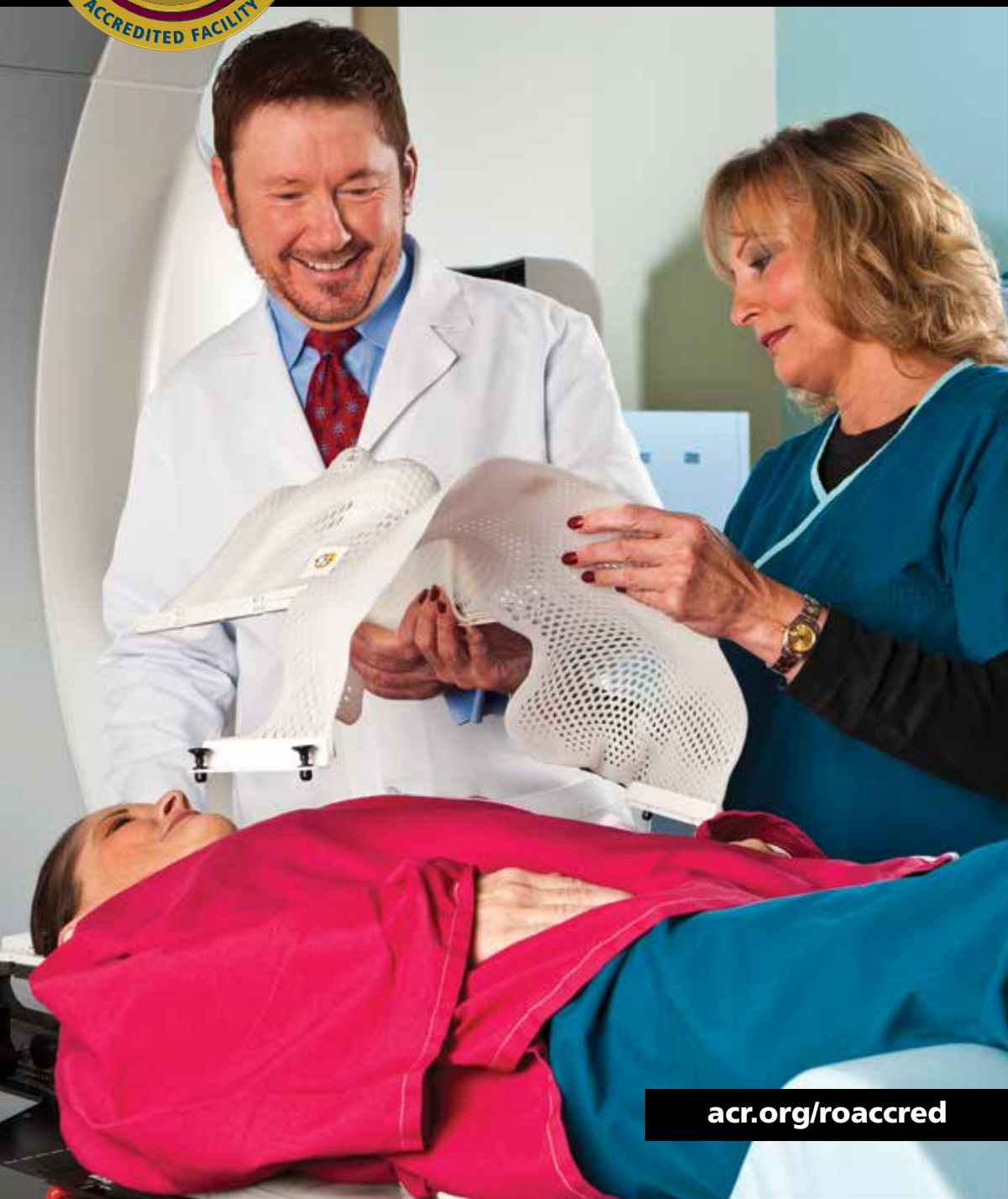
ACR Radiation Oncology Practice **Accreditation Program**

ACHIEVING EXCELLENCE IN RADIATION ONCOLOGY



acr.org/roaccred

ACR is the nation's oldest accepted accrediting body in radiation oncology. Achieving ACR accreditation demonstrates a commitment to quality and patient safety and to providing exceptional oncologic care. ACR accreditation assures all stakeholders, in particular our patients, that the facility is committed to excellence.

– William Small, Jr., MD, FACRO, FACR, FASTRO

Member, ACR Board of Chancellors
Chair, ACR Radiation Oncology Committee
Professor and Chairman
Department of Radiation Oncology
Stritch School of Medicine Loyola University Chicago

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Contact Information

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For assistance: **acr.org/ROInfo**
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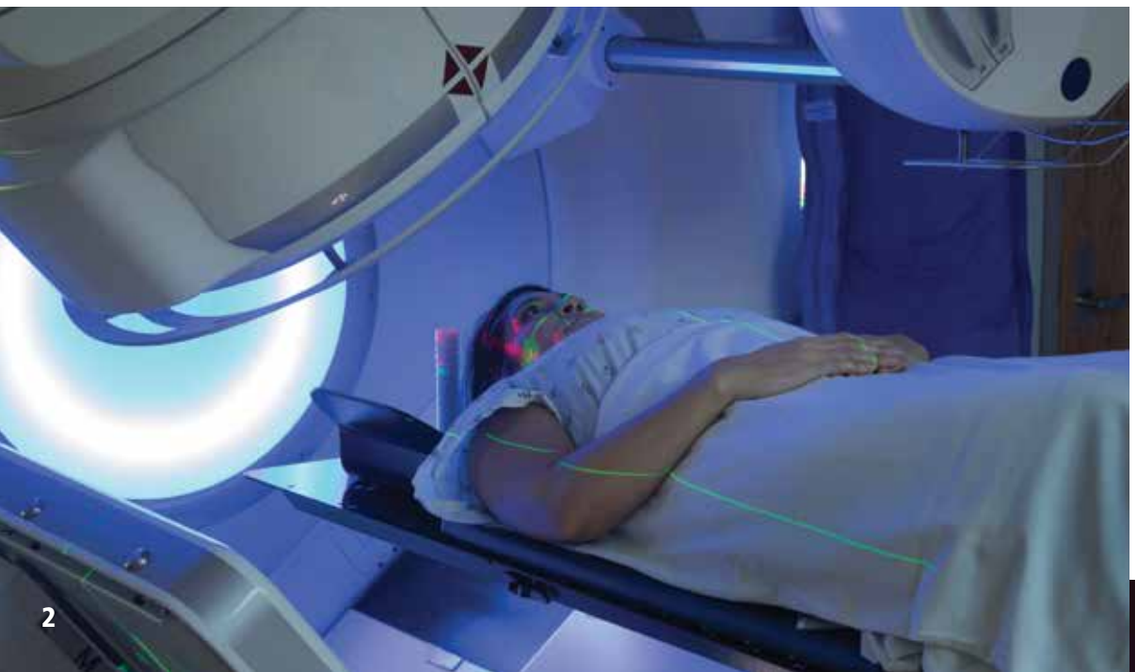
Introduction

The American College of Radiology® (ACR) Radiation Oncology Practice Accreditation (ROPA) program provides radiation oncologists with evaluation of patient care as well as third-party, impartial peer review of facility personnel, equipment, treatment planning, treatment records, patient safety policies and quality control/quality assessment activities. Recommendations for improvement are based on nationally recognized standards, including ACR Practice Parameters and Technical Standards, American Association of Physicists in Medicine (AAPM) Technical Standards, and AAPM Task Group Reports and Practice Guidelines.

The accreditation process, designed to promote quality and education, includes a survey performed by board-certified radiation oncologists and board-certified medical physicists. Each facility applying for accreditation must submit an application through the secure ROPA website, as well as facility treatment and equipment information, staffing levels and qualifications, and physics quality assurance/quality control documentation. If deficiencies or missing items are identified, the facility will be contacted to provide any missing items before the site survey is scheduled. When the application is complete, the date(s) of the survey will be confirmed.



ROPA Prices

The survey fee for the main facility is **$9,500**; each additional site is **$3,000**. **Fees are non-refundable and subject to change without notice.** If a facility has not been granted accreditation and requires a follow-up survey, a fee of **$5,000** must be submitted prior to scheduling the site visit. Checks should be made payable to the American College of Radiology.

Multiple Sites

A practice with multiple sites may be eligible for a single survey with a limited case review from each additional site. The criteria to determine eligibility include (but are not limited to):

- The physician group has a single medical director.
- The physicist group has a single director.
- Physicians' peer review includes all practice sites.
- All practice sites utilize uniform treatment methods.
- All practice sites have uniform chart organization and forms.
- Geographic accessibility (each site is within one-hour drive from main site).

If the practice does not meet the criteria, a full survey will be required for each site.

ROPA Price Guide

Sites	Cost*	Number of Days at Site
Main Site	$9,500	1
Main + 1 Satellite Site	$12,500	2
Main + 2 Satellite Sites	$15,500	2
Main + 3 Satellite Sites	$18,500	3
Main + 4 Satellite Sites	$21,500	3
Main + 5 Satellite Sites	$24,500	4
Main + 6 Satellite Sites	$27,500	4
Main + 7 Satellite Sites	$30,500	5
Main + 8 Satellite Sites	$33,500	5
Main + 9 or More Satellite Sites	Contact ACR Staff Member	-

*Includes surveyor team travel expenses for United States travel only

Checklist for Site Survey

The following items are required during the survey:

- If paper charts — a list of physicians, physicists and dosimitrists with their signatures and initials found in the patient records with printed identification (name) beside each signature.
- CVs for all physicians and physicists.
- Quality control and improvement documents, including:
  - Hospital, department, and physics policy and procedure manuals.
  - Radiation safety program documentation.
  - Physics quality control documentation.
  - Quality assessment and improvement meeting minutes.
  - Focus study and internal outcome documentation.
  - Physician peer review documentation.
  - Physicist peer review documentation.
  - Continuing Medical Education credits for all staff.
  - Licenses and/or certification for all staff.

Please arrange for the following:

- A quiet room to work, located within the radiation oncology department.
- A table surface large enough to review several charts/films/scans.
- Chairs for two surveyors.
- Two or more view boxes (if applicable).
- Two computers with dual monitors and wired internet access for each computer.
- Workstations with access to record and verify system as well as hospital/facility electronic medical records.
- Two facility staff members to assist surveyors during the site visit.

If your site cannot comply with the necessary items specified on the checklist, please contact an ACR staff member.

A member of the ACR staff will contact you prior to the survey for details such as parking, directions to site, survey agenda, etc.

Online ROPA Toolkit

The ROPA website includes a toolkit to help your practice prepare for its site survey. The physician and medical physicist data collection forms for preliminary self-assessment will be available on the website after the application has been accepted.

Include 10 cases representative of your patient mix for your self-assessment activity (e.g., breast, prostate and lung with treatment modalities such as intensity-modulated radiation therapy [IMRT], prostate seed implant, stereotactic radiosurgery, etc.). A radiation oncologist who ***did not*** provide the patient's care should complete the self-assessment forms prior to your site visit. ***Please ensure the self-assessment cases are different from the cases requested by the ACR for the surveyors to review.***

This self-assessment activity is an excellent tool for internal peer review activities of physicians and medical physicists as part of your continuous quality improvement program. While the forms are optional, it is recommended that you review and complete them before your site survey, as they will no longer be available after your survey is complete.

ROPA Survey

The ROPA survey is conducted over one business day (for a single facility). Multisite surveys require additional days based on the number of sites, geographic locations and practice patterns. During the survey, the surveyors will tour the facility; verify information submitted in the facility's application; conduct an interview with the chief/medical director of radiation oncology, the chief physicist, department administrator/chief therapist, dosimetrist, nurse and other key personnel; collect information about the facility's patient treatment policies, procedures, and safety initiatives; and review the selected cases.

The radiation oncologist and medical physicist will answer questions and review charts that include components, such as complete and signed prescriptions, consent forms, pathology reports, history and physical, physician management during treatment and follow-up, appropriateness of treatment, simulation/treatment planning, and dosimetry activities.

At the end of the day, the surveyors will meet with the group for a brief exit interview. This is primarily to clarify any issues prior to their departure; the team will not provide their recommendations at this time as that is a committee decision made following review of the survey results. For multisite surveys, the exit interview time and place will be determined with ACR and facility staff.

A comprehensive review of the facility's physics program is included as part of the application process and verified during the survey. The radiation oncology physicist is responsible for the design and implementation of a physics quality management program. The following areas **require documentation** submitted with the application:

- Documentation of compliance with AAPM TG-51, TG-106, TG-119, TG-120 and TG-142.
- Documentation of a treatment planning system quality assurance program in accordance with TG-53 or relevant AAPM Medical Physics Practice Guideline.
- Independent verification of each beam output.

During the survey, the qualified medical physicist's documentation of the following will be reviewed:

- Procedures for instrument calibration and periodic instrument constancy checks.
- Procedures to verify the manufacturer's specifications and establish baseline performance values for radiation therapy equipment.
- Quality management program for radiation therapy equipment, simulators, treatment planning systems and monitor unit calculations.
- Monitor unit calculation procedures and protocols.
- Physics chart check protocol for reviewing treatment delivery.
- Procedures for checking the integrity of mechanical and electrical patient care devices.
- Radiation protection program as it pertains to radiation oncology.
- Calculations related to patient dosimetry and/or physics measurements when such needs arise or per clinician's requests.

Frequent Deficiencies

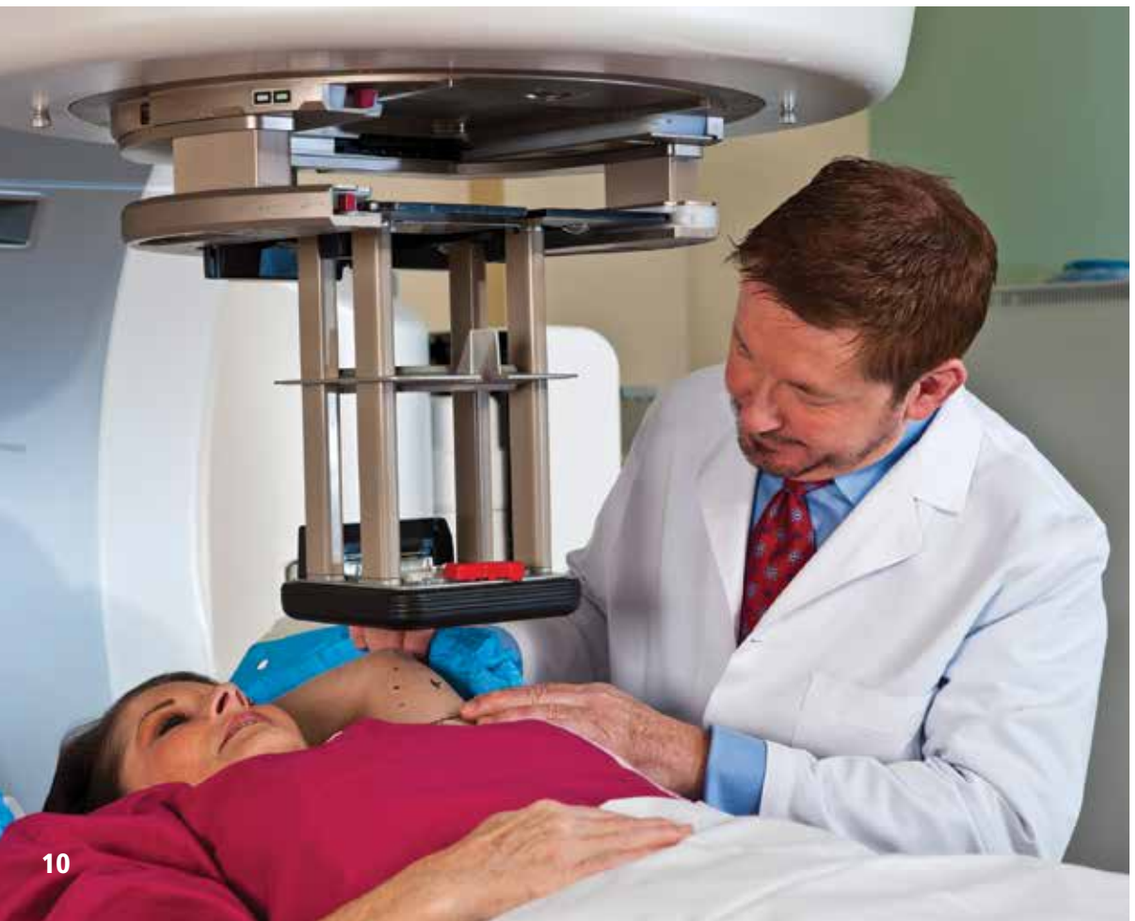
The following are deficiencies that are ***frequently*** found during a survey and will be included in the final report. These deficiencies must be addressed before a facility will be granted accreditation. Please note that other serious deficiencies, not seen frequently and therefore not listed, may also require corrective action and documentation prior to granting of accreditation.

- Insufficient information in consultative note.
- Incomplete patient history and physical examination.
- Incomplete treatment prescriptions.
- Lack of defined goals and requirements of treatment plan by radiation oncologist (e.g., dose constraints).
- No formal treatment planning quality assurance plan.
- Lack of dose volume histograms.
- Lack of proper treatment quality assurance prior to patient treatment (e.g., no IMRT QA).
- No written directive for brachytherapy procedure(s).
- Insufficient radiation oncologist coverage during patient treatment.
- Lack of port film verification.
- Lack of documented weekly patient visits.
- No documented patient follow-up plan.
- No formal quality assurance and improvement program documented (e.g., outcome studies, focus studies).
- No physician or physicist peer-review documented.
- End-of-treatment physics check not performed within a week.

Final Report

After the survey, the ACR Committee for Radiation Oncology Practice Accreditation issues a final report to the radiation oncologist who requested the survey. The report is generally sent within 8–12 weeks following the survey. The report is based on the findings of the surveyors as well as information provided in the initial application and verified by the surveyors. The accreditation report includes:

- Comparison of facility/staffing data with the accredited facility data.
- Evaluation of facility's compliance with parameters, standards, and program requirements from application information and review by surveyors.
- Surveyor comments on individual case reviews.
- Specific recommendations for improvement.



Staffing Levels*

In the final report, the facility's staffing levels for radiation oncologists, physicists, radiation therapists and dosimetrists are compared to the accredited facility averages and averages for the facility's stratum as defined in the following table. The table allows facilities to identify personnel and equipment utilization issues. Staffing recommendations may be part of the final report; however, variations from these levels generally do not result in the withholding of accreditation unless inadequate staffing levels result in non-compliance with ACR Practice Parameters and Technical Standards and/or compromise patient safety.

		New Patients Per:					FTE Therapists Per Treatment Machine
	FACILITY STRATUM	Radiation Oncologist	Physicist	FTE Dosimetrist	FTE Therapist	Treatment Machine	
	All Accredited Facilities	212	258	254	85	232	3.1
	Academic/Comprehensive Cancer Center/Main Teaching Hospital of a Med School	187	206	247	79	291	4.3
Hospital-Based	600 or more patients	273	280	297	96	295	3.2
	201–599 patients	225	255	257	84	223	2.9
	200 or fewer patients	139	188	180	65	136	2.4
Free-Standing	600 or more patients	263	343	318	97	328	3.8
	201–599 patients	239	326	285	101	267	3.5
	200 or fewer patients	141	236	209	71	141	2.3

*While it may be instructive to compare staffing data to the facility's stratum and to the national average for accredited facilities, note that this data is incomplete in some important aspects. The data does not account for the staff's other duties (e.g., simulation for therapists) nor is the data scaled for complexity or the proportion of different pathologies treated at any given clinic. Each facility should, when comparing their staffing data to stratum and national averages, consider their patient population, range, and complexity of services provided, and any staff duties outside of the core duties assumed in this data table.

Accreditation Status

The term of accreditation is three years. Facilities not granted accreditation will either be:

a) Deferred with 90 days to submit a Corrective Action Plan

After the Corrective Action Plan is approved by the committee, the facility may be required to perform a self-audit (measures for self-audit will be selected by the committee) and submit the results no later than six months after receipt of response to corrective action. Following committee approval of the self-audit, the facility may be granted a three-year accreditation. The committee may request a scheduled survey if Corrective Action Plan is approved. Additional fees may apply, including surveyor expenses such as travel and lodging.

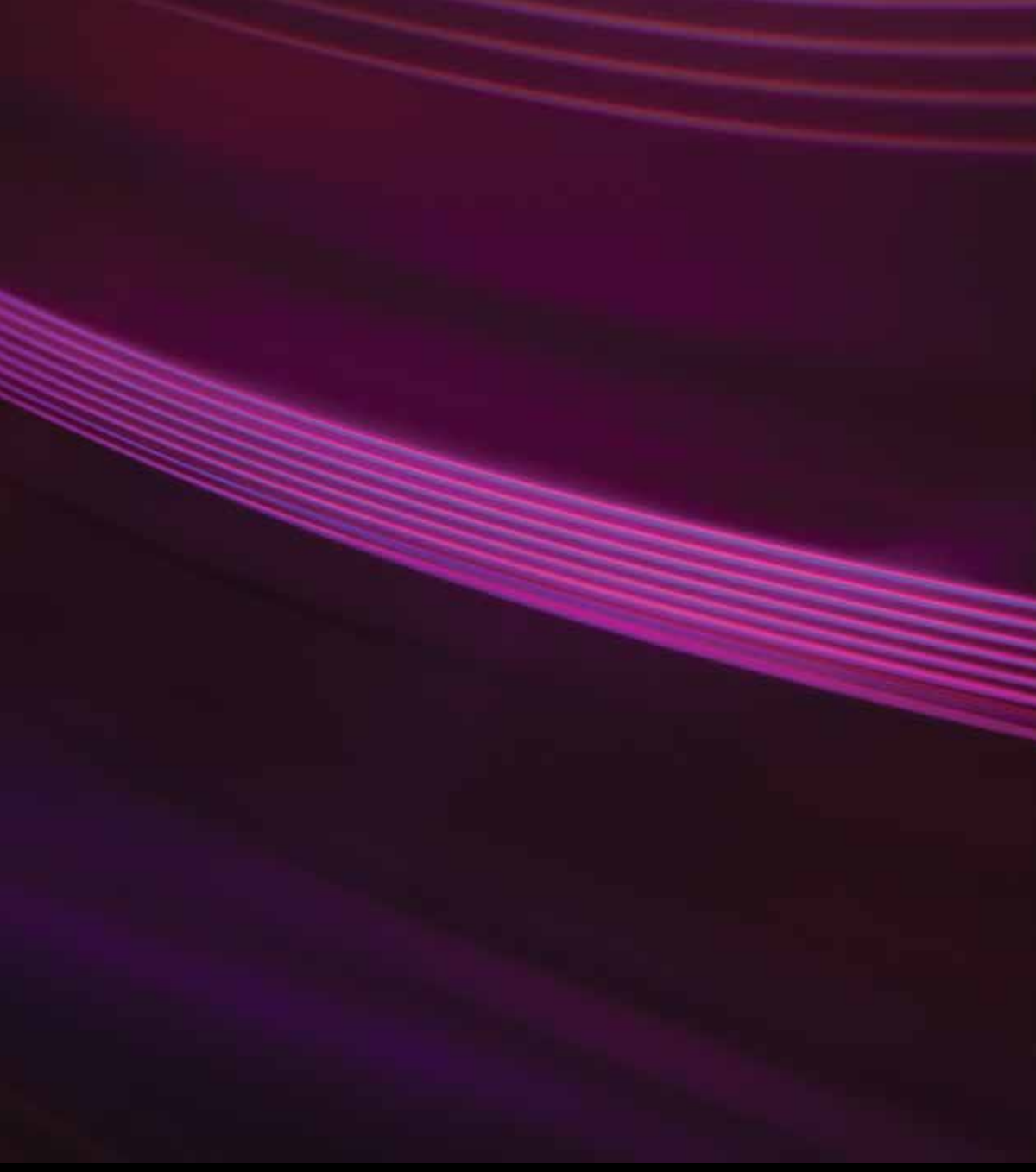
b) Denied with 90 days to submit a Corrective Action Plan

After the Corrective Action Plan is approved by the committee, the facility will be required to participate in a follow-up survey (six to nine months after receipt of corrective action response). **A re-application fee of $5,000 must be submitted with the survey agreement.** Additional fees may apply, such as surveyor expenses (e.g., travel and lodging). The surveyors will complete a report of findings to be reviewed by the committee. Following committee approval of this report, the facility may be granted a three-year accreditation.

R-O PEER and ACR M-P Peer Programs for Maintenance of Certification

R-O PEER® and ACR M-P PEER® are practice quality improvement (PQI) programs accepted by the American Board of Radiology (ABR), providing radiation oncologists and medical physicists an opportunity to fulfill Part Four: Practice Quality Improvement for the ABR Maintenance of Certification program. R-O PEER and ACR M-P PEER are part of the chart review during the ROPA site survey. Any radiation oncologist and/or medical physicist interested in participating in R-O PEER and ACR M-P PEER must complete and submit an application along with the ROPA electronic application. This PQI program does not require the submission of additional cases, but there must be at least two cases per physician participating in R-O PEER.

Following the ROPA survey, a final report and certificate of satisfactory completion of practice assessment will be issued to each participating radiation oncologist and medical physicist. If any recommended action measures are identified, the final report will request additional documentation demonstrating that such measures have been appropriately addressed.



ACR Online Resources

acr.org/ppts — ACR Radiation Oncology Practice Parameters and Technical Standards

acr.org/roaccred | 1·800·770·0145

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