Criteria

for Levels 1, 2 & 3

Glossary of key terms

Accreditation	The process whereby an association or agency grants public recognition to a hospital, health care institution or specialized program of care to ensure it has met certain established qualifications or standards as determined through initial and periodic evaluations. Both the qualifications and evaluations are determined by the accreditation organization.
Standardization	The process by which a product of service is assessed against standards and specifications
Certification	A voluntary process by which a nongovernmental agency or association grants recognition to an individual/organization who has met certain predetermined qualifications specified by that agency or association
Recognition	Award, something given in recognition of an achievement
GED	Geriatric Emergency Department
GEM	Geriatric Emergency Medicine
ACEP	American College of Emergency Physicians
SAEM	Society for Academic Emergency Medicine
AGS	American Geriatrics Society
ENA	Emergency Nurses Association

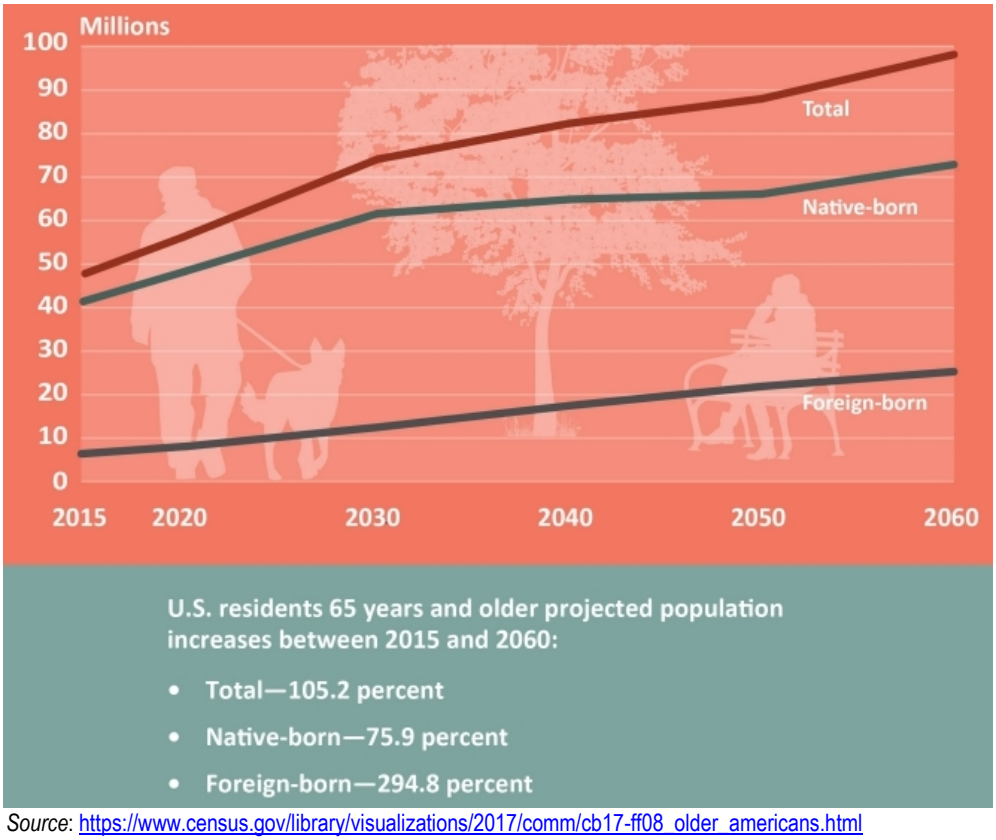
***Source*:** Knapp, J. (2000). Designing certification and accreditation programs. *American Society of Association Executives.*

Certifying an Emergency Department as Senior-Friendly – Why and How?

The proportion of the United States (U.S.) population over 65 years of age is projected to nearly double from 43 million in 2012 to 83 million in 2050.[1] Aging adults currently comprise 18% of total emergency department (ED) visits. This represents a 42% increase between 2002 and 2012 with anticipated continued expansion for decades to come.[2] Unique models of pre-hospital, ED, and inpatient geriatric healthcare delivery are being developed and evaluated partially because older adults are more likely to be admitted to the hospital after longer ED lengths of stay.[3] This population increase is partially responsible for the projected non-sustainable healthcare spending increase in the U.S. Health care spending is predicted to increase from the 2013 level of 17.4% of the U.S. gross domestic product (GDP) to 19.6% in 2024. At this point, medical costs will represent over 20% of U.S. GDP.[4,5]

The ED has historically been viewed as the front door of the hospital, determining use of inpatient versus outpatient resources. However a new model viewing the ED as the "front porch" of the hospital is emerging. In the "front porch" paradigm patients receive more definitive investigations and consultations in the ED without requiring a hospital admission. This practice evolution must occur without compromising patient safety or patient satisfaction.[6]

Figure 1. Projected number of U.S. residents 65 years and older



Source: https://www.census.gov/library/visualizations/2017/comm/cb17-ff08_older_americans.html

The American College of Emergency Physicians' Geriatric Section, in conjunction with the Society for Academic Emergency Medicine's Academy for Geriatric Emergency Medicine, the American Geriatrics Society, and Emergency Nurses Association have responded in a number of ways. These include the development of peer-reviewed and multi-stakeholder educational core competencies for certified emergency providers,[7] high-yield research opportunities to improve the underlying evidence-basis for specific recommendations,[8,9] and guidelines to focus resources on the most essential geriatric medical care priorities.[10] Implementation science (*also known as knowledge translation*) demonstrates the 17-year delay for only 14% of published recommendations to actually influence patient

care and improve patient outcomes.[11] Evidence shows how rare it is for ED nurses or physicians to follow published guidelines that recommend screening for common geriatric syndromes.,[12] These ED providers fail to identify delirium in up to 76% of cases,[13] and fail to provide recommended fall prevention interventions.[14] Dozens of U.S. hospitals have developed special emergency elder care processes, and refer to themselves as "Senior Friendly" or "Geriatric Emergency Departments" (GEDs). However, the attributes that differentiate these EDs from others lacking such processes remain poorly described. The characteristics of enhanced elder emergency services vary widely by location, with no standard reporting showing any improvement of patient outcomes .[15] How then can patients, healthcare providers, hospitals, or the public determine what enhancements truly improve elder emergency care? One approach is to standardize senior-friendly emergency care across multiple settings through an accreditation program based on objective measurable criteria.

Accreditation of facilities has long been used to assure and improve the quality of care rendered. From the first attempts in 1919 by the American College of Surgeons, accreditation programs have provided a framework of best practices and a level of public assurance regarding the quality of care provided. Trauma centers are an excellent example of a modern accreditation program that has impacted care. Early in their development, critics suggested trauma centers were unnecessary, that all general surgeons could provide equal care, and that postoperative rehabilitation in a community setting was preferred. However, trauma centers have had a positive impact on mortality and morbidity, and few today would argue against trauma center existence or certification, based on the recognized value created by these processes for patients, providers, and hospitals.

In this regard, accreditation of GEDs can provide value to patients, emergency physicians, and hospitals.

The value to our patients

- Accredited GEDs will provide a clearly defined set of measurable criteria, standardized to improve quality of emergency care for older adults.
- Patients and families can make more informed decisions when choosing a facility for care by searching for identified accredited GEDs.
- Patients will be protected from misleading marketing claims.
- There will be greater transparency regarding services provided in an emergency department
- Screening for geriatric syndromes improves the quality of life for older adults who otherwise might not receive such screening.
- Enhancements in policies, protocols, procedures, personnel, and equipment will improve health care delivery for older adults.
- Improving care for older adults will improve care for all patients. Complexity of care is not just age-based and additional resources can also be utilized for younger patients with multiple needs.

The value to our members

- ACEP accreditation provides members with maximal control and member participation in the criteria selected and the processes used to determine what is and what is not considered a GED.
- An ACEP-based program will emphasize those facets of geriatric emergency care that are most meaningful and feasible as determined by emergency physicians.
- ACEP accreditation will prevent the layering-on of unnecessary rules, additional educational requirements, and burdensome administrative obligations that could be imposed by accreditation from outside organizations.
- Availability of new resources helpful for patient care may be provided by hospitals that desire accreditation.
    - *For example*:

    - New personnel such as physical therapists, care managers or social workers.
    - Policies to expedite older patient discharge and care transitions.
    - Equipment such as blanket warmers, walkers, and mattresses.
    - Improvements to lighting and flooring in the ED.
- It will be important for our members to understand that every ED needs to have the basic resources to care for geriatric patients, which will be outlined our program. However, accreditation will highlight facilities that have advanced capabilities. Accreditation will provide a structure and a framework for improving care to rise to the next level.

The value to hospitals

- The structure of the program will be feasible in large and in small hospitals, permitting hospitals and hospital systems to improve care and attain accreditation.
- Cost for converting a standard treatment room to a geriatric room is about $1,500, making it affordable to all facilities.
- The program is flexible and designed to meet the needs of the community. In addition, by sharing innovations between accredited hospitals, institutions can choose to adopt those that are pertinent to their population.
- Geriatric EDs, when studied, have a lower admission rate, and a lower readmission rate to acute care hospitals and nursing homes. This not only reduces cost, but prevents hospital-acquired infections and reduces unnecessary procedures such as urinary catheters.

The value to ACEP

As the leader in emergency medicine, it is our duty to determine and promote best practices in the emergency care setting. GED accreditation:

- strengthens our brand and recognition with other organizations and the public.
- provides us an opportunity to work with AARP and other specialty organizations as patient advocates.
- provides an opportunity to partner with the CDC in injury prevention, specifically the fall prevention program.
- promotes the triple aim of healthcare and helps our members prepare for ACOs and population health.
- provides non-dues revenue for the college.

A key first step preceding accreditation is to distinguish higher and lower priorities based on general availability and anticipated patient-centric value. Establishing distinctions between sites that exhibit the highest level of senior-friendly care and other levels is also important. A working group of six ACEP Geriatric Emergency Medicine Section members identified by the ACEP President developed the following priorities and leveling recommendations over a series of meetings between November and December 2016. The following criteria relate to minimum standards across 3 levels of accreditation.

Level Three accreditation signifies excellence in older adult care as represented by one or more geriatric-specific initiatives that are reasonably expected to elevate the level of elder care in one or more specific areas. Additionally, personnel to implement these efforts are identified and trained.

Level Two accreditation identifies sites that have integrated and sustained older adult care initiatives into daily operations. They demonstrate interdisciplinary cooperation for delivery of senior-friendly services and have an established supervisor or director coordinating staff tasked with the daily performance of these services.

Level One accreditation defines an ED with, policies, guidelines, procedures, and staff (both within the ED and

throughout the institution) providing a coherent system of care targeting and measuring specific ED outcomes for older adults elevating ED operations and transitions of care both to and from the ED, all coordinated for the improved care of older adults. Additionally identified physical plant enhancements targeted to improve older adult care exist.

Criteria for any level of GED accreditation are comprised of the following seven categories:

a) Staffing
b) Education
c) Policies/protocols, guidelines and procedures
d) Quality improvement
e) Outcome measures
f) Equipment and supplies
g) Physical environment

The following section provides greater detail on accreditation criteria by level.

Level Three:

This is a basic standard of care that every ED should provide and focuses on the following domains:

a) Staffing:

1. The institution should ensure availability of at least one MD/DO on staff who can provide evidence of some focused emergency department physician education specifically relevant to the provision of emergency care of older people
2. The institution should ensure availability of at least one RN on staff who can provide evidence of some focused emergency nursing education specifically relevant to the provision of emergency care of older people

b) Education:

1. A physician champion / medical director is required for all levels of Geriatric ED. This physician champion / medical director must demonstrate focused training in geriatric emergency medicine that provides added expertise in the emergency care of older adults and added ability to teach other physicians and advanced practice providers how to improve this care.

   This training requirement must be demonstrated through coursework:

   1) focused on geriatric specific syndromes and concepts (e.g., atypical presentation of disease, changes with age, transitions of care) relevant to emergency medicine,

   2) focused on clinical issues nearly exclusive to geriatric ED patients (e.g., end of life care, dementia, delirium, systems of care for older adults), or

   3) discussing issues common to all ED patients but focused on the unique factors found in older adults (e.g., trauma in older adults, cardiac arrest care for the geriatric patient.)

   Training in common emergency medicine conditions (e.g., stroke) that happen to affect older adults does not qualify for this requirement. Qualifying training courses may be in person, web-based (e.g., Geri-EM.com) or equivalent provided through or led by an authoritative resource. *Reading a book or credit for a topic search in Up to Date (or similar) do not qualify for this training requirement unless CME is earned for this activity.*

- For physician champion / medical directors applying to lead Level 3 Geriatric EDs, 4 hours of education are required for the initial certification and for each renewal.

  These educational requirements may be demonstrated through appropriate geriatric-focused CME with completion certificates (please be ready to share these certificates and which of the above mentioned geriatric content this includes.) Alternatively, applicants may submit other coursework that they believe should fulfill this requirement for review by the GEDA Board of Governors. The Board of Governors are under no obligation to accept this other coursework.

2. Appropriate education will relate to the eight domains of Geriatric EM as defined by Hogan et al.:

   a. Atypical presentations of disease
   b. Trauma including falls

c. Cognitive and Behavioral disorders
d. Emergency intervention modifications
e. Medication management/polypharmacy
f. Transitions of care
g. Effect of comorbid conditions/polymorbidity
h. End-of-life care

3. Education of nursing personnel about geriatric emergency care of older patients is critically important in a Geriatric ED. A department should document its nursing educational activity and submit the documentation for consideration. Some examples:

    a. GENE course from Emergency Nurses Association https://www.ena.org/education/education/GENE/Pages/default.aspx
    b. Emergency Department nursing modules from NICHE http://www.nicheprogram.org/knowledge-center/webinars/archived-webinars/
    c. Locally developed nursing education modules

c) Policies/protocols, guidelines, and procedures:

Provide evidence of at least one geriatric-specific emergency care initiative (e.g. elder mistreatment, cognitive impairment, or other policies/ protocols / procedures.)

We are looking for protocols that specifically address the emergency care needs of older adults. These protocols or procedures should describe the process through which this care improvement activity takes place for older patients while in the ED and how it is tracked with regards to adherence and care (i.e., who does the process, on whom the process is done, and how the process is triggered, etc.)

Sites submitting hospital-wide policies / protocols / procedures should provide detailed explanation for how these are applied to older adults and address ED specific issues.

Describe at least one policy or protocol or procedure that you have implemented in your ED that is specific to high-quality care of older ED patients. This description should be detailed enough for the reviewers to understand how it is implemented, including information about staff education, how it is integrated into workflow, and strategies for tracking implementation. These protocols or procedures should describe the process through which a care improvement activity takes place for older patients while in the ED and how it is tracked with regards to adherence and improvement (i.e., who does the process, on whom the process is done, and how the process is triggered, etc.)

It is not sufficient to describe an already existent hospital-wide policy that just happens to include the ED or an already existent ED policy that just happens to include older patients. The following are *not* adequate for accreditation: a hospital-wide policy on reducing urinary catheter insertion which does not specify how this policy will be disseminated to ED nurses and physicians or how the policy will be adapted in the ED setting for geriatric patient specifically is not adequate for accreditation; an ED policy of routinely screening all patients for abuse which does not address the particular challenges of elder abuse (e.g., staff education in recognizing it, reporting requirements, strategies for tracking adherence.)

Applications that do not include these details about the geriatric-specific and ED-specific nature of the policies / protocols / procedures will not be accepted.

- Examples of suitable geriatric ED-specific policies can be found throughout the ACEP Geriatric ED Guidelines. They might include the following (or many others):
- A process for screening all older ED patients for delirium including staff training, tools to be used, strategies for follow up of positive screens, strategies for tracking adherence and quality improvement;
- A process for identifying functional decline in all older ED patients including staff training, tools to be used, strategies for tracking adherence and quality improvement;
- A process for assessing older ED patients who present with falls including staff training, tools/processes to be used, involvement of an interdisciplinary team, strategies for tracking adherence and quality improvement;
- A process for improving transitions of care e.g. ensuring accurate information returns to primary care provider or long-term care or community services, including staff training, the tool to be used, strategies for tracking adherence and quality improvement;
- A process for medication reconciliation for older ED patients; for reduced use of restraints for older ED patients; for pain management in older ED patients; for accessing palliative care services;

d) Quality improvement – *N/A*

e) Outcome measures – *N/A*

f) Equipment and supplies:

Access to mobility aids (4-point walkers, canes) for 24/7 use in the ED.

g) Physical environment:

Easy access to food and drink, 24 hours a day.

Level Two:

a) Staffing:

1. Physician

The institution should provide an emergency physician 'champion' or medical director who possesses expertise specifically relevant to the provision of emergency care of older people with the following responsibilities:

a. to act as Geriatric EM educational leader/coordinator for EM providers across multiple disciplines
b. to Oversee GED operations including:
    i. Implementation and regular assessment of protocol and policy guidelines of geriatric-specific initiatives
    ii. Coordination/guidance of GED staff workflow
    iii. Coordination of interdisciplinary team workflow in the GED
c. to act as the Quality improvement team leader overseeing adherence to geriatric-specific protocols
d. to develop and oversee outcome measures documentation including specific GED process and outcome metrics
e. to act as Coordinator for maintenance of GED environment (i.e., specific equipment and supplies)
f. to Liaison between hospital leadership and the GED
g. to act as Quality assurance team leader for geriatric patient case reviews/complaints
h. to Coordinator of GEM research initiatives (*if applicable*)

-EDs that seek accreditation but lack involvement of an emergency physician in the Geriatric ED Medical Director position should appoint co-directors of the geriatric emergency department. In these cases, one GED co-director would be an emergency physician who can then partner with the other co-director in the role of GED director.

-EDs that seek accreditation but lack any emergency physicians capable of serving as co-Medical Director at minimum must request a special exemption to appoint a non-emergency physician as Geriatric ED Medical Director for no more than three years while an emergency physician is recruited. Renewal of the exemption is unlikely without remarkable circumstances (e.g., an extremely rural hospital, failure of extensive attempts to recruit, etc.) We ask that this request come from hospital leadership (e.g., Chief Medical Officer or equivalent) to demonstrate their understanding of the issues present and commitment to adhering to the GEDA requirements in time for the first renewal.

2. Nursing

The institution should provide an identified nurse case manager or transitional care nurse or equivalent who should be present in the ED for at least **56** hours/week of clinical coverage. This nurse case manager or social worker shall have responsibility for complex geriatric patient care and responsibility for geriatric patient capacity development/performance improvement within the ED.

3. Interdisciplinary

The institution should ensure availability of an Inter-disciplinary geriatric assessment team, including at least 2 of the following roles available to the ED.

a. Physiotherapy, occupational therapy, social work, or medication management

4. **Administrative**
   The institution should ensure that at least one member of the executive/administrative team of the hospital should have, as a part of his/her portfolio, supervision of the Geriatric ED program and be actively committed to enhancing senior-friendly emergency care.

b) Education:

4. A physician champion / medical director is required for all levels of Geriatric ED. This physician champion / medical director must demonstrate focused training in geriatric emergency medicine that provides added expertise in the emergency care of older adults and added ability to teach other physicians and advanced practice providers how to improve this care.

   This training requirement must be demonstrated through coursework:
   2) focused on geriatric specific syndromes and concepts (e.g., atypical presentation of disease, changes with age, transitions of care) relevant to emergency medicine,

   2) focused on clinical issues nearly exclusive to geriatric ED patients (e.g., end of life care, dementia, delirium, systems of care for older adults), or

   3) discussing issues common to all ED patients but focused on the unique factors found in older adults (e.g., trauma in older adults, cardiac arrest care for the geriatric patient).

   Training in common emergency medicine conditions (e.g., stroke) that happen to affect older adults does not qualify for this requirement. Qualifying training courses may be in person, web-based (e.g., Geri-EM.com) or equivalent provided through or led by an authoritative resource. *Reading a book or credit for a topic search in Up to Date (or similar) do not qualify for this training requirement unless CME is earned for this activity.*

- For physician champion / medical directors applying to lead Level 2 Geriatric EDs, 6 hours of education are required for the initial certification and for each renewal.

   These educational requirements may be demonstrated through appropriate geriatric-focused CME with completion certificates (please be ready to share these certificates and which of the above mentioned geriatric content this includes.) Alternatively, applicants may submit other coursework that they believe should fulfill this requirement for review by the GEDA Board of Governors. The Board of Governors are under no obligation to accept this other coursework.

5. Appropriate education will relate to the eight domains of Geriatric EM as defined by Hogan et al.:

   i. Atypical presentations of disease
   j. Trauma including falls
   k. Cognitive and Behavioral disorders
   l. Emergency intervention modifications
   m. Medication management/polypharmacy
   n. Transitions of care
   o. Effect of comorbid conditions/polymorbidity
   p. End-of-life care

6. Education of nursing personnel about geriatric emergency care of older patients is critically important in a

Geriatric ED. A department should document its nursing educational activity and submit the documentation for consideration. Some examples:

d. GENE course from Emergency Nurses Association https://www.ena.org/education/education/GENE/Pages/default.aspx
e. Emergency Department nursing modules from NICHE http://www.nicheprogram.org/knowledge-center/webinars/archived-webinars/
f. Locally developed nursing education modules

c) Policies/protocols, guidelines and procedures:

At least **10** of the following items should be part of the ED's model of care (as evidenced by well-established policies and guidelines to ensure implementation and integration of those guidelines into electronic medical records, if possible and applicable). Applicants should provide supporting documentation demonstrating the application of these policies in the majority of eligible GED patients at their institution.

We are looking for protocols that specifically address the emergency care needs of older adults. These protocols or procedures should describe the process through which this care improvement activity takes place for older patients while in the ED and how it is tracked with regards to adherence and care. (i.e., Who does the process, on whom the process is done, and how the process is triggered, etc.)

Sites submitting hospital-wide policies / protocols / procedures should provide detailed explanation for how these are applied to older adults and address ED specific issues.

Describe at least one policy or protocol or procedure that you have implemented in your ED that is specific to high-quality care of older ED patients. This description should be detailed enough for the reviewers to understand how it is implemented, including information about staff education, how it is integrated into workflow, and strategies for tracking implementation. These protocols or procedures should describe the process through which a care improvement activity takes place for older patients while in the ED and how it is tracked with regards to adherence and improvement (i.e., who does the process, on whom the process is done, and how the process is triggered, etc.)

It is not sufficient to describe an already existent hospital-wide policy that just happens to include the ED or an already existent ED policy that just happens to include older patients. The following are *not* adequate for accreditation: a hospital-wide policy on reducing urinary catheter insertion which does not specify how this policy will be disseminated to ED nurses and physicians or how the policy will be adapted in the ED setting for geriatric patient specifically is not adequate for accreditation; an ED policy of routinely screening all patients for abuse which does not address the particular challenges of elder abuse (e.g., staff education in recognizing it, reporting requirements, strategies for tracking adherence.)

Applications that do not include these details about the geriatric-specific and ED-specific nature of the policies / protocols / procedures will not be accepted.

- Examples of suitable geriatric ED-specific policies can be found throughout the ACEP Geriatric ED Guidelines. They might include the following (or many others):

- A process for screening all older ED patients for delirium including staff training, tools to be used, strategies for follow up of positive screens, strategies for tracking adherence and quality improvement;
- A process for identifying functional decline in all older ED patients including staff training, tools to be used, strategies for tracking adherence and quality improvement;
- A process for assessing older ED patients who present with falls including staff training, tools/processes to be used, involvement of an interdisciplinary team, strategies for tracking adherence and quality improvement;
- A process for improving transitions of care e.g. ensuring accurate information returns to primary care provider or long-term care or community services, including staff training, the tool to be used, strategies for tracking adherence and quality improvement;
- A process for medication reconciliation for older ED patients; for reduced use of restraints for older ED patients; for pain management in older ED patients; for accessing palliative care services

Describing Patient Eligibility for GED Services

A patient's eligibility for GED initiatives may vary across intervention type and institution. For example, eligibility may be based on age, screening tool results, or prior ED history. While we will accept a range of definitions of patient eligibility, the applying institution should specify how they are defining eligibility for the purposes of measuring adherence (i.e., the denominator) for each criterion being evaluated.

Table 1. Level 2: GED policies/protocols, guidelines and procedures

1	A standardized delirium screening guideline (examples: DTS; CAM; 4AT, other) with appropriate follow-up
2	A standardized dementia screening process (Ottawa 3DY; Mini Cog; SIS; Short Blessed Test; other)
3	A guideline for standardized assessment of function and functional decline (ISAR; AUA; interRAI Screener; other) with appropriate follow-up
4	A guideline for standardized fall assessment guideline (including mobility assessment, e.g. TUG or other) with appropriate follow-up
5	A guideline for identification of elder abuse with appropriate follow-up
6	A guideline for medication reconciliation in conjunction with a pharmacist
7	A guideline for to minimize the use of potentially inappropriate medications (Beers' list, or other hospital-specific strategy, access to an ED-based pharmacist)
8	A guideline for pain control in elder patients
9	A guideline for accessing palliative care consultation in the ED
10	A guideline for accessing Geriatric Psychiatry consultation in the ED
11	Development and implementation of at least three order sets for common geriatric ED presentations developed with particular attention to geriatric-appropriate medications and dosing and management plans (e.g. delirium, hip fracture, sepsis, stroke, ACS)
12	A guideline to standardize and minimize urinary catheter use
13	A guideline to minimize NPO designation and to promote access to appropriate food and drink
14	A guideline to promote mobility
15	A guideline to guide the use of volunteer engagement
16	A standardized discharge guideline for patients discharged home that addresses age-specific communication needs (large-font, lay person's language, clear follow-up plan, evidence of patient communication)
17	A guideline for PCP notification
18	A guideline to address transitions of care to residential care
19	A guideline to minimize use of physical restraints including use of trained companions/sitters
20	Standardized access to geriatric specific follow-up clinics: comprehensive geriatric assessment clinic, falls clinic, memory clinic, other
21	A guideline for post-discharge follow up (phone, telemedicine, other)
22	Access to transportation services for return to residence
23	A pathway program providing easy access to short- or long-term rehabilitation services, including inpatient

24	Access to an outreach program providing home assessment of function and safety
25	Access to and an active relationship with community paramedicine follow up services
26	An outreach program to residential care homes to enhance quality of care and of ED transfers

d) Quality Improvement

There should be evidence of efforts to ensure effective and appropriate utilization of above policies and guidelines with adherence to the **10** components chosen in "*Policies guidelines and procedures*".

e) Outcomes measures

The ED should track both process and outcomes metrics related to eligible GED patients. These should include demonstration of process and outcome metrics in the majority of eligible GED patients in ***at least 3*** of the following metrics for ***at least 3*** of the policies/ protocols guidelines or procedures chosen in Section c. (please refer to the note on "Describing Patient Eligibility for GED Services" in part c ("Policies/protocols, guidelines and procedures above):

Table 2. Level 2: GED outcomes

1	Percentage of eligible patients who receive the designated intervention(s) above
2	Numbers of patients screening positively for applicable intervention(s)
3	Designation of a referral pathway for positively screened patients
4	Percentage of eligible positively screened patients who are referred as designated
5	Percentage of eligible positively screened patients who complete the referral
6	Outcomes of all completed referrals for positively screened patients
7	Numbers of older adults admitted to the hospital including the primary admitting diagnosis and chief complaint
8	Numbers of older adults discharged to home, SNF, or NH with including the primary ED diagnosis and chief complaint
9	Numbers of older adults with repeat ED visits and the percentage of all elder visits this represents
10	Numbers of older adults with repeat ED admissions and the percentage of all elder visits this represents
11	Number of older adults staying >8 hours in the ED and the percentage of all elder visits this represents

**Future re-accreditation will consider demonstration of implementation of successful QI projects that use these outcome measures*

f) Equipment and supplies

In-department access to four-point walkers, canes, and ***at least 3*** additional pieces of equipment/supplies from the following:

Table 3. Level 2: GED equipment and supplies

1	Non-slip socks
2	Pressure-ulcer reducing mattresses and pillows
3	Blanket warmer
4	Hearing assist devices
5	Bedside commodes
6	Condom catheters
7	Transition stools for each bed

g) Physical environment

Presence of the following characteristics to the GED physical environment:

Table 4. Level 2: GED physical environment

1	Two chairs per patient bed to promote visitors and the possibility of sitting
2	A large-face analog clock in each GED patient room
3	Easy access to food and drink

Level One:

All of the additional/different requirements to move from Level Two to Level One are marked *****

a) Staffing:

1. Physician

The institution should provide an emergency physician 'champion' or medical director expertise specifically relevant to the provision of emergency care of older people with the following responsibilities:

a. Geriatric EM educational leader/coordinator for EM providers across multiple disciplines
b. Oversee GED operations including:
    i. Implementation and regular assessment of protocol and policy guidelines of geriatric-specific initiatives
    ii. Coordination/guidance of GED staff workflow
    iii. Coordination of interdisciplinary team workflow in the GED
c. Quality improvement team leader for adherence to geriatric-specific protocols
d. Oversee outcome measures documentation including process and outcome metrics
e. Coordinator for maintenance of GED environment (i.e., specific equipment and supplies)
f. Liaison between hospital leadership and the GED
g. Quality assurance team leader for geriatric patient case reviews/complaints
h. Coordinator of GEM research initiatives (*if applicable*)

-EDs that seek accreditation but lack involvement of an emergency physician in the Geriatric ED Medical Director position should appoint co-directors of the geriatric emergency department. In these cases, one GED co-director would be an emergency physician who can then partner with the other co-director in the role of GED director.

-EDs that seek accreditation but lack any emergency physicians capable of serving as co-Medical Director at minimum must request a special exemption to appoint a non-emergency physician as Geriatric ED Medical Director for no more than three years while an emergency physician is recruited. Renewal of the exemption is unlikely without remarkable circumstances (e.g., an extremely rural hospital, failure of extensive attempts to recruit, etc.) We ask that this request come from hospital leadership (e.g., Chief Medical Officer or equivalent) to demonstrate their understanding of the issues present and commitment to adhering to the GEDA requirements in time for the first renewal.

2. Nursing

The institution should provide an identified nurse case manager or transitional care nurse or equivalent who should be present in the ED for at least **56** hours/week of clinical coverage. This nurse case manager or social worker shall have responsibility for complex geriatric patient care and responsibility for geriatric patient capacity development/performance improvement within the ED.

3. Interdisciplinary

The institution should ensure availability of an **Inter-disciplinary geriatric assessment team, including the following roles available to the ED.*

a. Physiotherapy, occupational therapy, social work, medication management

4. **Administrative**
   The institution should ensure that at least one member of the executive/administrative team of the hospital should have, as a part of his/her portfolio, supervision of the Geriatric ED program and be actively committed to enhancing senior-friendly emergency care.

5. **Patient advisor**
   The institution should ensure that ***A** patient advisor or patient council should be appointed and be able to provide at least monthly input on potential for quality improvement.*

b) Education:

7. A physician champion / medical director is required for all levels of Geriatric ED. This physician champion / medical director must demonstrate focused training in geriatric emergency medicine that provides added expertise in the emergency care of older adults and added ability to teach other physicians and advanced practice providers how to improve this care.

   This training requirement must be demonstrated through coursework:
   1) focused on geriatric specific syndromes and concepts (e.g., atypical presentation of disease, changes with age, transitions of care) relevant to emergency medicine,

   2) focused on clinical issues nearly exclusive to geriatric ED patients (e.g., end of life care, dementia, delirium, systems of care for older adults), or

   3) discussing issues common to all ED patients but focused on the unique factors found in older adults (e.g., trauma in older adults, cardiac arrest care for the geriatric patient).

   Training in common emergency medicine conditions (e.g., stroke) that happen to affect older adults does not qualify for this requirement. Qualifying training courses may be in person, web-based (e.g., Geri-EM.com) or equivalent provided through or led by an authoritative resource. *Reading a book or credit for a topic search in Up to Date (or similar) do not qualify for this training requirement unless CME is earned for this activity.*

- For physician champion / medical directors applying to lead Level 1 Geriatric EDs, 8 hours of education are required for the initial certification and for each renewal.

   These educational requirements may be demonstrated through appropriate geriatric-focused CME with completion certificates (please be ready to share these certificates and which of the above mentioned geriatric content this includes.) Alternatively, applicants may submit other coursework that they believe should fulfill this requirement for review by the GEDA Board of Governors. The Board of Governors are under no obligation to accept this other coursework.

8. Appropriate education will relate to the eight domains of Geriatric EM as defined by Hogan et al.:

   q. Atypical presentations of disease
   r. Trauma including falls
   s. Cognitive and Behavioral disorders
   t. Emergency intervention modifications
   u. Medication management/polypharmacy
   v. Transitions of care

w. Effect of comorbid conditions/polymorbidity
x. End-of-life care

9. Education of nursing personnel about geriatric emergency care of older patients is critically important in a Geriatric ED. A department should document its nursing educational activity and submit the documentation for consideration. Some examples:

    g. GENE course from Emergency Nurses Association https://www.ena.org/education/education/GENE/Pages/default.aspx
    h. Emergency Department nursing modules from NICHE http://www.nicheprogram.org/knowledge-center/webinars/archived-webinars/
    i. Locally developed nursing education modules

c) Policies/protocols, guidelines and procedures:

At least 20 of the following (*note*: guideline *1), should be part of the ED's model of care (as evidenced by well-established guidelines and with integration of those guidelines into electronic medical records, if applicable). Given the high likelihood of variability across sites, adherence and presence of policies and guidelines will determined primarily by reviewer evaluation during the site visit. In preparation for the site visit, applicants should be prepared to provide supporting documentation of relevant guidelines in the majority of eligible GED patients at their institution.

We are looking for protocols that specifically address the emergency care needs of older adults. These protocols or procedures should describe the process through which this care improvement activity takes place for older patients while in the ED and how it is tracked with regards to adherence and care. (i.e., Who does the process, on whom the process is done, and how the process is triggered, etc.)

Sites submitting hospital-wide policies / protocols / procedures should provide detailed explanation for how these are applied to older adults and address ED specific issues.

Describe at least one policy or protocol or procedure that you have implemented in your ED that is specific to high-quality care of older ED patients. This description should be detailed enough for the reviewers to understand how it is implemented, including information about staff education, how it is integrated into workflow, and strategies for tracking implementation. These protocols or procedures should describe the process through which a care improvement activity takes place for older patients while in the ED and how it is tracked with regards to adherence and improvement (i.e., who does the process, on whom the process is done, and how the process is triggered, etc.)

It is not sufficient to describe an already existent hospital-wide policy that just happens to include the ED or an already existent ED policy that just happens to include older patients. The following are *not* adequate for accreditation: a hospital-wide policy on reducing urinary catheter insertion which does not specify how this policy will be disseminated to ED nurses and physicians or how the policy will be adapted in the ED setting for geriatric patient specifically is not adequate for accreditation; an ED policy of routinely screening all patients for abuse which does not address the particular challenges of elder abuse (e.g., staff education in recognizing it, reporting requirements, strategies for tracking adherence.)

Applications that do not include these details about the geriatric-specific and ED-specific nature of the policies / protocols / procedures will not be accepted.

- Examples of suitable geriatric ED-specific policies can be found throughout the ACEP Geriatric ED Guidelines. They might include the following (or many others):

- A process for screening all older ED patients for delirium including staff training, tools to be used, strategies for follow up of positive screens, strategies for tracking adherence and quality improvement;
- A process for identifying functional decline in all older ED patients including staff training, tools to be used, strategies for tracking adherence and quality improvement;
- A process for assessing older ED patients who present with falls including staff training, tools/processes to be used, involvement of an interdisciplinary team, strategies for tracking adherence and quality improvement;
- A process for improving transitions of care e.g. ensuring accurate information returns to primary care provider or long-term care or community services, including staff training, the tool to be used, strategies for tracking adherence and quality improvement;
- A process for medication reconciliation for older ED patients; for reduced use of restraints for older ED patients; for pain management in older ED patients; for accessing palliative care services

Describing Patient Eligibility for GED Services

A patient's eligibility for GED initiatives may vary across intervention type and institution. For example, eligibility may be based on age, screening tool results, or prior ED history. While we will accept a range of definitions of patient eligibility, the applying institution should specify how they are defining eligibility for the purposes of measuring adherence (i.e., the denominator) for each criterion being evaluated.

Table 1a. Level 1: GED policies/protocols, guidelines, and procedures

***1**	*A guideline to define criteria for access to Geriatric Emergency Department Care from ED triage*
2	A standardized delirium screening guideline (examples: DTS; CAM; 4AT, other) with appropriate follow-up
3	A standardized dementia screening process (Ottawa 3DY; Mini Cog; SIS; Short Blessed Test; other)
4	A guideline for standardized assessment of function and functional decline (ISAR; AUA; interRAI Screener; other) with appropriate follow-up
5	A guideline for standardized fall assessment guideline (including mobility assessment, e.g. TUG or other) with appropriate follow-up
6	A guideline for identification of elder abuse with appropriate follow-up
7	A guideline for medication reconciliation in conjunction with a pharmacist
8	A guideline for to minimize the use of potentially inappropriate medications (Beers' list, or other hospital-specific strategy, access to an ED-based pharmacist)
9	A guideline for pain control in elder patients
10	A guideline for accessing palliative care consultation in the ED
11	A guideline for accessing Geriatric Psychiatry consultation in the ED
12	Development and implementation of at least three order sets for common geriatric ED presentations developed with particular attention to geriatric-appropriate medications and dosing and management plans (e.g. delirium, hip fracture, sepsis, stroke, ACS)
13	A guideline to standardize and minimize urinary catheter use
14	A guideline to minimize NPO designation and to promote access to appropriate food and drink;
15	A guideline to promote mobility
16	A guideline to guide the use of volunteer engagement
17	A standardized discharge guideline for patients discharged home that addresses age-specific communication needs (large-font, lay person's language, clear follow-up plan, evidence of patient communication)
18	A guideline for PCP notification
19	A guideline to address transitions of care to residential care

20	A guideline to minimize use of physical restraints including use of trained companions/sitters
21	Standardized access to geriatric specific follow-up clinics: comprehensive geriatric assessment clinic, falls clinic, memory clinic, other
22	A guideline for post-discharge follow up (phone, telemedicine, other)
23	Access to transportation services for return to residence
24	A pathway program providing easy access to short- or long-term rehabilitation services, including inpatient
25	Access to an outreach program providing home assessment of function and safety
26	Access to and an active relationship with community paramedicine follow up services
27	An outreach program to residential care homes to enhance quality of care and of ED transfers

**New criteria*

d) Quality Improvement

There should be evidence of efforts to ensure effective and appropriate utilization of above policies and guidelines to the 20 components chosen in "*Policies guidelines and procedures*".

e) Outcomes measures

The ED should track both process and outcomes metrics related to eligible GED patients. These should include demonstration of process and outcome metrics in the majority of eligible GED patients in ***at least 5*** of the following metrics for ***at least 5*** of the "policies/ protocols, guidelines or procedures" chosen in Section c.

(please refer to the note on "Describing Patient Eligibility for GED Services" in part c ("Policies/protocols, guidelines and procedures" above):

Table 2a. Level 1: GED outcomes

1	Percentage of eligible patients who receive the designated intervention(s) above
2	Numbers of patients screening positively for applicable intervention(s)
3	Designation of a referral pathway for positively screened patients
4	Percentage of eligible positively screened patients who are referred as designated
5	Percentage of eligible positively screened patients who complete the referral
6	Outcomes of all completed referrals for positively screened patients
7	Numbers of older adults admitted to the hospital including the primary admitting diagnosis and chief complaint
8	Numbers of older adults discharged to home, SNF, or NH with including the primary ED diagnosis and chief complaint
9	Numbers of older adults with repeat ED visits and the percentage of all elder visits this represents
10	Numbers of older adults with repeat ED admissions and the percentage of all elder visits this represents
11	Number of older adults staying >8 hours in the ED and the percentage of all elder visits this represents

**Future re-accreditation will consider demonstration of implementation of successful QI projects that use these outcome measures*

f) Equipment and Supplies

Easy in-department access to four-point walkers, canes, and the following list of equipment/supplies (*note*:*1 and *2)

Table 3a. Level 1: GED equipment and supplies

***1**	*Low beds*
***2**	*Reclining arm chairs*
3	Non-slip socks
4	Pressure-ulcer reducing mattresses and pillows
5	Blanket warmer
6	Hearing assist devices
7	Bedside commodes
8	Condom catheters

**New criteria*

g) Physical environment

Ideally a separate physically enclosed space for the Geriatric ED is identified. If that is not possible a space that prioritizes the best qualities of senior-friendly environmental design with attention to the following (*note:* * indicates new criteria for Level 1 accreditation).

Table 4a. Level 1: GED physical environment

***1**	*Ample seating for visitors and family (at least 2/room)*
2	A large-face analog clock in each patient room
3	Easy access to food and drink
***4**	*Enhanced lighting (e.g. natural light, artificial skylight or window, etc.*
***5**	*Efforts at noise reduction (separate enclosed rooms*
***6**	*Non-slip floors*
***7**	*Adequate hand rails*
***8**	*High-quality signage and way-finding*
***9**	*Wheel-chair accessible toilets*
***10**	*Availability of raised toilet seats*

**New criteria*

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REFERENCES

1. Ortman J, Velkoff VA, Hogan H. *An Aging Nation: The Older Population in the United States: Population estimates and Projections,* Washington DC: US Census Bureau; 2012.

2. Pines JM, Mullins PM, Cooper JK, et al. National trends in emergency department use, care patterns, and quality of care in older adults in the United States. *J Am Geriatr Soc.* 2013;**61**:12–7.

3. Carpenter CR, Platts-Mills TF. Evolving prehospital, emergency department, and "inpatient" management models for geriatric emergencies. *Clin Geriatr Med.* Feb 2013;29(1):31-47.

4. Keehan SP, Cuckler GA, Sisko AM, et al. National health expenditure projections, 2014-24: spending growth faster than recent trends. *Health Aff.* Aug 2015;34(8):1407-1417.

5. Keehan SP, Poisal JA, Cuckler GA, et al. National Health Expenditure Projections, 2015-25: Economy, prices, and aging expected to shape spending and enrollment. *Health Aff.* Aug 2016;35(8):1522-1531.

6. Hwang U, Shah MN, Han JH, et al. Transforming emergency care for older adults. *Health Aff.* Dec 2013;32(12):2116-2121.

7. Hogan TM, Losman ED, Carpenter CR, et al. Development of geriatric competencies for emergency medicine residents using an expert consensus process. *Acad Emerg Med.* Mar 2010;17(3):316-324.

8. Carpenter CR, Heard K, Wilber ST, et al. Research priorities for high-quality geriatric emergency care: medication management, screening, and prevention and functional assessment. *Acad Emerg Med.* Jun 2011;18(6):644-654.

9. Carpenter CR, Shah MN, Hustey FM, et al. High yield research opportunities in geriatric emergency medicine research: prehospital care, delirium, adverse drug events, and falls. *J Gerontol Med Sci.* Jul 2011;66(7):775-783.

10. Rosenberg M, Carpenter CR, Bromley M, et al. Geriatric Emergency Department Guidelines. *Ann Emerg Med.* May 2014;63(5):e7-e25.

11. Carpenter CR, Lo AX. Falling Behind? Understanding Implementation Science in Future Emergency Department Management Strategies for Geriatric Fall Prevention. *Acad Emerg Med.* Apr 2015 22(4):478-480.

12. Carpenter CR, Griffey RT, Stark S, et al. Physician and Nurse Acceptance of Geriatric Technicians to Screen for Geriatric Syndromes in the Emergency Department. *West J Emerg Med.* Dec 2011;12(4):489-495.

13. Han JH, Zimmerman EE, Cutler N, et al. Delirium in older emergency department patients: recognition, risk factors, and psychomotor subtypes. *Acad Emerg Med.* Mar 2009;16(3):193-200.

14. Tirrell G, Sri-on J, Lipsitz LA, et al. Evaluation of older adult patients with falls in the emergency department: discordance with national guidelines. *Acad Emerg Med.* Apr 2015 22(4):461-467.

15. Hogan TM, Olade TO, Carpenter CR. A profile of acute care in an aging America: snowball sample identification and characterization of United States geriatric emergency departments in 2013. *Acad Emerg Med.* Mar 2014 21(3):337-346.

Table 1. Criteria by accreditation level

CRITERIA	LEVEL 3	LEVEL 2	LEVEL 1
a) Staffing			
1 MD/DO with evidence of focused education for geriatric EM	X	X	X
1 RN with evidence of focused education for geriatric EM	X	X	X
Physician champion/Medical director		X	X
Nurse case manager/transitional care nurse present > 56 hrs/week		X	X
Interdisciplinary geriatric assessment team includes ≥ 2 roles		X	
Interdisciplinary geriatric assessment team includes ≥ 4 roles			X
> 1 executive/administrative sponsor supervising GED program		X	X
Patient advisor/patient council			X
b) Education			
Staff physician education (hours) related to 8 domains of GEM	4	6	8
Nursing education in geriatric emergency care	X	X	X
c) Policies/protocols guidelines & procedures			
Evidence of a geriatric emergency care initiative	X	X	X
≥ 10 items as part of the ED model of care for patients >65ysr		X	
≥ 20 items as part of the ED model of care for patients >65yrs			X
d) Quality improvement			
Adherence to 10 policies/protocols, guidelines & procedures		X	
Adherence to 20 policies/protocols, guidelines & procedures			X
e) Outcome measures			
Track ≥ 3 process and outcome metrics for eligible patients		X	
Track ≥ 5 process and outcome metrics for eligible patients			X
f) Equipment and supplies			
Access to mobility aids (canes, walkers)	X	X	X
Access to ≥ 5 supplies (including mobility aids)		X	
Access to the following 10 supplies			X
g) Physical environment			
Easy access to food/drink	X	X	X
2 chairs per patient bed		X	X
Large analog clock		X	X
Enhanced lighting			X
Efforts at noise reduction			X
Non-slip floors			X
Adequate hand rails			X
High quality signage and way-finding			X
Wheel-chair accessible toilets			X
Availability of raised toilet seats			X