The Smile Train
245 5th Avenue, Suite 2201, New York, NY 10016 USA
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Treatment Partnership Application For Tertiary Care Centers

WHAT: Smile Train Tertiary Care Center Treatment Partnership is a unique program designed to identify and empower those international centers whose multidisciplinary cleft teams exhibit the ability to successfully manage the complex needs of the secondary cleft patient while embracing an educational program leading to the creation of a second generation of skilled cleft surgeons. If requirements are met, designated Tertiary Care Centers may submit up to 40% secondary repairs (Fistula Repair, Secondary Cleft Palate/Velopharyngeal Repair, Lip and/or Nose Revision, Alveolar Bone Graft) of all Smile Train-sponsored surgeries.

WHO: Medical professionals, hospitals, and organizations providing treatment for indigent children in developing countries, who have at least two years standing as a Smile Train Treatment Partner, and who have proven ability in the management of both primary and secondary cleft defects. These participants must be part of a recognized multidisciplinary cleft team, at a dedicated cleft center, and cleft care should be a major practice focus. The center must include a resident or fellowship-training program designed to graduate a physician versed in the management of the cleft patient from infancy to adulthood.

HOW: ***The certified center must be a Smile Train Treatment Partner for at least two years before applying.*** In addition, a tertiary center must submit the following*****:

1) *Curriculum Vitae for all members of the treating cleft team.*

2) *A case list for the previous 12 months supporting the practitioner's ability to perform the specific secondary cases expected to be performed at the center.*
   a) *For secondary lip, nose, lip/nose and palatal fistula repair cases, pre and post-operative photos documenting pre-operative defects and post-operative results of five (5) consecutive cases are required.*
   b) *For cases involving alveolar bone grafting and/or orthognathic surgical procedures, pre and post-operative photographs and pre and post-operative radiographs documenting the pre-operative osseous deficiency or the dental disharmony and the resultant post-operative outcome for five (5) consecutive cases are required.*

3) *Teams wishing to perform alveolar bone grafting and/or orthognathic surgery must document the involvement of a trained orthodontist in each index case. All cases must document a pre-operative orthodontic assessment. All orthognathic cases must document the involvement and utilization of orthodontic manipulation pre and post-operatively. Alveolar bone grafting cases should document orthodontic care appropriate to the deformity.*

4) *Teams wishing to treat velopharyngeal incompetence must have an available means of objectively documenting the presence of VPI prior to surgical intervention and documentation that the patient has been and will subsequently receive speech therapy.*

5) *Tertiary centers must forward an outline of all resident/fellow didactic material and annually submit a case list pertaining to resident training cases. A standardized means of resident/fellow testing and evaluation will be documented and results submitted.*

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Treatment Partnership Application
For Tertiary Care Centers

ABOUT YOU:

Applicant: ______________________________________ Title: ____

Hospital/Organization: ________________________________ Are you a non-profit organization? □Yes □ No

Address: ____

State/Province: _____________________ Postal Code: ___________________ Country: _________________________

Telephone: ______________ Fax: ________________ Email: __________________ Web site: ____________________

ABOUT YOUR CLEFT CARE PROGRAM:

Medical Professional(s) Overseeing the Project: ____Please submit CV

Do you belong to any associations? □No □ Yes, ____(please specify)

Does your organization adhere to The Smile Train Safety and Quality Improvement Protocol? □Yes □ No

Number of years your organization has been involved with cleft care: ____

Does your center provide interdisciplinary team care? □ No □ Yes: □ Plastic Surgery □ Oral-Maxillofacial Surgery □ Dentistry □ Speech Pathology □ Orthodontics □ Other: ____

Is your facility affiliated with a medical school or teaching hospital? □No □ Yes: __________________________________

Does your facility have experience providing pediatric anesthesia? □No □ Yes: __________________________________

Number of beds your hospital/organization has: ____

Number of children with clefts who receive surgical care at the hospital/center each year: __________________________

Number treated per year: primary lip/nose unilateral: _________ primary lip/nose bilateral: __________________________

primary cleft palate: ________ alveolar nasal fistula: _________ fistula: ______ palatal fistula: _____________________

lip/nose revision: ___________alveolar bone graft: ___________VPI: ________orthognathic:_______________________

Number of patients receiving speech therapy/year: _____Number of patients receiving orthodontic treatment/year: ______

Does your hospital/organization currently have a waiting list for cleft surgery? □No □ Yes: Number waiting: ____________

Number of children waiting for primary surgery:__________ Number of children waiting for secondary surgery: _________

Date began Smile Train Partnership: ___________Number of children helped by Smile Train partnership: ____________

Please submit Curriculum Vitae for all members of the treating cleft team.

Please attach any additional information on how designation as a Smile Train Tertiary Care Center will enable you to improve the quality of cleft care provided and/or increase the number of cleft surgeries performed.

***Only complete applications with all necessary attachments will be reviewed.**

I certify that the information in this application is true and accurate:

Signed: __________________________Name: _____________________ Title: _____________ Date: ______________

Requirements for Tertiary Care Centers

1. All patients undergoing Smile Train–funded secondary surgeries must qualify for American Society of Anesthesiology (ASA) physical status class 1 or class 2 as defined in the Smile Train Safety & Quality Improvement Protocol.

2. All Secondary cases will be reviewed through the medical record database, Smile Train Express. As a prerequisite to secondary surgery, the operating surgeon is charged with the task of ensuring follow-up evaluations occur at a minimum of 1 year post-operatively. Each visit shall be charted and photographically documented (VPI cases do not require photographic records) in Smile Train Express.

3. In cases of Velopharyngeal Incompetence (VPI) all patients must be under the continuing care of a cleft trained speech pathologist and only cases with objective documentation of VPI, consisting of nasendoscopy, videofluroscopy, nasalence, and/or aerodynamic testing will be sanctioned by The Smile Train. Other subjective analyses do not meet Smile Train criteria.

4. In cases of residual alveolar clefts, all patients must be under the continuing care of an orthodontist and appropriate radiographic documentation must be part of the Smile Train Express medical record database. In the absence of pre-operative orthodontic preparation and appropriate post-operative follow-up, no case will be sanctioned.

5. All tertiary care centers shall utilize experienced teaching surgeons who have documented proficiency in both primary and secondary cleft care. The secondary cases supported by Smile Train will be surgeon specific and reflect only cases and techniques that have been pre-approved by the Medical Advisory Board. The Medical Advisory Board's evaluation will be based upon the submitted case list and an accompanying photographic/radiographic and/or speech data that have been presented to the Board during the application process.

6. In the face of osseous manipulation, effective means of segment stabilization must be available in hospital. All centers must have the appropriate mechanical devices (saws, drills etc.) and stabilizing hardware on hand whenever osseous segments are to be manipulated in the management of secondary cleft deformities.

I certify that __________________________ (hospital/organization) meets and will adhere to the requirements:

Signed: ___________________________ Name: ______________________ Title: ______________ Date: ______