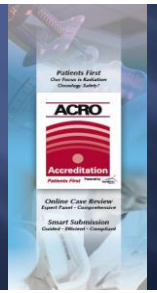

ACRO Practice Accreditation Program

Matthew B. Podgorsak

Disclosures

- Chief Physicist, Roswell Park Cancer Institute
- Member – ACRO Physics Standards Committee
- Site Surveyor – ACRO PAP
- Receive honoraria for completed site surveys

Acknowledgement

- *Claudio Sibata, PhD, FACRO*
- *Shannon Sperati*

What is ACRO?

- American College of Radiation Oncology
- Formed in 1990
- About 1200 members, primarily Radiation Oncologists, but Medical Physicists can join as Associate Members (about 50)

ACRO Mission Statement

ACRO strives to ensure the highest quality care for radiation therapy patients and promote success in the practice of radiation oncology through education, responsible socioeconomic advocacy, and integration of science and technology into clinical practice.

History

- ACRO developed a program in 1995 to accredit radiation oncology practices (ACRO-PAP).
- Since then, ACRO-PAP has undergone periodic revisions to reflect clinical and scientific advances within the field.
- In October 2010, ACRO-PAP emerged from an extensive administrative review with an updated and intuitive Web-based accreditation system, powered by EqualEstro.

Goals of Accreditation

- To assist practices in providing comprehensive state-of-the-art care
- To assist the healthcare consuming public to identify centers with the best practices
- To provide a comprehensive program for the continuous improvement of patient care

Program Features

- 100% focus on radiation oncology
- Detailed & organized online process, with automatic status updates
- 100% electronic submission of patient case files and other data / documentation
- Unbiased, blind, online case reviews by a panel of disease site experts

Program Features (con't)

- Onsite physics and administrative review
- Onsite equipment review
- HIPAA compliant
- Comprehensive
- Delivered in timely fashion
  - Expectation: 90 days to accreditation decision

Accreditation Decision

- Full Accreditation
  - all guidelines met
  - valid for 3 years
- Provisional Accreditation
  - some guidelines not met
  - valid for up to 1 year
  - must submit corrective actions within 1 year
  - if acceptable, will convert to Full Accreditation for remainder of 3 year time period
- Deferred Accreditation

Directors

- ***Medical Director – Jaroslaw Hepel, MD, FACRO***
  - oversees all aspects of medical chart reviews
  - oversees medical physics and administrative components of accreditation review
  - makes final recommendation for accreditation to Executive Committee
- ***Physics Director - Claudio Sibata, PhD, FACRO***
  - oversees all aspects of the medical physics review
  - reviews all physics reports
- ***Administrative Director – Audrey Hide, BS, RT(T)***
  - oversees all aspects of the administrative review
  - reviews all administrative reports

Key Personnel

- ***Practice Coordinator:*** Designated contact person at a practice applying for accreditation, and is the single point of contact with ACRO.
- ***ACRO Accreditation Coordinator:*** Responsible for day-to-day administration of the process, and is the primary ACRO contact for the Practice Coordinator.
- ***Disease Site Reviewers/Leaders:*** Disease site specific experts, overseen by a team leader.

Key Personnel (con't)

- ***Surveyors:*** Board certified physicists and certified RTT/CMDs; complete the onsite review of equipment, facilities and case records of a practice.
- ***Executive Committee, ACRO Board of Chancellors:*** This Committee oversees the day-to-day functions of the College and assigns formal accreditation status on behalf of the ACRO Board of Chancellors.
- ***Executive Director:*** Delivers final accreditation report to a practice.

Process

1. Practice Coordinator submits application and application fee at acro.org
2. ACRO Accreditation Coordinator contacts Practice Coordinator to complete payment form.
3. ACRO Accreditation Coordinator creates online profile and sends Practice Coordinator login/submission instructions.

Process (con't)

4. Practice Coordinator completes online practice survey and uploads patient case list with disease site and procedure information.
5. ACRO Accreditation Coordinator randomly selects cases for review and directs Practice Coordinator to upload the selected patient case files.
6. Disease site experts review uploaded case files using a standardized format and submit reports to the ACRO Accreditation Program Medical Director.

Process (con't)

7. ACRO Accreditation Coordinator arranges for an on-site visit through the Practice Coordinator. On-site reviewers file reports with the Medical Director, ACRO Accreditation.
8. The Medical Director, ACRO Accreditation forwards a formal report and recommendation of accreditation status to the ACRO Executive Committee for review and action.
9. The Executive Director delivers a report to the Practice Coordinator that includes the level of accreditation, and a certificate of accreditation is issued.

Disease Site Team Leaders

Breast Cancer Jaroslaw Hepel, MD, FACRO	**Gastro-Intestinal Cancer** William Regine, MD, FACRO and Navesh Sharma, MD, FACRO
Genitourinary Cancer Peter Orio III, MD, FACRO	**Gynecologic Cancer** Arno J. Mundt, MD, FACRO
Head and Neck Cancer Dwight Heron, MD, FACRO	**Lung Cancer** Shilpen Patel, MD, FACRO
Lymphoma & Sarcoma Mary Hebert, MD, FACRO	**Neurological Cancer** Dheerendra Prasad, MD, FACRO

Brachytherapy
D. Jeffrey Demanes, MD, FACRO

Disease Site Team Leader Responsibilities

- ❑ develop and maintain chart measures to establish chart review standards
- ❑ maintain ACRO Clinical Guidelines
- ❑ oversee/mentor chart reviewers

Chart Reviewer Responsibilities

- each chart reviewer electronically audits and grades charts using furnished online grading tool
  - tool vetted and periodically amended
- questions, concerns, discrepancies resolved w/ disease site team leader
- charts are to be reviewed and evaluation completed within 11 calendar days of acceptance (includes two weekends)

Chart Reviewer Qualifications

- Board Certification in radiation oncology
- actively practicing
- ACRO member in good standing
- no less than five years of practice experience
- complete an initial training course
- maintain annual certification as an active reviewer

Administrative Review

- **Administrative Director –** Audrey Hide, BS, RT(T)
  - oversees all aspects of administrative reviews
  - updates evaluation metrics/standards to reflect the current state-of-the-art
  - reviews all administrator survey reports
  - makes recommendation for accreditation to Medical Director
- **Administrative Surveyors**
  - experienced staff with clinical, technical and supervisory skills
  - 5 years experience and are certified RTT/CMDs
  - provide onsite evaluation of the technical delivery of treatment
  - provides an independent report in the accreditation process

Administrative Onsite Survey

- Review chart reports done by chart reviewers
  - investigate any problems uncovered during chart reviews
- Active treatment chart review:
  - Simulation documentation
  - Treatment imaging documentation
  - Treatment delivery documentation

Administrative Onsite Survey (con't)

- P&P related to Patient safety
- annual training, in-services, competencies
- certifications and/or licensure
- staffing levels
- interview with administrator, chief therapist and/or any other key personnel
- tour of the facility

Physics Review

- Physics Director
  - Claudio H Sibata, PhD, FACRO
    - oversees medical physics aspects of the program
    - reviews all medical physics reports
    - makes recommendation of accreditation status to the Medical Director

Physics Review (con't)

- Physics Committee
  - review physics reports when there are issues that need to be decided by the committee:
    - conflict of interest
    - new procedures not covered in the standards
    - new standards
  - reviews standards for accreditation
  - annual review of practice guidelines
- Members:
  - Ray Kaczur, MS
  - Bhudatt Paliwal, PhD
  - Matthew Podgorsak, PhD

Physics Review (con't)

- Physics Surveyors
  - experienced clinical physicists
  - Board-certified
  - provide onsite evaluation of the technical delivery of treatment
  - provides an independent report in the accreditation process

Physics Surveyor Training

- Webinar with the Physics Director
  - requirements to be a surveyor
  - process of accreditation, concentrated on the physics guidelines
  - report requirements
- One on-site survey with experienced physics surveyor
  - offered to all new physics surveyors

Physics Onsite Survey

- Review all uploaded documentation prior to visit. Any issues needing verification noted.
  - Staffing
  - Major Equipment
  - Physics Equipment
  - QA Program
  - CQI Program
  - Registration & State Inspections
  - Internal/External Audits
  - Peer Review
  - Charts Review

Physics Onsite Survey

- QA Program
  - Beam data comparison with published data
  - Calibration done by independent method of all clinical beams
  - Any other independent checks done on procedures
  - All therapy (external and brachytherapy) and ancillary devices have adequate QA program comprised of daily, monthly and annual checks with appropriate comprehensive documentation

Physics Onsite Survey

- QA Program
  - All treatment planning systems (external and brachytherapy) have commissioning reports and QA program with appropriate documentation
  - All special procedures have QA program and appropriate documentation

Physics Onsite Survey

- QA Program
  - Treatment QA
    - second MU independent check/IMRT QA prior to 1st fraction
    - initial, weekly and end-of-treatment chart check
    - in vivo dosimetry. Are tolerances reasonable?
    - are manual entries allowed in R&V?
    - are changes allowed in R&V parameters once the plan is imported?

Physics Onsite Survey

- CQI Program
  - committee
  - chart rounds
  - M&M conferences
  - peer review
  - annual review of charts (external beam and brachytherapy)
- License & registration
  - state inspection recommendations
  - internal/external audit recommendations

Accreditation Result

- 25% Full Accreditation
- 74% Provisional Accreditation
- <1% Deferred Accreditation

Some Common Reasons for Provisional Accredititaion

- missing acceptance testing / commissioning documentation for equipment (linac, CT sim, TPS)
- lack of P&P that two registered and licensed Therapists must be engaged at the console (linac or CT scanner) during the delivery of a patient treatment or patient simulation
- equipment service reports not reviewed / signed by the Medical Physicist prior to the equipment being released for clinical use

Some Common Reasons for Provisional Accredititaion

- lack of a multi-disciplinary enterprise-wide Quality Assurance committee that can oversee all aspects of the Continuous Quality Improvement (CQI) plan
- lack of the necessary software to enable a second monitor unit (MU) calculation for all IMRT / VMAT treatment plans
- all patient final physics checks not completed within one week of a patent's completion of treatment

Some Common Reasons for Provisional Accredititaion

- TPS quality assurance program does not meet appropriate AAPM protocols and Task Group recommendations
- lack of a peer-review program (Radiation Oncologist & Medical Physicist)
- annual linac focused reviewed not comprehensive (e.g., DLG not measured, no comparison to TPS parameters)
- lack of a near miss / medical event reporting system

Summary

- ACRO-PAP structured to help practices achieve excellence
- Comprehensive review of clinical practice:
  - appropriateness of clinical care
  - P&P
  - QA procedures / documentation
  - equipment maintenance
- Physics guidelines are current, based on AAPM Reports, MPPGs, other publications, etc.
- Comprehensive report outlining any deficiencies is provided

Thank you!