American College of Emergency Physicians® | ACEP Geriatric Emergency Department Accreditation

Geriatric Emergency Department **Criteria**

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An accreditation program of the
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

Table of Contents

Table of Contents 2
Acknowledgements 3
Why Certify as a GED 4
The value to patients 5
The value to ACEP members 5
The value to hospitals 6
The value to ACEP 6
Accreditation Overview 7
Criterion Categories 7
Accreditation Guidelines and Instructions 8
Physician and Nurse Champions 8
Qualifying Physician Champion Education 8
Qualifying Nurse Champion Education 9
Additional Physician and Nurse Champion Responsibilities – Level 1&2 9
Additional GED Team Members – Level 1&2 10
Geriatric ED Care Processes 11
Care Process Executive Summaries 13
Care process description 13
Quality Improvement and Tracking – Level 1&2 14
Workflows and Dashboard – Level 1&2 14
Staff Education – Level 1&2 14
Metrics and Outcome Measures 15
ED Boarding Metrics 15
Additional Outcome Measures 15
Equipment and Physical Resources 16
Summary of accreditation requirements 16
Approval Process 17
Renewal Applications 17
Glossary of key terms 19
References 19
Appendix 21
GEDA Care Processes Implementation and Tracking 21
Glossary and References for Screening Tools 30

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Disclaimer

These criteria and standards are intended solely as qualification for Geriatric ED Accreditation. They do not represent a legal or medical standard of care and are not intended to replace the clinical judgment of the physician or healthcare professional in an individual care encounter.

Why Certify as a GED

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] Older adults currently comprise 18% of total emergency department (ED) visits, with anticipated continued growth for decades to come.[2] Older adults have unique pre-hospital, ED, and inpatient healthcare needs that deserve specially designed care delivery processes. Older adults are more likely to be admitted to the hospital and to have longer ED lengths of stay.[3]

New methods of care delivery and integration are important to provide high quality care and to manage healthcare expenditures. The older adult population growth 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.[4,5]

The ED has historically been viewed as the front door of the hospital. Decisions are made in the ED about whether the patient requires inpatient versus outpatient resources. However, a newer model involves viewing the ED as the "front porch" of the hospital. In the "front porch" paradigm, patients receive more definitive, holistic assessments and consultations in the ED without requiring a hospital admission. In addition, more options are being developed for dispositions that expand the traditional dichotomy of admission and discharge. Innovations such as hospital-at-home, as well as more integrated coordination of outpatient care and services from the ED can provide a greater array of options to meet patients' needs and ensure safer transitions of care. This practice evolution must occur without compromising patient safety or patient satisfaction.[6]

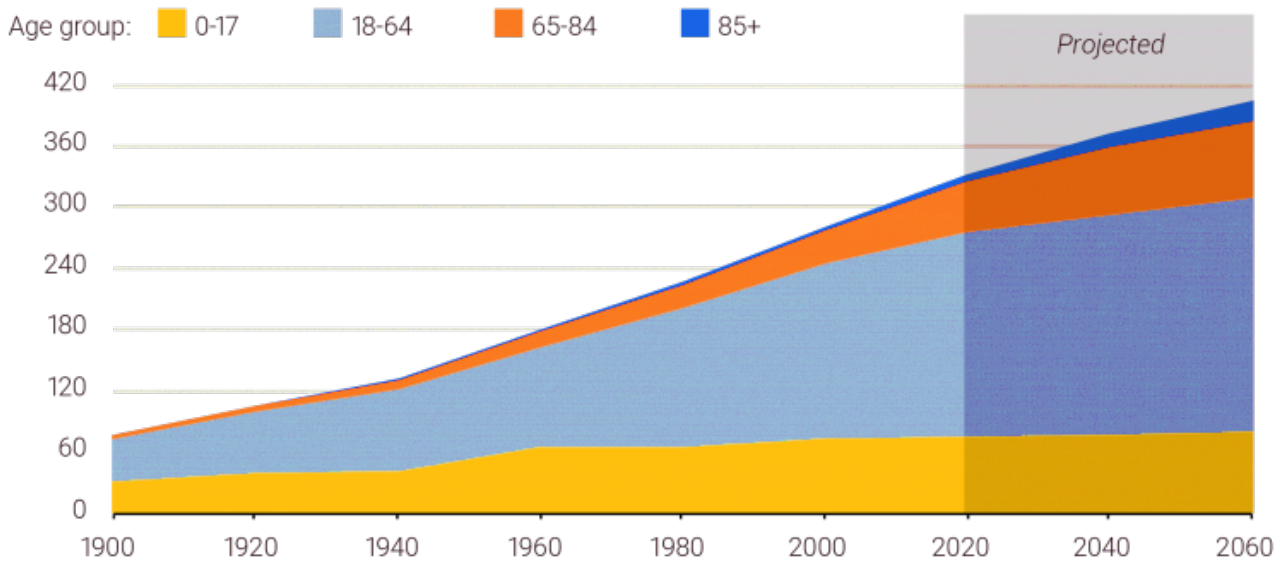

Figure 1. Projected number of U.S. populations by age group. Source: United States Census Bureau

The American College of Emergency Physicians' Geriatric Section, together with the Society for Academic Emergency Medicine's Academy for Geriatric Emergency Medicine, the American Geriatrics Society, and Emergency Nurses Association have responded to the care needs of the growing older adult population in several ways. Responses 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] Knowledge translation from research to practice can take up

to 17-years for even 14% of published recommendations to influence patient care and improve patient outcomes.[11] The GEDA program seeks to catalyze change and adoption of evidence- and consensus-based geriatric care guidelines through accreditation of sites that implement the GEDA care processes.

Accreditation of facilities has long been used to assure and improve the quality of care provided. From the first programs in 1919 by the American College of Surgeons, accreditation programs have provided a framework of best practices and a level of public assurance regarding quality of care. 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. Similarly, accreditation of GEDs can provide value to patients, emergency physicians, and hospitals.

The value to 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 ACEP 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 ACEP's duty to determine and promote best practices in the emergency care setting. GED accreditation accomplishes that mission in the following ways:

- Strengthens recognition of emergency medicine 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.

Accreditation Overview

A key first step before applying for accreditation is to determine the level of accreditation your site will pursue. The next step is to review the requirements for the accreditation level and determine the care processes that your site will implement. The decision of which care processes to select should be guided by their anticipated impact on patient care and the feasibility of implementation within your system.

There are three levels of accreditation. Level 1 represents the highest level of investment in and impact on geriatric patient care. For all levels, sites will identify an EM-boarded physician champion and a nurse champion who will help select, develop, and implement the care changes at their site and monitor their impact.

Level 3 accreditation represents excellence in older adult care through implementation of four or more geriatric-specific initiatives and care processes that are reasonably expected to elevate the level of elder care in one or more specific areas. Additionally, EM-boarded personnel to implement these efforts are identified and trained. Level 3 accreditation is designed to be reasonably achievable by an ED in the United States, whether an academic, rural, urban, or critical access site.

Level 2 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. Sites will demonstrate implementation of ten or more geriatric-specific care processes.

Level 1 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. Level 1 sites will have robust processes of elevating ED operations and transitions of care both to and from the ED, coordinated for the improved care of older adults. They will also have clear metrics measuring and monitoring the impact of their care processes, with established quality improvement plans. Level 1 sites will also implement physical plant enhancements targeted to improve the patient experience of older adults.

Criterion Categories

To achieve accreditation at any level, sites will meet criteria in the following categories. The sections that follow provide greater detail on accreditation criteria at each level.

- Staffing and Education
- Care Processes
- Quality Improvement (QI) and monitoring outcome measures
- Equipment and Physical Resources

Accreditation Guidelines and Instructions

The following section provides guidance about requirements common to all accreditation levels.

Physician and Nurse Champions

Each institution should identify both a physician and a nurse champion who will lead GED accreditation efforts. Both champions will submit a templated job description that includes their responsibilities and their geriatric education. They will also submit their official job description from their institution and certificates of the geriatric-specific training received. The template is available on the GEDA website.

The physician champion will be a board-certified Emergency Physician (MD or DO) on staff. This physician should have a job description that includes oversight of the ED geriatric operations and leadership of the GEDA application development.

The nurse champion will help lead the GEDA team, help with care process development where relevant, engage in nurse education, and lead or assist with implementation of protocols and monitoring of metrics.

Qualifying Physician Champion Education

The physician champion should complete at least four, six, or eight hours of training relevant to geriatric emergency care for Level 3, 2, and 1 accreditation respectively. The courses or training in geriatric emergency medicine should provide the physician champion with added expertise in the emergency care of older adults and enhance their ability to teach other physicians and clinicians how to improve their care. This training requirement must be demonstrated through coursework specific to older adults. For example, training could focus on clinical issues nearly exclusive to geriatric ED patients, such as end of life care, dementia, delirium, systems of care for older adults. Alternatively, training could be on issues common to all ED patients but focused on the unique factors found in older adults, such as trauma in older adults, cardiac arrest care for the geriatric patient. *Training in common emergency medicine conditions, such as 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 ACEPeCME or the Geriatric ED Collaborative) or other equivalent delivery modes but must be provided through or led by an authoritative resource. *Reading a book or completing a topic search in Up to Date or another similar resource do not qualify for this training requirement unless Geriatric CME certificates are supplied for the activity.*

These educational requirements may be demonstrated through appropriate geriatric-focused CME certificates. Applicants may submit other, non-CME coursework that they believe fulfills the education requirement for review by the GEDA Board of Governors, which will determine whether it meets the requirements.

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

1. Atypical presentations of disease
2. Trauma including falls

3. Cognitive and Behavioral disorders
4. Emergency intervention modifications
5. Medication management/polypharmacy
6. Transitions of care
7. Effect of comorbid conditions/polymorbidity
8. End-of-life care

Qualifying Nurse Champion Education

There are a number of high-quality nursing education resources that the nurse champion and other nurses can pursue. The nurse champion must demonstrate at least one hour of geriatric-specific training. However, most sites support the nurse champion to pursue one of the following courses.

1. The Geriatric Emergency Nursing Education (GENE) course from the Emergency Nurses Association
2. The Emergency Department nursing modules from the Nurses Improving Care for HealthSystem Elders (NICHE).
3. Locally developed nursing education modules

Additional Physician and Nurse Champion Responsibilities – Level 1&2

The physician and nurse champions at level 1 and 2 sites should have additional responsibilities for medical direction and leadership of the GED. The physician champion should be an EM-Boarded emergency physician (MD or DO) who can serve as the medical director of GED operations with the following responsibilities:

1. Serve as leader of or provide oversight for geriatric EM education for ED physicians and other clinicians.
2. Oversee GED operations including:
    a. Implementation and regular assessment of care processes.
    b. Coordination/guidance of GED staff workflow.
    c. Coordination of interdisciplinary team workflow in the GED.
3. Oversee quality improvement team monitoring adherence to geriatric-specific care processes.
4. Oversee documentation of outcome measures including process and outcome metrics.
5. Coordinate maintenance of GED environment, such as availability of specific equipment and supplies.
6. Serve as a liaison between hospital leadership and the GED.
7. Serve as team leader for quality assurance team for geriatric patient case reviews/complaints.
8. Coordinate GEM research initiatives if applicable.

EDs that are applying for accreditation but do not have an EM-boarded emergency physician who can serve as the Geriatric ED Medical Director position on their own should appoint co-directors of the geriatric emergency department. In these cases, one GED co-director would be a boarded emergency physician who can then partner with the other co-director (who is not an EM-boarded physician) to share the role of GED director.

EDs that seek accreditation but lack any EM-boarded emergency physicians who can serve as the primary or co-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.

Additional GED Team Members – Level 1&2

Level 1 and 2 GEDs should have additional inter-disciplinary team members who are engaged with GED operations and who provide leadership and input into the care processes implemented. Level 1 and 2 sites should both have at least 56 hours/week of coverage by a transitional care nurse, nurse case manager, or equivalent who can assist with patient assessments and transitions of care in the ED. As an example, 8 hours or more per week of the 56 hour requirement can be covered by a social worker.

Level 1 and 2 sites should also have a hospital or health-system level executive or administrative sponsor who is supportive of the GED program. This individual can help in many ways, such as: provide resources or funding IT or data support, serve as a liaison with upper management, provide a link to hospital quality improvement initiatives, assist with seeking funding for staff or personnel.

Level 1 and 2 sites should also have at least 4 (Level 1) or 2 (Level 2) of the following team members:

- Physical Therapist
- Occupational Therapist
- Pharmacist or other individual responsible for medication management
- Social Worker

Finally, Level 1 sites should also have a patient advisor or patient council member. This role can be considered one of patient advocate. They should be invited to meetings at least monthly to give valuable insight from the patient perspective, and feedback on how patients may interpret care processes. They could be a prior patient in the ED, a community member, or family member of a prior patient. They can give input on what modifications to the ED would provide the best patient experience.

Geriatric ED Care Processes

The implementation of geriatric-focused care processes constitutes the largest component of accreditation and has the greatest potential for direct improvement of patient care and outcomes. The care processes selected should be done so thoughtfully and with consideration of their impact on patient outcomes and experience in addition to their feasibility, sustainability, cost, and potential hospital-wide benefits.

As of July 1, 2023, three care processes are required and must be implemented by all sites pursuing new accreditation or renewing their accreditation, for all levels. These are care processes A.1 (minimization of urinary catheterization), A.2 (minimization of NPO status), and A.3 (minimization of physical restraint use). These three represent basic processes that all geriatric-friendly EDs should adhere to.

Sites will select an additional 1, 7, or 17 care processes to implement for accreditation at level 3, 2, and 1 respectively. Applicants for level 1 and 2 accreditations should also submit the required metrics and evidence of implementation and impact of the care processes as listed in the Care Process Description document on the GEDA website. This document also provides more details and references for the example screening tools suggested in the care processes.

The patient's eligibility for GED initiatives may vary based on 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.

Sites applying at Level 1 or Level 2 have the option of submitting one novel care process that is not included elsewhere. The care process should be specific to the care of older adults, should impact the patient care or experience, and should include a strategy for assessing its implementation and/or impact. Applicants should explain the rationale for selecting this process and how it improves the care of older people in the emergency department.

Table 1. GEDA Care processes and categories.

#	Care Process
Baseline care processes required by *all* GEDA sites	
A.1	Protocol or care process to standardize and minimize urinary catheter use.
A.2	Protocol or care process to minimize NPO status and promote access to appropriate food and drink.
A.3	Protocol or policy to minimize use of physical restraints and promote use of trained companions or sitters instead.
Medication Safety and Orders	
B.1	Care process for medication reconciliation to be performed by pharmacist or pharmacy technician.
B.2	Guidelines to minimize potentially inappropriate medication use. This could be through an ED-based pharmacist or through a hospital-specific or other list of potentially inappropriate medications (PIMs) or dosing.
B.3	Guidelines for safe pain control including multi-modal options for mild, moderate, or severe pain.
B.4	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).
ED Specialty Consultation Resources	

C.1	Care process for accessing palliative care consultation in the ED
C.2	Care process for accessing geriatric psychiatry consultation in the ED.
C.3	Care process to guide the use of volunteers in the care of older ED patients.
ED Screening	
D.1	Protocol for structured delirium screening with an established tool, with appropriate follow-up actions based on screening results. Example tools include the DTS followed by the bCAM, 4AT, or others.
D.2	Protocol for structured cognitive impairment screening with an established tool, with appropriate follow-up actions based on screening results. Example tools include the Ottawa 3DY, mini-cog, SIS, short blessed test, or others.
D.3	Protocol for structured assessment of function and functional decline with an established tool, with appropriate follow-up actions based on screening results. Example tools include the ISAR, interRAI AUA screener, or others.
D.4	Protocol for structured falls and mobility assessment using an established tool, with appropriate follow-up actions based on screening results. Example tools include the Timed Up and Go (TUGT), or other tools.
D.5	Protocol for structured screening or assessment for elder abuse using an established tool, with appropriate follow-up actions in response to screening results. Example tools include EM-SART, ED Senior AID, EASI or H-S/EAST, or others.
D.6	Protocol for structured depression screening using an established tool, with appropriate follow-up actions in response to screening results. Example tools include DIA-S4, PHQ9, GDS short form, or others.
D.7	Protocol for structured screening or assessment for social isolation with appropriate follow-up actions in response to screening results. Example tools include the Duke Social Support Index and the UCLA 3-Item Loneliness Scale.
D.8	Protocol for screening for alcohol or substance use with appropriate follow-up actions in response to screening results. Example tools include a 2-item quantity/frequency screener, SMAST-G, AUDIT-C, or others.
D.9	Protocol for screening of nutritional status or food insecurity with appropriate follow-up actions in response to screening results. Example tools include HFIAS, MNA.
Transitions of Care	
E.1	Care process for PCP notification of ED visit.
E.2	Care process to enable transitions of care from the ED to residential care. This could be for new placements to residential care, and/or a care transition plan on discharge to an existing placement.
E.3	Care process to address age-specific communication needs at discharge (e.g. large font, lay person language, clear follow-up plan, evidence of patient communication).
E.4	Care process to provide easy access to short- or long-term inpatient or outpatient rehabilitation services, and protocol or guidelines for how to access the pathway.
E.5	Care process for referrals to geriatric-specific follow-up clinics such as: comprehensive geriatric care clinic, falls clinic, memory clinic, or others.
E.6	Care process for accessing an outreach program that provides home assessments of function and safety such as a visiting nurse association (VNA) or physical therapy (PT) home safety evaluation.
E.7	Care process for coordinating with a community paramedicine group to perform a home visit after discharge.
E.8	An outreach program to residential care homes to enhance the quality of care of ED transfers. This should involve meetings with representatives at residential care homes to improve transfer to or from the ED.
E.9	Protocol for post-discharge follow-up with the patient or caregiver (e.g., phone call, telemedicine, or other follow-up). This could be to reassess their condition, assess needs, ensure follow-up or access to medications, to review discharge plans, or provide other services.
E.10	Patient access to transportation services for return to their residence.
Hospital Operations	

F.1	Care process to minimize ED boarding for geriatric patients or a sub-group of geriatric patients at particularly high risk for harm due with prolonged ED stay (e.g. with delirium).
F.2	Care process to optimize care of geriatric patients or sub-group of geriatric patients at particularly high risk for harm (e.g. those with delirium) who are boarding in ED for extended period after admission decision.
F.3	Care process to ensure "what matters most" is asked about, to identify the patient's priorities, and incorporate their priorities into the care provided.
Novel Policy (Level 1 and 2 only)	
Z.1	Create, implement, and describe a policy, protocol, or care process that does not fall into the above categories. It should be specific to the acute care of older patients. Include a strategy for assessing implementation and metrics to measure successful implementation. As with the above protocols, you will have the opportunity to describe it in the Care Process Executive Summary Template.

Care Process Executive Summaries

Care Process Description

For each care process, sites will submit a templated executive summary that describes the care process, the patients to whom it will apply, who will be responsible for performing it, where the care process fits within the ED workflow, how it is geriatric-specific, and any further follow-up or interventions involved. In addition, the executive summary will include a description of how the relevant staff will be educated about the care process, and how the site will monitor adherence to the care process. Level 1 and 2 applicants will also submit a description of how they will monitor the care process and what data they will collect, and will submit at least 3 months of tracking data using the metrics or measures required in the Care Process Description document. All templates are available on the GEDA website.

Sites submitting hospital-wide care processes should provide a detailed explanation for how the process is applied specifically to older adult care in the ED. *It is not sufficient to describe an already existing hospital-wide policy that also includes the ED. It is also not sufficient to describe an ED policy that happens to include older patients but is not specific to older patients.* Applications that do not include the required information about the geriatric-specific and ED-specific nature of the care processes will not be accepted.

For clarity, the following examples are provided of care processes that would *not* meet accreditation standards:

- A hospital-wide policy on reducing urinary catheter insertion that 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 that does not address the particular challenges of elder abuse (e.g., staff education in recognizing it, reporting requirements, strategies for tracking adherence).

The following are examples of suitable care processes that are specific to geriatric patients and to the ED:

- 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.

The ACEP GEDA website provides multiple examples of completed templated executive summaries of sample care processes.

Quality Improvement and Tracking – Level 1&2

Level 3 sites do not need an official QI program for their Geriatric EDs. However, they should monitor implementation and adherence to the care process implemented and have a plan for improving uptake. A description of how the ED is ensuring that the care process instituted is implemented and adhered to is sufficient. We expect adherence will not be 100%, especially at first, but also expect that there is a plan to track the implementation and an expectation of aiming towards continued improvement in adherence. For example, adherence could be monitored through a monthly chart review of modest number of random charts, or EHR data tracking of patients of interest, etc. It should be clearly explained who is expected to receive the intervention - denominator- and how you will know if the intervention or screening was performed - numerator.

Level 1 and 2 sites will need to submit data showing implementation and/or impact of their selected care processes. The Care Process Description document on the GEDA website details the options or the required metrics that should be included for each of the care processes. 3 months of data should be submitted with the initial application. The data and QI plan can be inserted into the care process executive summary template for each care process.

Workflows and Dashboard – Level 1&2

Level 1 and 2 sites should both submit a process map/workflow of their GED process flow. There are examples on the GEDA website. Level 1 sites should also submit a copy of their GED dashboard showing how their track and monitor execution of the relevant care processes.

Staff Education – Level 1&2

For each care process, Level 1 and 2 sites should submit their plan for how they will educate the relevant ED staff, physicians, and stakeholders about the process. The education plan information will be submitted in the care process executive summary template for each care process. These sites should also indicate a responsible individual who will manage education about care processes. The physician geriatric medical director should ultimately have oversight and ensure the education occurs.

Metrics and Outcome Measures

Level 3 sites do not need to submit additional tracking or outcome measures data. Level 1 and 2 sites will need to submit at least 3 months of data for the following metrics.

ED Boarding Metrics

ED Boarding is a major impediment to care and challenge to ED operations at many sites. Therefore, it is important to monitor boarding in order to assess the impact of care process changes on boarding metrics. In response to the national ED boarding crises it is important for GEDs to monitor their boarding metrics and so that they can better inform their efforts reduce the boarding of older patients. Starting January 1, 2024, all Level 1 and 2 new or renewal geriatric EDs should monitor ED boarding times for geriatric patients.

Level 1 and 2 GEDs are required to monitor how long older adults (65 and older) board in the ED while awaiting transfer to an inpatient unit after an admission decision is made using the metrics below. For purposes of comparison, sites should also monitor boarding for non-geriatric adult patients (age 19-64).

Required boarding metrics include:

- Median boarding time in ED after admission decision for geriatric patients and comparison to non-geriatric patients
- % of geriatric patients who board in ED for a prolonged period (≥4 hours) after admission decision and comparison to non-geriatric patients
- % of geriatric patients who board in ED for a very prolonged period (≥8 hours) after admission decision in comparison to non-geriatric patients
- % of geriatric patients who board in ED for an extremely prolonged period (≥12 hours) after admission decision in comparison to non-geriatric patients

The time at which boarding starts, or the time-zero, is the time at which the decision has been made to admit or place the patient into observation status. Boarding ends when the patient is physically transferred from the ED to another unit within the hospital or, in the case of free-standing EDs and/or critical access hospitals, physically departs the ED for the admitting hospital.

Additional Outcome Measures

Level 1 and 2 sites should provide evidence of tracking at least 5 (Level 1) and 3 (Level 2) of the following additional metrics. Sites will upload or enter evidence of tracking, such as screenshots, dashboard examples, or other data. The uploaded evidence should include a description of how often and by whom the outcome is measured or tracked. The measures can be selected from any among the following two lists.

Care process metrics: For one of the care processes you implemented, report on the following. You can pick different care processes for different metrics.

- Percentage of patients who screen positive with one of the screening care processes who receive an intervention or relevant referral for other services or care.
- Percentage of patients who are referred for services or care who complete the referral.
- Outcomes of completed referrals, such as further care recommendations, changes to care plan, follow-up plans, etc.

Additional metrics that can be submitted:

- Number of older adults admitted to the hospital including the primary admitting diagnosis and chief complaint.
- Number of older adults discharged to home, SNF, or NH including the primary ED diagnosis and chief complaint.
- Number of older adults with repeat ED visits and the percentage of all elder visits this represents.
- Number of older adults staying >8 hours in the ED and the percentage of all elder visits this represents.

Equipment and Physical Resources

Each site should have several required pieces of equipment or physical environment enhancements to improve the care experience and safety of older patients. The equipment and physical resources required or recommended for each level are shown below. There should be easy, in-department access for the required items. Level 3 sites will need provide pictorial evidence of mobility aids (4-point walkers, canes) for 24/7 use in the ED and of evidence of free food and drink, 24 hours a day. Vending machines do not meet the requirement for available food in the ED. Level 1 and 2 sites can attest to the available resources. Optional resources and physical environment enhancements are recommended, particularly for Level 1 applications. Level 1 and 2 applicants will need to attest to having all the required resources and indicate which of the recommended resources they have. The full list of required and recommended resources is shown in the summary table in the following section.

Summary of accreditation requirements

Table 2: The following table summarizes the requirements for each level. Required resources are indicated with an (X). Recommended, optional resources are indicated with an (O).

Staffing	Level 3	Level 2	Level 1
EM physician champion with the following hours of CME	4	6	8
Nurse champion with evidence of focused education in geriatric EM	X	X	X
Additional EM physician champion leadership responsibilities		X	X
Additional nurse champion leadership responsibilities		X	X
Nurse case manager or transitional care nurse present ≥ 56 hrs/wk (up to 28 hours/wk can be covered by a social worker)		X	X
Additional required geriatric team member roles		2	4
Executive or administrative sponsor		X	X
Patient advisor or patient council			X
Care Processes	**Level 3**	**Level 2**	**Level 1**
Required care processes, A.1 – A.3	3	3	3
Additional selected care processes	1	7	17
Required education dissemination plan		X	X
Required metrics and QI plan with 3 months of demonstrated tracking		X	X
Workflow and Metrics	**Level 3**	**Level 2**	**Level 1**
Submission of process map/workflow		X	X
Submission of GED Dashboard			X
Submission of 3 months of evidence for the 4 metrics related to ED boarding		X	X

Submission of 3 months of evidence for the following # of additional metrics		3	5
Required Resources	**Level 3**	**Level 2**	**Level 1**
Access to mobility aids (canes and walkers) 24/7	X	X	X
Access to free food and drink 24/7	X	X	X
Additional Recommended Resources			
Low beds, reclining armchairs, non-slip socks, pressure-ulcer reducing mattresses and pillows, blanket warmer, hearing assist devices, bedside commodes, condom catheters		0	0
Physical Environment Enhancements			
Ample seating for visitors and family (at least 2 seats per room)		X	X
Large-face analog clock in each patient room		X	X
Efforts at noise reduction (e.g., separate, enclosed rooms)		0	0
Enhanced lighting (e.g., natural light, windows, artificial skylight, light box, dimmable lights)		0	0
Adequate handrails		0	0
Non-slip floors		0	0
High-quality signage and wayfinding		0	0
Wheelchair-accessible toilets		0	0
Availability of elevated toilet seats		0	0

Approval Process

After submission, each application will be carefully considered by an expert team of reviewers. The applications will be reviewed by the following individuals with the potential outcomes as listed.

1. **ACEP GEDA staff review**. GEDA staff may request additional information or adjustments from the applicants. Once the application has all the necessary components, it will be assigned for review.
2. **GEDA Reviewer**. GEDA reviewers are physicians or nurses who have been trained in the GEDA criteria and components. They will thoroughly review the application and create a report. They may request additional information or revisions.
3. **GEDA Board of Governors Reviewer.** This is a physician with expertise in geriatric EM care who is serving on the GEDA board. This individual will review the application and the report created in Step 2 and may request additional information. If the application meets all the criteria, then it will be:
    a. Approved for Level 3 applications.
    b. Presented to the full Board of Governors for a vote on approval for Level 1 and 2 applications. For Level 1 sites, the board of governors reviewer may request a phone call or virtual site visit with the site leaders.

If the application meets criteria at the time of its initial submission, then the approval process will be faster. However, if there are missing components, or areas that do not meet the required criteria and the applicant has to develop and submit the modifications, the process may take longer.

Renewal Applications

For sites seeking to renew their applications, they should carefully read the above criteria as the criteria evolve over time as the GEDA process continues to develop, and as changes in the

workplace environment impact care in new ways, such as boarding. Renewal applications will need to meet all the requirements at the time of submission, similar to new applications. It is expected that sites seeking renewal will have higher levels of adherence to care processes, and more robust QI programs, given the longer time since implementation. If there were any concerns or contingencies at the time of initial accreditation, the sites should demonstrate in their renewal application how they have worked to improve those areas.

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
SNF	Skilled Nursing Facility
NH	Nursing Home

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

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.*
11. May 2014;63(5):e7-e25.
12. 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.
13. 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.
14. 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.
15. 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.
16. 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.

Appendix

GEDA Care Processes Implementation and Tracking

This table provides more detailed guidance on the reporting and monitoring requirements for each protocol for Level 1 and 2 sites. For protocols with options to demonstrate implementation, adherence, or impact (*), sites can select one or more of these options to submit as evidence of process implementation. Other reasonable options can also be submitted. The reported measure should be assessed approximately every 3 months. For care processes with required metrics (**), sites should submit at least 3 months of tracked data using the metrics noted.

	Care process description	Options to demonstrate implementation, adherence or impact*	Required tracked metrics**
Baseline care processes required by *all* GEDA sites			
A.1	Protocol or care process to standardize and minimize urinary catheter use.	• Chart review of 10 catheter placements per month and assessment of validity of indications. • Screenshots of EMR hard-stops to require selection of valid reason for catheter order placement. • Track percentage of older adults with order for urinary catheter placement. Numerator: Number of OA with order for urinary catheter. Denominator: All OA • Plan of QI process to review indications for urinary catheterization placement	n/a
A.2	Protocol or care process to minimize NPO status and promote access to appropriate food and drink.	• Chart review of 10 random NPO orders per month and assessment of validity of indication. • Screenshots of EMR hard-stops to require selection of valid reason for NPO status. • Track percentage of older adults with order for NPO status. Numerator: Number of OA with NPO order. Denominator: All OA • Track time until electronic order placed for diet order. Time of diet order minus time clinician signed up for patient. • Track percentage of older adults with LOS>8 hours without a diet order and/or NPO designation. Numerator: Number of OA without diet/NPO order at 8hrs LOS. Denominator: All OA.	n/a

A.3	Protocol or policy to minimize use of physical restraints and promote use of trained companions or sitters instead.	• Chart review of 10 random restraint orders per month and assessment of validity of indication. Assess for system improvements or alternatives, such as increased sitter availability. • Screenshots of EMR hard-stops to require selection of valid reason for restraint use. • Track percentage of older adults with orders for restraint use. Numerator: Number of OA with physical restraint orders. Denominator: All OA.	n/a
Medication Safety and Orders			
B.1	Care process for medication reconciliation to be performed by pharmacist or pharmacy technician.	• Chart review of 10 random charts per month of OA discharged home to assess for completion of medication reconciliation. • Track percentage of medication reconciliations completed for older adults prior to ED discharge. Numerator: Number of OA with med rec performed. Denominator: All OA.	n/a
B.2	Guidelines to minimize potentially inappropriate medication use. This could be through an ED-based pharmacist or through a hospital-specific or other list of potentially inappropriate medications (PIMs) or dosing.	• Chart review of 10 random charts per month of OA to assess for administration of PIMs, with further review of whether it was an inappropriate medication or dose, and any adverse events. • Review of overrides of EMR alerts regarding PIMs to identify potential systematic changes or QI opportunities. • Run reports on use of specific PIMs (such as benzodiazepines or diphenhydramine) and frequency of use in the ED. Determine the percentage of orders that were potentially inappropriate.	n/a
B.3	Guidelines for safe pain control including multi-modal options for mild, moderate, or severe pain.	• Track frequency of use of geriatric pain treatment order set if available. • Chart review of 10 random charts per month of patients with painful condition or specific chief complaints, reviewing for completion of pain assessment, treatment adherent to guidelines, and/or appropriate analgesia.	n/a
B.4	Development and implementation of at least three order sets for common	• Report on frequency of use of order sets, e.g. numerator: older patients with documented order set use, denominator: # older patients with protocol-related complaint or diagnosis.	

	geriatric ED presentations developed with particular attention to geriatric-appropriate medications and dosing and management plans (e.g. delirium, hip fracture, sepsis, stroke, ACS).	• Report on rates of order set use per month. • Random chart review of 10 patients per month with condition for which order set could be used and assess for use.	
ED Specialty Consultation Resources			
C.1	Care process for accessing palliative care consultation in the ED	• Report on rates of palliative care consultations, e.g. # of older adults receiving consultation per month. • Report on time from entering order for palliative care consultation to consult completion. • Perform chart review of 10 charts per month of patients who received consultations to review indications for consultation and impact.	n/a
C.2	Care process for accessing geriatric psychiatry consultation in the ED.	• Report on frequency of geriatric psychiatry consultation, e.g. # of older adults receiving consultation per month. • Report on time from entering order for geriatric psychiatry consultation to consult completion. • Perform chart review of 10 charts per month of patients who received consultations to review indications for consultation and impact.	n/a
C.3	Care process to guide the use of volunteers in the care of older ED patients.	• Maintain roster of volunteers. • Maintain list of activities volunteers can perform to better serve older adults in the ED. • Report on hours of volunteer availability in the ED. • Submit description of geriatric-specific training that volunteers receive, and number of volunteers who have received it.	n/a
ED Screening			
D.1	Protocol for structured delirium screening with an established tool, with appropriate follow-up actions based on screening	n/a	• Report on screening rates with numerator: # of patients screened and denominator: total eligible patients. Eligible patients are those to whom the screening would generally be applied, such as those 65 years and older.

	results. Example tools include the DTS followed by the bCAM, 4AT, or others.		• Report on delirium detection rates with numerator: # of patients with a positive delirium screen and denominator: all patients screened. • QI plan to review appropriate follow-up actions, such as further referrals, additional services, orders, or disposition.
D.2	Protocol for structured cognitive impairment screening with an established tool, with appropriate follow-up actions based on screening results. Example tools include the Ottawa 3DY, mini-cog, SIS, short blessed test, or others.	n/a	• Report on screening rates with numerator: # of patients screened and denominator: total eligible patients. Eligible patients are those to whom the screening would generally be applied, such as those 65 years and older. • Report on cognitive impairment detection rates with numerator: # of patients with a positive cognitive impairment screen and denominator: all patients screened. • QI plan to review appropriate follow-up actions, such as further referrals, additional services, orders, or disposition.
D.3	Protocol for structured assessment of function and functional decline with an established tool, with appropriate follow-up actions based on screening results. Example tools include the ISAR, interRAI AUA screener, or others.	n/a	• Report on screening rates with numerator: # of patients screened and denominator: total eligible patients. Eligible patients are those to whom the screening would generally be applied, such as those 65 years and older. • Report on function/functional decline detection rates with numerator: # of patients with a positive or high-risk screen and denominator: all patients screened. • QI to review appropriate follow-up actions such as further referrals (care management, home health services, further referral, additional services recommended or provided, orders, or disposition.
D.4	Protocol for structured falls and mobility assessment	n/a	• Report on screening rates with numerator: # of patients screened and denominator: total

	using an established tool, with appropriate follow-up actions based on screening results. Example tools include the Timed Up and Go (TUGT), or other tools.		eligible patients. Eligible patients are those to whom the screening would generally be applied, such as those 65 years and older. • QI to review appropriate follow-up actions such as further referrals (care management, home health services, PT/OT), additional services recommended or provided, orders, or disposition.
D.5	Protocol for structured screening or assessment for elder abuse using an established tool, with appropriate follow-up actions in response to screening results. Example tools include EM-SART, ED Senior AID, EASI or H-S/EAST, or others.	n/a	• Report on screening rates with numerator: # of patients screened and denominator: total eligible patients. Eligible patients are those to whom the screening would generally be applied, such as those 65 years and older. • Report on elder abuse detection rates with numerator: # of patients positive or high-risk for elder abuse and denominator: all patients screened.
D.6	Protocol for structured depression screening using an established tool, with appropriate follow-up actions in response to screening results. Example tools include DIA-S4, PHQ9, GDS short form, or others.	n/a	• Report on screening rates with numerator: # of patients screened and denominator: total eligible patients. Eligible patients are those to whom the screening would generally be applied, such as those 65 years and older. • Report on depression detection rates with numerator: # patients who screen positive and denominator: all patients screened • QI to review appropriate follow-up, such as psychiatry referral, home health services, community resource referrals, etc.
D.7	Protocol for structured screening or assessment for social isolation with appropriate follow-up actions in response to screening results. Example	n/a	• Report on percentage of older adults screened for social isolation (# older patients screened/total eligible patients) • Report on social isolation detection (# patients with +isolation screen/all patients screened)

	tools include the Duke Social Support Index and the UCLA 3-Item Loneliness Scale.		• QI to review appropriate follow-up (psychiatry referral, home health services, community resources, technology resources)
D.8	Protocol for screening for alcohol or substance use with appropriate follow-up actions in response to screening results. Example tools include a 2-item quantity/frequency screener, SMAST-G, AUDIT-C, or others.	n/a	• Report on percentage of older adults screened for alcohol or substance use (# older patients screened/total eligible patients) • Report on alcohol and substance use detection (# patients with + alcohol or substance use/all patients screened) • QI to review appropriate follow-up (psychiatry referral, home health services, community resources)
D.9	Protocol for screening of nutritional status or food insecurity with appropriate follow-up actions in response to screening results. Example tools include HFIAS, MNA.	n/a	• Report on percentage of older adults screened for nutritional status (# older patients screened/total eligible patients) • Report on food insecurity detection (# patients with + food insecurity screen/all patients screened) • QI to review appropriate follow-up (Meals on Wheels, social work, community resources)
Transitions of Care			
E.1	Care process for PCP notification of ED visit.	• Review 10 charts per month to ensure PCP notification has taken place	n/a
E.2	Care process to enable transitions of care from the ED to residential care. This could be for new placements to residential care, and/or a care transition plan on discharge to an existing placement.	• Review 10 charts per month to ensure care process to enable transitions of care from the ED to residential care is occurring as designed.	n/a
E.3	Care process to address age-specific communication needs at discharge (e.g. large font, lay person language,	• Review 10 charts per month to ensure care process to address age-specific communication is occurring as designed.	n/a

	clear follow-up plan, evidence of patient communication).		
E.4	Care process to provide easy access to short- or long-term inpatient or outpatient rehabilitation services, and protocol or guidelines for how to access the pathway.	• Report on frequency of rehab or PT orders or referrals. Eg. # orders placed for older adults/total older adults or # orders placed for older adults per month.	n/a
E.5	Care process for referrals to geriatric-specific follow-up clinics such as: comprehensive geriatric care clinic, falls clinic, memory clinic, or others.	• Report on number of referrals placed for follow-up care E.g. # referrals placed in EMR for older adults/total older adults or # orders placed for older adults per month.	n/a
E.6	Care process for accessing an outreach program that provides home assessments of function and safety such as a visiting nurse association (VNA) or physical therapy (PT) home safety evaluation.	• Report on number of referrals placed for home evaluation. E.g. # referrals placed in EMR for older adults/total older adults or # orders placed for older adults per month.	n/a
E.7	Care process for coordinating with a community paramedicine group to perform a home visit after discharge.	• Report on number of referrals placed for paramedicine visit. E.g. # referrals placed for older adults/total older adults or # orders placed for older adults per month.	n/a
E.8	An outreach program to residential care homes to enhance the quality of care of ED transfers. This should involve meetings with representatives at residential care homes to improve transfer to or from the ED.	• Record meetings with skilled nursing home or residential facility representatives, including key agenda items.	n/a

E.9	Protocol for post-discharge follow-up with the patient or caregiver (e.g., phone call, telemedicine, or other follow-up). This could be to reassess their condition, assess needs, ensure follow-up or access to medications, to review discharge plans, or provide other services.	• Record post-discharge follow-up calls or contacts • Report on rates of eligible patients contacted. E.g. # follow-up calls for older adults/total eligible older adults or # follow-up calls per month.	n/a
E.10	Patient access to transportation services for return to their residence.	• Report number of transports requested by older adults per month. Record the time from request- to time to patient leaving the ED.	n/a
Hospital Operations			
F.1	Care process to minimize ED boarding for geriatric patients or a sub-group of geriatric patients at particularly high risk for harm due with prolonged ED stay (e.g. with delirium).	Recommended metrics are as follows. Please note, comparison data to non-geriatric patients and/or geriatric patients who are not identified as high risk should be provided. In addition to reporting these metrics, we recommend setting a threshold or goal for your metric (e.g. 90% of patients have transitioned out of the main ED within 4 hours after an admission decision). ● Median boarding time in ED after admission decision for geriatric patients (or sub-group of geriatric patients identified as at particularly high risk for harm) in comparison to non-geriatric patients and/or geriatric patients who do are not identified as high risk ● % of geriatric patients (or sub-group of geriatric patients identified as at particularly high risk for harm) who board in ED for a prolonged period (≥4 hours) after admission decision in comparison to non-geriatric patients and/or geriatric patients who do are not identified as high risk ● % of geriatric patients (or sub-group of geriatric patients identified as at particularly high risk for harm) who board in ED for a very prolonged period (≥8 hours) after admission decision in comparison to non-geriatric patients and/or geriatric patients who do are not identified as high risk	

		• % of geriatric patients (or sub-group of geriatric patients identified as at particularly high risk for harm) who board in ED for an extremely prolonged period (≥12 hours) after admission decision in comparison to non-geriatric patients and/or geriatric patients who do are not identified as high risk	
F.2	Care process to optimize care of geriatric patients or sub-group of geriatric patients at particularly high risk for harm (e.g. those with delirium) who are boarding in ED for extended period after admission decision.	• Track percentage of eligible patients who receive the designated interventions (e.g. private room in ED, hospital bed, prioritization of assignment of admitting team, prioritization of movement to transitional / initiation care area, quality improvement case review for patients with extreme boarding times – i.e. ≥12 hours)	
F.3	Care process to ensure "what matters most" is asked about, to identify the patient's priorities, and incorporate their priorities into the care provided.	• Chart review of 10 random charts per month of older adult patients to assess for the presence of documentation of the older adult patient's responses to the questions about (1) concerns and fears and (2) desired outcomes of the ED visit. • While not required, chart review/audit to assess for documentation of how answers are incorporated into the care provided as well as whether the incorporation of patient priorities into care was optimal/appropriate is the best approach to assess implementation, adherence, and impact. • For EDs with structured documentation of assessment of patient priorities (beyond goals of care), evaluating the rate of completion of this documentation.	
Novel Policy			
Z.1	Create, implement, and describe a policy, protocol, or care process that does not fall into the above categories. It should be specific to the acute care of older patients. Include a strategy for	Using the above validation and metrics requirements for inspiration and ideas, create a comparable plan that demonstrates the implementation, scope, and/or impact of your novel protocol. Submit 3 months of data if you are submitting data.	

	assessing implementation and metrics to measure successful implementation. As with the above protocols, you will have the opportunity to describe it in the Care Process Executive Summary Template.	

Glossary and References for Screening Tools

The full names of screening tools listed above are provided below. Example references are shown that can help sites and applicants assess the tool and its effectiveness. Other appropriate or validated tools may also be used.

Delirium Screening

DTS: Delirium Triage Screen

Han JH, et al. Diagnosing delirium in older emergency department patients: validity and reliability of the delirium triage screen and the brief confusion assessment method. Ann Emerg Med. 2013 Nov;62(5):457-465. doi: 10.1016/j.annemergmed.2013.05.003. Epub 2013 Jul 31. PMID: 23916018; PMCID: PMC3936572.

bCAM: Brief Confusion Assessment Method

Mariz J, et al. Delirium Diagnostic and Screening Instruments in the Emergency Department: An Up-to-Date Systematic Review. Geriatrics (Basel). 2016 Sep 1;1(3):22. doi: 10.3390/geriatrics1030022. PMID: 31022815; PMCID: PMC6371145.

4AT: Arousal, Attention, Abbreviated Mental Test, Acute Change

Tieges Z, et al. Diagnostic accuracy of the 4AT for delirium detection in older adults: systematic review and meta-analysis. Age Ageing. 2021 May 5;50(3):733-743. doi: 10.1093/ageing/afaa224. PMID: 33951145; PMCID: PMC8099016.

Cognitive Impairment Screening

Ottowa 3DY: What is the Day? What is the Date? Spell the word "worlD" backwards; and What is the Year?

Eagles D, et al. Evaluation of the Ottawa 3DY as a screening tool for cognitive impairment in older emergency department patients. Am J Emerg Med. 2020 Dec;38(12):2545-2551. doi: 10.1016/j.ajem.2019.12.036. Epub 2019 Dec 20. PMID: 31937444.

Mini-Cog: 3-item recall and clock draw

Borson S, et al. The mini-cog: a cognitive 'vital signs' measure for dementia screening in multi-lingual elderly. Int J Geriatr Psychiatry. 2000 Nov;15(11):1021-7. doi: 10.1002/1099-1166(200011)15:11<1021::aid-gps234>3.0.co;2-6. PMID: 11113982.

SIS: Six-Item Screener

Carpenter CR, et al. The Six-Item Screener and AD8 for the detection of cognitive impairment in geriatric emergency department patients. Ann Emerg Med. 2011 Jun;57(6):653-61. doi: 10.1016/j.annemergmed.2010.06.560. Epub 2010 Sep 19. PMID: 20855129; PMCID: PMC3213856.

SBT: Short Blessed Test

Carpenter CR, et al. Four sensitive screening tools to detect cognitive dysfunction in geriatric emergency department patients: brief Alzheimer's Screen, Short Blessed Test, Ottawa 3DY, and the caregiver-completed AD8. Acad Emerg Med. 2011 Apr;18(4):374-84. doi: 10.1111/j.1553-2712.2011.01040.x. PMID: 21496140; PMCID: PMC3080244.

Functional Status or Decline

ISAR: Identification of Seniors At Risk

Slankamenac K, et al. Prediction of Emergency Department Re-Visits in Older Patients by the Identification of Senior at Risk (ISAR) Screening. Geriatrics (Basel). 2018 Jun 21;3(3):33. doi: 10.3390/geriatrics3030033. PMID: 31011071; PMCID: PMC6319249.

AUA: Assessment Urgency Algorithm created by interRAI

Mowbray FI, et al. Examining the utility and accuracy of the interRAI Emergency Department Screener in identifying high-risk older emergency department patients: A Canadian multiprovince prospective cohort study. J Am Coll Emerg Physicians Open. 2023 Jan 13;4(1):e12876. doi: 10.1002/emp2.12876. PMID: 36660313; PMCID: PMC9838565.

Falls and Mobility Assessments

TUGT: Timed Up and Go Test

Huded JM, et al. Screening for Fall Risks in the Emergency Department: A Novel Nursing-Driven Program. West J Emerg Med. 2015 Dec;16(7):1043-6. doi: 10.5811/westjem.2015.10.26097. Epub 2015 Dec 10. PMID: 26759651; PMCID: PMC4703188.

Elder Abuse

EM-SART: Elder Mistreatment Screening and Response Tool

Platts-Mills TF, et al. EM-SART: a scalable elder mistreatment screening and response tool for emergency departments. Gener J Am Soc Aging. 2020; 44(1): 51- 58.

Makaroun LK, et al. Leveraging VA geriatric emergency department accreditation to improve elder abuse detection in older Veterans using a standardized tool. Acad Emerg Med. 2023 Apr;30(4):428-436. doi: 10.1111/acem.14646. Epub 2023 Jan 17. PMID: 36575600; PMCID: PMC10192131.

ED Senior AID: ED Senior Abuse Identification Tool

Platts-Mills TF, et al. Development of the Emergency Department Senior Abuse Identification (ED Senior AID) tool. J Elder Abuse Negl. 2018 Aug-Oct;30(4):247-270. doi: 10.1080/08946566.2018.1460285. Epub 2018 Apr 13. PMID: 29652592; PMCID: PMC6774613.

EASI: Elder Abuse Suspicion Index

Yaffe MJ, et al. Development and validation of a tool to improve physician identification of elder abuse: the Elder Abuse Suspicion Index (EASI). J Elder Abuse Negl. 2008;20(3):276-300. doi: 10.1080/08946560801973168. PMID: 18928055.

H-S/EAST: Hwalek-Sengstock Elder Abuse Screening Test

Neale, AV, M Hwalek, MC Sengstock, RO Scott, & C Stahl. "Validation of the Hwalek-Sengstock Elder Abuse Screening Test." Journal of Applied Gerontology, 10 (4): 417-429 (1991)

Depression screening

DIA-S4: Depression in old Age Scale with 4 items

Heidenblut S, Zank S. Screening for Depression in Old Age With Very Short Instruments: The DIA-S4 Compared to the GDS5 and GDS4. Gerontol Geriatr Med. 2020 Dec 10;6:2333721420981328. doi: 10.1177/2333721420981328. PMID: 33354593; PMCID: PMC7734509.

PHQ9: Patient Health Questionnaire 9-question tool

Kroenke K,et al. The PHQ-9: Validity of a brief depression severity measure. J Gen Intern Med 2001;16(9):606–13

GDS short form: Geriatric Depression Scale short form

Hustey FM, Smith MD. A depression screen and intervention for older ED patients. Am J Emerg Med. 2007 Feb;25(2):133-7. doi: 10.1016/j.ajem.2006.05.016. PMID: 17276800.

Social Isolation

DSSI: Duke Social Support Index

Koenig HG, et al. Abbreviating the Duke Social Support Index for use in chronically ill elderly individuals. Psychosomatics. 1993 Jan-Feb;34(1):61-9. doi: 10.1016/S0033-3182(93)71928-3. PMID: 8426892.

UCLA 3-Item Loneliness Scale: relational connectedness, social connectedness and self-perceived isolation

Russell D (1996) UCLA Loneliness scale (Version 3): reliability, validity, and factor structure. J Pers Assess 66:20–40.

Alcohol and Substance use

Quantity/Frequency questions: A 2-question screener to identify high-risk alcohol use

Shenvi CL, et al. Identification and characterization of older emergency department patients with high-risk alcohol use. J Am Coll Emerg Physicians Open. 2020 Jul 17;1(5):804-811. doi: 10.1002/emp2.12196. PMID: 33145524; PMCID: PMC7593462.
Han BH, Moore AA. Prevention and Screening of Unhealthy Substance Use by Older Adults. Clin Geriatr Med. 2018 Feb;34(1):117-129. doi: 10.1016/j.cger.2017.08.005. Epub 2017 Oct 7. PMID: 29129212; PMCID: PMC5718360.

AUDIT-C: Alcohol Use Disorders Identification Test Abbreviated Form

van Gils Y, et al. Validation of the AUDIT and AUDIT-C for Hazardous Drinking in Community-Dwelling Older Adults. Int J Environ Res Public Health. 2021 Sep 2;18(17):9266. doi: 10.3390/ijerph18179266. PMID: 34501856; PMCID: PMC8431181.

SMAST-G: Short Michigan Alcoholism Screening Test – Geriatric Version

Blow FC, et al. Brief screening for alcohol problems in elderly populations using the Short Michigan Alcoholism Screening Test-Geriatric Version (SMAST-G) Alcohol Clin Exp Res. 1998;22(Suppl):131

Nutritional Status or Food Insecurity

MNA: Mini Nutritional Assessment

Vellas B, et al. The Mini Nutritional Assessment (MNA) and its use in grading the nutritional state of elderly patients. Nutrition. 1999 Feb;15(2):116-22. doi: 10.1016/s0899-9007(98)00171-3. PMID: 9990575.

HFIAS: Household Food Insecurity Access Scale

Coates J, et al. Household food insecurity access scale (HFIAS) for measurement of food access: Indicator guide. Washington, DC: Food and Nutrition Technical Assistance Project, Academy for Educational Development. 2007
Burks CE, et al. Risk Factors for Malnutrition among Older Adults in the Emergency Department: A Multicenter Study. J Am Geriatr Soc. 2017 Aug;65(8):1741-1747. doi: 10.1111/jgs.14862. Epub 2017 Mar 21. PMID: 28322438; PMCID: PMC5555801.