American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

ACEP
EMERGENCY DEPARTMENT
ACCREDITATION PROGRAM

Emergency Department Accreditation Criteria

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2025 Board of Governors

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Accreditation Criteria Overview

The American College of Emergency Physicians (ACEP) believes that board certification in emergency medicine and/or pediatric emergency medicine is the highest standard for training of emergency clinicians -who take care of patients in emergency settings. Throughout the document there are references to a qualified emergency physician or pediatric emergency physician which are defined as the following:

- A qualified emergency physician is defined as a physician who is board certified or board eligible (BC/BE) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) and cares for patients of all ages in the ED.
- A qualified pediatric emergency physician is defined as a physician who is BC/BE in pediatric emergency medicine by ABEM or the American Board of Pediatrics and cares for pediatric-aged patients as defined by the institution where the services are provided.

There are currently six major criteria that differentiate the four accreditation levels and 33 common criteria that are required for all accreditation levels. The first three accreditation levels are applicable to any emergency department (ED) and the fourth is only applicable to hospitals with a federal designation of either Rural Emergency Hospital or Critical Access hospital. Level I is considered the highest designation level given the resources needed to meet the criteria; however, all levels meet the standard of ACEP accreditation and serve to improve quality and safety.

The *first differentiating criterion* defines the staffing model and level of supervision of physician trainees, nurse practitioners (NPs) and/or physician assistants (PAs) in the care of patients. As it relates to physician supervision the following definitions apply:

- Direct Supervision: When the supervising physician personally examines/evaluates the patients. This is the gold standard of supervision.
- Indirect Supervision: When the supervising physician contemporaneously discusses or reviews the management of patients but does not personally examine/evaluate the patient.
- Oversight: When the physician is available for supervision of PAs or NPs or other emergency clinicians in the care of emergency patients in the ED but is not involved in real-time patient care or does not examine/evaluate the patient directly and does not discuss or review the management of the patient.
- Onsite: When the supervising physician is physically present in the ED and is available to examine/evaluate the patient.
- Offsite: When the supervising physician is not physically present in the ED but is available 24/7/365 for real-time consultation such as by telehealth.

The *second criterion* is applicable to sites applying for Level 1, 2, and 3 accreditation and requires that the physician staffing the ED be trained as an Emergency Physician or Pediatric Emergency Physician. The American College of Emergency Physicians believes that board certification in emergency medicine and/or pediatric emergency medicine is the highest standard of training for emergency clinicians who take care of patients in emergency settings.

The *third criterion* requires a pharmacist to respond onsite or virtually to the ED to provide support for medication delivery to enhance patient quality and safety. This criterion is required for Level I (onsite) and Level II (onsite or virtually) accredited EDs.

The *fourth criterion* requires a respiratory therapist to be readily available to respond to the emergency department to support patient quality and safety; this criterion is required only for Level I and II accredited EDs.

The *fifth criteri*on requires varied availability of advanced imaging onsite based on level of accreditation. All accreditation levels require ED point-of-care ultrasound availability 24/7 for use by emergency physicians for diagnostics and for procedures as applicable, and a plan for timely reading of advanced imaging (e.g., computed tomography (CT), MRI, ultrasound) studies by a radiologist.

The *sixth criterion* requires availability of social services. Although ideally all EDs at all levels of accreditation would have availability of social services to assist with social issues such as housing, public resources, and substance use programs, this criterion is required for only Level I and II accredited EDs.

Finally, for all levels of accreditation it is assumed that a patient may request to be evaluated by a physician.

Accreditation Criteria

LEVEL I

Staffing/Supervision:

There is a qualified emergency physician and/or pediatric emergency physician available onsite 24/7/365. Every patient encounter is directly or indirectly supervised by a qualified emergency physician and/or pediatric emergency physician.

There is an established policy or plan to define patients that should be directly supervised by a qualified emergency physician (e.g., age considerations, critical presentations, and Emergency Severity Index (ESI) triage level).

There is an established process for education and training of all staff including a plan to ensure that physicians, nurse practitioners (NPs) and physician assistants (PAs) receive training and onboarding which includes a period of proctoring.

There is an onsite pharmacist, ideally with emergency training, who responds to the ED to provide support for medication management to enhance patient quality and safety.

There is an onsite respiratory therapist to assist the ED and responds to resuscitation and critical patients to enhance patient quality and safety.

Advanced Imaging:

- Computed tomography (CT), ultrasound (US) and radiology technologists are available onsite 24/7/365 for imaging.
- MRI should be available 24/7/365 for time sensitive conditions and exams should be timely performed based on clinical judgement of the ordering physician. The MRI technologist should be promptly available (<60 minutes).
- There is a plan for timely interpretation of advanced imaging by a radiologist.

Social Services:

There is access to a social worker or case manager 7 days per week at least 12 hours per day. This service can be virtual.

Level II

Staffing/Supervision:

There is a qualified emergency physician and/or pediatric emergency physician available onsite 24/7/365. All high acuity patients are directly or indirectly supervised by an emergency physician. Lower acuity patients may be seen by a physician, NP or PA who will consult an emergency physician as needed.

There is an established policy or plan to define patients that should be directly supervised by a qualified emergency physician (e.g., age considerations, critical presentations, and ESI triage level).

There is an established process for education and training of all staff including a plan to ensure that physicians, NPs and PAs receive training and onboarding which includes a period of proctoring.

There is a pharmacist who responds onsite or virtually to the ED to provide support for medication management to enhance patient quality and safety.

Support of a respiratory therapist to assist the ED and responds to resuscitation and critical patients to enhance patient quality and safety.

Advanced Imaging:

- Computed tomography (CT), and radiology technologists are available onsite 24/7/365 for imaging.
- US and MRI should be available 24/7/365 and should be timely performed based on the clinical judgement of the ordering physician.
- The US and MRI technologist should be promptly available (<60 minutes).
- There is a plan for timely interpretation of advanced imaging by a radiologist.

Social Services:

There is access to a social worker or case manager 5 days per week at least 8 hours per day. This service can be virtual.

Level III

Staffing/Supervision:

There is a qualified emergency physician and/or pediatric emergency physician available onsite 24/7/365. Patients may be seen by a physician NP or PA who will consult a qualified emergency physician as needed.

There is an established policy or plan to define patients that should be directly supervised by a qualified emergency physician (e.g., age considerations, critical presentations, and ESI triage level).

There is an established process for education and training of all staff including a plan to ensure that physicians, NPs and PAs receive training and onboarding which includes a period of proctoring.

Advanced Imaging:

- CT equipment is available onsite 24/7/365. There is a written plan for timely interpretation of advanced imaging by a radiologist.
- Technologist(s) are onsite to perform radiography and CT 24/7/365.
- There is a written plan in place to obtain emergent MRI and US onsite or through other local hospital resources or via transfer to another facility.

Federally Designated Rural and Emergency Hospital and Critical Access Hospital

Staffing/Supervision:

There is a physician on site 24/7/365 in the ED. The physician can be a qualified emergency physician or an American Board of Medical Specialties (ABMS) BC/BE physician. Patients may be seen by a NP or PA who will consult a physician as needed.

The Medical Director of the ED must be a qualified emergency physician.

There is an established policy or plan to define patients that should be directly supervised by a physician (e.g., age considerations, critical presentations, and ESI triage level).

There is an established process for education and training of all staff including a plan to ensure that physicians, NPs and PAs receive training and onboarding which includes a period of proctoring.

Advanced Imaging:

- CT equipment is available onsite 24/7/365. There is a plan for timely interpretation of advanced imaging by a radiologist.
- A technologist is onsite to perform radiography 24/7/365. A CT technologist may be on call and promptly available for emergent patients requiring CT.
- There is a written plan in place to obtain emergent MRI and US onsite or through other local hospital resources or via transfer to another facility.

The following oversight, policies, quality, and resource sections are to be met by all emergency departments seeking accreditation:

ED Administrative Leadership and Oversight:

- ED physician leader (e.g. medical director, chair of the department or chief) is a qualified emergency physician or pediatric emergency physician.
- ED leadership includes an ED physician leader (e.g., medical director, chair of the department or chief) and ED nurse leader (e.g., ED nurse director or manager) who collaborate to support operations within the department.
- The ED physician leader (e.g., medical director, chair of the department or chief) has direct authority of and is responsible for assessment of clinical privileges of physicians and PA/NPs working in the ED; the ED nurse leader (e.g., ED nurse director or manager) has direct authority for the nursing staff in the ED.
- The ED physician leader (e.g., medical director, chair of the department or chief) is responsible for the ongoing practice evaluation of each NP and PA in the ED.
- The ED physician leader (e.g., medical director, chair of the department or chief) in collaboration with the ED nurse leader (e.g., ED nurse director or manager), will develop the ED quality improvement plan which will include a process for oversight of clinical care in the ED either contemporaneously or retrospectively.
- ED physician and nurse leadership will ensure that all practitioners complete required continuing education requirements as a part of hospital credentialing.
- The ED physician leadership will establish confidential and appropriate processes for completion of exit interviews with physicians who leave the practice to determine the root causes of job transitions.
- Emergency physicians shall document all direct supervision encounters with patients but are not required to sign charts of patients they did not directly or indirectly supervise.
- In a designated trauma center, the shared roles and responsibilities of emergency physicians and/or residents with other members of the trauma team should be established in collaboration with trauma program leadership.

Policies:

- A policy for formal onboarding and standardized training process for all ED staff members to ensure that staff optimize patient care in the emergency setting.
- A policy that plans for a timely reporting of all radiology study results to the ED.
- A policy that describes the notification of patients or their outpatient health care team (as available and as appropriate) of critical imaging and laboratory results identified after patients' discharge in a timely manner. This policy includes identified FTE(s) to complete this work and is not left as additional work for emergency physicians, NPs, or PAs who are actively taking care of ED patients and has the support of emergency medicine, laboratory and radiology leadership.
- A policy that includes specified time periods are tracked, collected, and shared with consultants. This includes specified time intervals from time of consult call to patient evaluation, and from time of patient evaluation to provision of care plan recommendations.
- A hospital disaster plan that includes a plan for adult and pediatric patient surge to the ED.

- A hospital policy or multidisciplinary plan to address ED boarding to include mitigation strategies.
    - Included in this plan should be a policy that states the admitting physician/team is responsible for all care of the patient once the admitting physician/service accepts the patient. The emergency physicians, however, do not yield the authority to prioritize all patient care activities while boarding in the ED and manages resources at their discretion.
    - Included in this plan should also be a policy that outlines who is responsible for the care of patients with primary psychiatric disease who are boarded in the ED (i.e., physician responsible and protocols for care).
- A hospital policy that allows emergency physicians to perform procedural sedation in accordance with ACEP guidelines (i.e., including propofol and ketamine, non-fasting, single physician with nurse).
- A policy that specifies that patients' weights are recorded in kilograms.
- A policy that ED staff are permitted to eat and drink at specified workstations while on duty.
- A policy that specifies mandatory reporting of verbal and physical assault to the hospital.
- A policy that outlines security response and joint drills between ED and hospital security staff. The security response should include processes for when the ED is at heightened risk of safety threat (e.g., assault of health care workers, combative patients, or officer-involved shooting victim). In addition, the policy should detail approach to controlled access to the facility, processes for lock down, and rapid law enforcement response, in event of active shooter in the ED.
- A policy that qualified emergency physicians who are participating in continuing certification are not required to take additional life support courses (e.g., Basic Life Support (BLS), Advanced Life Support (ACLS), Pediatric Advanced Life Support (PALS), or Advanced Trauma Life Support (ATLS) certification) as a part of their credentialing.

Quality:

Each ED shall have an emergency physician-led quality improvement (QI) plan which, in conjunction with nursing leadership, will include the following components:

- The ED must establish a multidisciplinary performance improvement committee responsible for continuously evaluating and improving clinical care, operational efficiency, patient safety, and overall quality outcomes. This committee should include representatives from various clinical and operational areas within the ED.
- The ED must establish baseline metrics and set performance targets for key phases of patient care (e.g., time from patient presentation to discharge for treat-and-release cases; time from patient presentation to the decision to admit; time from admission decision to the patient leaving the ED; and monitoring of frequency and duration of boarding of patients requiring admission, intensive care, behavioral health and/or mental health emergencies).
- The ED must have a system to select indicators for tracking performance improvement for critical illness and injury conditions in adults and children and a system to identify variance in performance.
- The ED must review its pediatric readiness status at least every two years, including participation in the National Pediatric Readiness Assessment (www.pedsready.org). The ED must document their gap analysis and develop action plans to address any identified deficiencies.

- Regular reviews of the practice of emergency physicians, non-emergency physicians, PAs and NPs staffing the ED must occur. This review must include input from multiple sources such as chart reviews of criteria-based cases or cases referred from other clinical departments.
- Quarterly performance and quality measure reports for individual emergency physicians, physician assistants, and nurse practitioners should be provided. These reports must compare their performance to emergency staff peers in an anonymous manner and, when available, benchmark against national or regional data.

Resources:

- Emergency physicians, regardless of employment status, have the same rights and privileges as other members of the medical staff.
- Resources are in place to provide safety of staff, visitors, and patients.
- ED point-of-care ultrasound is available 24/7 for use by emergency physicians for diagnostics and for procedures as applicable.
- The ED has resources for victims of domestic/interpersonal violence.
- Translation services are available in person or via telehealth.
- There is a sanitary, private, non-bathroom area proximal to the ED for ED employees who are breastfeeding.

Note: Exemptions may be made for applicants to the above criteria if they conflict with state regulations.