Instructions for Completing the Application for Approval of Cleft Palate and Craniofacial Teams

Please use the following guidelines to help us successfully process your application. Email cat@acpa-cpf.org, or call (919) 933-9044 with any questions.

- ☐ When preparing this application, teams are encouraged to refer to the implementation language associated with each standard as outlined in the Standards for Cleft and Craniofacial Teams document.
  To view examples of documentation that Teams have submitted as evidence of compliance of the Standards for Cleft Palate and Craniofacial Teams, please visit: http://www.acpa-cpf.org/standards-examples
- ☐ The application must be typed. Hand-written applications will be returned. Attachments that are originally hand-written, such as medical records, are accepted.
- ☐ IMPORTANT NOTES REGARDING MEDICAL RECORDS:
  - ☐ All reports should be current (within three years of submission date).
  - ☐ Please comply with HIPAA regulations.
  - ☐ Omit all patient identifying information (including patient names and photos).
  - ☐ **Applications containing Protected Health Information will not be reviewed and will be returned unprocessed.**
  - ☐ Please check and re-check the application to be sure patient information is removed before sending in the document as Protected Health Information is often embedded in the report.
  - ☐ Examples of patient records or other documentation may be used as evidence of compliance with more than one standard; in such cases, **omit patient identifying information**, make a separate copy for each standard you are using it for and label it as instructed for that standard.
  - ☐ Do not send the entire medical record.
  - ☐ Please send only the pertinent pages that address the standard.
  - ☐ For teams printing from electronic systems, please place a star by the section(s) on the attachments that document compliance with the standard and remove extraneous pages.
- ☐ Avoid permanent binding, hole-punching, sheaths, or staples.
- ☐ Submit a complete application. Please limit your application to 80 pages or fewer and limit each attachment to 5 pages or fewer (not including standard 5). Applications that go beyond the page limitations will not be reviewed. All items are required unless you are applying only as a cleft palate team (CPT), then you will not complete the sections specifically noted for craniofacial teams (CFT).
- ☐ Make sure the application and attachments are in order and clearly marked. All attachments should follow the application. Please do not insert the attachments within the application.
- ☐ Download the application and fill it out on the computer. Text boxes will expand as necessary.
- ☐ Include all required attachments. Clearly label each attachment with the corresponding attachment label affixed to (or number marked on) the first page of each respective attachment. Place a star by the section(s) on the attachments that document compliance with the standard. Please use a paper clip or binder clip to keep each attachment organized together. Do not staple.
- ☐ Use a binder clip to attach the application to the attachments.
- ☐ Make a copy of your entire submission and keep it on file.
- ☐ Include payment to ACPA by check, Visa, MasterCard, Discover, or American Express.
- ☐ I affirm that I have read this application in its entirety, confirm the accuracy of all of the information contained within this application, that **patient identifying information has been omitted from all attachments**, that our team abides by all of the information provided herein, and that all patients receiving care from this team are managed either by an appropriate team member, so identified in this application, or with full knowledge of the person evaluating or treating patients if referred to a professional person not specifically identified by name and profession within this application.

Signature of team leader Name (printed)

- ☐ Mail your materials to:

  Attn: CAT
  1504 East Franklin Street, Suite 102
  Chapel Hill, NC 27514

Please sign and place this completed checklist on the front of your application.

Commission on Approval of Teams

INVOICE

1504 East Franklin Street, Suite 102
Chapel Hill, NC 27514

TEL (919) 933-9044 FAX (919) 933-9604

INVOICE - CAT REGION III
DUE DATE: JULY 1, 2017

TO: [PLEASE FILL IN YOUR TEAM'S INFORMATION HERE]
Team ID:
Team Leader:
Team Name:
Address:

City, State Zip:

FOR:
Application Fee for
Commission on Approval of Teams

DESCRIPTION	AMOUNT
Commission on Approval of Teams Application Fee	**$250.00**
TOTAL	**$250.00**

Please mark a payment option and fill out the related fields underneath. This fee is non-refundable. A listing fee of $175 along with an update form will be due annually for continued listing:

☐ Credit card payment

Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ AMEX

Card Number:

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiration: ☐☐ / ☐☐

3 or 4 Digit Security Code: ☐☐☐☐

☐ Check Payment

Check # _____

Institution name & address on check: _____

Make checks payable to:
ACPA
Team Services Dept, 1504 East Franklin Street, #102
Chapel Hill, NC 27514

If you would like a receipt, please provide the email (preferred) or fax number where you would like it sent:

Attachment Label Instructions: Print on Avery 5160 labels 1" x 2.63". Peel and affix to top right hand corner of the first page of each attachment. If you are unable to print labels, please clearly mark the upper right hand corner. Place a star by the section(s) on the attachments that document compliance with the standard.

(1.1.3) Attach one example of published materials (e.g., letterhead, business card, Web page, etc.) with the coordinator's name listed and identified as Coordinator. Limit attachment to 1 page.

(1.2.6) Submit pages from one patient Team report that document the participation of the speech-language pathologist, surgeon, and orthodontist. Don'tsend the entire record. Place a star by the section(s) on the attachments that document compliance with the standard. Limit attachment to 5 pages or fewer & omit PHI.

(1.4.9) If applying as a CFT, attach a **team report** concerning a patient with a craniofacial condition (requiring transcranial surgery) that documents the participation of the transcranial craniofacial surgeon as well as other team members. Limit attachment to five pages or fewer & omit PHI.

(1.4.11) If applying as a CFT, provide an example of a patient that requires transcranial surgery that documents a referral from the team to a specialist listed in 1.4.10. Limit attachment to five pages or fewer & omit PHI.

(1.4.12) If applying as a CFT, provide the report from the specialist resulting from the referral. (If you choose imaging, a test alone does not meet the standard. Please demonstrate the interaction/participation of the radiologist.) Limit attachment to 5 pages or fewer & omit PHI.

(2.2.19) Attach a copy of the release of information form used by the team. The form typically includes a space for the parent, patient, or patient legal representative to sign. Limit attachment to 5 pages or fewer.

(4.2.33) Attach a copy of the Patient's Bill of Rights (a privacy policy does not qualify).

(5.1.35) Attach an example from a patient's team record of a referral for evaluation or treatment of **emotional** or **behavioral** concerns and the resulting report from that evaluation or treatment. Limit attachment to ten pages or fewer & omit PHI.

(5.2.37) Attach an example from a patient's team record of a referral for evaluation or treatment of **cognitive development** concerns and the resulting report from that evaluation or treatment. Limit attachment to ten pages or fewer & omit PHI.

(5.3.38) If applying as a CFT, provide an example that cognitive psychometric testing has been performed on a patient who is age 4 or older & has a craniofacial condition requiring transcranial surgery. Include results of the testing along with the name and specialty of the person performing the test. Limit attachment to 10 pages & omit PHI.

Application for Approval of Cleft Palate and Craniofacial Teams

Commission on Approval of Teams

The administrative organization* named below seeks approval of its Cleft Palate and/or Craniofacial Team by the Commission on Approval of Teams (CAT) and hereby applies for an evaluation of this Team. The sponsoring organization agrees to cooperate fully in the evaluation procedures therein described, including furnishing such written information to the CAT as shall be required for evaluation of the Team. The sponsoring organization further agrees to submit an annual update form and pay the annual fees for listing as an approved Team due each year that the Team remains approved.

This application can be withdrawn by the Team without prejudice at any time and for any reason before final action by the CAT.

The administrative policies of the sponsoring organization and the Team must comply with federal, state, provincial, and local laws, regulations, or executive orders with respect to equitable treatment of patients without regard to gender, sexual orientation, age, race, religious preference, national origin, or disabling condition.

Administrative or Sponsoring Organization*	Authorized Institutional Officer (AIO)** (print name)
Address	AIO Title
	AIO Signature
City, State/Province, Postal Code	AIO Phone
Country	AIO Email

*The administrative organization may be a hospital, university, corporation, or self-sponsored private practice group.

**The purpose of this requirement is to document that someone with fiduciary responsibility for the institution/practice acknowledges and supports the operation of the team at its facility. This would typically be the chief executive officer, the chief medical officer, the dean of the medical school or college, or the owner of the practice in which the team operates. For this purpose, a department chair is not the appropriate person.

Application for Approval of Cleft Palate and Craniofacial Teams

Commission on Approval of Teams

The purpose of the application for approval is to provide information as it relates to your Team's compliance with the Standards for Cleft Palate and Craniofacial Teams. The outline presented here must be followed when submitting an application. Please submit one paper copy to the Commission according to the specific application preparation instructions provided. Please retain a copy for your own records.

Team ID: _____ (Contact cat@acpa-cpf.org if you are unsure.)

Please check all that apply:
Applying as a ____ **Cleft Palate Team and/or** ____ **Craniofacial team (teams performing transcranial procedures)**

Date:	
***Name of Team:**	
***Team Address:**	
***Team Web Site**	
***Patient Age Range**	
***Team Coordinator:**	
***Team Coordinator Phone #:**	
***Team Coordinator E-mail:**	
***Team Coordinator Fax #:**	
***Team Leader:**	
Team Leader Phone #:	
Team Leader Email:	
Name and Title of Individual Completing Application:	
Phone #:	
Email:	

*Upon Team's approval by the Commission on Approval of Teams, fields with asterisks will be used for the Team's listing with the American Cleft Palate-Craniofacial Association and Cleft Palate Foundation.

APPLICATION PREPARATION INSTRUCTIONS:

- **This application must be typed. Hand-written applications will not be accepted.**
- **Include attachments in chronological order at the end of the application and place labels in the upper right corner.**
- **IMPORTANT NOTES REGARDING MEDICAL RECORDS:**
  - **Comply with HIPAA regulations.**
  - **Omit all patient identifying information (including patient names and photos).**
  - **Applications containing Protected Health Information will not be reviewed and will be returned unprocessed.**
  - **Please check and re-check the application to be sure patient information is removed before sending in the document as Protected Health Information is often embedded in the report.**
  - **Examples of patient records or other documentation may be used as evidence of compliance with more than one standard; in such cases, omit patient identifying information, make a separate copy for each standard you are using it for and label it as instructed for that standard.**
  - **Do not send the entire medical record. Please send only the pertinent pages that address the standard.**
- **For complete instructions, see cover page of this packet.**

Standard 1: Team Composition

1.1 The Team includes a designated patient care coordinator to facilitate the function and efficiency of the Team, ensure the provision of coordinated care for patients and families/caregivers and assist them in understanding, coordinating, and implementing treatment plans.

1. List the name of the team member who serves as the team coordinator and his/her specific title.

   _____

2. Describe the specific roles and responsibilities of the coordinator and how these ensure coordinated care.

3. Attach one example of published materials (e.g., letterhead, business card, Web page, etc.) with the coordinator's name listed and identified as Coordinator. Label as 1.1.3 and limit the attachment to 1 page.

1.2 The Team includes speech-language pathology, surgical, and orthodontic specialties.

4. In Table 1, list your Team's *lead* member in the core disciplines of speech-language pathology, surgery, and orthodontics.

Table 1 – Lead Team Member in Core Disciplines

Name	Degree(s)	Specialty

5. In Table 2, list all current participating members (excluding trainees) of the Cleft Palate or Craniofacial Team. (*Expand table as needed.*)

Table 2 – Comprehensive Team Roster

Name	Degree(s)	Specialty

6. Submit pages from one patient Team report that document the participation of the speech-language pathologist, surgeon, and orthodontist. Do not send the entire record. Place a star by the section(s) on the attachments that document compliance with the standard. **Omit all patient identifying information.** Label as 1.2.6 and limit the attachment to five pages or fewer.

1.3 The Team demonstrates access to professionals in the disciplines of psychology, social work, audiology, genetics, dentistry, otolaryngology, and pediatrics/primary care.

7. In Table 3, provide the name of one professional and his/her affiliated institution for each of the disciplines indicated in Standard 1.3 that are not represented on your team. (*Expand table as needed.*)

Table 3 – Other Disciplines

Name	Degree(s)	Specialty	Institution

If not seeking approval as a Craniofacial Team, skip to Standard 2.

Craniofacial (surgery involving a transcranial procedure) Teams must meet Standards 1.1 through 1.3 related to Team Composition, as well as the following Standard.

To view examples of standard 1.4 documentation that Teams have submitted as evidence of compliance of the Standards for Cleft Palate and Craniofacial Teams, please visit: http://www.acpa-cpf.org/standards-examples

1.4 The Craniofacial Team must include a craniofacial surgeon who has specialized training and experience in surgical management of patients with syndromic and other craniofacial anomalies. Such training includes surgical procedures for syndromic patients involving the maxillofacial and craniofacial structures, and must include transcranial surgery. In addition, the Craniofacial Team must have access to a psychologist who does neurodevelopmental and cognitive assessment. The results of the neurodevelopmental and cognitive assessment must be part of the CFT team assessment record. The Team also must demonstrate access to refer to a neurosurgeon, ophthalmologist, radiologist, and geneticist. The participation of these individuals should be documented in each patient's team report.

8. List the name of the Team's lead member trained in transcranial craniofacial surgery.

   _____

9. Attach a **team report** concerning a patient with a craniofacial condition (requiring transcranial surgery) that documents the participation of the transcranial craniofacial surgeon as well as other team members. **Omit all patient identifying information.** Label as 1.4.9 and limit the attachment to five pages or fewer.

10. Describe the process used to obtain evaluation or treatment services by a neurosurgeon, ophthalmologist, radiologist, or geneticist.

11. Provide an example of a patient that requires transcranial surgery that documents a referral from the team to a specialist listed in 1.4.10. **Omit all patient identifying information.** Label as 1.4.11 and limit the attachment to five pages or fewer.

12. Provide the report from the specialist resulting from the referral. (If you choose imaging, a test alone does not meet the standard. Please demonstrate the interaction/participation of the radiologist.) **Omit all patient identifying information.** Label as 1.4.12 and limit the attachment to five pages or fewer.

Standard 2: Team Management and Responsibilities

To view examples of standard 2 documentation that Teams have submitted as evidence of compliance of the Standards for Cleft Palate and Craniofacial Teams, please visit: http://www.acpa-cpf.org/standards-examples

2.1 The Team has a mechanism for regular meetings among core team members to provide coordination and collaboration on patient care.

13. How often does your team meet?
    [ ] Quarterly
    [ ] Monthly
    [ ] Bi-weekly
    [ ] Weekly
    [ ] Other. Please describe:

14. Describe the procedure used by your team if one or more of your usual core team members cannot attend a team meeting.

15. Describe how a patient receives comprehensive same-day face-to-face multidisciplinary evaluation. In so doing, describe a typical team meeting with patients and how this leads to integrated decision making.

16. Describe how the results of the interdisciplinary conference for each individual patient are recorded and become a part of the patient's Team report.

2.2 The Team has mechanisms for referral and communication with other professionals.

17. Describe the process for information exchange with schools, primary care professionals, outside agencies, and other professionals involved with the welfare of the patient.

18. Attach a copy of the release of information form used by the team. The form typically includes a space for the parent, patient, or patient legal representative to sign. Label as 2.2.19 and limit the attachment to five pages or fewer.

19. How does your team deal with infants with failure to thrive?

20. How does your team deal with children with recurrent otitis media?

21. Describe how the team facilitates the transition to adult care if the team does not accept patients after age 18 or 21.

2.3 The Team reevaluates patients based on the Team's recommendations.

22. Describe the usual intervals for reevaluating patients by a speech pathologist, surgeon, and orthodontist, and also for comprehensive group reevaluation (e.g., 1 year, 18 months, 2 years, etc.).

2.4 The Team must have central and shared records.

23. Describe the mechanisms for record-keeping (e.g., where housed and maintained, access to records, etc.).

24. Describe how recommendations become part of the patient record when patients are evaluated outside of the Team setting.

Standard 3: Patient and Family/Caregiver Communication

To view examples of standard 3 documentation that Teams have submitted as evidence of compliance of the Standards for Cleft Palate and Craniofacial Teams, please visit: http://www.acpa-cpf.org/standards-examples

3.1 The Team provides appropriate information to the patient and family/caregiver about evaluation and treatment procedures orally and in writing.

25. Who is responsible for providing information about patient evaluation and the recommended treatments to families and patients? How is the information communicated to them?

3.2 The Team encourages patient and family/caregiver participation in the treatment process.

26. Describe how the family/caregiver has opportunities to play an active role in the decision-making process for the treatment plan.

27. Describe how the patient is involved in the decision-making process for the treatment plan at an appropriate age.

3.3 The Team will assist families/caregivers in locating resources for financial assistance necessary to meet the needs of each patient.

28. Describe the process for informing families/caregivers of financial and insurance-related resources. These might include federal, state, and provincial regulations specifically governing the treatment of cleft/craniofacial anomalies. (e.g., insurance, state agencies, Public Law 94-142, 504s, and individual educational plans).

Standard 4: Cultural Competence

To view examples of standard 4 documentation that Teams have submitted as evidence of compliance of the Standards for Cleft Palate and Craniofacial Teams, please visit: http://www.acpa-cpf.org/standards-examples

4.1 The Team demonstrates sensitivity to individual differences that affect the dynamic relationship between the Team and the patient and family/caregiver.

29. How do you communicate with patients and families for whom English is not their primary language? Do you use interpreters or translated materials?

30. Do you have training in cultural and ethnic diversity for your team members? How is this training applied in clinical encounters? Please describe:

4.2 The Team treats patients and families/caregivers in a non-discriminatory manner.

31. How do you inform patients and families/caregivers of their rights (e.g., patient bill of rights, Web site, institutional literature, etc.)?

32. Attach a copy of the Patient's Bill of Rights. A privacy policy does not qualify. Label as 4.2.33 and limit the attachment to five pages or fewer.

Standard 5: Psychological and Social Services

To view examples of standard 5 documentation that Teams have submitted as evidence of compliance of the Standards for Cleft Palate and Craniofacial Teams, please visit: http://www.acpa-cpf.org/standards-examples

5.1 The Team has a mechanism to initially and periodically assess and treat, as appropriate, the psychological and social needs of patients and families/caregivers and to refer for further treatment, as necessary.

33. Describe how the Team identifies patients and families/caregivers who may be in need of further evaluation and treatment for emotional or behavioral issues. The use of a psychologist or social worker is encouraged to serve this function. If another professional serves in this role, please describe his/her qualifications.

34. Attach an example from a patient's team record of a referral for evaluation or treatment of **emotional** or **behavioral** concerns and the resulting report from that evaluation or treatment. If these services are provided internally by a professional listed on the team roster (must be listed on Table 2 of this application), submit a note or report from that provider; documentation of a referral is not necessary. **Omit all patient identifying information.** Label as 5.1.35 and limit the attachment to ten pages or fewer.

5.2 The Team has a mechanism to assess cognitive development.

35. Describe how the Team identifies patients who may be in need of further evaluation or treatment for cognitive development issues. The use of a psychologist or social worker is encouraged to serve this function. If another professional serves in this role, please describe his/her qualifications.

36. Attach an example from a patient's team record of a referral for evaluation or treatment of **cognitive development** concerns and the resulting report from that evaluation or treatment. If these services are provided internally by a professional listed on the team roster (must be listed on Table 2 of this application), submit a note or report from that provider; documentation of a referral is not necessary. **Omit all patient identifying information.** Label as 5.2.37 and limit the attachment to ten pages or fewer.

If not seeking approval as a Craniofacial Team, skip to Standard 6.

Craniofacial (surgery involving a transcranial procedure) Teams must meet Standards 5.1 through 5.2 related to Psychological and Social Services, as well as the following Standard.

To view examples of standard 5 documentation that Teams have submitted as evidence of compliance of the Standards for Cleft Palate and Craniofacial Teams, please visit: http://www.acpa-cpf.org/standards-examples

5.3 The team conducts formal assessment of cognitive functioning of patients when deemed necessary.

37. Provide an example that cognitive psychometric testing has been performed on a patient who is age 4 or older and who has a craniofacial condition requiring transcranial surgery. If a professional person other than a psychologist performs this function, please describe his/her qualifications. Include results of the testing along with the name and specialty of the person performing the test. **Omit all patient identifying information.** Label as 5.3.38 and limit the attachment to ten pages or fewer. Note: the person performing the test may be a regular team member or a referral.

Standard 6: Outcomes Assessment

To view examples of standard 6 documentation that Teams have submitted as evidence of compliance of the Standards for Cleft Palate and Craniofacial Teams, please visit: http://www.acpa-cpf.org/standards-examples

6.1 The team uses a process to evaluate its own performance with regard to patient assessment, treatment, or satisfaction and to make improvements as a result of those evaluations.

38. In the textbox below describe either:

    1) an example of how assessment or treatment data have been used to change the team's procedures (e.g., modify surgical treatment, change referral criteria, etc.),

       OR

    2) an example of how other data the team has collected have been used to change the team's process (e.g., address clinic processes to increase patient/family satisfaction).

39. If your team does not currently have a quality management system, please describe your plan for implementing one.

PROGRAM SELF-ASSESSMENT

In going through this application process, what have you identified as your team's strengths?

What have you identified as areas for improvement?

What are your plans to improve these areas?
