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The mission of ASTRO’s Accreditation Program for Excellence (APEx®) is to recognize facilities by objectively assessing the radiation oncology care team, policies and procedures, and the facility.
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In October 2012, the ASTRO Board of Directors voted to develop a radiation oncology practice accreditation program. This decision provides the opportunity to build upon and integrate ASTRO’s quality improvement initiatives. Findings from APEx will potentially highlight variances in the delivery of radiation oncology care, inform educational offerings, and identify topics for clinical practice statements and quality measures development. The ASTRO Accreditation Program for Excellence (APEx®) was created to support quality improvement in radiation therapy practices. The program establishes standards of performance derived from white papers and consensus practice guidance for radiation oncology. Facilities that obtain practice accreditation will have the systems, personnel, and policies and procedures that are needed to meet the APEx standards for high-quality patient care.

The mission of the ASTRO Accreditation Program for Excellence is to recognize facilities by objectively assessing the radiation oncology care team, policies and procedures, and the facility.

APEx provides an objective review by professional peers of essential functions and processes of radiation oncology practices. It offers transparent, measurable, evidence- and consensus-based standards that emphasize a professional commitment to safety and quality. Radiation oncology practices accredited by ASTRO will:

• Undergo an objective, external review of radiation oncology programs, policies and processes;
• Demonstrate respect for protecting the rights of patients and responsiveness to patient needs and concerns; and
• Adopt procedures to encourage safety and quality of care.

**DEFINITION OF RADIATION ONCOLOGY PRACTICE**

APEx defines a radiation oncology practice (ROP) as a medical practice offering radiation therapy services in the U.S., utilizing the services of intradisciplinary professionals under the direction of a board certified radiation oncologist.

An ROP may be a multi-facility practice (e.g., a ‘main facility’ with satellites) with:

1. Common policies and procedures for key evidence indicators.
2. A medical director who is responsible for each facility and one individual from practice leadership who is responsible for the culture of safety standard operating procedure.
3. All facilities located within a 50 mile radius of the main facility.
4. The same corporate ownership of all the facilities.
THEMATIC FOCUS OF APEx STANDARDS

The program standards are organized around five Pillars as described below:

**PILLAR ONE: THE PROCESS OF CARE**

The “process of care” in radiation oncology refers to a conceptual framework for delivering appropriate, high-quality and safe radiation therapy treatment to patients. Use of ionizing radiation in medical treatment requires direct or personal physician management as the leader of the radiation oncology team, as well as input from various other essential coworkers. The standards in this chapter derive from the model Process of Care flow diagram in the consensus report *Safety is No Accident: A Framework for Quality Radiation Oncology Care.*

**PILLAR TWO: THE RADIATION ONCOLOGY TEAM**

The radiation oncology team works to provide every patient undergoing radiation treatment with the appropriate level of medical, emotional and psychological care before, during and after treatment, through a collaborative multidisciplinary approach. The primary radiation oncology team consists of, but is not limited to, radiation oncologists, medical physicists, medical dosimetrists, oncology nurses and radiation therapists.

**PROGRAM STANDARDS DEVELOPMENT TIMELINE**

The standards represent the cornerstone of the practice accreditation program. Development of the program standards can be characterized as interdisciplinary, evidence-based, inclusive and transparent as detailed in the process below:

**December 2012 - March 2013:** The interdisciplinary APEx Work Group drafted and refined the program standards. Using *Safety Is No Accident: A Framework for Quality Radiation Oncology and Care,* a comprehensive set of 19 standards was drafted. The Work Group was very cognizant of assessing the feasibility of the standards regardless of the size or structure of the radiation oncology practice.

**April 7 - May 17, 2013:** The draft standards were posted for public comment. More than 700 respondents provided feedback on the standards, including representatives of every member of the radiation oncology team and payers. After the public comment period closed, staff collated the comments and made recommendations to the Work Group. Once the changes were made, drafts of the recommendations were circulated to the Work Group for approval prior to the next in-person meeting.

**June 2013:** The Work Group met for two days in Chicago to review and refine the standards.

Once the draft standards were agreed to by the Work Group in June, staff began further specifying the standards including:

- Streamlining the evidence indicators. (Objective evidence that demonstrates compliance with the standard.)
- Developing the questionnaire statements.
- Documentation requirements, exclusions, data sources.
- Scoring.

**November 2013:** A subject matter expert reviewed the specifications with the Work Group during a series of teleconferences and drafted a working set of standards for the feasibility testing which occurred in mid-November 2013.

Further refinements to the draft standards were made post-feasibility testing. Some evidence indicators were deleted because of redundancy while others were promoted to ‘mandatory’ status. Some standards were held for future updates to the program. The Work Group was re-surveyed in late November to assess the degree to which there was consensus with proposed modifications. There was overwhelming consensus among Work Group members.

**January 2014:** A final list of 16 standards was presented to the ASTRO Board of Directors. The Board approved the 2014 APEx standards.
PILLAR THREE: SAFETY
The radiation oncology practice creates an interdiscipli-
inary team-based culture of safety that continuously reviews,
monitors and adapts all aspects of safety.
• Standard 7: Culture of Safety
• Standard 8: Radiation Safety
• Standard 9: Emergency Preparation and Planning

PILLAR FOUR: QUALITY MANAGEMENT
The ROP has a quality management program that includes
the facility, equipment, information management, treat-
ment procedures and modalities, and peer review.
• Standard 10: Facility and Equipment
• Standard 11: Information Management and Integration
  of Systems
• Standard 12: Quality Management of Treatment
  Procedures and Modalities
• Standard 13: Peer Review of Clinical Processes

PILLAR FIVE: PATIENT-CENTERED CARE
The APEx patient-centered care standards aim to make
care safer by promoting effective communication, coor-
dination of care and engaging patients and families as
partners in care. These priorities are reflected in the APEx
standards and performance measures for the practice of
radiation oncology.
• Standard 14: Patient Consent
• Standard 15: Patient Education and Patient Health
  Management
• Standard 16: Performance Measurement and
  Outcomes Reporting

BASIS FOR STANDARDS
The standards reflect competencies and practices identi-
fied and endorsed in the publication, Safety is No Accident:
A Framework for Quality Radiation Oncology and Care. This
framework provides guidance for essential practices in
radiation oncology. It describes a multidisciplinary ap-
proach to care that focuses on quality measurement to
encourage safe, effective and peer-reviewed radiation
oncology care. The ASTRO standards translate the goals
outlined by the Framework into objective, verifiable ex-
pectations for performance in radiation oncology practice.
Performance expectations identified in the Framework
were supplemented by other resources that include:
• ASTRO Q/A White Paper on Intensity Modulated
  Radiation Therapy (IMRT) Safety (July 2011).
• ASTRO Q/A White Paper on Stereotactic Body
  Radiation Therapy (SBRT) Safety (January 2012).
• ASTRO Q/A White Paper on Peer Review (March, 2013).
• ASTRO Q/A White Paper on Image Guided Radiation
  Therapy (IGRT) Safety (July 2013).
• ASTRO Q/A White Paper on High Dose-Rate Brachy-
  therapy (2014).
• ASTRO Clinical Practice Guidelines.
• AAPM Task Group Reports.
• Canadian Partnership for Quality Radiotherapy.
• Agency for Healthcare Research and Quality.
• National Quality Forum measures and recommenda-
tions.
• Other professional recommendations and peer
  reviewed literature.

It is expected ASTRO will work closely with radiation on-
cologists, interdisciplinary radiation therapy professionals,
consumers and payers to identify improved performance
indicators and measures of quality improvement. Through
this continuous quality improvement, the APEx program
and its accredited facilities will be on the forefront of qual-
ity and performance.
ELIGIBILITY

Radiation oncology practices (ROPs) based in the United States may apply for APEx accreditation. ROPs may be either a single facility or multi-facility practice. Practices that operate multiple facilities under a standardized set of operating procedures and a single corporate designation may apply for multi-facility accreditation. For multi-facility practices, APEx will review corporate level operating procedures and will carry out facility-specific verification of compliance for each facility included in the accreditation application.

RADIATION ONCOLOGY PRACTICE

For purposes of the program, an ROP is defined as a medical practice offering radiation therapy services, utilizing the services of intradisciplinary professionals under the direction of a board certified radiation oncologist. An ROP may be a multi-facility practice (e.g., a ‘main facility’ with satellites). All of the following criteria will be used to determine if a multi-facility practice can apply for all facilities to be covered by the same accreditation application:

- common policies and procedures of key evidence indicators;
- a medical director who is responsible for each facility and one individual from practice leadership who is responsible for the culture of safety;
- all facilities located within a 50 mile radius of the main facility; and
- the same corporate ownership of all the facilities.

Note, although a multi-facility practice may be covered under one application, accreditation determinations will be made for each facility individually.

Example:

Green University academic practice has four facilities:
- Facility 1 = main campus
- Facility 2 = freestanding center
- Facility 3 = Green University affiliated hospital center
- Facility 4 = community hospital contract

In this example, the ROP may apply for a multi-facility practice review for facilities 1-3. Facility 4 will need a separate application because the community hospital has its own distinct policies and procedures.

LENGTH OF ACCREDITATION CYCLE AND PRICING

APEx accreditation is granted for a four year cycle. In order to avoid a lapse in accreditation, the ROP must complete the reaccreditation facility visit no later than 90 days after expiration of the accreditation date.

Example:

The reaccreditation process consists of application and payment, self-assessment and facility visit.

The base fee for practice accreditation is $12,000. An additional $4,000 is required for each additional facility. If your practice has more than 10 facilities, please contact apexsupport@astro.org for pricing information.

APEx accreditation is granted for a four year cycle. In order to avoid a lapse in accreditation, the ROP must complete the reaccreditation facility visit within a specified timeframe.
APEx ACCREDITATION SCOPE

APEx consists of a series of standards and measures relating to the performance of a radiation oncology practice. APEx evaluates the clinical programs provided by radiation oncology practices, focusing on quality and safety of radiation oncology processes.

It is expected applicants comply with all applicable local, state and federal regulatory requirements. In addition, all professional staff must adhere to the ethical and professional standards of their respective professional associations. The APEx standards identify systematic quality and safety approaches that build on the regulatory framework to add value for practitioners and health care consumers.

ASTRO reviews all treatment modalities in operation at the time of the accreditation application and survey facility visit. Practices may not imply or state that equipment or facilities not reviewed by ASTRO are accredited.

SURVEYOR ORIENTATION

APEx surveyors are provided with an intense orientation that consists of a series of interactive online modules. Surveyors are required to complete these modules prior to conducting their first survey. These modules include an overview of the APEx program, HIPAA, surveyor roles and responsibilities, as well as a detailed review of the program standards. Participants will be eligible to earn continuing education credits for completing the orientation.

The orientation modules begin with HIPAA and an overview module which are foundational to the overall program success. Surveyors will be automatically enrolled in these modules as soon as their surveyor application has been accepted. Throughout the months leading up to a surveyor’s first facility visit, they will complete modules based on the five pillars of the APEx program. Lastly, each surveyor will take a roles and responsibility module that is based on the two primary facility visit surveyor roles. All of the courses will include a series of short knowledge checks, as well as a content assessment.

ACCREDITATION GOVERNANCE AND DECISION-MAKING

APEx taps into the deep expertise of ASTRO members. The accreditation process includes an objective review of applicant information by staff accreditation reviewers, and verification of compliance by practicing radiation oncology professionals. APEx includes objective review by practicing radiation oncology professionals with facility visits as part of the evaluation process.

The Practice Accreditation Committee is charged with reviewing blinded facility survey reports, issuing accreditation decisions, and when necessary, reviewing applicant appeals. Members of the Practice Accreditation Committee are trained in compliance requirements of the APEx accreditation standards. Each member attests to any potential conflicts of interest and adheres to ASTRO’s policy of recusals where a conflict may be present.
ACCREDITATION PROCESS OVERVIEW

Phase I (Complete Application)
- The ROP submits information about facilities including, annual number of new patients treated, treatments offered and equipment.
- Information on all currently commissioned radiation therapy equipment.
- A signed facility agreement and HIPAA business associate agreement.
- Nonrefundable payment.

Phase II (Assess for Readiness)
- Practice receives APEX Self-assessment Guide, which is a comprehensive document providing a step-by-step process for completing the self-assessment.
- Submits self-assessment documentation including results of medical record abstraction, policies and procedures, and other supportive materials.
- ASTRO staff and surveyors review self-assessment and supporting documentation. An interim report is issued identifying strengths and gaps in compliance with the standards.

Phase III (Survey Preparation)
- Facility visit and surveyors are scheduled.
- Pre-facility visit teleconference is conducted with the radiation oncology practice and ASTRO staff. The purpose of the teleconference is to verify staffing, equipment, changes to the application, facility expectations, HIPAA security policies and other logistical arrangements.
- ROPs are expected to provide the following resources during the facility visit:
  o Patient list by name and case identification numbers.
  o Access to medical records/paper charts.
  o Two computers per surveyor. (One computer is needed to access the electronic medical record and another for the Web-based electronic data entry platform).
  o Staff resource to guide the surveyor through the medical record.
  o Dedicated work space for the surveyor team.
  o Access to key staff for interviews.
  o Signature list (staff names, titles and signatures).

Phase IV (Facility Visit)
- Surveyors conduct a facility visit using a Web-based tool.
- Facilities provide feedback regarding experience with surveyors.

Phase V (Disposition)
- Surveyors submit final report.
- Practice Accreditation Committee makes final determination (accredit, provisionally accredit, deny).
- ASTRO notifies facility of determination.

PRACTICE ACCREDITATION COMMITTEE DETERMINATIONS
The committee will make one of three determinations based on a practice’s score:
- **Accredit** – The ROP complies with the APEX standards; accreditation will be recognized for four years.
- **Provisionally Accredit** – The ROP does not proficiently comply with the APEX standards and will need to satisfy specifications of a Corrective Action Plan (CAP) within a pre-determined time frame.
- **Deny** – The ROP does not comply with the APEX standards and will need to make considerable modifications to their policies and procedures and re-apply.

ACCREDITATION PROCESS IN DETAIL
An ROP interested in seeking accreditation should expect the following process steps:

**Accreditation Initiation:** Eligible applicants gain access to APEX Web-based application and self-assessment submission tool. The application is officially in process when ASTRO receives:
- A completed facility agreement and HIPAA business associate agreement.
- All required fees.

**Accreditation Application:** This process is described in detail below: ROPs will submit an online application with supporting documentation, and will undergo a facility visit from professional peers. The submitted application
includes detailed information about the ROP's equipment, programs, personnel and treatment processes; the APEx interview and facility visit validates submitted information and offers objective review by practicing radiation oncology professionals.

Data Collection Methods: To assess the degree to which the standards are met, objective data will be collected through documented evidence, policies and procedures, interviews with key staff, and medical record abstraction. All data are recorded through a Web platform.

Results: Data collection results will be summarized and generated electronically. The facility visit report will be reviewed by the Practice Accreditation Accreditation Committee, an independent, multidisciplinary committee.

Accreditation Decision: Accreditation decisions are made by the the Practice Accreditation Accreditation Committee, which reviews reports from the practice application, self-assessment and facility visit. After official notification of determination, ROPs may announce their accreditation status and use the APEx accreditation seal in accordance with ASTRO’s communications policies. ASTRO will provide template materials for news releases and language that can be incorporated into marketing material.

Interim Period: APEx accreditation is granted for four years. ROPs are expected to maintain accreditation compliance between accreditation reviews. APEx may conduct interim facility visits on a random basis or to address a specified concern. Expectations for the interim period are described later in this guide.

APEx REQUIREMENTS

The APEx accreditation review includes two layers of review:

1. A self-assessment that includes documented evidence of compliance with each standard either through existing policies and procedures or medical record abstraction;
2. Participation of the ROP in a facility visit that includes staff interviews, document review and further medical record review to verify information in the self-assessment.

Each ROP will submit detailed information regarding characteristics of the practice that demonstrate compliance with the APEx standards.

THE ACCREDITATION APPLICATION

Each applicant is required to submit an application for accreditation, along with supporting documentation. The application includes the following information:

Practice Information:

- Name, address and contact information for the ROP, along with any additional facilities of services (satellites).
- Name, contact information and credentials of each member of the facilities' key personnel.
- Identification of the point of contact for questions relating to the application and scheduling facility visits.
- Radiation equipment.
- List of all practicing radiation oncologists.

A completed table of services that includes the following information:

- Number of adult patients.
- Number of pediatric patients.
- Types of disorders (both malignancies and other diseases) treated.
- Types of treatments offered (i.e., IMRT, SBRT, IGRT, HDR, SRS, proton therapy, etc.).

Data Collection Methodology

Each document submitted to ASTRO provides evidence of compliance with APEx accreditation standards. Documents should be uploaded to the Web platform as a PDF file and should be clearly paginated. Detailed instructions on the information to be provided are included in the APEx self-assessment guide. Examples include:

- Policies and procedures for the practice.
- Job descriptions for each staff member or category of staff member (e.g., radiation therapist, dosimetrist, physicist).
- Minutes, meeting summaries or other documentation showing that the applicant carries out requirements of the standards.
**Submission of Medical Records**

Standards requiring patient-centered information will be collected through medical record abstraction. The number of medical records from which data is collected is based on the patient population of the main facility.

For a single facility seeking accreditation, no less than 15 records and no more than 25 records may be abstracted based on size. Satellites will not be required to provide medical records for the self-assessment, but will be required to undergo a medical record audit with the surveyor on-site. Additional medical records (see chart below) are required and must meet the same criteria as the main facility.

Medical record abstraction occurs within Phase II and Phase IV of the accreditation process.

- **Phase II (Assess for Readiness):** Self-assessment – During the self-assessment, data obtained through medical record abstraction are derived from medical records chosen by the main facility. The information provided to ASTRO as a result of this self-assessment will not be patient protected health information. The medical records chosen by the facility for the self-assessment must meet the following requirements:
  - Records must be pulled proportionate to the number of physicians in the practice (e.g., three physicians in practice with 300 patients per year, each physician should be represented by five medical records).
  - Diversity in modality must be present; Each modality the practice uses must be represented by a minimum of one record.

- **Phase IV (Facility Visit):** Facility surveyor review — During the facility visit, a specified proportion of the medical records used in the self-assessment must be included in the facility visit surveyor review of records. The surveyor will review a sample of the medical records that the ROP reviewed during their self-assessment as well as a set of new charts.
  - The medical records used for both self-assessment and facility visit as well as the medical records used only for the facility visit, must meet the same two criteria listed above.

### NUMBER OF MEDICAL RECORDS

<table>
<thead>
<tr>
<th>Annual patients per year</th>
<th>MAIN FACILITY</th>
<th>Satellite Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Self-assessment</td>
<td>Facility Visit: Review</td>
</tr>
<tr>
<td>&lt;600</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>600 - 1200</td>
<td>20</td>
<td>7</td>
</tr>
<tr>
<td>&gt;1200</td>
<td>25</td>
<td>8</td>
</tr>
</tbody>
</table>

**Self-Assessment:** The number of medical records that the facility will review and report on during the self-assessment phase of APEx.

**Review:** The number of medical records included in the self-assessment, that the APEx surveyors will “review” at the main facility during the facility visit phase of APEx.

**Facility Visit/Main Facility:** The number of “new” medical records that the APEx surveyors will “review” at the main site during the facility visit phase of APEx.

**Satellite Visit/ Satellite:** The number of “new” medical records that the APEx surveyors will “review” at the satellite site during the facility visit phase of APEx.
A listing of the medical records should be provided to the surveyors during the facility visit. APEx will assign numbers to map to the list. After the facility visit is completed, the ROP will maintain the list with the medical record numbers and the numbers assigned by APEx. This approach avoids the collection and documentation of protected health information and allows the ROP to crosswalk the findings of the APEx survey to patients’ medical records.

**OTHER DATA COLLECTION INFORMATION**

The two surveyors at the main facility will include a radiation oncology medical physicist (P) and one of the following: radiation oncologist, or other radiation oncology personnel (O).

<table>
<thead>
<tr>
<th>STANDARD</th>
<th>ASSIGNED SURVEYOR</th>
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<tbody>
<tr>
<td>Standard 1</td>
<td>O</td>
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<tr>
<td>Standard 2</td>
<td>P</td>
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<tr>
<td>Standard 3</td>
<td>P</td>
</tr>
<tr>
<td>Standard 4</td>
<td>O</td>
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<td>Standard 5.1-5.6</td>
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<tr>
<td>Standard 5.7</td>
<td>O</td>
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<td>Standard 6.1-6.3</td>
<td>P</td>
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<td>Standard 7</td>
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<td>Standard 11</td>
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<tr>
<td>Standard 13</td>
<td>P</td>
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<td>Standard 14</td>
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<td>Standard 15</td>
<td>O</td>
</tr>
<tr>
<td>Standard 16</td>
<td>O</td>
</tr>
</tbody>
</table>

**STANDARDS COMPLIANCE REVIEW**

ASTRO staff will verify that the applicant has submitted the required documentation. This documentation will be reviewed remotely. These materials will be reviewed to assess initial compliance with each element of the standards.

Radiation oncology practices must demonstrate that they have been compliant with the standards for at least six months for first time applicants. Accreditation renewal applicants are expected to maintain compliance throughout the accreditation period. For renewal applicants APEx may conduct chart reviews for patients seen in the year prior to the accreditation application and may assess the ROP’s activities during the period.

Based on information submitted to APEx as part of the self-assessment process, ASTRO staff will provide feedback on the practice’s performance and provide the practice with an interim feedback report. Applicants are cleared to proceed before a facility visit will be scheduled. A facility visit will be used to confirm compliance through interviews, observation and random audits of patient records and other documentation. ROPs whose documentation is not cleared may submit additional documentation or information in order to proceed.

Where applicable, the applicant should show a standard operating procedure (SOP) that documents the ROP’s policies and procedures. ASTRO will verify ongoing implementation of the standard requirement as assigned in the self-assessment guide.

The standards build the expectation that practices will have documented SOPs for all key functions of the practice. Facility visit interviews will validate information.

Radiation oncology practices must demonstrate that they have been compliant with the standards for at least six months for first time applicants.
THE SURVEYOR TEAM

Each survey to a single location practice or ‘main facility’ will consist of a two-person team (a medical physicist and a radiation oncologist, or other member of the radiation oncology team) that will last one day. The primary team will conduct an in-depth review at the main location and additional surveyors will conduct expedited reviews of key evidence indicators at the satellite facilities lasting approximately four hours. One additional medical physicist will be added for every two satellite facilities. Medical physicists will be used exclusively for satellite facility site visits to confirm appropriate quality assurance (QA) activities.

Prior to the facility visit, the surveyor team will have access to the radiation oncology practice’s file including the application (which describes the staffing, modalities, record and verification system, electronic medical record platform, and the documents uploaded in the self-assessment).

ACCREDITATION PROCESS TIMELINE

The following timeframes are associated with key activities related to the accreditation. Note that the time required for preparation may vary for different ROPs based on readiness for an accreditation review. ROPs that have been previously accredited may require less preparation.

**Accreditation Application Submission** (approximately two weeks):
- An application is submitted electronically.

**Self-assessment** (approximately 6-12 weeks):
- Upon application and receipt of required fees, the practice is provided access to the self-assessment tool.
- Applicant conducts self-assessment to identify strengths, weaknesses and gaps in compliance with standards.
  - Applicant develops and implements required policies and procedures identified in self-assessment gap analysis.
  - Applicant trains staff in required procedures.
  - Applicants should be able to demonstrate that they have implemented each required process for at least three months.

**Self-assessment Review** (approximately eight weeks):
- The purpose of the self-assessment review is to facilitate the ROP’s readiness for accreditation.
- ASTRO staff review documentation submitted with the self-assessment to ensure that all required materials have been submitted.
- ASTRO staff will contact the applicant for additional information if needed.
- An interim feedback report is issued to the practice identifying strengths and areas where there are gaps in compliance.
- Applicants are notified if they are ready to proceed for a facility visit or if they must complete the self-assessment again.
- Applicants receiving a green light to proceed will be contacted to schedule a facility visit.
- Applicants determined to need additional information will have 90 days to correct deficiencies and train staff on updated procedures. After 90 days the applicant will submit updated documentation, which must show compliance with the standards requirements during the 90 days. At that time, instruction to proceed will be granted.

**Facility Visits**
- Applicants assigned a facility visit will have it within 60 days of the interim feedback report/proceed decision (approximately eight weeks from the submission of the self-assessment).

**Practice Accreditation Committee Review**
- Following completion of the facility visit, a report and supporting documentation will be submitted to the Practice Accreditation Committee. The Committee meets monthly to review accreditation reports. The Committee’s final decision is made at the meeting and is conveyed to applicants.
Once a facility has been accredited by ASTRO, its accreditation status can be revoked or a practice could be put on probation.

- **Revocation** of accreditation status can happen when the Practice Accreditation Committee determines that the practice has a persistent or significant lapse in safety that impacts the decision on compliance with one or more of the APEx standards, has falsified information provided to ASTRO or has materially changed the ROP to the extent that it is no longer eligible for or compliant with ASTRO’s accreditation requirements.

- **Probation** of a facility can occur if ASTRO learns that a practice is not currently in satisfactory compliance with the APEx standards or does not cooperate in a complaint investigation. Probationary status continues for such period until ASTRO determines that full accreditation should be resumed or until accreditation is revoked.

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**ACCREDITATION REPORTS**

APEx believes that performance review and feedback are an important value-added aspect of the accreditation program. An interim feedback report will be provided to the practice upon completion of the self-assessment.

At the time of the final accreditation determination by the Practice Accreditation Committee, ASTRO will provide a written summary to applicants. For each standard, ASTRO will identify areas of compliance and non-compliance. ROPs will also be benchmarked against other ROPs who have participated in the program. This document should be reviewed by the quality management team of the applicant in order to identify areas of opportunity for quality improvement.

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**ACCREDITATION DECISIONS**

The final accreditation status of applicants is determined by the Practice Accreditation Committee. Decisions are made on the basis of the final accreditation application score and review of any additional information or reports. The following status determinations are available:

- **Accreditation**: This is a four year accreditation awarded to applicants who comply with APEx standards.

- **Provisional Accreditation**: This is a temporary accreditation awarded to applicants who are in the process of achieving compliance with the APEx standards by completing a corrective action plan (CAP). Applicants meet all of the mandatory standards but may have some shortcomings in other areas of performance. Within the timeframe outlined in the CAP, applicants must submit updated information to ASTRO in identified areas of shortcomings. If the applicant meets requirements of the standards, the provisional accreditation designation is converted to accreditation for the remainder of the four years since the initial determination.

- **Denied**: ROPs that are determined not to meet the requirements of the standards following a full review are denied accreditation by the Practice Accreditation Committee and may reapply after one year. In instances where an ROP is denied accreditation due to submission of false information to ASTRO, ASTRO may, in certain circumstances, allow the ROP to reapply. Reapplication in these circumstances is in the sole discretion of ASTRO.

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**APPEALS**

The following decisions are subject to appeals rights:

- In the case of a facility applying for accreditation, a denial of full or provisional accreditation.
- In the case of a facility applying for accreditation, the award of provisional, instead of, accreditation.
- In the case of a provisionally accredited facility, a denial of accreditation or revocation of provisional accreditation.
- In the case of a fully accredited facility, a decision to revoke the facility’s accreditation.
- In the case of a facility on probationary status, a decision to revoke accreditation.
SCORING

Total score is based on the aggregate scores of each evidence indicator. Compliance with each evidence indicator will be collected through a Primary Measure Type (listed below).

APEx provides information to the applicants on their performance on each evidence indicator. Some evidence indicators are designated as “mandatory.” These evidence indicators are considered an essential aspect of ROP services or they directly impact patient safety. Regardless of scores on non-mandatory indicators, applicants must meet all mandatory standards in order to pass accreditation.

Each indicator takes into account exclusionary criteria relevant to medical record abstraction data (e.g., pregnancy status is not applicable in a male record). Evidence indicators within the standards may contain “exclusion criteria” which will negate the inclusion of points from that evidence indicator. Points withheld based on exclusions will not count negatively towards final score. Final scores are adjusted accordingly for exclusionary criteria.

In addition to passing mandatory evidence indicators overall performance on other evidence indicators will be calculated to create a final score. Accreditation decisions will be based on this final score.

MEASURE TYPES

**Medical Record Abstraction:** A portion of medical records is reviewed by the ROP in advance of the facility visit using the self-assessment tool, and a portion is reviewed during the facility visit by APEx surveyors.

**Document Upload:** The ROP uploads documents to APEx to substantiate compliance.

**Interview:** Questions and activities involving APEx surveyors during the facility visit. For evidence indicators that require interview, examples are provided in the self-assessment and other preparatory documents.

ASTRO is committed to improving the quality and safety of patient care in our specialty. To this end, APEx establishes standards of performance derived from white papers and consensus practice guidance and provides an objective review by practicing radiation oncology professionals of the essential functions and processes of radiation oncology practices. Facilities that obtain practice accreditation through APEx will have the systems, personnel, policies and procedures to provide high quality, safe patient care. ASTRO looks forward to working with all members of the radiation oncology community as we work toward this common goal.