Cleft Palate and Craniofacial Teams in the United States and Canada: A National Survey of Team Organization and Standards of Care

RONALD P. STRAUSS, D.M.D., PH.D.
THE AMERICAN CLEFT PALATE-CRANIOFACIAL ASSOCIATION (ACPA) TEAM STANDARDS COMMITTEE*

Objective: **This study is the first comprehensive national survey of the organization, function, and composition of cleft palate and craniofacial teams in the U.S. and Canada. Complete descriptions of cleft and craniofacial teams are not currently provided in the literature, and this study will provide an overview for health services research and policy use. Conducted by a national organization, this study examines teams in detail using a pretested and standardized methodology.**

Design: **All known (n = 296) North American cleft palate and craniofacial teams were contacted for team listing purposes using a self-assessment method developed by an interdisciplinary committee of national stature. Team clinical leaders classified their teams into several possible categories and provided data on team care. The response rate was 83.4% (n = 247).**

Results: **The distribution of listed teams was: 105 (42.5%) cleft palate teams, 102 (41.3%) craniofacial teams (including craniofacial teams that are both cleft palate and craniofacial teams), 12 (4.9%) geographically listed teams, and 28 (11.3%) other teams (including interim cleft palate teams, low-density cleft palate teams, and evaluation and treatment review cleft palate teams). Eighty-five percent of all teams systematically collected and stored clinical data on their team's patient population in the past year. Furthermore, 50% of all teams had a quality assurance program in place to measure treatment outcomes. Other findings presented include the annual number of face-to-face team meetings; new and follow-up patient censuses; and surgical rates for initial repair of cleft lip/palate, orthognathic/osteotomy procedures, and intracranial/craniofacial procedures.**

Conclusions: **Two of five North American teams classify themselves as having the capacity to provide both cleft palate and craniofacial care. An additional two of five teams limit their primary role to cleft palate care. Issues are raised regarding the distribution of teams, the regionalization of craniofacial services, health policy, and resource allocation.**

KEY WORDS: *cleft palate team, craniofacial team, standards of care, team organization*

The purpose of this paper is to give a complete description of the activities of cleft palate and craniofacial teams in the U.S. and Canada and to provide information about health services and policy with regard to craniofacial care. The team survey presented is the first comprehensive national study of the organization, function, and composition of cleft palate and craniofacial teams in North America. Previous research has examined the roles (Horwitz, 1970; Furnham et al., 1981; Logan and McKendry, 1982; Nason, 1983; Temkin-Greener, 1983) and ideology of the interdisciplinary health care team (Nagi, 1975; Brill, 1976; Dingwall, 1980; Kane, 1980; Payne, 1982; Feinstein, 1983; Margolis and Fiorelli, 1984) and the settings for interdisciplinary team practice (Briggs, 1980; Campbell and Whitenack, 1983; De Santis, 1983). The cleft palate or craniofacial team has received limited study as an organization (Koepp-Baker, 1979; Day, 1981; MacGregor, 1982; Strauss, 1985; Nackashi and Dixon-Wood, 1989), with specific focus placed on issues related to team communications (Lillywhite, 1957) and function (Mason and Riski, 1982; Noar, 1992). In particular, the mental health and support functions of the interdisciplinary health care team have been examined

Dr. Strauss was Chair, the ACPA Team Standards Committee. He is Professor and Chair, Department of Dental Ecology, UNC School of Dentistry; and Professor, Department of Social Medicine, UNC School of Medicine, University of North Carolina at Chapel Hill, North Carolina.

* The ACPA Team Standards Committee are Samuel Berkowitz, D.D.S., M.S.; Philip J. Boyne, D.M.D., M.S.; Arthur Brown, M.D.; John Canady, M.D.; Marilyn Cohen, B.A.; Linda Hallman, D.D.S., Ph.D.; Robert Hardesty, M.D.; Marilyn Jones, M.D.; Kathleen Kapp-Simon, M.A., Ph.D.; Pat Landis, M.A.; James Lehman, M.D.; Lynda Power, R.N.; Craig Senders, M.D.; Helen Sharp, M.S.; Barry Steinberg, D.D.S., M.D., Ph.D.; Timothy Turvey, D.D.S.; and Duane VanDemark, Ph.D.

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Reprint requests: Dr. Ronald P. Strauss, University of North Carolina at Chapel Hill, School of Dentistry, C.B. 7450, Chapel Hill, North Carolina 27599-7450.
E-mail: ron_strauss@unc.edu.

(Lonsdale et al., 1980; Webb and Hobdell, 1980; Cluff and Cluff, 1983; DeSpirito and Grebler, 1983; McKeganey and Bloor, 1987).

Over the past 9 years, the American Cleft Palate–Craniofacial Association (ACPA) has worked to revise its mechanism for listing teams in the ACPA Membership-Team Directory. In recent years, it has become apparent that public funding agencies and many health insurance or managed care providers have begun to set criteria for cleft palate and craniofacial team care. Believing that a professional association should provide leadership in such matters, ACPA initiated efforts to define basic and minimal standards for team listing that include a categorization of teams. The process of drafting the team listing instrument was open, and many individuals and organizations provided comments to the ACPA Team Standards Committee prior to its use in this survey.

The ACPA ''Team Self-Assessment Instrument'' employs specific criteria to list teams. Team categorization is achieved through a self-rating process, and no examiners or site visitors evaluated or monitored the process. The clinical team director filled out the questionnaire and signed a pledge of veracity. The team listing instrument was pretested and employed a standardized questionnaire.

Standards for listings permit the specification of two principal types of teams, the cleft palate team and the craniofacial team (Appendix A). A given center may be listed in either or both of these categories. As defined in this instrument, a cleft palate team provides coordinated and interdisciplinary evaluation and treatment to patients with cleft lip and/or cleft palate. The cleft palate team is required to meet eight basic criteria plus 30 of 35 additional criteria (Appendix B). As defined in this instrument, a craniofacial team provides coordinated and interdisciplinary evaluation and treatment for patients with a range of craniofacial anomalies or syndromes. This includes the provision of craniofacial surgery, which is defined as diagnosis, treatment planning, and surgical procedures in which the intracranial approach to the midfacial segment (includes the orbit and/or supraorbital rim) is used. The craniofacial team is required to meet all 45 criteria specified (Appendix C).

It should be noted that no teams or centers were denied listing in the ACPA Team Directory. However, some did not self-qualify as either cleft palate or craniofacial teams. Other special categories of teams listed included (Appendix A):

- *evaluation and treatment review teams,* defined as teams that provide evaluation services but not clinical care;
- *low population density teams,* defined as teams that are in low-population and rural states;
- *interim teams,* defined as teams that are new or in transition; and
- *geographically listed teams,* defined as teams that do not currently qualify to fit into other specified categories.

Methods

All known (n = 296) North American cleft and craniofacial teams identified through the records of the American Cleft Palate–Craniofacial Association were contacted for team listing purposes. Team Clinical Directors were sent a questionnaire in May 1996 and were given until August 1, 1996, to reply. Respondents were provided with assistance in filling out the questionnaire by a selected group of volunteer professionals in their region. Team clinical leaders classified their teams into several possible categories and provided other data on team care. The response rate was 83.4% (n = 247).

Results

The 1996 team listings offer a comprehensive overview of the organization, function, and composition of cleft and craniofacial teams in the U.S. and Canada. In 1996, the distribution of listed teams (n = 247) was:

- 105 (42.5%) cleft palate teams (also including cleft palate teams with interim craniofacial teams, with low-density craniofacial teams, or with evaluation treatment review craniofacial teams),
- 102 (41.3%) craniofacial teams (including craniofacial teams that are both cleft palate and craniofacial teams, craniofacial teams alone (n = 8), and craniofacial teams with interim cleft palate teams),
- 12 (4.9%) geographically listed teams, and
- 28 (11.3%) other teams (including interim cleft palate teams, low-density cleft palate teams, and evaluation and treatment review cleft palate teams).

Findings from this study indicate that 85% of all teams systematically collected and stored clinical data on their team's patient population in the past year. Furthermore, 50% of all teams had a quality assurance program in place to measure treatment outcomes.

Annual Face-to-Face Team Meetings

As shown in Table 1, nearly half of the teams studied meet 6 to 12 times a year, meaning monthly or bimonthly meetings. Approximately 10% of teams meet at least weekly over the course of a year. Craniofacial teams have a higher mean number of team meetings per year than do teams that are only cleft palate teams.

New Team Patients in the Past Year

As shown in Table 2, 41 teams had over 100 new patients in the past year, while 36 teams had 10 or less new patients. Cleft palate teams averaged 38 new patients in the past year, while craniofacial teams averaged 106.

Team Patients in Active Treatment or Follow-up in the Past Year

As shown in Table 3, only 6 teams in North America follow or treat more than 2000 patients, while another 11 teams treat

TABLE 1 Annual Face-to-Face Team Meetings*

No. of Meetings	*All Teams (%)*	*Cleft Palate Teams (%)*	*Craniofacial Teams (%)*
1–5	8	1	1
6–12	48	66	30
13–18	7	7	9
19–24	13	10	20
25–30	5	4	9
31–36	4	4	7
37–42	4	3	7
43–54	7	7	11
≥55	3	0	7

* Mean number of face-to-face team meetings annually: all teams, 19; cleft palate teams, 16; craniofacial teams, 28; geographically listed teams, 7; other teams, 7.

1000 to 2000 team patients. At the other end of the continuum, 26 teams follow a total of 50 patients or less. Substantial differences exist in patient load between types of teams, with craniofacial teams serving larger patient populations, followed by cleft palate teams. Craniofacial teams follow more than twice as many patients as do cleft palate teams.

Variations in Surgical Treatments

Variations exist in terms of surgical treatments performed on different types of teams. In this survey, we collected data on four types of procedures.

Initial Repairs of Cleft Lip

More than a third of the teams studied performed 10 or less primary lip repairs in the past year, while nearly a third performed more than 20 such procedures (Table 4). In the past year, cleft palate teams averaged 15 primary lip repairs, and craniofacial teams (including teams listed as both cleft palate and craniofacial teams) averaged 22.

Initial Repairs of a Cleft Palate

Sixty-six teams performed 10 or less initial palate repairs in the past year (Table 4). Similar to the case for cleft lip repairs, approximately a third of the teams performed over 20 such procedures in the past year. In that time frame, cleft palate teams averaged 18 primary palate repairs, while craniofacial teams (including teams listed as both cleft palate and craniofacial teams) averaged 29 procedures.

In both the primary lip and palate repair, geographically listed and other teams had markedly lower surgical activity.

Maxillary and Mandibular Osteotomy Procedures

Team-based maxillary and mandibular osteotomy surgical activity differed from team-based cleft lip/palate repair experience (Table 5). It is noteworthy that 36 teams did not perform this type of surgery in the past year, and 100 teams performed 10 or less such procedures. Only 5 teams performed over 100 osteotomies in the past year. It is evident that cleft palate teams performed substantially fewer (9) osteotomies than did craniofacial teams (23) in the past year. Interestingly, some geographically listed teams appear to specialize in osteotomy surgery, and the mean for geographically listed teams was 18 osteotomy patients in the past year.

TABLE 2 New Team Patients in the Past Year*

Number of New Patients	*Number of Teams*
1–10	36
11–20	42
21–30	32
31–50	46
51–100	49
101–200	25
>200	16

* Mean number of new team patients in the past year: all teams, 62; cleft palate teams, 38; craniofacial teams, 106; geographically listed teams, 16; other teams, 13.

TABLE 3 Team Patients (active and/or routine follow-up) in the Past Year*

Number of Team Patients	*Number of Teams*
1–50	26
51–100	53
101–300	89
301–500	31
501–1000	30
1001–2000	11
>2000	6

* Mean number of team patients (active and/or routine follow-up) in the past year: all teams, 352; cleft palate teams, 256; craniofacial teams, 559; geographically listed teams, 73; other teams, 74.

Craniofacial (Intracranial) Procedures

Two of five teams (40%) did not perform craniofacial surgical procedures (as specifically defined in Appendix C) in the past year. An additional 20% of teams performed 10 or less such operations. It is interesting to note that only five teams in North America performed over 50 craniofacial procedures in the past year. Cleft palate teams averaged 3 craniofacial procedures in the past year, compared with 21 such procedures for craniofacial teams.

Areas of Noncompliance to Team Standards Criteria

Aside from the surgical activity variations, other criteria for team listing were found to vary between teams. All cleft palate teams, which are freestanding or are associated with craniofacial teams, were asked about their compliance with 43 standards of care. Several standards stood out as common areas of noncompliance.

Among the cleft palate teams (n = 105), the following nine criteria were most commonly not met (>5% of teams):

- 36 (34%) do not have a psychologist, clinical social worker, or other mental health professional who evaluates all patients on a regular basis;

TABLE 4 Cleft Lip and Palate Surgical Repair Activity*†

Initial Repairs of a Cleft Lip Done by Team on Team Patients in Past Year (n = 229 teams)	
1–10 patients	84 teams (37%)
11–20 patients	72 teams (31%)
>20 patients	66 teams (29%)
Don't know	7 teams (3%)
Initial Repairs of a Cleft Palate Done by Team on Team Patients in Past Year (n = 229)	
1–10 patients	66 teams (29%)
11–20 patients	76 teams (33%)
>20 patients	80 teams (35%)
Don't know	7 teams (3%)

* Mean number of initial repairs of a cleft lip done by team on team patients in the past year: all teams, 17 patients; cleft palate teams, 15 patients; craniofacial teams, 22 patients; geographically listed teams, 5 patients; other teams, 5 patients.

†Mean number of initial repairs of a cleft palate done by team on team patients in the past year: all teams, 22 patients; cleft palate teams, 18 patients; craniofacial teams, 29 patients; geographically listed teams, 5 patients; other teams, 7 patients.

TABLE 5 Craniofacial Surgical and Max/Mandibular Osteotomy (orthognathic) Procedures Done by Team on Team Patients in the Past Year (n = 229)*†

Craniofacial (intracranial) Procedures Done by Team on Team Patients in the Past Year	
0 patients	91 teams (40%)
1–10 patients	45 teams (20%)
11–20 patients	47 teams (21%)
21–50 patients	36 teams (16%)
>50 patients	5 teams (2%)
Don't know	5 teams (2%)
Max/Mandibular Osteotomy (orthognathic) Procedures Done by Team on Team Patients in the Past Year	
0 patients	36 teams (16%)
1–10 patients	100 teams (44%)
11–20 patients	45 teams (20%)
21–100 patients	36 teams (16%)
>100 patients	5 teams (2%)
Don't know	7 teams (3%)

* Mean number of craniofacial (intracranial) procedures done by team on team patients in the past year: all teams, 11 patients; cleft palate teams, 3 patients; craniofacial teams, 21 patients; geographically listed teams, 1 patient; other teams, 0 patients.

†Mean number of max/mandibular osteotomy (orthognathic) procedures done by team on team patients in the past year: all teams, 15 patients; cleft palate teams, 9 patients; craniofacial teams, 23 patients; geographically listed teams, 18 patients; other teams, 4 patients.

- 27 (26%) do not have a team record that includes a social and psychological history;
- 21 (20%) do not routinely test or screen patients for learning disabilities and developmental, psychological, and language skills;
- 12 (11%) do not have a team record that includes a complete medical history;
- 9 (9%) do not make intraoral dental casts on patients when indicated;
- 9 (9%) do not routinely (or, for each evaluation) write reports or summary letters containing a treatment plan that are sent to the family in a timely manner;
- 8 (8%) do not take facial photographs of patients in treatment or evaluation;
- 8 (8%) do not include a hearing test by an audiologist beginning before 1 year of age as part of their evaluation;
- 6 (6%) do not include an ear examination by an otolaryngologist on a routine basis beginning before 1 year of age.

Although craniofacial teams were expected to comply with all 45 listed standards, among craniofacial teams (n = 102), three criteria were most commonly not met (>5% of teams):

- 10 (10%) do not have a psychologist, clinical social worker, or other mental health professional who evaluates all patients on a regular basis;
- 7 (7%) do not routinely (or, for each evaluation) write reports or summary letters containing a treatment plan that are sent to the family in a timely manner;
- 5 (5%) do not have a team record that includes a social and psychological history.

Conclusions

Over 80% of North American cleft palate and craniofacial teams participated in criteria-based team listing. There are nearly equal numbers of cleft palate and craniofacial teams meeting team standards, and together, they comprise 84% of the teams listed. There are substantial differences in patient load and surgical activity between cleft palate and craniofacial teams in the aggregate.

There is a group of cleft palate teams that are not located in low-density or rural settings, but who annually care for small numbers of patients with cleft lip/palate and perform very few surgical procedures. Eighty-four teams do 10 or less primary cleft lip repairs per year. Sixty-six teams do 10 or less primary cleft palate repairs per year.

There is a group of teams that are not located in low-density or rural settings, but who annually care for small numbers of patients with craniofacial conditions and perform very few surgical procedures. Forty-five teams do 10 or less intracranial craniofacial procedures per year.

The team self-assessment methodology offers opportunities for teams to identify ways to improve team organization and care delivery. The areas of noncompliance were striking and suggest the need for specific efforts to assure the availability of psychological and social services to team patients. Also, improvements in record keeping, postevaluation reports and letters, and early hearing and ear examinations are needed.

The findings from this survey raise issues regarding the distribution of teams, the regionalization of craniofacial services, health policy, and resource allocation. Should team networks and referral protocols be established to assure that patients receive care from a team that is experienced and prepared to provide the specific services they require? Should there be efforts to assure that teams perform a minimum number of evaluations or procedures in order to maintain competency? What is a reasonable level of activity to achieve competency? Does quantity of experience translate into quality? Clearly, experience is not sufficient to produce quality care; however, one might speculate that the absence of experience assures lower quality and lower competency.

Data that provide a more complete picture of team-based care will be helpful in guiding efforts directed toward protecting the public trust and enhancing craniofacial care delivery. This survey suggests the need for further health services research into cleft palate and craniofacial teams in North America.

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APPENDIX A

Team Listing Categories

Cleft Palate Team:

The Cleft Palate Team (CPT) provides coordinated and interdisciplinary evaluation and treatment to patients with cleft lip and/or cleft palate.

The Craniofacial Team

The Craniofacial Team (CFT) provides coordinated and interdisciplinary evaluation and treatment for patients with a wide range of craniofacial anomalies or syndromes.

For the purposes of the categorization, craniofacial anomalies or syndromes are defined as congenital conditions other than cleft lip/palate, unless cleft lip/palate is a feature of another condition, anomaly, or syndrome. The specific definition of craniofacial surgery being used states that ''craniofacial surgery consists of the diagnosis, treatment planning, and surgical procedures in which the intracranial approach to the midfacial segment (includes the orbit and/or supraorbital rim) is used.''

Special Categories of Teams

1. EVALUATION AND TREATMENT REVIEW TEAM (ERT):

Teams that function solely as an evaluation center or a treatment review/planning panel or board, and where members do not generally serve as the providers of clinical care or treatment, will be listed as an Evaluation and Treatment Review Team (ERT) and are not expected to meet the specified criteria for teams that provide clinical care or treatment.

2. LOW POPULATION DENSITY TEAM (LPT):

Teams that serve low population and rural states or regions, or rural provinces in Canada will be listed as a Low Population Density Team, if that designation is desired. Such teams are in states or provinces with populations of less than 2 million persons or in areas where there is a mean population density of less than 30 persons/square mile.

3. INTERIM TEAM (IT):

The category is reserved for ''young or markedly changing'' teams. These include teams in operation for less than five calendar years at the time of initial categorization, or teams adding or deleting services to an existing team and which thereby expect to qualify for a new categorization within a five year period. Teams with an Interim Team listing may hold that listing up to five years.

APPENDIX B

Standards for Listing the Cleft Palate Team

The Cleft Palate Team (CPT) provides coordinated and interdisciplinary evaluation and treatment to patients with cleft lip and/or cleft palate.

Basic Criteria

The Cleft Palate Team (CPT) meets the 8 following basic criteria defined by the ACPA Committee on Team Standards, plus meets 30 of the 35 additional criteria.

1. The CPT meets face-to-face for regularly scheduled meetings for treatment planning and case review, at least six times per year, with at least four specialties represented.
2. The CPT evaluated at least fifty new or recall patients with cleft lip/palate in the past year.
3. The CPT keeps a central and shared file on each patient.
4. The CPT has at least an actively involved Surgeon, Orthodontist and Speech-Language Pathologist, who attend team meetings. As a minimum, patients evaluated by the CPT are seen by these specialties plus at least one additional team specialty that attends the CPT meetings.
5. The CPT assures that each child has health evaluation by a primary care Physician (Pediatrician, Family Physician or General Internist) in the community or on the team. The CPT uses the findings from the health evaluation to guide its treatment planning and team meeting deliberations.
6. Evaluations at the CPT include a screening hearing test and tympanogram. All patients with clefts of the palate, or hearing concerns, or abnormal typmanograms or hearing tests, are referred to an Otolaryngologist (E.N.T.) for examination, consultation, or treatment.
7. At least one Surgeon on the CPT operated on ten or more patients for primary repairs of a cleft lip and/or cleft palate in the past year.
8. For patients requiring facial skeletal surgery, the CPT has or refers to a surgeon whose education, training and experience has adequately prepared him/her to provide facial skeletal surgery (bone graft, orthognathic surgery) and who has performed ten or more major maxillary or mandibular osteotomies in the past year (not necessarily on patients with cleft lip and/or cleft palate.

Additional CPT Criteria:

The Cleft Palate Team (CPT) meets 30 of the following 35 additional criteria:

1. The CPT has a Speech-Language Pathologist(s) who attends team meetings and whose education, training and experience have adequately prepared him/her for the diagnosis and treatment of patients with cleft lip/palate.
2. At least one Speech-Language Pathologist on the CPT provided speech therapy and/or a complete speech and language evaluation to a minimum of 10 patients (team or other patients) with cleft lip/palate in the past year.
3. The CPT Speech-Language Pathologist performs a structured speech assessment during team evaluations.
4. The CPT uses clinical speech instrumentation (such as endoscopy, pressure flow, videofluoroscopy, etc.) to assess velopharyngeal function, when indicated.
5. CPT has an Orthodontist who attends team meetings and whose education, training and experience have adequately prepared him/her for the diagnosis and treatment of patients with cleft lip/palate.
6. At least one Orthodontist on the CPT provided orthodontic treatment for a minimum of 10 patients with cleft lip/palate in the past year.
7. The CPT refers patients requiring orthognathic treatment to an Orthodontist(s) whose education, training and experience have adequately prepared him/her for the provision of orthodontic care as a part of orthognathic treatment.
8. Orthognathic surgical treatments are adequately documented with intraoral dental casts, facial and intraoral photographs, and appropriate radiographs.
9. Orthognathic surgical planning and outcomes are routinely discussed at the CPT meetings for patients requiring such care.
10. The CPT has, or refers to, a Pediatric Dentist/General Dentist/Prosthodontist(s) whose education, training and experience have adequately propared him/her for the dental diagnosis and treatment of patients with cleft lip/palate.
11. CPT has a Surgeon(s) who attends team meetings and whose education, training and experience have adequately prepared him/her for the diagnosis and treatment of patients with cleft lip/palate.
12. The CPT has a Psychologist, Clinical Social Worker, or other Mental Health Professional(s) who evaluates all patients on a regular basis.
13. The CPT routinely tests or screens patients for learning disabilities and developmental, psychological, and language skills.
14. The CPT collects school reports and other information relative to learning in school-age patients, when indicated.
15. The CPT has a nurse or other trained professional who regularly provides supportive counseling and instruction (feeding, developmental) to parents of newborns.
16. The CPT sponsors or makes referrals to a parent support group or parent network in the community (if available), as desired by families.
17. The CPT regularly provides supportive counseling and instruction to parents and patients pre- and post-operatively.
18. The CPT provides for formal genetic counseling or a clinical genetic evaluation for parents and patients.
19. The CPT evaluation includes a hearing test by an Audiologist(s) beginning before one year of age.
20. The CPT has an Otolaryngologist(s) whose education, training and experience have adequately prepared him/her for the diagnosis and treatment of patients with cleft lip/palate. The Otolaryngologist provides examination, consultation and treatment to patients evaluated by your team.
21. The CPT evaluation includes ear examinations by an otolaryngologist(s) on a routine basis beginning before one year of age.
22. After a CPT evaluation, the patient and family have an

opportunity to ask questions and discuss the treatment plan with a team representative.
23. The CPT routinely (for each evaluation) writes reports or summary letters, containing a treatment plan, which are sent to the family in a timely manner.
24. CPT reports are routinely sent in a timely manner to the patient's care providers in the community (schools, health department, local professionals) with the family's permission.
25. The CPT record includes a diagnosis(es).
26. The CPT team record includes a complete medical history.
27. The CPT record includes a treatment plan or goals which are reviewed periodically on a formal basis.
28. The CPT record includes a social and psychological history.
29. The CPT record includes dental and orthodontic findings and history.
30. The CPT makes intraoral dental casts on patients, when indicated.
31. The CPT takes facial photographs on patients in treatment or evaluation.
32. The CPT obtains appropriate radiographs, including lateral cephalometric radiographs on patients, when indicated.
33. The CPT has an office and coordinator or secretary.
34. The CPT supports, encourages, or offers continuing education in cleft lip/palate care for its members.
35. The CPT provides case management (follow-up, referral, and coordination of care) and benefits advocacy/assistance (help families obtain financial or programmatic support), as needed.

APPENDIX C

Standards for Listing the Craniofacial Team

The Craniofacial Team (CFT) provides coordinated and interdisciplinary evaluation and treatment for patients with a range of craniofacial anomalies or syndromes.
For the purposes of the categorization, craniofacial anomalies or syndromes are defined as congenital conditions other than cleft lip/palate, unless cleft lip/palate is a feature of another condition, anomaly or syndrome. The specific definition of craniofacial surgery being used states that ''craniofacial surgery consists of the diagnosis, treatment planning, and surgical procedures in which the intracranial approach to the midfacial segment (includes the orbit and/or supraorbital rim) is used.''
The Craniofacial Team (CFT) meets all of the following criteria defined by the ACPA Committee on Team Standards:

1. The Operation Surgeon(s), Mental Health Professional(s) and Speech-Language Pathologist(s) on the CFT meet face-to-face at a scheduled team meeting or conference to evaluate patients with craniofacial anomalies or syndromes at least 6 times per year. The meeting may or may not coincide with CPT meetings.
2. The CFT evaluated at least 20 patients with craniofacial anomalies or syndromes in the past year.
3. The CFT assures that each child has health evaluation by a primary care Physician (Pediatrician, Family Physician or General Internist) in the community or on the team. The CPT uses the findings from the health evaluation to guide its treatment planning and team meeting deliberations. A community or team-based primary care Physician evaluates all patients prior to craniofacial surgery.
4. Craniofacial surgical treatments are adequately documented with facial and intraoral photographs, and appropriate radiographs.
5. Craniofacial treatment plans and treatment outcomes (results) for patients with craniofacial anomalies or syndromes are discussed at CFT meetings.
6. The CFT has a Surgeon(s) who attends team meetings and whose education, training and experience have adequately prepared him/her for the diagnosis and treatment of patients requiring craniofacial surgery.
7. At least one Surgeon on the CFT provided craniofacial surgical treatment (surgical procedures in which the intracranial approach to the midfacial segment—includes the orbit and/or supraorbital rim—is used) for a minimum of 10 patients with craniofacial anomalies or syndromes in the past year.
8. The CFT has an Orthodontist(s) who attends team meetings and whose education, training and experience have adequately prepared him/her for the orthodontic diagnosis and treatment of patients with craniofacial anomalies or syndromes.
9. At least one Orthodontis on the CFT provided orthodontic evaluation or treatment for a minimum of 10 patients with craniofacial anomalies or syndromes in the past year.
10. The CRT has a Speech-Language Pathologist(s) who attends team meetings and whose education, training and experience have adequately prepared him/her for speech and language diagnosis and treatment of patients with craniofacial anomalies or syndromes.
11. At least one Speech-Language Pathologist on the CFT provided speech therapy and/or a complete speech and language evaluation to a minimum of 10 patients (team or other patients) with craniofacial anomalies or syndromes (or cleft lip/palate) in the past year. The CFT Speech-Language Pathologist performs a structured speech assessment during team evaluations.
12. The CFT uses clinical speech instrumentation (such as endoscopy, pressure flow, videofluoroscopy, etc.) to assess velopharyngeal function, when indicated.
13. The CFT has a Mental Health Professional(s) (Psychologist, Social Worker, Developmental Pediatrician, Psychiatrist) who attends team meetings and whose education, training and experience have adequately prepared him/her for the psychological and psychosocial diagnosis and treatment of patients with craniofacial anomalies or syndromes.
14. The CFT has a Mental Health Professional(s) who evaluates all patients on a regular basis.
15. The CFT routinely tests or screens patients for learning disabilities and developmental, psychological, and language skills.
16. The CFT collects school reports and other information relative to learning in school-age patients, when indicated.
17. The CFT has a nurse or other trained professional who

regularly provides supportive counsling and instruction (feeding, developmental) to parents of newborns.
18. The CFT sponsors or makes referrals to a parent support group or parent network in the community, as desired by families.
19. The CFT regularly provides supportive counseling and instruction to parents and patients pre- and post-operatively.
20. The CFT has a Neurosurgeon(s) whose education, training and experience have adequately prepared him/her for the neurosurgical diagnosis and treatment of patients with craniofacial anomalies or syndromes and who provides examination, treatment and consultation for CFT patients with craniofacial anomalies or syndromes.
21. The CFT has an Ophthalmologist whose education, training and experience have adequately prepared him/her for the ophthalmological diagnosis and treatment of patients with craniofacial anomalies or syndromes and who provides examination, treatment and consultation for CFT patients with craniofacial anomalies or syndromes.
22. The CFT has an Otolaryngologist(s) whose education, training and experience have adequately prepared him/her for the otolaryngologic diagnosis and treatment of patients with craniofacial anomalies or syndromes and who provides examination, treatment and consultation for CFT patients with craniofacial anomalies or syndromes.
23. The CFT evaluation routinely includes hearing evaluation by an audiologist and/or otologic evaluations by an otolaryngologist.
24. The CFT has a Radiologist(s) whose education, training and experience have adequately prepared him/her for the radiological evaluation of patients with craniofacial anomalies or syndromes and who provides examination, treatment and consultation for CFT patients with craniofacial anomalies or syndromes.
25. The CFT facility has C.T. capability and access to M.R.I.
26. The CFT obtains lateral cephalometric radiographs (or the equivalent) on patients, when indicated.
27. The CFT has a Pediatric Dentist/General Dentist/Prosthodontist(s) whose education, training and experience have adequately prepared him/her for the dental diagnosis and treatment of patients with craniofacial anomalies or syndromes and who provides examination, treatment and consultation for CFT patients with craniofacial anomalies or syndromes.
28. The CFT makes intraoral dental casts on patients, when indicated.
29. The CFT has an Audiologist(s) whose education, training and experience have adequately prepared him/her for the audiologic diagnosis and treatment of patients with craniofacial anomalies or syndromes and who provides examination, treatment and consultation for CFT patients with craniofacial anomalies or syndromes.
30. The CFT has a Geneticist(s) whose education, training and experience have adequately prepared him/her for the genetic diagnosis and treatment of patients with craniofacial anomalies or syndromes and who provides examination, treatment and consultation for CFT patients with craniofacial anomalies or syndromes.
31. The CFT provides for formal genetic counseling or a clinical genetic evaluation for parents and patients.
32. The CFT facility has a Pediatric Intensive Care Unit (P.I.C.U.) in the facility where they perform craniofacial surgery.
33. After a CFT evaluation, the patient and famliy have an opportunity to ask questions and discuss the treatment plan with a team representative.
34. The CFT (for each evaluation) writes reports or summary letters, containing a treatment plan, which are sent to the family in a timely manner.
35. CFT reports are sent in a timely manner to the patient's care providers in the community (schools, health department, local professionals) with the family's permission.
36. The CFT keeps a central and shared file on each patient.
37. The CFT record includes a diagnosis(es).
38. The CFT record includes a complete medical history.
39. The CFT record includes a treatment plan or goals which are reviewed periodically.
40. The CFT record includes a social and psychological history.
41. The CFT record includes dental and orthodontic findings and history.
42. The CFT takes facial photographs on patients in treatment or evaluation.
43. The CFT has on office and coordinator or secretary.
44. The CFT supports, encourages, or offers continuing education in craniofacial care for its members.
45. The CFT provides case management (follow-up, referral, and coordination of care) and benefits advocacy/assistance (help families obtain financial or programmatic support), as needed.