



Anatomy of Cleft/Craniofacial Service: Seattle Experience

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Why do Cleft Craniofacial Teams Exist?

The Model of Interdisciplinary Care - 3 inches from the TMJ

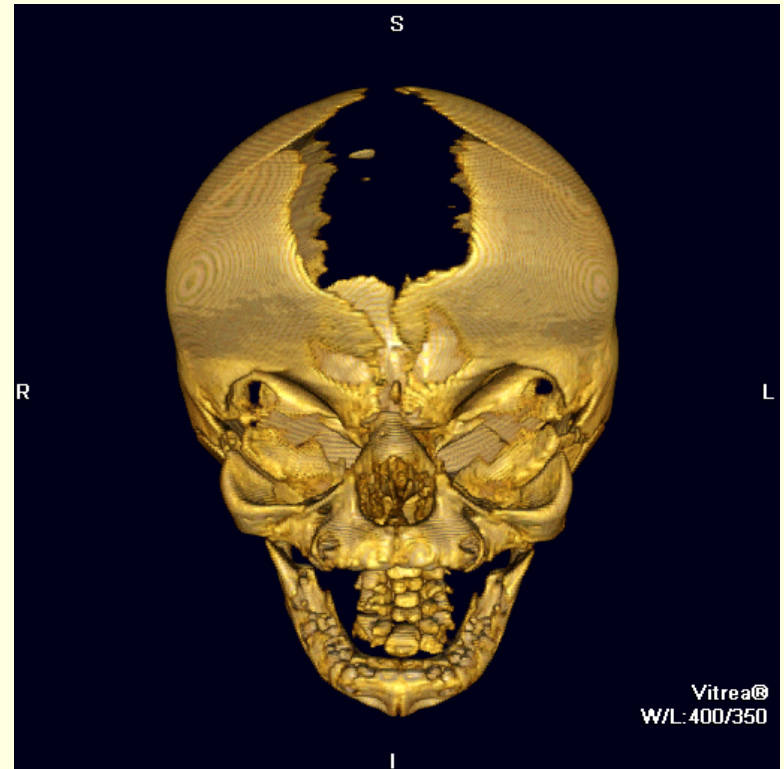


- Audiology
- Dentistry
- ENT
- Gastroenterology
- OMFS
- Neurosurgery
- Ophthalmology
- Plastics
- Pulmonology
- Speech Pathology

Is interdisciplinary craniofacial team care reserved for the most “complex” cases?



Hereditary Craniosynostosis
Cognitive Impairment
Respiratory Failure



Midfacial Deficiency
Proptosis
Hand and Foot Malformations

CRANIO  **FACIAL**

Is Orofacial Clefting “Simple” ?



The only craniofacial team providers that this patient is unlikely to need is:

Neurosurgery

Children's Craniofacial Center

47 Team Members representing 19 disciplines

Audiology

Jessika F. Horn, MS, CCC-A

Craniofacial Genetics

Ian Glass, MD

Penny Schubert, MS

Database Manager

Judy Iwata, MS

Dental Medicine

Bryan Williams, DDS, MSD

Cynthia Koudela, DDS, MSD

Developmental Genetics

Timothy Cox, PhD

Genetic Epidemiology

Jackie Starr, MS, MPH, PhD

Neurosurgery

Richard G. Ellenbogen, MD

Anthony Avellino, MD

Nursing

Kimberly Hughes, RN

Darcy King, ARNP

Marsha Ose, RN, MS, BSN

Suzanne Siegel, RN

Bay Sittler, RN, MS, ARNP

Nutrition

Camille Lanire, MSRD, CD

Regina Nagy-Steinert, CD

Occupational/Physical Therapy

Gayle Bonato, PT, MPH

Robin Glass, MS, OTR

Jane Mason, PT

Lynn Wolf, MOT, OTR

Ophthalmology

Avery Weiss, MD

Oral and Maxillofacial Surgery

Mark Egbert, DDS

Otolaryngology

Jonathan Perkins, DO

Kathleen Sie, MD

Pediatrics

Michael L. Cunningham, MD, PhD

Carrie Heike, MD, MS

Anne Hing, MD

Charlotte Lewis, MD, MPH

Plastic & Reconstructive Surgery

Joseph Gruss, MD

Richard Hopper, MD, MS, FRCSC

Jennifer Keagle, MD

Craig Birgfeld, MD

Pulmonology & Sleep Medicine

Yemi Kifle, MD

Maita Chen, MD

Psychiatry

Matthew Speltz, PhD

Brent Collett, PhD

Respiratory Home Care Specialist

Leslie Hill, RRT, LRPC

Carol Franzen, RRT, LRPC

Social Work

Cassandra Aspinall, ACSW

Monica Andrews, MSW

Speech Pathology

Wendy Bell, MA, CCC, SLP

Linda Eblen, MA, CCC

Sara Kinter, MS, CCC-SP

Administrative Program Assistants

Jerri Bishop

Kana Crealock

Marti Davis

Michael L. Cunningham, Medical Director
Richard A. Hopper, Surgical Director

The “Largest” Craniofacial Center in the United States

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The Pacific Northwest Region
(Washington, Alaska, Montana, Idaho, and Wyoming)
3.3% of the US population (~10 million people).

Our region has eight programs that treat children
with cleft and craniofacial malformations.

Over 85% of these children are treated
at Children’s Craniofacial Center

- Last year we evaluated 1691 children
- Scheduled 10,008* medical and dental evaluations
- Performed 1650 surgical procedures

**Including 1308 plagiocephaly visits*



Neonatology – treating the youngest children





Levels of Neonatal Care



- Maternity Hospitals
(Deliver babies)

I—Basic newborn care

II—Intermediate care
(preemies > 32 weeks)

III—Subspecialty care
(preemies of all ages)

IV—Full spectrum of
medical & surgical care

Free-standing Children's Hospitals

Do not deliver babies

All babies in the NICU are
transported from other
hospitals

Usually provide Level IV
services

What is unique about Children's NICU?



- We provide the highest quality care for the region's sickest babies
- The only Level IV Neonatal unit in the region:
 - Surgery for the most complex defects, including heart and brain
 - ECMO
 - All pediatric subspecialties are immediately available
- Prenatal Diagnosis & Consultation program with UW perinatologists

Advances in Neonatology



- Prenatal diagnosis
- Steroids given to mothers before preterm birth
- Surfactant—premature lung disease
- ECMO (heart-lung bypass machine)
- New ventilators
- New drugs: Inhaled nitric oxide
- Improved nutrition



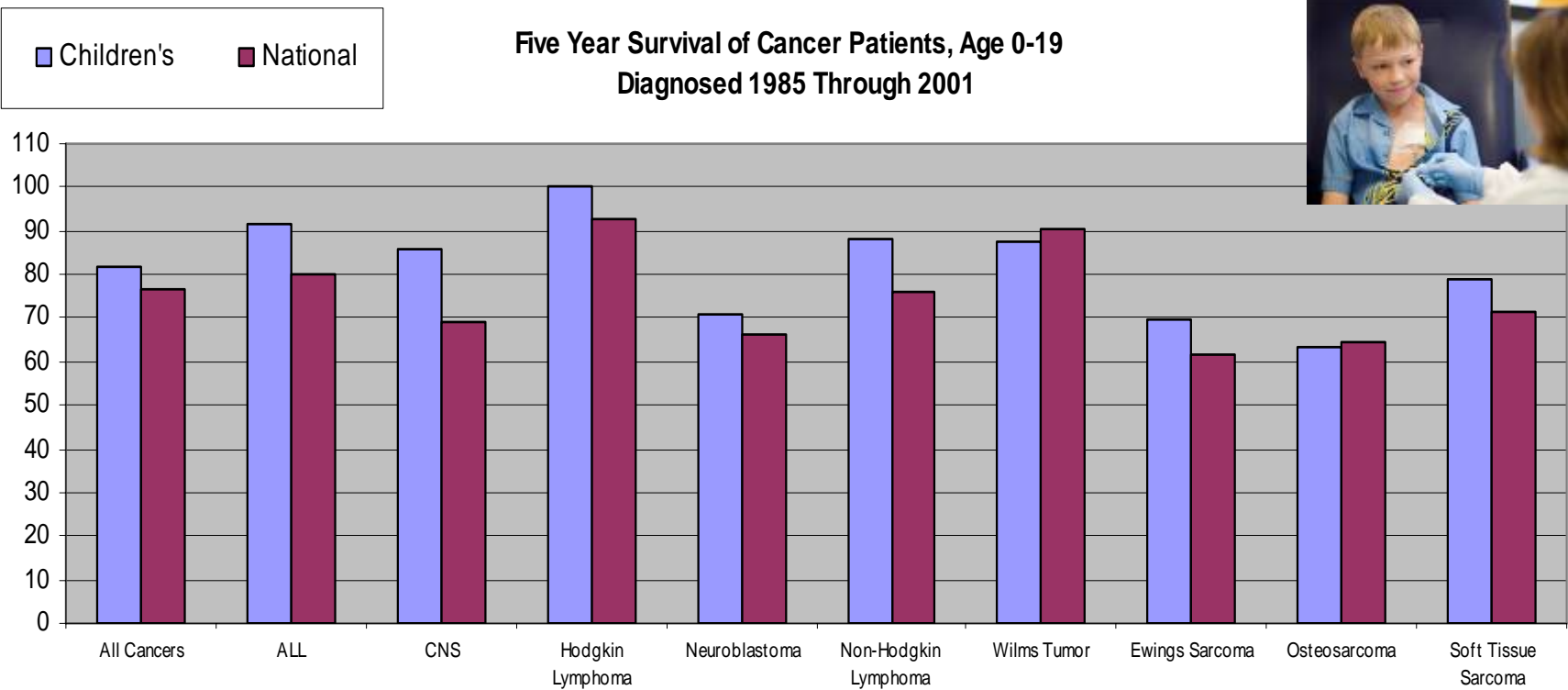
Cancer







**Five Year Survival of Cancer Patients, Age 0-19
Diagnosed 1985 Through 2001**



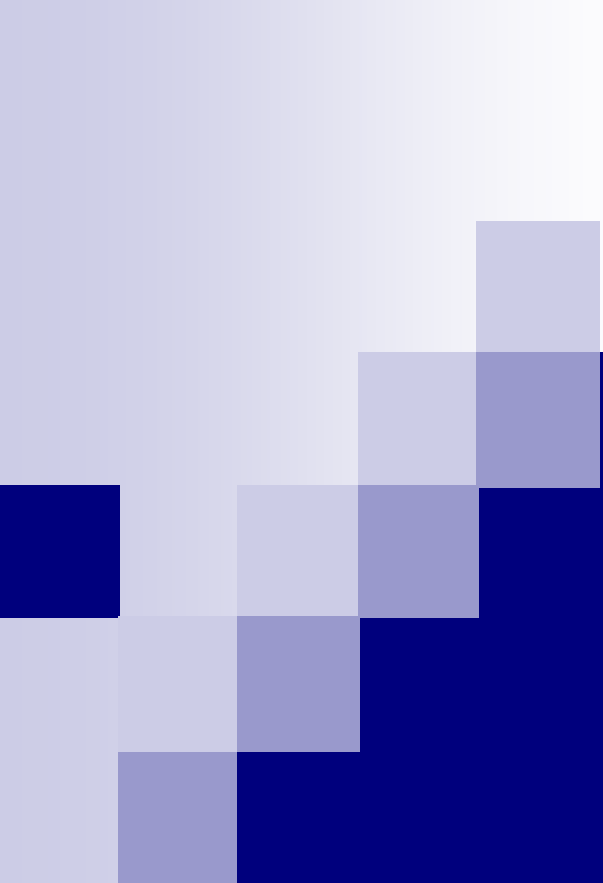
Data Source & Methods:

1. Children's Hospital and Regional Medical Center Cancer Registry. Seattle, WA. Analytic diagnoses, Kaplan-Meier Adjusted Model.
2. National: Ries LAG, Eisner MP, Kosary CL, Hankey BF, Miller BA, Clegg L, Mariotto A, Feuer EJ, Edwards BK (eds). SEER Cancer Statistics Review, 1975-2002, National Cancer Institute. Bethesda, MD, http://seer.cancer.gov/csr/1975_2002/, based on November 2004 SEER data submission, posted to the SEER web site 2005.

Diagnoses grouped according to International Classification of Childhood Cancer (ICCC) criteria

Data as of 10/06: +/- 2% error rate





Washington State Certificate of Need-- Purpose and Process

Health Facilities Planning and
Development
Seattle, WA

What is Certificate of Need?

- CN is a State statutorily-defined process, the purpose of which is to:
 - promote, maintain, and assure the health of all citizens in the state,
 - provide access to health services, health manpower and health facilities, and
 - avoid unnecessary duplication and control increases in costs.

- Administered by the Department of Health (DOH)



What is Certificate of Need?

- New licensed hospital bed capacity is one category subject to prior review and approval.
- Process generally takes 6-9 months from submittal.
 - Opportunity for public input/comment

What is required of applicants in a CN process?

- To gain approval, an applicant must demonstrate that its proposed project is:
 - needed
 - financially viable
 - can be operated in conformance with certain quality assurances, and
 - contains costs

What do CN guidelines require to be included with the initial submittal?

- Quantifiable demonstration of need
- Capital costs refined so as to be within +/-12% of actual at completion
- Project timeline (project must be commenced within 2 years of approval—or CN is forfeited)
- Architectural drawings
- Demonstration of site control
- Documentation that the proposed site may be used for the proposed project and is appropriately zoned

What do CN guidelines require to be included with the initial submittal?

- For hospitals, commitment to charity care
- Demonstration of quality/ability to operate within Medicare/Medicaid requirements
- Ability to staff appropriately
- Pro forma financials
- Commitment for financing

How does DOH project need for hospital beds?

- Separate and distinct methodologies for acute (medical/surgical) and psychiatric.
- Both methodologies have been in place since late 1970s.
- For acute care:
 - Establishes 52 geographic “planning areas” statewide
 - Estimates future population
 - Regresses 10 years of historical data on providers and residents of the planning area (“use rates”) into the future

How does DOH project need for hospital beds?

- In 1984, in recognition of its unique position among Washington's hospitals, Children's was placed into a separate planning area — known as the “Children's Hospital Planning Area”, which encompasses the state in its entirety.
 - **No other hospital has such a planning area**

How does DOH project need for hospital beds?

- In addition to the methodology, DOH has the ability to consider other factors unique to a planning area/provider:
 - Midnight occupancy levels
 - Peak capacity
 - Demand for specialized beds/lack of interchangeability among units
 - “Regionalness” of service

DOH's projections are sensitive to volume impacts and actual experience

Children's Projected Bed Need at 65% Midnight Occupancy
Using DOH Original Projections (2002) versus Updated Actual Patient Data thru Sept., 2007

