



Accreditation Program Guide

Diagnostic Imaging - 4 year accreditation

August 2021 V10

College of Physicians & Surgeons of Alberta (CPSA) accredited facilities and other approved users may download, print or make a copy of this material for their non-commercial personal use. Any other reproduction in whole or in part requires written permission from CPSA and the material must be credited to CPSA.

1.0 Purpose of Accreditation.....	4
2.0 College of Physicians & Surgeons of Alberta (CPSA) Accreditation Program ..	5
2.1 CPSA LINES OF BUSINESS	5
CPSA regulates the practices of medicine in Alberta including:	5
2.2 CPSA MISSION, VISION, VALUES.....	5
2.3 CPSA ORGANIZATIONAL STRUCTURE (ACCREDITATION DEPARTMENT) - FIGURE 17	
2.4 ACCREDITATION PROGRAM HISTORY	8
2.5 AUTHORITY AND OVERSIGHT	8
2.6 OVERVIEW OF DIAGNOSTIC IMAGING (DI) ACCREDITATION PROGRAM.....	10
2.7 PERSONNEL	12
2.7.1 CPSA DI facility accreditation personnel and roles	12
2.7.2 Advisory Committee on Diagnostic Imaging	13
2.8 ASSESSMENT TEAMS.....	13
2.8.1 Assessment coordinator	14
2.8.2 Physician reviewer	14
2.8.3 Team selection	14
2.8.4 Assessment team training	15
2.8.5 Conflict of interest / confidentiality agreements / liability.....	15
3.0 Standards Document	15
3.1 STANDARDS OVERVIEW	15
3.2 FORMAT OF STANDARDS	18
3.3 ASSESSMENT OF COMPLIANCE (AOC)	20
3.4 TERMS AND DEFINITIONS.....	21
3.5 REFERENCE LISTING	21
3.6 REVIEW AND REVISION OF STANDARDS.....	21
4.0 Accreditation Process – 4-year Re-accreditation	23
4.1 INITIATION	24
4.2 PRE-ASSESSMENT.....	25
4.3 PRE-ASSESSMENT.....	31
4.4 ON-SITE ASSESSMENT	33
5.0 Honoraria and Expense Reimbursement.....	47
6.0 Annual/Assessment Fees	47

1.0 Purpose of Accreditation

Accreditation is defined as the public recognition of quality achievement by a healthcare organization, as demonstrated through an independent external peer comparison of the organization's performance against current best practices.

The College of Physicians & Surgeons of Alberta (CPSA) diagnostic accreditation programs:

- assist facilities with a process of ensuring accuracy and reliability of examination/services
- provide standards of practice and assess compliance to these standards
- identify deficiencies that affect the quality of examination/services, and impact patient and/or staff safety
- evaluate a facility's quality system's ability to identify and mitigate risk and variability in system processes
- gives formal recognition of a facility's provision of quality diagnostic services
- encourage and facilitate peer review
- provide educational opportunities for both the facility being accredited and the Assessment Team
- promote uniformity in practice provincially, where variations in practice are counter-productive for the province
- maintain a comprehensive data repository for scope of service/levels of imaging and resources
- promote standardization and educational initiatives across Canada through inter-provincial collaboration
- promote and encourage dialogue amongst stakeholders on best practices and best ways to incorporate them into the workflow
- ensure effective medical direction over medical practices so that business interests do not determine the standards of care

2.0 College of Physicians & Surgeons of Alberta (CPSA) Accreditation Program

2.1 CPSA LINES OF BUSINESS

CPSA is mandated by legislation to regulate the practice of medicine in Alberta and is responsible for licensing physicians, administering standards of practice and conduct, and resolving physician-related complaints.

It also provides leadership and direction on issues of importance to the health care system such as access to services, quality improvement, patient safety and privacy.

The Council of CPSA is composed of physicians elected by members of the profession in Alberta, Deans of Medicine in Alberta members of the public appointed by the Minister of Health.

CPSA regulates the practices of medicine in Alberta including:

- registering physicians
- accrediting health facilities
- supporting continuing competence
- investigating and resolving physician-related complaints
- contributing to public policy affecting health care delivery
- guiding professional conduct and ethical behavior

2.2 CPSA MISSION, VISION, VALUES

Our vision

The highest quality medical care for Albertans through regulatory excellence.

Our mission

Serving the public by guiding the medical profession.

Our values

We do the right thing.

We act responsibly, respectfully and with integrity, aspiring to be fair and responsible. We acknowledge our mistakes as well as our successes, and strive to do what's right in the service to the public.

We make informed decisions.

Our decisions are based on evidence, knowledge, experience and best practice. We plan, measure outcomes and apply what we learn.

We empower people.

We believe people perform best when they see the Vision, set their own goals, have the resources they need and aspire to excellence and personal growth.

We collaborate.

We invite others to contribute to achieving our goals and value their time and expertise. We share what we know generously within our legislated limits, and seek opportunities to collaborate externally in areas of mutual interest.

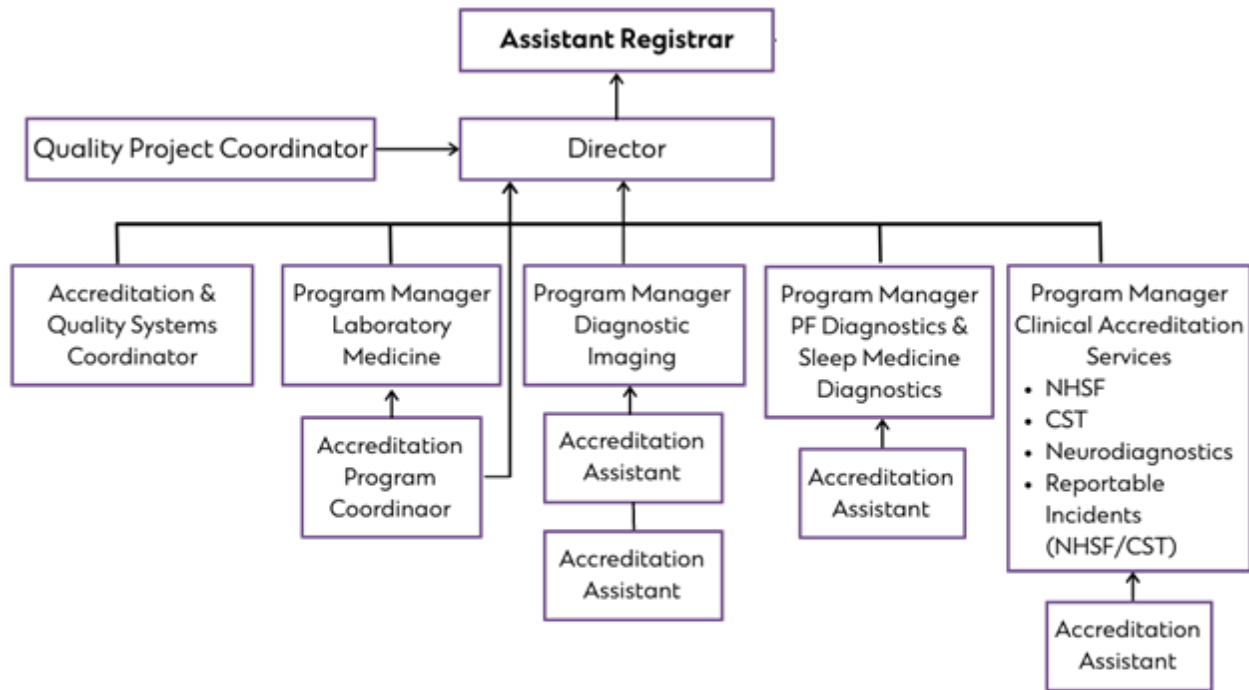
We are innovators.

We think ahead to create opportunity. We set the bar high and value creativity in exploring new and better ways of doing our work.

We enjoy and find meaning in our work.

We care about what we do and give our best. While our work is serious, we enjoy camaraderie with our coworkers and take time to celebrate each other's milestones and achievements.

2.3 CPSA ORGANIZATIONAL STRUCTURE (ACCREDITATION DEPARTMENT) - FIGURE 1



CPSA November 2020

2.4 ACCREDITATION PROGRAM HISTORY

In 1965, CPSA, upon recommendation from the Alberta Society of Pathologists, took steps to set up a program for accreditation for diagnostic medical laboratories. The Advisory Committee on Laboratory Medicine, which then reported to Council of the CPSA, was formed. The mandate of the Committee was to monitor and improve the quality of clinical laboratory services in Alberta. In order to meet this mandate, the Committee developed a process for accreditation that included requirements for on-site assessments of medical laboratories and a proposal for a proficiency-testing program to monitor testing performed.

The first assessments for accreditation took place in 1968 and included only non-hospital based laboratories. In 1970 the Alberta Department of Health entered into a contract with CPSA to accredit hospital-based laboratories on their behalf and to make recommendations to them pertaining to accreditation.

The CPSA Accreditation scope includes:

- Diagnostic Imaging (DI)
- Diagnostic Laboratory (LAB)
- Neurodiagnostics (NEURO)
- Cardiac Stress Testing (CST)
- Sleep Medicine Diagnostics (SMD)
- Hyperbaric Oxygen Therapy (HBOT)
- Pulmonary Function Diagnostics (PFD)
- Non-Hospital Surgical Facility (NHSF)

2.5 AUTHORITY AND OVERSIGHT

The College of Physicians & Surgeons of Alberta is constituted under the *Health Professions Act* (Schedule 21) with a mandate to regulate medical practitioners and medical practice in the best interests of the public of Alberta. Authority to accredit specified medical services and facilities is one aspect of that mandate.

Pursuant to section 8.4 of Schedule 21 of the *Health Professions Act*, and the Bylaws of CPSA, facility staff are required to cooperate fully with any assessment, which shall include:

- a) permitting the assessment team to enter the imaging facility and assess the premises and all diagnostic equipment located therein;

- b) permitting the assessment team to assess all records pertaining to the provision of diagnostic imaging services, and providing copies of the same if so requested;
- c) providing to the assessment team, information requested by them in respect of the provision of diagnostic imaging services, in the facility;
- d) providing the information described in clause (c) in the form requested by the assessment team;
- e) providing requested samples or copies of any material, specimen, or product originating from the diagnostic imaging services, provided by the facility;
- f) answering questions posed by the assessment team as to procedures or standards of performance and if requested, providing copies of records relating to procedures followed and standards of performance applied in the diagnostic imaging facility;
- g) providing requested copies of all documents and information relating to business arrangements involving the practice conducted in the diagnostic imaging facility.

Although CPSA's statutory authority does not extend to health services in approved hospitals or healthcare facilities operated by the Government of Canada or the Government of Alberta (*Health Professions Act* Schedule 21 - 8.1(1)), the value of practice uniformity between the private and public sectors and the credibility of CPSA's programs have long been acknowledged by practitioners and government. Consequently, four of CPSA's accreditation programs (laboratory medicine, diagnostic imaging, pulmonary function and neurophysiology) are under contract with government agencies (AHS) to provide accreditation of public sector facilities.

CPSA's accreditation programs are overseen by a standing committee, the Medical Facility Accreditation Committee (MFAC), with members appointed by the Council from diverse disciplines in clinical and diagnostic medicine. MFAC conducts a secondary review of practice standards developed by the accreditation advisory committees, hears argument on all changes to accreditation standards and reviews facility accreditation statuses. A member of the MFAC also attends a full meeting of the individual accreditation advisory committees each year to report on the diligence and objectivity of the work conducted.

The 6 standing advisory committees are composed of peer professionals (both physician/technical) who identify the needs and realities of Alberta stakeholders based on local practice.

2.6 OVERVIEW OF DIAGNOSTIC IMAGING (DI) ACCREDITATION PROGRAM

CPSA administers accreditation programs for those services that Council determines deserve explicit standards and verification of compliance with those standards, whether pertaining to the qualifications of physicians who provide them or the safety of those services to the public.

Accreditation looks at compliance, emphasizing continuous quality improvement and promoting optimum performance. More specifically, CPSA's accreditation program looks closely at policies, processes and procedures to assess the safety and reliability of the service being provided, as well as the performance of the people involved and the product produced.

The DI Accreditation Program examines all aspects of imaging quality and operations including:

- organization, management and personnel
- quality management systems including policy, process and procedure
- physical DI facilities
- radiation equipment
- supplies, consumables
- imaging information systems and archival
- pre-examination, examination and post-examination activities
- quality assurance activities
- safety
- infection, prevention and control

The DI Accreditation Program is a peer review process with a goal to improve diagnostic imaging service provision and performance through objective evaluation. Assessors evaluate the DI facility's compliance with the specific requirements of a standard based on objective observation and assessment. All accreditation assessment findings are vetted by the Advisory Committee on Diagnostic Imaging to eliminate any potential personal Assessor bias, ensure a consistent and thorough approach for all DI facilities, and to review standards for applicability to current best practice.

Benefits of CPSA DI accreditation program

- Assists DI facilities with the process of ensuring accuracy and reliability of imaging services
- Provides standards of practice and assesses compliance to the standards
- Identifies deficiencies that affect the quality of imaging services, as well as patient and staff safety
- Provides educational opportunities for both the DI facility being accredited and the Assessment Team
- Promotes uniformity in practice provincially – where variations in practice are counter-productive for the province.
- Promotes standardization and educational initiatives across Canada through interprovincial collaboration
- Maintains a comprehensive data repository for scope and complexity of imaging services, and resources within the province
- Promotes and ensures dialogue amongst imaging service providers and administrators on best practices and best ways to incorporate them into the workflow
- Encourages and facilitates peer review
- Ensures effective medical direction over medical practices so that business interests do not determine the standards of care

Confidentiality

All assessment findings are confidential and are only disclosed to parties explicitly associated with an assessment. Documented consent must be obtained from the assessed facility for release of assessment findings or accreditation certificates to other parties.

Frequency and selection of diagnostic imaging facilities to be assessed

DI facilities are assessed initially when opened, subsequently on a four (4) year rotation and if they relocate their facility to a different physical location. This does not preclude an interim assessment that may be required as a result of expansion of imaging services or an unsatisfactory performance complaint.

Assessments are conducted by geographical zone areas ensuring that all DI facilities within the designated zone are assessed in the same calendar year. Ideally, the CPSA attempts to assess larger imaging group facilities in the same assessment cycle. At the beginning of the year, all DI facilities due to be assessed are identified by the CPSA, and the Assessment Team is assigned.

After a new DI facility is registered and initially accredited, it will then be added in to the regular zone geographical 4-year cycle. If the timing of this next 4-year cycle is very close to when the new DI facility was accredited, the CPSA may choose not to re-assess the DI facility during that cycle.

On-going self-assessment

The CPSA DI accreditation process does not have a requirement for self-assessment. However, the DI General Standards require DI facilities to conduct formal internal audits of all system elements, both managerial and technical, at a frequency defined in their quality management system. The CPSA accreditation standard tools are a significant resource for self-audits as they promote a constant state-of-readiness. DI facilities are able to customize the standards tools by:

- documenting/embedding links to policies, processes, procedures, records, forms and labels beside the relevant standard
- utilizing the tool for the performance of comprehensive or targeted audits in between the 4-year assessments

2.7 PERSONNEL

2.7.1 CPSA diagnostic imaging accreditation personnel and roles

The Assistant Registrar for Accreditation has overall responsibility for the diagnostic accreditation programs and is supported by the Director of Accreditation, the Program Manager for Diagnostic Imaging Accreditation Services, an Accreditation Assistant, an Administrative Assistant and the Accreditation Program Coordinator.

2.7.2 Advisory Committee on Diagnostic Imaging

The Advisory Committee on Diagnostic Imaging (ACDI) oversees the CPSA's accreditation program for medical diagnostic imaging DI facilities, for community DI facilities as defined in CPSA by-laws and for public DI facilities through contract with Alberta Health Services. Through the development of evidence based standards and monitoring DI facility compliance with those standards, the Committee promotes high standards of medical practice in diagnostic imaging facilities.

Roles and responsibilities of the ACDI

- Develop and maintain evidence based standards for imaging practice
- Provide advice/recommendations to the Medical Facility relating to the provision of diagnostic imaging services
- Monitor compliance with CPSA approved standards through reviewing anonymized trends/themes stemming from on-site assessment accreditation reports
- Provide education to promote safety and quality improvement initiatives
- Respond to the needs of stakeholders for improved imaging services in Alberta
- Review and audit of the business practices of the DI facility to ensure compliance with relevant CPSA By-laws and Standards

Membership

Membership considers expertise, geographic location, urban versus rural and public versus private representation. Members who serve by virtue of their position, serve as long as they fill that position.

All voting members are registered health professionals responsible to their respective professional regulatory body for their competence, their standards of practice and their conduct.

The Chair is selected from the membership and appointed by the MFAC. In the absence of the Chair, an alternate will be selected from the members present.

It is the responsibility of the Chair to represent the Committee (either in person or virtually) for any appeals of Committee decisions that are made to MFAC.

Membership is comprised of a minimum of 11 voting members and 4 non-voting members.

For voting members, representation includes but is not limited to the following:

- Radiologists
- Cardiologists

Non-Voting Members:

- Assessment Coordinators

Tenure

Committee members are appointed by MFAC for the following terms:

Chair – Three year term with the option of a one year extension

Voting members – Five year term with the option of a one year extension

2.8 ASSESSMENT TEAMS

2.8.1 Assessment Coordinator

Each assessment team will include an Assessment Coordinator who is a consultant of CPSA. Their primary role is to coordinate, organize, and facilitate the assessment process.

2.8.2 Physician Reviewer

A Physician Reviewer can be assigned to an Assessment Team when the CPSA has reviewed the 4-yr Accreditation report and feels that an image review is warranted based on report citations and benchmarked against defined criteria within the CPSA Image Review policy.

2.8.3 Team Selection

CPSA selects the members of the Team which includes experienced imaging technologists and sonographers. All Team members are provided with the training, information and material necessary by the CPSA to conduct a fair and thorough assessment.

Selection of the Assessment Team is based on:

- scope and complexity of imaging services
- number/geographic location of DI facilities
- experience of Team members
- mitigation regarding conflict of interest

The Assessment Coordinator(s) are present at each on-site assessment to promote consistency and continuity and to ensure an un-biased process; they do not perform assessment duties.

2.8.4 Assessment team training

All assessment team members are required to participate in a CPSA Assessor Training module, within 6 weeks prior to performing an on-site assessment. Following completion of the training module, assessment team members must demonstrate competency by successful performance of an on-line examination.

Upon successful completion of the training module and exam, all assessors receive a continuing professional development certificate.

2.8.5 Conflict of interest / vaccination status / confidentiality agreements / liability

All members of CPSA accreditation committees and assessment teams sign a Confidentiality Agreement with CPSA on an annual basis. Committee members and assessors are also required to confidentially destroy all confidential assessment materials or return to CPSA for confidential disposal.

Assessment team members are also required to sign a Conflict of Interest and Vaccination Status Attestation for each assessment cycle to ensure there are no potential conflicts specific to that assessment.

CPSA's liability insurance specifically extends to cover assessors who are employed, contracted or act as agents. As well, the *Health Professions Act* extends liability protection to all CPSA staff, contractors and agents. While performing assessments for CPSA, assessors are advised not to display conduct that can be reasonably construed as a solicitation or offer consultant services that may compromise the objectivity of the assessment.

3.0 Standards Document

3.1 STANDARDS OVERVIEW

The Standards are the basis for accreditation decisions and are compiled by CPSA and stakeholder experts, reviewed and are reviewed and approved by the ACDI, with final vetting and approval by MFAC.

The Standards are evidence based and reference accepted best practices, provincial and federal legislation, relevant International Organization for Standardization (ISO) standards, and other recognized provincial, national and international standards. Each accreditation standard has an accompanying reference citation(s).

All standards included in the documents are mandatory requirements for accreditation.

The Standards are process-based and incorporate a quality management system approach.

A review of accreditation standards occurs on an ongoing basis, considering and incorporating stakeholder feedback. Comprehensive formal review occurs on an annual basis.

The CPSA Diagnostic Imaging Accreditation program currently maintains the following standards documents for the assessment of diagnostic imaging facilities:

- General (which includes Radiography, Fluoroscopy and Interventional)
- Bone Mineral Densitometry
- Computed Tomography
- Echocardiography
- Magnetic Resonance Imaging
- Mammography
- Nuclear Medicine and Positron Emission Tomography
- Ultrasound

All accredited Alberta DI facilities receive a complete standards document set. CPSA accredited imaging facilities and other approved users may access, print or make a copy of the standards for their non-commercial personal use. Any other reproduction in whole or in part requires written permission from the CPSA and the material must be credited to the CPSA.

Prior to each assessment, standards documents applicable to the scope of the imaging services of a DI facility will be made available to:

- DI facilities for self-assessment and/or to prepare for an on-site CPSA assessment

- CPSA Assessors in preparation for on-site assessments and to record objective evidence/ observations while performing on-site assessments

3.2 FORMAT OF STANDARDS

The standards are process-based and incorporate a quality management system approach. The language, terms and organization of the documents are consistent (where relevant) with current ISO 15189/9001.

All standards documents are consistently organized in the following order (as applicable in each document):

- Organization, Management & Personnel
- Quality Management System
- Physical Facilities
- Equipment, Consumables and Supplies
- Diagnostic Imaging Information Systems
- Pre-examination policies, processes and procedures
- Examination policies, processes and procedures
- Quality Assurance of examination procedures
- Post-examination policies, processes and procedures
- Safety
- Infection, Prevention and Control

The 'General Standards' document includes ALL standards common to ALL modalities.

To eliminate redundancy, the modality-specific standards include ONLY those standards specific and relevant to each modality.

Figure 2 - Standard Document Format Example

#	Standard	Reference	Assessment of Compliance
IG.1.2 Organization & DI facility Management - Personnel			
IG.1.2.2	The DI facility has comprehensive written personnel comprehensive written policies, processes and procedures, which include comprehensive job descriptions that define qualifications and duties for all personnel.	Safety Code 35, Health Canada (A) AC ¹ RIS – 3.1 AC ² MIC - 5.1 CLSI QMS08-A2 – 6.3.1 IANZ ¹ - 5.1.1, 5.1.2, 5.1.7 ISO 15189 – 5.1.3, 5.1.9.a-d NCCLS ⁵ HS1-A2 – 5.3.1 RANZCR 4.1.1.2	Are there comprehensive written DI facility personnel (technical, medical and other) policies and job descriptions that define the qualifications, responsibilities and expectations of DI facility personnel? C <input type="checkbox"/> P <input type="checkbox"/> E <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>
			Observation:

Each standard consists of the following components:

- **CPSA standard number**
- **Patient or staff safety risk category** (where applicable):
 - Each standard has been reviewed to determine if it represents a direct and/or immediate patient or staff safety risk.
 - Those with either a patient safety (PS) or staff safety (SS) designation indicate that any non-compliance may have direct and/or immediate impact on safety.
 - PS/SS standards are 'shaded' for ease of detection
 - Assessors must ensure that ALL standards with either a PS or SS designation are directly assessed at the time of the on-site assessment.
- **Description of standard requirement**
- **Specific reference(s)** linked to reference listing at the end of the document
- **Interpretation guidance** where relevant regarding the application of requirements

- **Assessment of compliance questions (AOC)** that provide specific guidance and practical direction for evaluation of compliance with the standard
- **Compliance assessment category checkboxes**
- **Observation field for recording of objective evidence** (field is expandable in electronic document)

3.3 ASSESSMENT OF COMPLIANCE (AOC)

- Although the AOC questions address the key evidence required to meet the intent of each standard, they **are not meant to be all encompassing**.
- There may be other evidence that demonstrates compliance with the intent of the standard. Individual assessors apply their own expertise in determining compliance with each standard.
- Compliance with the standard may be assessed by review of documents and records, observation, interviews or a combination of these techniques.
- Where AOCs state “All of the following”, compliance with all elements is expected to achieve compliance with the standard.

Assessment of Compliance Categories – the CPSA “PEN” or CPEN

Compliance Assessment Category:	
C	meets intent and requirements of standard
P	in progress (working towards meeting intent and requirements of standard; assessor notes evidence of progress towards full compliance)
E	exceeds requirements of standard
N	does not meet intent and/or requirements of standard
N/A	not applicable to scope of service or testing

N - Upon assessment of the objective evidence, failure to meet the intent and/or requirement of the standard will result in an assessment of non-compliance.

The standards are process based and a single non-compliance may encompass one or more observations. In assessing compliance with the standard, assessors will record direct specific objective evidence, which will be included in the report for each non-compliance.

P - “In Progress” citations require submission of future evidence of compliance based on direction from the assessor and/or the Advisory Committee. Examples where this assessment may be applied include situations such as: equipment purchased but not on-site and/or implemented; renovations in progress but not complete

Receipt of “FULL” accreditation status is contingent upon satisfactory resolution of all non-compliances (N and P).

E - “Exceeds Requirement” recognizes those situations where a facility exceeds the intent of the standard and employs commendable practice. The intent of capturing these occurrences is to promote and focus on quality initiatives.

3.4 TERMS AND DEFINITIONS

A listing of applicable terms and definitions is provided at the end of each standards document.

3.5 REFERENCE LISTING

A detailed reference listing is provided at the end of this document. Specific reference citation details can be accessed by clicking on individual link(s) included beside each standard. The references support the content and intent of each standard. It should be noted that all components of the cited references may not always be relevant and/or applicable. Compliance is expected with CPSA Standards.

3.6 REVIEW AND REVISION OF STANDARDS

A comprehensive review of references occurs annually to ensure they are compliant with current standard references and best practices. Supporting references and any new references are reviewed, updated and their impact (if any) on the wording of the requirement is assessed.

Any stakeholder may offer suggestions for standards revision at any time.

Revision submissions are considered by CPSA ONLY if they meet the following conditions:

- submitted using the [Stakeholder Standards Review Form](#).
- identification of specific standard or section if applicable to multiple standards

- supported by detailed rationale/justification AND verifiable references (link or attachment must be included)
- applicable to all diagnostic imaging facilities across the province and are not limited to organization specific practice
- contact information included for use by CPSA if clarification of submission is required

4.0 Accreditation Process – 4-year Re-accreditation

Note:

Time frames are approximations and may vary depending on the scope, scheduling of the individual assessments, and unforeseen circumstances such as facility renovations, or staff resource issues.

		CPSA				Zone Group Facility	Assessment Coordinator	Assessment Team Members			
Initiation	~ January of assessment year	1	2		3	3/4					
Pre-Assessment	~ 12-16 weeks before assessment	5	6	7	9	8					
	~ 12-16 weeks before assessment	10	12	13		11					
		14	15	16	17	18					
	~6-8 weeks before assessment	20		21 21a			19				
	~2-6 weeks before assessment	23	24	25 25a				22			
On-site Assessment	Assessment day					28	26	27	29	30	31
							32	33			
Post-Assessment	ASAP after each on-site assessment						34				
	Before Advisory Committee Meeting	35	36	37							
	Within 15 business days after Committee Meeting	38		39							
	30/90 days past report distribution					40					
	Next Advisory Committee meeting after response is received	41	42	43	44 45						

4.1 INITIATION

November/December of previous year / January of current year

Responsibility		Task	Additional Information
1	CPSA Pre-assessment	Identifies zone / group / DI facility (ies) to be assessed notifies DI facility Medical Director(s) and / or identified Executive leadership	<ul style="list-style-type: none"> • facilities revert to provisional accreditation status throughout the accreditation process • entire zone / imaging group is assessed within the same calendar year • zone / group / DI facility (ies) are given their specific assessment initiation timelines at the beginning of the assessment calendar year • <i>INITIAL COMMUNICATIONS</i> –initiation communications, as well as Assessment Logistic Form (ALF) – will go directly to the Group / Zone (e.g. AHS Quality Department) identified key contact(s) – which will then disseminate accordingly. <p>Once key zone / facility accreditation contacts are designated and identified through the completed ALF, CPSA will then liaise directly with the primary identified accreditation contacts for:</p> <ul style="list-style-type: none"> • team approvals • lunch provision • pre assessment data verification • on-site logistics • report acquisition and dissemination as appropriate • report responses • submission of responses to the CPSA in the designated timeframe
2	CPSA Pre-assessment	Selects Assessment Coordinators (AC)	Potential conflicts of interest are considered and mitigated when selecting proposed AC(s).
3	CPSA Pre-assessment	Provides zone / group / DI facility (ies) to be assessed with the Assessment Logistics Form {ALF}	<p>The zone area / group / DI facility Medical Director or authorized Executive leadership designate is requested to complete and sign the Assessment Logistics Form (ALF) which includes:</p> <ul style="list-style-type: none"> • provision of 1-2 key assessment / accreditation contacts for a zone / group / DI facility (ies) • approval of proposed Assessment Coordinator(s)

4.1 INITIATION - CONTINUED

Responsibility		Task	Additional Information
4	Zone, Group or Facility Pre-assessment	Completes Assessment Logistics Form {ALF}	Completed ALF is submitted with signatures to CPSA within the specified timeline CPSA sets up secure Facility SharePoint access for the key zone / group / DI facility (ies) assessment contacts and communicates this information.
	CPSA Pre-assessment		

4.2 PRE-ASSESSMENT

~12-16 weeks prior to assessment

Responsibility		Task	Additional Information
5	CPSA Pre-assessment	Determines specific assessment dates and prepares draft schedule	CPSA determines the specific assessment cycle dates. Assessment cycles are kept to 5 consecutive business days (one week is considered a cycle) to minimize the required Assessor time commitment. CPSA prepares and distributes draft assessment schedules to zone / group/ DI facility (ies). <ul style="list-style-type: none"> Ensures that the zone / group / facility (ies) have reviewed and have no justifiable concerns with the schedule
6	CPSA Pre-assessment	Training session for zone / group / DI facility(ies) personnel	CPSA provides the following information: <ul style="list-style-type: none"> program guide to review DI Accreditation Standards overview of assessment process steps direction on the use of the Standards assessment logistics & timelines Guidelines for Assessment Contacts DI facility training sessions are made available on the facility SharePoint and focus on: <ul style="list-style-type: none"> overview of assessment process steps use of the standards tool assessment day expectations assessment logistics & timelines

4.2 PRE-ASSESSMENT - CONTINUED

Responsibility		Task	Additional Information
7	CPSA Pre-assessment	Provides each DI facility to be assessed with a Pre-assessment Data Verification Form {PADV}	CPSA initially pre-populates the PADV with the most current information within CPSA database, and DI facilities are directed to carefully review pre-populated data prior to resubmission to CPSA. The PADV requests submission of facility policies, processes, procedures and records to support the virtual hybrid model assessment.
8	DI facility Pre-assessment	Completes Pre-assessment Data Verification Form and submits with required signature within the specified timeline {PADV}	CPSA reviews individual PADV (s) for completeness. CPSA follows up directly with the DI facility accreditation contact regarding any missing documentation or documentation requiring additional clarification in the PADV.

4.2 PRE-ASSESSMENT - CONTINUED

Responsibility		Task	Additional Information
9	CPSA Pre-assessment	Selects Assessment Team members (Assessors) based on zone/group/DI facility scope of modalities, availability and experience	<p>CPSA reviews the scope of modalities for each DI facility based on the submitted PADV documentation.</p> <p>The Assessment Coordinator does not assess; they are responsible for coordinating and leading the Assessment Team.</p> <p>Selection of the Assessment Team is based on:</p> <ul style="list-style-type: none"> • scope and complexity of imaging services • requirement for out-of-province Assessors (if necessary) • number / geographic location of DI facilities • experience of Team members • mitigation – conflict of interest (employment / affiliation) <p>CPSA ensures separate Assessors (i.e. not the AC) are assigned for the assessment of all components of the General Standards.</p> <p>Each modality-specific Assessor also reviews the relevant sections of the General Standards in conjunction with their modality specific assessment.</p>
10	CPSA Pre-assessment	Advises DI facility Medical Director and / or designated Executive leadership of proposed Assessment Team members and requests formal written approval using the Proposed Team Member Form {Team Approval Form}	<p>For each zone / group / DI facility (ies) assessment, the DI facility Medical Director and/or designated Executive leadership receives a listing of the proposed Team members including their:</p> <ul style="list-style-type: none"> • name • scope of assessment activities • location of employment/employer
11	DI facility Pre-assessment	Submits written approval of Assessment Team members to CPSA	<p>If any original members are not approved by the zone / group / DI facility (ies) due to an identified conflict of interest, the CPSA will solicit alternate Assessment Team members and then request approval.</p>

4.2 PRE-ASSESSMENT - CONTINUED

Responsibility		Task	Additional Information
12	CPSA Pre-assessment	Sends confirmation of Team approval and assessment dates to Assessors and ACs	CPSA sets up Assessor access to Assessor SharePoint and sends notifications.
13	CPSA Pre-assessment	Ensures relevant assessment tools (Standards documents) are available to identified DI facility accreditation contacts via Facility SharePoint	<p>Facility SharePoint houses the General DI Standards, plus the relevant modality specific Standards available.</p> <p>There may be individual sections, as well as within sections, that are not applicable to each DI facility. Assessors will not be assessing these specific requirements.</p> <p>Facility / Zone / Group assessment contacts to ensure that all sites and personnel have access to the standards.</p>
14	CPSA Pre-assessment	Prepares documents for provision to Assessors	<p>CPSA prepares tools/supporting documentation for Assessors:</p> <ul style="list-style-type: none"> • summary of previous citations and responses referenced to current standards • PADV and requested facility submitted documentation • modality specific Assessor guides • 4 year Accreditation program guide
15	CPSA Pre-assessment	Prepares final summary schedule and detailed DI facility schedules	Schedules are finalized.
16	CPSA Pre-assessment	<p>Distributes final summary and detailed DI facility schedules</p> <p>{Summary Assessment Schedule}</p> <p>{Individual Facility Schedule}</p>	<p>Final summary assessment schedules are uploaded to the DI facility and Assessor SharePoint sites.</p> <p>Detailed individual facility schedules are uploaded to the DI facility SharePoint site.</p>

4.2 PRE-ASSESSMENT - CONTINUED

Responsibility		Task	Additional Information
17	CPSA Pre-assessment	Provides each DI facility to be assessed with an On-Site Logistics Form {OLF}	<p>Coordinates assessment logistics with the DI facility / zone area accreditation contact.</p> <p>CPSA requests the following for zone / group / DI facility(ies) by requesting completion of the assessment On-site Logistics Form.</p> <p>Each DI facility is required to provide:</p> <ul style="list-style-type: none"> • dedicated meeting room for the Assessment Team to work in • if the assessment is a full day, then the facility will be asked to arrange the lunch for the Team via OLF; the CPSA reimburses the facility. Where it is not possible for facility to arrange for lunch, facility is asked to provide information on lunch options for the Team. • If there are two assessments in one day, the morning facility will be asked to provide recommendations close for the Team to obtain lunch in between facility assessments • access to any imaging records located outside the DI facility or department
18	Zone/Group/DI facility Pre-assessment	Sends completed On-site Assessment Logistics – Zone & DI facilities forms {OLF}	<p>Completed forms are submitted within the specified timelines.</p> <p>Zone / group / DI facility (ies) have self-identified key DI facility interviewees.</p> <p>CPSA confirms receipt of all information regarding the above arrangements and follows-up with DI facilities regarding any missing or conflicting information.</p>

4.3 PRE-ASSESSMENT

~6-8 weeks prior to assessment

Responsibility		Task	Additional Information
20	CPSA Pre-assessment	Distributes assessment documentation to each Assessment Team member to facilitate adequate preparation	<p>CPSA provides each Team member the appropriate information for the assessment, including:</p> <ul style="list-style-type: none"> • completed PADV and appropriate supporting documents based on assessor assignment • summary of previous citations and responses • modality specific Assessor guides for each DI facility • copy of the General Standards and relevant Modality Standards • all assessment information is provided to Team members via their secure SharePoint site <p>The facility has confirmed with CPSA the date/times of the CPSA interviews to be conducted are acceptable and finalized.</p>
21	CPSA Pre-assessment	CPSA provides Assessment Team training session	<p>CPSA Assessment Team training:</p> <p>Mandatory for all Assessment Team members to participate in one session prior to the on-site assessment.</p> <p>Training is conducted by recorded webinar or on-line training module. Following completion of the training session, Assessors must demonstrate competency by successful performance on an examination. Continuing education certificates are provided upon successful demonstration of competency, as requested.</p> <p>Training sessions encompass:</p> <ul style="list-style-type: none"> • Overview of the CPSA assessment process and standards documents • General assessment guidance and techniques • CPSA Assessor policies (e.g. confidentiality, conflict of interest, honoraria, expenses, etc.) • Specific assessment logistics
21a	Facility Training	Tools to facilitate facility training	CPSA uploads facility training tools to the Facility SharePoint site and notifies Zone/Group/facility accreditation contact to disseminate to facility or multiple facilities for staff review

4.3 PRE-ASSESSMENT

~2-6 weeks prior to assessment

Responsibility		Task	Additional Information
22	Assessment Team Pre-assessment	Reviews assessment documentation and materials in preparation for the on-site assessment.	<p>Each Assessment Team member is expected to review the assessment documentation relevant to their scope of assessment activities to ensure that they are adequately prepared to perform a thorough and efficient assessment.</p> <p>The primary purpose is to:</p> <ul style="list-style-type: none"> • become familiar with the General and applicable modality-specific standards • become familiar with the scope of modality including which programs/processes are zone managed • identify areas of concern for further follow-up during the assessment (previous citations) <p>Standards tools can be customized by each Assessor to meet their personal preferences for recording of observations and assessment categories on-site (e.g. add personal comments/directives, add additional space for recording, etc.)</p> <p>Assessors are expected to bring their own customized tools, either paper or electronic tablet version, to use during the assessment.</p>
23	CPSA Pre-assessment	Provides assessment documentation to AC	CPSA prepares all relevant assessment documentation to the assessment team, including all submitted documents from the PADV that supports the hybrid model of a virtual desktop assessment first prior to the on-site assessment.
24	CPSA Pre-assessment	Conducts Assessment Team teleconference	CPSA/ACs conducts a brief teleconference with the Assessment Team to review assessment logistics and expectations and answer questions.

4.3 PRE-ASSESSMENT - CONTINUED

~2-6 weeks prior to assessment

Responsibility		Task	Additional Information
25	CPSA Pre-assessment	Distributes electronic surveys {recipients were identified in the completed PADV}	<p>Electronic surveys are conducted and to be completed in the weeks before the assessments. To facilitate consistency, thoroughness and objectivity, CPSA uses a standardized electronic survey, which is based on the role of the DI facility staff member or stakeholder. Comments will be summarized and included on the accreditation reports.</p> <p>Surveys are sent to:</p> <ul style="list-style-type: none"> external / DI facility: DI facility Medical Director, imaging liaison physician, medical staff / client physicians – based on clinical service internal DI facility: imaging supervisor, imaging manager, imaging director, zone / group / facility quality manager imaging specialists: an imaging specialist who consults for more than one DI facility included in the assessment cycle only needs to be interviewed once per assessment cycle <p>Surveys encompass stakeholder satisfaction with:</p> <ul style="list-style-type: none"> general DI facility services consultant imaging services general on-site imaging services including available examinations, and turn-around time of reports/results referral services communication workload competency <p>If survey feedback indicates a potential standard non-conformance, the CPSA directs the Assessment Team to probe further and obtain objective, corroborative evidence.</p>
25a	CPSA QMS Assessor	Reviews Zone / Group / facility QMS p/p/p	Assigned QMS Assessor conducts the QMS assessment virtually and disseminates findings to the Assessment team to support the onsite assessment.

4.4 ON-SITE ASSESSMENT

Responsibility		Task	Additional Information
26	AC On-site	<p>Conducts pre-Assessment Team briefing meeting</p> <p>*can be conducted via Zoom</p>	<p>Prior to the initiation of on-site assessment the AC(s) conducts a briefing meeting for Assessment Team members.</p> <p>If possible - held the evening prior to the on-site assessment cycle, meetings encompass:</p> <ul style="list-style-type: none"> • team introductions • assessment schedules and logistics review • CPSA Assessor name tags distribution • discussion of areas for focus/concern • confirmation of areas of focus for each Assessment Team member • Assessor questions/ clarifications
27	AC On-site	<p>Conduct an opening meeting with zone / DI facility personnel</p>	<p>At the beginning of the on-site assessment at each DI facility, the AC conducts an opening meeting for zone / group / DI facility(ies) personnel that encompasses:</p> <ul style="list-style-type: none"> • introductions • assessment logistics and timelines • assessment process outline • facility to determine if imaging specialist on site wishes to be interviewed
28	DI facility On-site	<p>Conducts DI facility tours for Assessment Team members</p>	<p>An initial tour of the DI facility will give a general overview of the imaging operation and key personnel.</p>
29	Assessment Team members On-site	<p>Conduct on-site assessments in areas of expertise</p> <p>If necessary/required:</p> <p>*Health "Fit for work" assessments completed daily for each Assessor</p> <p>*PPE protocols in place for Assessors, PPE available</p>	<p>The Assessment Process – General</p> <p>The Accreditation assessment process involves:</p> <ul style="list-style-type: none"> • verifying compliance with the intent of accreditation standards • follow-up of previously identified areas of concern • interaction with imaging staff at all levels • review of zone managed areas (as identified by the facility) • imaging specialist on-site interview BY facility/image specialist request only (AC to ask facility in the pre-assessment meeting; QMS Assessor conducts requested interview) <p>Assessor Behavior</p> <ul style="list-style-type: none"> • engage in clear and concise dialogue with DI facility staff

		<ul style="list-style-type: none"> • explain the assessment process to DI facility staff, as required • exhibit positive body language • assess according to the standards (unbiased approach) • there are many ways to meet the intent of a standard • adopt an educational rather than a consultative OR punitive approach • the goal of the assessment is imaging improvement • do not act as a consultant • be conscious of timelines and assessment schedules and obligations • do not engage in confrontational behavior • be facilitative, professional • ask leading questions (“so explain to me how, or.. “where would you find...”) <p>The CPSA Assessment Tool The on-site assessment is performed using the DI facility specific standards document tools.</p> <p>Each Assessor must utilize both the General Standards tool and the modality-specific Standards tool(s).</p> <p>The General Standards document includes all standards common to all modalities. To eliminate redundancy, the modality-specific standards include ONLY those standards specific and relevant to each discipline. For example, general quality control, equipment, supplies, consumables and procedure manual standards are not repeated in each discipline specific standard.</p> <p>Assessment of Compliance Although the AOC questions address the key evidence required to meet the intent of each standard, they are not meant to be all encompassing. There may be other evidence that demonstrates compliance with the standard. Where AOCs state “<i>all of the following</i>”, compliance with all elements is expected (e.g. test request form). Individual Assessors apply their own expertise in determining compliance with each standard. Compliance with the standard may be</p>
--	--	--

			assessed by review of documents and records, observation, interviews or a combination of these techniques.
--	--	--	--

Responsibility		Task	Additional Information
29	Team members On-site	Conduct on-site assessments in areas of modality expertise	<p>Guidance for Assessors</p> <p>When assessing DI facility imaging sections:</p> <ul style="list-style-type: none"> • It is not possible to review the entire scope of imaging operations <ul style="list-style-type: none"> ◦ focus on areas of highest and lowest imaging volumes, likely problem areas and imaging results with highest impact on patient care ◦ directly assess ALL standards with either a PS or SS designation ◦ verify that all non-conformances cited on the previous assessment have been corrected ◦ utilize CPSA Assessor Guides to focus / direct the your on-site modality specific assessment • Review zone / centrally managed programs / processes • Review documents (policies, processes and procedures (P / P / P) and records <ul style="list-style-type: none"> ◦ the Assessor should choose a random, representative selection of documents, records, images and reports to review ◦ Assessors should not rely solely on documents, records, images and reports chosen or selected by the DI facility for review. • Review PACS • Observe activities: <ul style="list-style-type: none"> ◦ engage in meaningful dialogue with DI facility imaging and non-imaging staff (ask open ended questions such as: (what, when, where, why, who, how) ◦ compare observed activities to the DI facility policies, processes and procedures ◦ use techniques, such as: <ul style="list-style-type: none"> ▪ tracer method: follow a sample through pre-examination, examination & post-examination ▪ drill-down: further investigate areas of concern ▪ show/Teach me: staff members describe a procedure as they perform it • Gather information:

			<ul style="list-style-type: none"> ○ always seek corroboration / validation / verification of findings ○ evaluate for significance ○ if the Assessor determines (due to professional judgement) that the facility will require a Physician Reviewer intervention, they will start to collect examination information (accession numbers) of random examinations as per the 'minimum' number of exams 8.0). They will take this information to the AC; the AC will forward to CPSA. When the report is discussed at the ACDI, and the decision is to involve a PR, the site will be asked to submit the examinations that the Assessor listed ● Determine the scope and nature of potential citations: <ul style="list-style-type: none"> ○ is there a P / P / or P? ○ is the P / P / or P in compliance with the standards? ○ is the P / P / or P being followed as written? ○ is there evidence of training/competency assessment for the activity? ○ is there acceptable documentation of the activity? ○ is the required review of the activity performed and documented? ● Discuss / confirm potential deficiencies with DI facility representatives
--	--	--	--

4.4 ON-SITE ASSESSMENT - CONTINUED

Responsibility		Task	Additional Information
29	Assessment Team members On-site	Conduct on-site assessments in areas of modality expertise	<ul style="list-style-type: none"> • Record objective evidence: <ul style="list-style-type: none"> ◦ as immediately as possible after encountering citation ◦ using the assessment standards tool (paper or electronic) ◦ do not rely on memory ◦ be factual and thorough ◦ provide ample background detail for interpretation and determination by the CPSA of the requirement / EOC • Photographic evidence for CPSA: <ul style="list-style-type: none"> ◦ for safety related citations, consult with AC for necessity to corroborate observation with photographic evidence ◦ AC will be responsible for notifying the DI facility contact and for taking required photographs ◦ AC will ensure that no individuals, nor confidential patient or staff information, is identifiable in the photographs <p>Compliance Assessment Categories</p> <ul style="list-style-type: none"> • Non-conformances (N) • In-progress citations (P) • Exceeds requirement citations (E)
30	Assessment Team members On-site	Initiate CPSA Critical Findings process if necessary	<p>Assessors encountering any situation that in their judgment, represents potential for significant immediate harm to staff or patients are directed to bring it to the attention of:</p> <ul style="list-style-type: none"> #1 - the imaging personnel for immediate action as deemed appropriate #2 - AC who will consult with CPSA immediately via telephone <p>CPSA Critical Findings policy, process and procedure will be followed, if necessary.</p>

4.4 ON-SITE ASSESSMENT - CONTINUED

Responsibility		Task	Additional Information
31	Assessment Team members On-site	Assessors communicate PEN findings to AC while on-site	<p>PEN Findings</p> <p>The AC will determine and communicate the timelines and frequency for debriefing Assessors to obtain assessment PEN findings. At larger DI facility assessments this could be multiple times per day.</p> <p>AC will ask Assessors to provide the following for each citation and record the details in the citation recording template:</p> <ul style="list-style-type: none"> ○ standard number (if known) ○ compliance assessment category (PEN) ○ detailed observation/objective evidence ○ comments (where applicable) <p>The AC ensures all citations include sufficient and clear detail in the objective evidence to facilitate CPSA determination of the requirement, EOC, and timeline for EOC.</p> <p>The AC will reiterate back to the Assessors the information so that there is not a misunderstanding regarding the potential non-conformance, as well as ensuring there is enough detail given.</p> <p>If the Assessor and / or AC is unable to determine the appropriate standard number to reference the citation, ACs are advised to record the other citation details and CPSA will make the determination.</p>
32	AC On-site	Conduct pre-summation conference Team meeting	<p>The AC de-briefs with the entire Assessment Team <u>prior to the DI facility summation conference</u> to determine and summarize key findings for presentation at the summation conference.</p> <p>The AC will make particular note of systemic zone / group issues (e.g. document control in multiple DI facility imaging sections)</p>

4.4 ON-SITE ASSESSMENT - CONTINUED

Responsibility		Task	Additional Information
33	AC On-site	Conduct a summation conference for the DI facility management and personnel	<p>The primary purpose of the summation conference is to highlight the key findings and outline the next steps in the assessment process.</p> <p>The AC serves as the primary spokespersons during the summation meeting in order to bring consistency of format and detail to the process.</p> <p>In person summation conferences are conducted at each DI facility at the end of the DI facility assessment.</p> <p>Summation conference agenda:</p> <ul style="list-style-type: none"> • start by offering positive feedback on any processes or observations, examples and kudos to the facility • acknowledgement of DI facility personnel for their cooperation and support of the accreditation process • short review of the objectives of the accreditation process • Review of commendable findings and practices including any 'E' citations • review of significant non-conformances. (The purpose of this is to ensure that there are no "significant surprises" in the report when received by the DI facility / zone.) • review of purpose and inclusion of interview findings in final reports • overview of the next steps in the CPSA accreditation process including timelines for: • meeting of the ACDI to review the draft final report • distribution of final report • DI facility responses and submission of EOC • DI facility questions

4.5 POST-ASSESSMENT

Responsibility		Task	Additional Information
34	AC Post On-site	Submits DI facility specific Citation Recording Summaries to CPSA via secure SharePoint	<p>As soon as possible (same day, preferably) following each DI facility's on-site assessment, the AC securely submits for each DI facility:</p> <ul style="list-style-type: none"> • Citation Recording Summaries including: <ul style="list-style-type: none"> ○ standard number (if known) ○ compliance assessment category (PEN) ○ detailed observation/objective evidence ○ comments (where applicable) ○ completed imaging specialist interview, if applicable <p>AC should include any additional information or direction regarding on-site findings that would assist CPSA in finalizing the requirements and requested EOC.</p>
35	CPSA Post On-site	Formats and finalizes draft DI facility reports	<p>Based on the citation recording summaries provided by the AC and CPSA completed electronic survey data, the CPSA completes / finalizes the following for each DI facility report:</p> <ul style="list-style-type: none"> • DI facility demographics and key personnel • assessment information and Team details • accreditation process dates • DI facility overview • imaging specialist interview, if applicable • citations: <ul style="list-style-type: none"> ○ standard number ○ safety Risk category ○ compliance assessment category (PEN) ○ detailed observation/objective evidence requirement ○ evidence of Compliance (where applicable) ○ timeline for submission of EOC <p>Guidelines for requirement of 30 day EOCs:</p> <ul style="list-style-type: none"> • significant safety issue <p>All other requests for 90 day EOCs are based on the judgment of the Assessors/CPSA and the ACDI and include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • all 'P' – 'In Progress' citations • issues cited on previous assessment reports • all requirements categorized as PS/SS • systemic / multi-DI facility issues

			<p>CPSA ensures consistent/uniform:</p> <ul style="list-style-type: none"> • application of the standards based on similar observations • wording of requirements and EOC • timelines for submission of EOC
36	CPSA Post On-site	Prepares Zone or large group aggregate report and citation cross-reference	<p>Based on the draft reports, CPSA compiles a zone/ large group aggregate report that includes:</p> <ul style="list-style-type: none"> • aggregate assessment information (DI facilities / assessment dates) • link to a detailed citation document that lists each separate standard citation by number and cross-references which DI facilities are cited for each standard
37	CPSA Post On-site	Authors final DI facility reports	<p>CPSA schedules ACIDI meetings to occur within 15 business days of the last day of the assessment cycle.</p> <p>If there are issues or concerns based from report non-conformances that require the ACIDI's expertise, the CPSA will bring anonymized / redacted issues / themes forward for discussion. The AC will be available at the ACIDI meeting to responding to additional questions or clarification requests (anonymized discussion; the facility will not be named – no identifiers used, e.g. name, group or Zone).</p> <p>CPSA reviews / revises / approves the DI facility assessment citations to:</p> <ul style="list-style-type: none"> • eliminate any personal bias • ensure consistent application of the standards from one Assessor/assessment to another • endorse EOC requirement and timeline for EOC submission based on risk assessment • ensure standards/requirements reflect current best practice <p>If the CPSA determines that image reviews are required based on high-risk cited non-conformances and benchmarked against the CPSA Image Review policy / criteria (see step 41):</p> <ul style="list-style-type: none"> • a request for images is included in the report with a 30 day timeline (done by CPSA) • a Physician Reviewer is assigned to review the images upon submission by the facility (conflict of interest mitigated):

			<ul style="list-style-type: none">○ The Reviewer must be available to review the images and submit a report within one week of the facility submission to the CPSA
--	--	--	--

4.5 POST-ASSESSMENT - CONTINUED

Responsibility		Task	Additional Information
38	CPSA Post On-site	Distributes final DI facility report	<p>Within 15-20 business days of the ACDI meeting, the CPSA posts the finalized individual DI facility report on the secure CPSA SharePoint site.</p> <p>CPSA notifies the DI facility Medical Director, facility Accreditation contact or designated executive leadership that the final report is available electronically in the Facility SharePoint.</p> <p>The final report is formatted to include a section for a DI facility response to each individual non-conformance/in-progress citations.</p>
39	CPSA Post On-site	Provides accreditation evaluation forms to DI facilities and Assessors	<p>To evaluate the effectiveness of the assessment process and customer satisfaction, DI facilities and the Assessment Team are asked to provide feedback on the Accreditation Evaluation Forms.</p> <p>Stakeholders are afforded the opportunity for anonymous comment.</p> <p>Results are compiled and reviewed annually by CPSA.</p> <p>Changes to process are implemented as appropriate based on feedback.</p>
40	DI facility Post On-site	Submits a response to requirements and requested evidence of compliance – if required	<p>DI facilities are required to electronically input their response directly into the report and embed any requested supporting documentation / EOC as applicable. Responses are uploaded by the designated accreditation contacts to secure DI facility SharePoint site.</p> <p>For requirements with requests for EOC: DI facilities must provide a response and required EOC based on timelines specified in the report (30 or 90 days from the date of the report).</p> <p>Responses to requirements without requests for EOC: DI facilities must provide a response within 90 days from the date of the report.</p>

4.5 POST-ASSESSMENT - CONTINUED

Responsibility		Task	Additional Information
41	Image Review Post On-site	CPSA initiates image review if required	<p>If CPSA determines that image reviews are required based on high-risk cited non-conformances and benchmarked against the CPSA Image Review policy/criteria:</p> <ul style="list-style-type: none"> • report identifies that an image review is being requested • CPSA will notify the facility Medical Director in writing within 5-10 business days to initiate the process
42	CPSA Post On-site	Reviews zone / group / DI facility (ies) responses to requirements and requested evidence of compliance	<p>CPSA reviews zone / group / DI facility (ies) responses to requirements and requested evidence of compliance. If necessary, and provides recommendations to the ACDI as to the appropriateness of the response.</p> <p>If there are issues or concerns based from responses that require the ACDI's expertise, the CPSA will bring anonymized and redacted issues/themes forward for discussion. The AC will be available at the ACDI meeting to responding to additional questions or clarification requests (anonymized discussion; the facility will not be named – no identifiers used, e.g. name, group or Zone).</p> <p>The CPSA provides a section in each report to facilitate the CPSA responses.</p>
43	CPSA Post On-site	Reviews/approves DI facility responses	<p>At the next meeting following the receipt of 30 and 90 day responses, the CPSA reviews/ revises/ approves the recommendations of the AC on the DI facility responses, with a view to:</p> <ul style="list-style-type: none"> • acceptability of response/corrective action • further action/clarification required <p>Evidence of Compliance (EOC) may be required for any response based on submitted response, regardless of whether EOC was requested in the initial report.</p>

4.5 POST-ASSESSMENT - CONTINUED

Responsibility		Task	Additional Information
44	CPSA Post On-site	Recommends Full accreditation status	<p>CPSA determines if any outstanding non-conformances (either due to volume or type of non-conformances) would substantiate a reversion to "Provisional" status. If this decision is made, a "Provisional" certificate is issued and the DI facility is advised to replace their "Full" certificate with the "Provisional" certificate.</p> <p>Once the identified "provisional" non-conformance(s) are satisfactorily addressed, the DI facility is granted "Full Accreditation" status and a certificate is issued.</p> <p>Accreditation recommendations of the CPSA are reviewed and approved by MFAC.</p> <p>If the CPSA recommends that a DI facility is denied accreditation, the DI facility may access the CPSA formal appeal process.</p>
45	CPSA	Stakeholder / facility survey feedback	CPSA electronically sends out assessment invoices as well as post accreditation stakeholder surveys.

5.0 Honoraria and Expense Reimbursement

For assessors - Refer to the current Honoraria and Expense Policy (on the CPSA Assessor SharePoint site) for guidance and information.

6.0 Annual/Assessment Fees

Annual Fees

Facilities will be invoiced annually in December for the upcoming fiscal period of April 1 – March 31 for the Annual Admin Fee.

Assessment Fees

An assessment fee will be invoiced on a quarterly basis for facilities assessed in that quarter.