

## 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.

8. How often does your team meet?

Quarterly

Monthly

Bi-weekly

Weekly

Other. Please describe:

Meetings are held face-to-face immediately following the patient assessments for the Cleft Palate Clinic (weekly), Craniofacial Clinic (monthly), and Velopharyngeal Disorders Clinic (monthly) with each provider and the coordinator(s) present. We also have a monthly 22q Clinic with; the team meeting is one week later to facilitate coordination and collaboration given the number of laboratory investigations for this population. Providers have the option to attend in person or via a call / video conference.

Additionally, the team has the ability to coordinate meetings with core members to discuss complex and difficult cases to ensure coordination and collaboration.

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

The core member completes the assessment and dictates the note prior to the team meeting as usual. If this cannot be done a substitute provider is scheduled. The team leader and nurse coordinator rotates with the core member, taking notes of questions and concerns that need to be brought to the team discussion. A discussion is had with that provider and key findings and questions he/she would like discussed during the meeting. The team leader follows-up with that provider to review the care plan after. Virtual communication (encrypted email, staff messaging) are used to facilitate group discussion to gain consensus as needed. Follow-up meetings are scheduled in select instances, particularly for complex cases.

10. 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.

Patients receive a comprehensive team visit with individual consultations with each team member, 8:15 a.m. to 11:00 a.m. (for Cleft Team). The coordinator meets with the patient/family to gain an understanding of needs and goals, which is the foundation for integrated decision making. The team members meet after the individuals are completed (usually 11:00 a.m.-12:00 noon). During this meeting, each patient is reviewed (about 8 patients per clinic) and each Team member provides their input regarding patient care. The Team director facilitates the meeting and assures that a comprehensive care plan is the outcome. This information is shared verbally and in written form with the patient and family after the team meeting.

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

Each team member provides a note summarizing their clinical evaluation and recommendations, in addition to their oral commentary during the Team meeting. The nurse coordinator writes a consensus care plan during the team conference and it is reviewed by the Team director immediately following the meeting. The consultation notes and care plan are compiled into one report. The coordinator, team director, and executive assistant are responsible for compiling, reviewing, and distribution of the team report for each patient.

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

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

Multiple mechanisms ensure ongoing communication before and after a patient's visit to the team, including but not limited to:

- Exchange of team report and records: communication via encrypted email, fax, telephone, and mail
- Providers in the community who are directly involved in the patient's care are encouraged to come to the team visit. We have had many community providers come, particularly speech-language pathologists. They observe the evaluations and participate in the team meeting.
- Continuing education (formal and informal) is provided within the region, which builds collaborative relationships that impacts professional communication.

13. 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.

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

Failure to thrive is managed with an interdisciplinary family approach with close collaboration with the pediatric primary care provider. The specific evaluation and treatment needs are determined for each patient and family but guided by the following principles:

- Parent education and feeding plans are developed starting with the prenatal consultation and at birth. Feeding logs and (bi) weekly weight checks and collaboration with the infant's primary care provider is ensured by the nurse coordinator and team leader, enabling early identification of infants with failure to thrive.
- A work-up of contributing biological, psychosocial, and environmental completed to determine an action plan and necessary follow-up, including the need for hospital admission.
- The nurse coordinator obtains prior records from outside institutions, including growth charts.
- The team pediatric nurse practitioner and/or pediatric primary care provider completes an assessment, including a physical exam and plotting of the

growth measurements.

- The feeding evaluation is completed by the team SLP with observation during the caregiver and SLP feeding. Discussion occurs to determine need for feeding therapy, additional investigations, and/or referrals to manage the failure to thrive. While the specifics vary for each patient, in general the goal is to prevent failure to thrive through early management, including airway problems and any psychosocial difficulties.
- If warranted, the patient is referred to the Feeding Team if needed which is a multidisciplinary team including SLP, Occupational Therapy, Gastroenterologists, Nutrition, and Social Work.

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

Recurrent otitis media is managed by the ENTs on team, in collaboration with the audiologist. Clinical guidelines from the American Academy of Otolaryngology are followed. All patients are seen for hearing and otologic examinations within the first weeks through adulthood as a part of their comprehensive visit to the team to help manage the effects of recurrent otitis media. Shorter intervals for follow-up are set for patients with active problems.

Ear exams under anesthesia and placement of tubes are coordinated with other surgical procedures when the timing is appropriate. The team recommendations and plans regarding accommodations for hearing loss due to recurrent otitis media are communicated in the team report (e.g., hearing aid trial, classroom amplification preferential seating).

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

Adults are seen in our Clinic. We have a transition plan for adolescents to help them transition to adulthood, which is discussed in the team conference and led by the nurse practitioner on the team.

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

17. 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.).

The majority of our patients are seen for follow-up about once a year for comprehensive team evaluation. This allows a timely reevaluation and monitoring of progress in their care. However, there are circumstances with patients who are well-connected with their care providers and with well-motivated parents, when patients are seen every 2 years, particularly during times when treatment is less active with no procedures scheduled. In contrast, there are also patients who are seen every 3-6 months when it is more important to keep patients and their parents connected for various reasons including concerns with compliance, cultural or language barriers, etc.

Evaluation with the core providers are done within the Cleft-Craniofacial Clinic and also in providers' outpatient clinics. These are coordinated together as much as possible, usually every 3 to 6 months when there is an active need (e.g., staged

cleft lip repair with feeding and pre-surgical molding; alveolar bone grafting with Phase I orthodontic treatment and simultaneous speech-language therapy).

Surgery: evaluations are done within the team, pre-operatively and post-operatively. Growth and development monitored as a part of team visit annually.

Speech-language pathology: evaluation at birth for feeding; evaluation in conjunction with surgeon at 4-9 months prior to surgery (lip, palate, cranial vault) for pre-linguistic and follow-up feeding evaluation; re-evaluation after surgery (2-3 months after palate repair; 6 months after cranial vault); comprehensive evaluation as group every 6 to 12 months starting at 18 to 2 years of age. At age 5-7 years of age, follow-up may transition to screenings or become less frequent if communication and swallow/eating is within normal limits. If patients have velopharyngeal dysfunction they are seen for nasendoscopy with the SLP and surgeon. These patients require more frequent re-evaluation, as do patients with other speech-language disorders limiting daily function.

Orthodontic: Patient is seen at birth for pre-surgical orthopedics, if indicated. Subsequently seen starting at 3-4 years of age for annual visits, unless earlier need or parents request. Patients are referred directly to the Orthodontic Clinic or a community provider associated with team when it is determined complete records are needed for treatment planning. The frequency of re-evaluation is then based on the treatment plan and patient/family needs. The orthodontist sees patients annually through adulthood as a part of team visits.

#### 2.4 The Team must have central and shared records.

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

The Team continues to primarily use an electronic data base which includes patient reports, communication logs, photographs, radiographs and audio recordings. This has facilitated the core Team members and leaders in writing the Team reports, accessing reports and other data as needed. The database is housed on a central server of the [redacted] It has all necessary security and technical support provided by the [redacted] IT staff.

The team is in the process of transitioning records to an EDR (axiUm). All scheduling, a copy of reports, outpatient records, and therapy notes are being put into axiUm. We also interface with the hospital-based EMR system (EPIC).

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

Patients seen outside of the Team setting (e.g. nasendoscopic evaluation, other medical consultants within the [redacted] and associated hospitals) have the recommendations from these consultations transferred to a communication log within the patient record or access is provided through the electronic medical record (EMR) of the [redacted] (Epic). Dental records are available on the [redacted] s electronic record (EDR) set up by the [redacted] (axiUm) or the Division of Orthodontics (EDR) (Viewpoint / Dolphin).