUs should have their own freestanding critical care transport program with the following:   * Own Team Agree 24%; Disagree 76%; Abstain 0% * Own Equipment Agree 32%; Disagree 68%; Abstain 0% * Dedicated Rig Agree 21%; Disagree 79%; Abstain 0% | | |
| **Populations, Diseases & Levels of Care** | The following monitoring or specific management needs are appropriate indications for PICU transfer from a community level of care to a tertiary or quaternary level of care   * Intracranial Pressure Monitoring Agree 94%; Disagree 06%; Abstain 0% * Acute Hepatic Failure Leading to Coma Agree 100%; Disagree 0% Abstain 0% * Congenital Heart Disease with Unstable Cardiorespiratory Status Agree 97%; Disagree 03%; Abstain 0% * Need for Temporary Cardiac Pacemaker Agree 100%; Disagree 0%; Abstain 0% * Burns >10% of Body Surface area Agree 97%; Disagree 03%; Abstain 0% * Head Injury with Initial Glasgow Coma Scale =/+8 Agree 88%; Disagree 12%; Abstain 0% * Multiple Traumatic Injuries Agree 88%; Disagree 12%; Abstain 0% * Heart Failure Requiring Interventional Cardiology, Circulatory Assist or   ECMO for Acute Respiratory Failure Agree 100%; Disagree 0%; Abstain 0% | | |

\*% voting data rounded up .5 and higher to highest whole number