

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).

1.) Data collected in the EMR during clinic visits and surgical procedures on: 1. length of surgical time related to cleft palate repair by type of procedure, 2. Recorded occurrence of oral nasal fistula post palate repair, 3. Incidence of velopharyngeal insufficiency demonstrated a statistical significance in the incidence of VPI in the straight line repair group as opposed to the Modified Furlow cohort. A Modified Furlow double opposing z-plasty was considered a more superior surgery based on the elimination of velopharyngeal insufficiency, for both non syndromic and syndromic patients at our institution. Our fistula rates were nearly identical in each group, the operative times to complete each form of surgery was also indistinguishable. We concluded the Modified Furlow double opposing z-plasty along with levator veli palatini retropositioning followed by a spacer of alloderm placed between the posterior nasal spine and the muscle reconstruction of the levator for primary palatal repairs demonstrated superior perceptual speech outcomes and reduced the need for corrective secondary palatal surgeries.

2.) A Craniofacial Team project based on the Lean Six Sigma design examined the length the annual Craniofacial Team Clinic (CTC) visit. At baseline, patient's team clinic visit time averaged 4.1 hours and our CTC no show rate was 22%. Data collected on clinic flow and Patient and Family Satisfaction Survey(PFSS) demonstrated patients and families were spending 57% of the visit waiting for the next available team member assessment. After review of the data, and at the suggestions listed on the PFSS the scheduling process was changed from scheduling all clinic patients at the same time slot to dividing patients into two cohorts scheduled one and one half hours apart. This has resulted in a decrease in the average clinic visit to 2.5 hours from the previous 4.1 hours. The no show rate was reduced from 22% to 11% by scheduling patients while in clinic for their next annual visit and calling to confirm the week of the appointment. This has also allowed us to fill available clinic slots from the wait list.

- 3.) Review and determination of Craniofacial Team goals at Annual Team Retreat
- A. Outcomes of 2016 Craniofacial Team Retreat goals:
1. Goal-Implement a Cleft Feeding Team: Outcome- Standardized the process for scheduling, assessment and measuring effectiveness of feeding by the team speech pathologist, nurse, social worker and dietician.
 2. Goal-Improve communication with orthodontists: Outcome-Addition of organization position and hiring of craniofacial fellowship trained orthodontist to the Craniofacial Team who is responsible for contacting the patient's community orthodontist with team recommendations and timing of care.

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