American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

ACEP ED Accreditation

Emergency Department
Accreditation Criteria

DRAFT

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An accreditation program of the
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

ACEP.org/EDAP

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Introduction

Over the last three decades, American College of Emergency Physicians (ACEP) has developed numerous policies to help set the standard for the practice of Emergency Medicine. Currently, no accreditation or classification programs recognize emergency departments (EDs) that adhere to the policies and practice guidelines. The ACEP ED Accreditation Task Force proposes a tiered program to accredit hospitals with EDs and ED-related processes that meet several key criteria. The goal is to improve patient care and promote fair, productive working environments for emergency physicians through the implementation of evidence-based policies and practices as well as fair contracting and appropriate staffing models.

There have been several prior attempts by ACEP and other groups to create a classification or accreditation system, and the current effort can learn from past failures. Prior ACEP attempts have ultimately been plagued with complexity, heterogeneity of opinions around the purpose and criteria, and a lack of a consistent vision. In the 1990s the Society of Academic Emergency Medicine (SAEM) also attempted a certification program, but it suffered from too high a bar for accreditation, low levels of interest, and low perceived return on investment. Ultimately SAEM's program was discontinued after only one site became certified. Their goal was to set an aspirational level that would drive institutions to make changes to obtain certification. However, this goal was too far-reaching, leading to the program's failure.

Other programs, such as ACEP's Geriatric ED Accreditation (GEDA) program, have been successful. GEDA targets a specific area of patient care and has a clearly defined mission to "ensure that our older patients receive well-coordinated, quality care at the appropriate level at every ED encounter." GEDA owes its success to several factors. First, their criteria and processes have clear alignment with their mission. Second, the mission is one that many hospitals can embrace and use in marketing or public relations (PR)campaigns. Third, the tiered system aims to allow any ED to obtain at least a level 3 accreditation easily, while Level 1 and 2 sites involve more significant investments and demonstrate a true commitment to excellent geriatric care. Thus, access to accreditation is appealing to a range of sites, from small, rural hospitals to tertiary care academic centers. Accreditation can add value to all of them. The Level 3 status is by far the most common and is not perceived negatively compared to Level 1 by sites that pursue it. Finally, GEDA has been generously supported by outside funding through the John A. Hartford Foundation and the West Health Institute. GEDA revenue now accounts for 1% of ACEP's overall annual revenue.[i]

By incorporating lessons learned from prior programs and attempts, this group can help ensure the success of the current efforts. Key takeaways are: There must be a clear benefit to accreditation sites to want to invest in the program, the criteria must add value for physicians or patients and must align with the overall program goal, and accreditation must be achievable by enough sites that the program is operationally and financially viable.

The conclusion from the task force's review of prior ED-based accreditation programs and their failures is as follows:

> *"Hospitals are interested in third-party attestations of their ability to provide quality care. Some hospitals may seek to improve their market share, others to provide verification of interest and involvement in the community, while others may seek to keep local suburban or rural patients from being drawn to urban facilities. Regardless of the intent, the result is that a participating hospital in the accreditation program will provide the best care based on scientific evidence and the policies and established standards. The GEDA program also has shown the power of losing accreditation. While achieving accreditation is well received by a hospital Board of Trustees, losing accreditation is seen as a significant event.*
>
> *ACEP is the leading professional organization in the U.S. (and arguably in the world) for emergency physicians (EPs). We believe it is our duty to provide our members with the best environment to practice and care for their patients, and to provide the public with assurance that the ED they visit will provide quality care, regardless of the size of the institution. ED accreditation is for patients but will also provide important support for EPs, improving their workplace and career fulfillment."*

Acknowledgements

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The Emergency Department Accreditation Board of Directors provides ongoing leadership for program direction, development and implementation.

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Disclaimer

These criteria and standards are intended solely as qualification for 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.

Vision and Value Proposition: Why Certify

The American College of Emergency Physicians (ACEP), the leader in EM standards, will be accrediting hospitals with Emergency Departments (EDs) to improve patient care and promote better physician working environments by recognizing those hospitals that use evidence-based policies across all patient populations, practice settings and staffing models. The overall goal of ED accreditation is to elevate the practice of emergency medicine and the role of emergency physicians in leading the ED healthcare team. Meeting accreditation standards can add value for patients, physicians, and hospitals.

- **PATIENTS** will be able to see the hospital and emergency physician group's commitment to providing quality care in an optimal setting.
- **PHYSICIANS** and team members will work in fair, safe, productive, and efficient working environments.
- **HOSPITALS** will see market distinction through their commitment to the highest standards in emergency care.

The emergency department (ED) is the front door to the hospital. Up to 40% of inpatients and up to 70% of ICU patients enter the ED through the ED. In most areas of the country, patients have a choice of where they go for emergency care. However, until now there was little information to help them choose a facility. Certainly, trauma designation helps those most critically injured, but this represents a very small number of patients. Stroke and chest pain designation helps guide a few patients, but the vast majority of patients have no way to distinguish between facilities, especially if they are out of town. ED Accreditation will provide this crucial information. It will allow the public to find and utilize those facilities with the best staffing to handle any emergency.

Emergency Physicians decide who gets admitted, who goes home and who gets transferred. This decision has implications not only for patients but for the healthcare system. For rural hospitals, retaining a single patient as an admission more than pays for the cost of accreditation. For those urban facilities that function as an Accountable Care Organization, avoiding an unnecessary admission makes sense for the patient and the facility. The best individual to make this important decision is a physician who is board certified in Emergency Medicine.

The ED Accreditation program also ensures that staff work in an environment that best supports their practice. As we built this program, focus group participants repeatedly said 'I'd like to work in a place like this'. Physicians, and other staff, want to be able to care for patients where there are adequate resources and a reasonable environment. The ED Accreditation program ensures those exist.

The program is based on policies of the American College of Emergency Physicians. They have been proposed by emergency physicians, written and re-written by emergency physicians and

represent the values and desires of emergency physicians for their workplace. Most importantly, this program highlights staffing with a Board-Certified Emergency Physician. It recognizes the critical role of other clinicians and the need for resources to ensure that every patient receives the best possible care.

Accreditation Criterion Overview

There are currently two major criteria that differentiate the four accreditation tiers. The first three tiers are applicable to any emergency department (ED) and the fourth is applicable to hospitals with federal designation of rural emergency hospital or critical access hospital. The first differentiating criterion defines the staffing model and level of supervision of physician trainees, nurse practitioners (NPs) and/or physician assistants (PAs). As it relates to physician supervision the following definitions apply:

- Direct Supervision: When the supervising physician personally examines/evaluates the patients for which she/he is the supervisor. This is the gold standard of supervision.
- Indirect Supervision: When the supervising physician contemporaneously discusses or reviews the management of patients for which she/he is the supervising physician but does not personally examine/evaluate 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 the 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 abuse programs, this criterion is required for only Level I and II accredited EDs.

Accreditation Criteria

GOLD/ LEVEL I

Staffing/Supervision:
There is an American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM) board certified/board eligible (BC/BE) in emergency medicine and/or American Board of Pediatrics (ABP) BC/BE in pediatric emergency medicine, emergency physician on site 24/7/365 and directly supervises (personally examines/evaluates) the care of all patients.

Social Services:
There is access to a social worker or case manager 7 days per week at least 12 hours per day. This can be via telemedicine.

SILVER/ Level II

Staffing/Supervision:
There is an ABEM/AOBEM and/or ABP BC/BE emergency physician on site 24/7/365. The emergency physician examines/evaluates the patient or performs indirect supervision. All patients seen by physician trainees, NPs or PAs are presented to the emergency physician who then makes the decision as to whether he/she need to personally evaluate the patient.

Social Services:
There is access to a social worker or case manager 5 days per week at least 8 hours per day. This can be via telemedicine.

BRONZE/ Level III

Staffing/Supervision:
There is an ABEM/AOBEM and or ABP BC/BE emergency physician available onsite 24/7/365. All high acuity (e.g., ESI 1,2) patients are seen by an emergency physician. Moderate acuity (ESI level 3) patients must at least be presented to an emergency physician. Low Acuity (e.g., ESI

level 4 and 5) patients may be seen by a qualified NP or PA who will consult an emergency physician as needed.

Federally Designated Rural and Emergency Hospital and Critical Access Hospital

Staffing/Supervision:

There is a physician on site 24/7/365. All patients seen by NPs and PAs are presented to the physician who then makes the decision as to whether he/she needs to personally evaluate the patient. The physician can be a BC/BE emergency physician or an American Board of Medical Specialties (ABMS) BC/BE physician for presentations in-person. The Medical Director of the ED must be a BC/BE emergency physician.

The following physician oversight, policies, quality, and resource sections are to be met by all Emergency Departments seeking accreditation:

Physician oversight:

- ED medical director is ABEM/AOBEM or ABP certified in Emergency Medicine or Pediatric Emergency Medicine.
- The ED medical director is responsible for assessment of clinical privileges of physicians and PA/NPs working in the ED.
- The physician medical director is responsible for the ongoing practice evaluation of each NP and PA in the ED.
- 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 or indirect supervision encounters with patients but are not required to sign charts of patients they did not directly or indirectly supervise.
- The emergency physician and/or emergency medicine resident is a member of the trauma team if one exists.

Policies:

- Develop a formal onboarding and training process for all ED staff members that they employ to ensure that staff optimize patient are in the emergency setting.
- Develop a hospital policy that states the admitting physician is responsible for all care of the patient once the admitting physician accepts the patient; however, the emergency physicians do not yield the authority to prioritize all patients care activities in the ED and manages resources at their discretion.
- Ensure that there is a clearly defined process is in place for the following processes:
  1) identify all 'new' critical imaging results after patients' discharge and all incidental imaging findings and
  2) notify patients or their outpatient healthcare team (as available and as appropriate) in a timely manner. This process includes identified FTE to complete this work and is not left as additional work for emergency clinicians who are actively taking care of ED patients. This process has the support of both the emergency medicine group and the radiology group.
- Ensure that there is a hospital policy in place that supports timing of patient consults, including specified time periods from time of consult call to patient evaluation and from time of patient evaluation to provision of and care plan recommendations. These time

intervals are collected and shared with consultants and included in the ED quality improvement plan.

- Ensure that there is a disaster plan and a surge plan in place.
- Ensure that there is a policy that emergency physicians can perform procedural sedation in accordance with ACEPs guidelines (include propofol/ketamine, non-fasting, single physician with nurse).
- Ensure that there is a policy in place to identify 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).
- Develop a policy that patients' weights are recorded in kilograms.
- Develop a policy that ED staff are permitted to eat and drink at specified workstations while on duty.
- Develop a policy to require mandatory reporting of verbal and physical assault to the hospital.
- Develop a policy for security response and ensure that it is drilled jointly between ED and hospital security staff. The security response includes processes for when the ED is at heightened risk of safety threat (e.g., officer involved shooting victim) and processes for lock down and rapid law enforcement response in event of active shooter in the ED.
- Ensure that ABEM- and A**OB**EM board-certified emergency physicians that 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.
    - Note: exceptions may be made for states that have such requirements as a part of regulation.

#	ACEP Policy Statements/Guidelines
1	Emergency Department Planning and Resource Guidelines
2	Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department
3	Role of the Emergency Physician in the Care of Trauma Patients
4	Social Work and Case Management in the Emergency Department
5	Emergency Department Planning and Resource Guidelines
6	Responsibility for Admitted Patients
7	Advanced Practice Provider Point-of-Care Ultrasound Guideline
8	Due process for Physician Medical Directors of Emergency Medical Services
9	Medical Practice Review and the Practice of Medicine
10	Use of Short courses in Emergency Medicine as Criteria for Privileging or Employment
11	Emergency Physician Contractual Relationships
12	Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine
13	Pediatric Readiness in Emergency Medical Services Systems
14	Disaster Planning and Response
15	Ketamine Use in Prehospital and Hospital Treatment of the Acute Trauma Patient: A Joint Position Statement
16	Adult Psychiatric Emergencies
17	Pediatric Medication Safety in the Emergency Department
18	Food and Drink for Staff in the Emergency Department
19	Reporting of verbal and physical assault
20	Domestic Family Violence
21	Use of Medical Interpreters in the Emergency Department
22	Support for Nursing Mothers

Quality:

- Each ED shall have an emergency physician led quality improvement (QI) plan which includes the following:
    - Reviews of the practice of emergency physicians, non-emergency physicians, PAs, or NPs staffing the ED that includes input from multiple sources (e.g. case reviews of criteria based cases or cases referred from other clinical departments).
    - Quarterly reports on performance and quality measures for individual physicians, PAs, and NPs which are compared to other staff in an anonymous manner and, if available, to national or regional data.
    - Documentation of a review of their ED pediatric readiness status at least every two years (e.g. participation in the pediatric readiness assessment at www.pedsready.org) and action plans to correct deficiencies.
    - Monitoring and recording of time from presentation to discharge for treat and release patients.
    - Monitoring and recording of time from presentation to the decision to admit and time from decision to admit until the patient leaves the ED.

Resources:

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

BLUE RIBBON RECOGNITION

The following additional components are not required for accreditation but worthy of acknowledgment because of the hospitals or the emergency medicine staffing model's commitment to physician staff are ensured:

- Due process for emergency physicians regardless of employment/contractual arrangements.
- Contracts with the EPs, including both hospital and contracting group, do not include a restrictive covenant (non-compete).
- Medical staff credentialing and privileging forms do not include questions regarding prior psychiatric care, unless impacting work performance.
- Emergency physicians have the right to view itemized reports of what is billed and collected for their service at least semi-annually.