Dissemination of geriatric emergency department accreditation in a large health system

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Abstract
The population of older adults in the United States is expanding rapidly. With this expansion, the healthcare system, and emergency departments (EDs) in particular, should provide geriatric-focused care tailored to the needs of this population. To this end, the American College of Emergency Physicians (ACEP) released a geriatric emergency department accreditation (GEDA) to certify EDs that have the staffing, training, and resources to provide high-quality, geriatric-focused, emergent care. Our healthcare system set out to achieve the GEDA at all system hospitals using a service-line approach and standardized policies. The implementation and application process was completed through strong partnerships between the Emergency Medicine Service Line and the Division of Geriatrics and Palliative Medicine. Further partnerships with ACEP were vital to completing the application process and using a standardized application. Through these partnerships, all 17 of our system hospitals achieved tier 3 accreditation. Through this process, we were able to identify opportunities to improve the care provided to older adults in the ED, particularly via staff education. We also gathered lessons learned for system-level accreditation, including fostering close partnerships, meeting the unique needs of each ED, and strategically planning when and where to increase tier levels. This practice of large-scale, system-wide standardization, rather than individual site implementation, is an effective measure to provide geriatric-focused care to the large and growing population of older adults.

KEYWORDS
geriatric emergency department, GEDA

1 INTRODUCTION

By 2030, the number of those aged 65 years and older is expected to reach 20% of the population of the United States.1 With this growth, older adults will outnumber those younger than the age of 18 for the first time in US history.2 Particular geographic subsections within the United States are experiencing a more concentrated increase in their aging populations as a result of larger population sizes and a higher density of older adults. For example, New York state has the fourth largest population of adults aged 65 years and older.3 In particular, the New York metropolitan area has experienced a 19.5% population increase in those aged 65 years and older over a 10-year period.
| Geriatric emergency department accreditation level | Personnel requirements | Policy/metric requirements | Environmental requirements |
|-------------------------------------------------|------------------------|---------------------------|---------------------------|
| 3                                               | 1 Physician            | Evidence of geriatric-focused guidelines | 24/7 access to food and drink |
|                                                 | 1 Nurse champion       |                           | Durable medical equipment |
|                                                 |                        |                           |                           |
| 2                                               | All of the above, plus | Evidence of geriatric-focused guidelines | All of the above, plus |
|                                                 | Executive sponsor      | 10 QI components          | 2 chairs per patient bed |
|                                                 | Nurse case manager or  | 10 Policies/guidelines/procedures | Large analog clock |
|                                                 | transitional care manager > 56 hours per week | 3 Outcome measures |                           |
|                                                 | Access to at least 2 of the below: | Educational program for ED nurses and physicians |                           |
|                                                 | Physical therapy       |                           |                           |
|                                                 | Occupational therapy   |                           |                           |
|                                                 | Pharmacy               |                           |                           |
|                                                 | Social work            |                           |                           |
| 1                                               | All of the above, plus | Evidence of geriatric-focused guidelines | All of the above, plus |
|                                                 | Access to all of the below: | 20 QI components          | Enhanced lighting |
|                                                 | Physical therapy       | 20 Policies/guidelines/procedures | Noise reduction |
|                                                 | Occupational therapy   | 5 Outcome measures | Nonslip floors |
|                                                 | Pharmacy               | Educational program for ED nurses and physicians | Hand rails |
|                                                 | Social work            |                           | Signage and wayfinding |
|                                                 |                        |                           | Wheelchair-accessible toilets |

ED, emergency department; QI, quality improvement.

This increase, which outpaces the increase in overall population and the increase in population younger than 65 years, has led to older adults representing 13.2% of the population of New York City. The counties surrounding New York City have seen an even more intense rise in their older adult populations, with 22% and 34% increases in Nassau and Suffolk counties, respectively.

This expanding population nationwide will likely put increased strain on emergency departments (EDs) as older adults often require additional and more complex levels of care in the ED compared with other age groups. Although the ED remains a common source of care for older adults, physicians in the ED report insufficient training for caring for this population, which may result in high burnout levels. Pediatric EDs have been widely recognized as resources for specialized emergency care, but the same recognition has only recently begun to gain traction for geriatric EDs.

In 2013, the American College of Emergency Physicians (ACEP), Emergency Nurses Association, American Geriatrics Society, and the Society for Academic Emergency Medicine released guidelines for geriatric emergency department accreditation (GEDA). These guidelines provide a framework for an accreditation to certify EDs that meet criteria surrounding emergency care of older adults. These criteria include policies, education, definition of the physical ED space, and provision of resources for older adults within the ED. The GEDA program launched in May 2018. It promotes an interdisciplinary approach to quality care for older adults, including transitions of care and quality improvement outcomes. The GEDA accreditation is divided into 3 levels, similar to trauma designation (Table 1). Since the inception of the GEDA process, the ACEP has accredited >100 EDs in the United States. To date, there are 143 EDs with a level 3 certification, 13 EDs with a level 2 certification, and 10 EDs with a level 1 certification.

Recognizing the growing need for education and specialized care for this growing population in our health system catchment area, the health system’s Emergency Medicine Service Line (EMSL) and Division of Geriatrics and Palliative Medicine (GAP) collaborated and created a dedicated relationship to pursue GEDA.

2 | METHODS

2.1 | Model description

Our health system’s EMSL is made up of 17 EDs: 5 tertiary EDs, 11 community EDs, and 1 freestanding ED. The EMSL is responsible for the clinical and operational performance of these 17 EDs as well as hospital-based observation units and a rapidly expanding network of urgent care centers. In total, the EMSL sees nearly 900,000 visits annually and spans New York City, Westchester, and Long Island. Of these visits, 26.3% are patients aged 65 years and older, with this number expected to increase in the coming years.

To support these varied departments and the 450 employed emergency physicians, the EMSL has centralized operations that serve the individual and collective needs of our EDs. The central operations team partners with each ED to standardize quality, operations, finance,
and physician recruitment across the health system. This, for example, includes coordination between system-level and site-level administrations to allocate resources where appropriate, standardize within-system recruitment, and manage large-scale improvement initiatives. The EMSL also partners with hospital leadership at each site to create a collaborative approach to acute unscheduled care in the hospitals and prioritize emergency medicine goals and strategy. In addition, as a member of an integrated health system, the EMSL also works closely with other health system programs, particularly the GAP division, to build collaborative relationships to share responsibility for the care of patients seeking acute unscheduled care.

The academic division of GAP consists of interdisciplinary teams at 2 tertiary hospitals and 1 ambulatory location. In addition to the academic sites, the division has relationships with geriatric and palliative teams across the health system, ranging from community hospitals to additional tertiary locations. In total, there are 11 physician-led GAP teams across the system, with an additional 3 nurse-led teams at the smaller community hospitals. These relationships, although not supervisory, are structured to provide clinical oversight, dissemination of best practice, and leadership support to the separate sites across the system. The GAP team is closely aligned with post-acute services within the health system, including home care services, 2 skilled nursing facilities, and a hospice care network. The GAP division has previously partnered with the EMSL to establish an interdisciplinary ED team to screen older adult patients presenting to the ED and connect them to community resources. These relationships across the health system facilitated the dissemination of geriatric principles and assisted in the coordination of the geriatric ED accreditation process.

2.2 | Application preparation

The geriatric emergency medical services (GEM) leadership team, including members from EMSL and GAP, met with the ED leaders at each of the 17 ED sites to discuss the GEDA application questions. Each ED had an appointed GEM physician, nurse, and administrator tasked with completion of the applications. In addition to the time and effort of the local champions, the EMSL and GAP division used protected time for 2 physician leaders and administrative support from 3 system directors/managers as the centralized team to maintain this effort. As continuous quality improvement is an expectation for all of our EDs, and our academic institutions in particular, provisions and adjustments for the time and effort needed to complete this process was accommodated by leadership.

To standardize the application process, a needs assessment guide was used by each ED leadership team to formulate their applications (Table 2). The system-wide GEM leadership team reviewed these applications for both individual merit and to ensure appropriate standardization across all applications submitted by the system. This review found that although there were many policies and programs implemented across the EMSL to support the care of older adults, much of this work was “silied” within individual sites (Table 2). The GEDA application created the opportunity to aggregate all of the process improvement projects that were already ongoing within the EDs and assess which projects were most relatable to all EDs and which projects were more likely to be measurable using data from the electronic medical record (EMR). In particular, we chose to highlight our system catheterization policy and catheter-associated urinary tract infection reduction strategy for all applications. This policy requires that all geriatric patients arriving to the ED with a Foley catheter are assessed for appropriate placement and documented in a designated screen on our EMR. Although all of our EDs were aware of the policy before the GEDA application process, we were able to clarify clinical questions and improve consistency of policy application for geriatric patients via the GEDA needs assessment.

Although we strived for standardization among our EDs in some areas, we recognized the unique challenges faced at each site and highlighted them throughout the application. The vast majority of sites were prepared for the GEDA application process, and EDs with opportunities for improvement partnered with their hospital leadership and the GAP team to achieve the requirements of the GEDA application. Partnership with local GAP teams was facilitated by divisional GAP leadership, who also provided support and guidance to EDs that did not have a local GAP team onsite. Across all sites, the needs assessment found a gap in education specific to geriatric emergency medicine, which we ameliorated with focused training for our geriatric ED champions.

In reviewing the application process and the scale of this venture, we determined that partnership with ACEP would be needed for successful communication and expectation setting. Through conference calls between members of the health system GEM leadership team and representatives from ACEP, we were able to gain a detailed understanding of the certification process and describe the structure of our unique health system. The applications were submitted in multiple batches across a 6-month timespan. After submission of the first batch of 5 applications, the health system GEM team and ACEP representatives discussed these applications to resolve concerns and opportunities for application improvement. Using these updated guidelines, the original applications were successfully resubmitted. The remaining applications were re-evaluated and adjusted based on the updated recommendations from the ACEP representatives, including adding educational and quality project collateral to support the application for the individual EDs. These remaining applications were submitted in smaller batches of 5 to 6 to avoid overwhelming the board members who would be reading the applications.

3 | AMERICAN DISCUSSION

During the course of 1 year, our health system was able to achieve tier 3 GEDA at all 17 of our system EDs. Through this process, we were able to identify sections of our educational, administrative, and operational practices that were improved by the work done to achieve the GEDA accreditation.
| Question                                                                 | Action                                                                 | Assessment                                                                                                                                 |
|-------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|
| Who are your geriatric ED champions?                                    | Names were recorded for further communication.                        | All EDs provided at least 1 geriatric ED champion.                                                                                      |
| Have the champions had prior training in geriatrics or geriatric emergency medicine? | If yes: we asked for proof of content and completion and invited to our in-house education. If no: we invited them to our in-house education. | Two individuals had prior training in geriatrics, all remaining champions were required to attend the in-house education. |
| Are you familiar with the ______ policy?                                | All said yes; no action needed.                                        | All EDs were familiar with our designated policy.                                                                                        |
| How have you made the ______ policy specific to (hospital name) ED?     | Specific adaptations to the policy were noted to be included in the application for individuality. | All EDs articulated how the policy was implemented at their sites. Because of the systematic nature of our implementations, most presentations were identical; however, there was some variation in implementation based on ED flow and the role of frontline leaders. |
| How have you made the ______ policy geriatric specific?                 | Specific adaptations to the policy were noted to be included in the application for individuality; best practices were shared during upcoming GEM meetings. | Two sites had unique best practices that were shared with the group.                                                                 |
| What data are you tracking to ensure compliance with the ______ policy?  | Three metrics were added to service-line dashboards.                  | All data are service-line driven, so all metrics collected were the same. However, the assessment created the opportunity for sites to request additional metrics; 3 new metrics were added to all sites’ dashboards. |
| Does the ED keep mobility aids within the department?                   | All said yes; no action needed. Photo was requested for inclusion in the application. | All EDs had mobility aids readily available in the department.                                                                        |
| What kind of mobility aids are available in the ED?                    | Responses were noted individually for each site.                      | All EDs had access to crutches, canes, and walkers. Three EDs also had 4-point canes available. Two sites had additional aids available. |
| How does a patient access the mobility aids?                           | Responses were noted individually for each site.                      | Patient can access mobility aids through their ED nurse. On-site physical therapy is available 24/7 at 3 sites; at the remaining sites, arrangements were set up with case management or social work to cover overnight requests. |
| Are the mobility aids available 24/7? If no, what is the process to access the mobility aids during off hours? | If yes, noted and no action needed. If no, the off-hours process was chronicled. If process was unclear, the ED team solidified a process based on the location of mobility aids. | All EDs had mobility aids available 24/7, which can be accessed by the ED nurses. Accompanying PT consults were available 24/7 at 3 EDs. At 5 EDs, there was a discussion with PT to clarify the process during off hours so that a site standard now exists. |
| Do patients who receive a mobility aid also receive a consult with physical therapy? | Response was noted in the application if affirmative (not required by the ACEP guidelines). | When physical therapy is on site, all sites were affirmative if the mobility aid is being sent home with the patient. During off hours, 14 sites work with case management to set up at-home PT. |
| What food is available within the ED for patients?                     | Responses were noted individually for each site, including a list of all special diet guidelines that are met. If food in the ED was limited, we noted where other types of food are available. | All EDs have food available for free to patients with multiple diets available, with a minimum of 3 special diets and up to 6. |
| Where is the food kept?                                                 | Responses were noted individually for each site.                      | All EDs have food available to patients and family members 24/7. More robust access to food was suggested for 4 sites.              |

(Continues)
TABLE 2  (Continued)

| Question                                                                 | Action                                                                 | Assessment                                                                                                                                 |
|--------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
| Is the food available 24/7? If not, what is the process for obtaining food during off hours? | If yes, response was noted. If no, the off-hours process was noted.    | All sites have food available 24/7. Four sites added more robust access during the overnight hours.                                       |
| How does the patient access the food?                                    | Responses were noted individually for each site.                       |                                                                                                                                            |
| Is the food free?                                                         | If yes, response was noted. If no, the ED team worked with on-site nutrition to increase access to free, healthy food for patients. | Two sites increased the types of free food available to patients.                                                                          |
| Is the food available to the family members?                             | Response was noted if affirmative. If negative, we encouraged the ED team to make food available to family members of older adults. | Three sites did not have designated food for family members, so made the availability of food to family members more transparent.       |

ACEP, American College of Emergency Physicians; ED, emergency department; GEM, geriatric emergency medical services; PT, physical therapy.

3.1 | Education

Across the service line, the area with the most opportunity was the education of our ED practitioners and staff. Our work to earn accreditation showed us that our geriatric patients are receiving a high standard of care with active participation from ancillary services, but that our EDs do not have easy access to resources outside of the hospital. To relay best practice for the care of older adults and meet GEDA requirements, the EMSL and GAP teams collaborated to prepare courses for all EMSL geriatric ED champions to attend. The courses, led by our EMSL and GAP clinical leaders, integrated emergency medicine practices and geriatric practice with a focus specifically on the health system’s processes and resources for older adults. Leveraging the strong relationships and frequent communication among GEM leadership, the GEM educational series was launched to disseminate information regarding the processes, policies, and practices for older adults that are successful in our EDs. This series opened collaboration and conversation about the additional resources available in the community and from the health system’s ambulatory programs. To ensure that our curriculum fit standard educational requirements, we partnered with our institutional Office of Continuing Medical Education to associate continuing medical education and continuing education units credits with our courses.

The GEM system leadership and site champions meet monthly for ongoing education and initiative coordination. Each site is required to have at least 1 site champion attend each meeting, which is held as a video conference to ensure participation from across the health system. Each month, a subject expert speaks with the group about their specialty and how it pertains to geriatric patients in the ED. The chosen topics are also designed to align with 1 of the 4 Ms of geriatrics (ie, mentation, mobility, medications, and what matters most). During our inaugural year, we had speakers from clinical pharmacy, population health, social work, and case management among other traditional speakers (Table 3). Our geriatric ED physician leads also present regularly to remind the teams about existing resources in the ED. In addition to the educational presentations, quality and process improvement projects are a recurring agenda item for GEM meetings. Champions also review and discuss clinical cases with a focus on geriatric-friendly practices applicable to the case and make recommendations for future similar cases. Our goal is to provide our geriatric champions with tools and education that are directly relevant to their practice and adaptable by frontline teams for use during geriatric patient encounters.

3.2 | Challenges

One of the first and longest sustained challenges we encountered was the dedicated time and effort required for compiling and executing the requirements of the GEDA application. Although this dedication resulted in system coordination and education, the initial start-up requirements were substantial. Developing and coordinating 17 applications required 3 EMSL administrative leaders plus clinical oversight from both the EMSL and individual EDs. This coordination included developing system-wide policies, updating metrics-based dashboards,
and implementing standardized educational rounds. Although our health system uses the service-line model to standardize practice across multiple hospital sites, there was still significant variation in how individual EDs delivered care. Some of this variation was required to meet the unique needs of each community served, but other points of variation represented opportunities for standardization and adoption of best practice. Striking the right balance between customization and standardization required thoughtful analysis and discussion among several administrative and clinical levels.

Coordination of the financial component to the GEDA application across varying sites and budgetary timelines also represented a challenge. Because the applications were staggered across multiple budgetary periods, additional checks and balances were required to ensure appropriate funding was available for each submission. The initial application preparation extended longer than the planned budget allowed, which required a reassessment of funding allowances and sources.

4 | LESSONS LEARNED

Our health system faced challenges during the course of the GEDA application process, but the overall process resulted in several lessons learned and improvements across the EMSL (Table 4).

4.1 | Lesson 1: Partnership and communication

Leveraging the expertise of the GAP division and the EMSL was imperative to the successful applications. Creating a cohesive team with system leaders from both departments who had an interest in improving care for older adults in our EDs and achieving GEDA designation was a vital initial step. The system-wide perspective of these leaders allowed the GEM team to pull best practices and efficiently share with EDs across the system. Together, we were able to create a comprehensive understanding of the needs of the older adult populations within the ED and out in the community. This close communication allowed for streamlined initiatives and improved the potential for sustainability, as resources were efficiently used and the replication of tasks was minimized.

4.2 | Lesson 2: Meeting unique needs

In reviewing each GEDA application, we took the time to assess the communities that each hospital, and the health system overall, served. This process was important to understand the needs of the patients and families using our EDs and how the GEDA accreditation would benefit them. The population in the catchment area of our health system is aging rapidly and requires increased levels of support both in the community and within the hospitals. The GEDA application process forced each ED to highlight their strengths and opportunities in the care of older adults. The uniform needs assessment standardized our applications but also allowed each hospital to provide context for the unique needs of their communities. This process also encouraged communication of best practice between EDs and adaptation of these practices to fit the needs and resources available in each ED. We believed that pursuing the GEDA accreditation would be a meaningful measure to ensure best practice and attention to detail in the care of older adult patients across our health system.

4.3 | Lesson 3: Strategic planning

Upon achieving level 3 GEDA accreditation status for all 17 health system EDs, discussions began on appropriate locations to “level up” to levels 1 and 2. Although all sites will strive to continually improve care and leverage best practice, the decision to apply for a higher level GEDA designation should be made strategically. For example, the higher levels of accreditation may be a means to encourage patients to use facilities that have the appropriate capacity and expertise to provide high-quality care tailored to the older adult population. Additional considerations for health systems may include regional geography, leadership readiness, cost, and facility capacity.

5 | CONCLUSION

Healthcare is just beginning to understand the needs of an aging population. ACEP is leading the mission to establish standards of care for this new normal. Our health system also recognizes this growing demand. After investing time and effort while combining our expertise, the EMSL and the GAP division were able to earn level 3 GEDA accreditation at all 17 health system EDs. We recognize this is not a stagnant endeavor and must ensure ongoing commitment and education. The
process and lessons learned should be used for other health systems looking to engage in this process.

CONFLICTS OF INTEREST
The authors have no disclosures or conflicts of interest to report.

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