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Editorial Comment

Geriatric Emergency Departments: An Urgent Imperative for Aging Societies

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Central Illustration. Conceptual illustration of Geriatric Emergency Departments (GED). The illustration emphasizes patient-centered geriatric emergency care supported by key domains: policy engagement, accreditation, workforce training, financial models, digital innovation, global collaboration, and quality improvement.

Population aging has become a formidable challenge for healthcare systems in developed countries. Although older adults are living longer lives, a higher prevalence of multimorbidity, geriatric syndromes, frailty, and functional decline has emerged. This demographic shift creates unprecedented demand on acute care systems, particularly emergency departments (ED), where older adult patients frequently seek urgent help. Furthermore, their clinical presentations are often complex and atypical, leading to diagnostic uncertainty, increased hospitalization, prolonged length of stay, and higher readmission rates. As a result, older adults place a disproportionate burden on already strained emergency care resources.

In this context, the concept of the Geriatric Emergency Department (GED) has emerged as a crucial innovation. Originating in the United States in 2008, GEDs were developed based on the Acute Care for Elders model, which emphasizes interdisciplinary collaboration, patient-centered care, and disability prevention. In 2014, the American College of Emergency Physicians, in partnership with the American Geriatrics Society and other professional bodies, published the first GED guidelines.[1,2] This was followed by the launch of the Geriatric Emergency Department Accreditation (GEDA) program in 2018, which established a structured three-tier accreditation system (gold, silver, bronze) to guide hospitals in implementing age-friendly EDs. By December 2022, nearly 400 EDs across the United States had achieved GEDA recognition, rendering it an integral component of the American emergency care landscape.

The recent study by Lee et al. (2025), entitled "*Continuous Promotion of Geriatric Emergency Department through Collaboration between Government and Healthcare Professional Organizations in Taiwan*", provides a timely and insightful contribution from an Asian perspective.[3] Taiwan has one of the fastest growing aging populations globally, has piloted a unique government–professional society partnership model for promoting GEDs. By adopting a nine-step continuous promotion framework, involving the Health Promotion Administration, the Taiwan Society of Emergency Medicine, and multiple professional associations, the program demonstrated notable improvements across seven GED domains, ranging from interdis-

ciplinary team development to care protocols and quality indicators. Importantly, over 200,000 older adult patients were reached within a seven-month period, with more than 49,000 successful transitional care referrals, thereby underscoring the feasibility and impact of systematic GED promotion.

This collaborative Taiwanese model highlights two critical lessons for global health systems. First, policy-level engagement is essential: Although the U.S. GEDA program relies on hospital initiative and professional accreditation, the Taiwanese model illustrates how government support can provide financial, political, and organizational leverage for large-scale dissemination. Second, local adaptation matters: Despite international guidelines, implementation must be sensitive to the healthcare financing structures, workforce availability, and cultural contexts of each country.

In terms of broader implications, GEDs are no longer optional enhancements but a strategic necessity for sustainable healthcare systems. They represent a convergence of acute and geriatric care, thereby bridging emergency medicine, primary care, and long-term care. By preventing functional decline, reducing unnecessary hospitalizations, and strengthening transitional care, GEDs not only improve outcomes for vulnerable older adults but also mitigate healthcare costs, which is an increasingly urgent concern in aging societies.

Looking forward, the following prospects warrant attention.

1. Integration into national health policies and reimbursement systems: GED care should be recognized and incentivized within insurance and payment structures to ensure sustainability.
2. Expansion of workforce training and certification: Formal curricula and board recognition for geriatric emergency medicine will elevate expertise and attract younger professionals.
3. Digital innovation and telegeriatric care: Leveraging health information technology, artificial intelligence, and remote monitoring may enhance screening, risk stratification, and continuity of care beyond the ED. A recent randomized clinical trial (MIGHTy-Heart trial) compared a mobile integrated health model (including community paramedic home visits, telehealth access, and nurse coordination) with a more traditional transitions-of-care coordinator approach among discharged patients with heart failure. This suggests that targeted digital–traditional hybrid interventions could be integrated into GED programs to extend their influence beyond the hospital walls.[4]
4. Global collaboration and research: Multinational efforts should evaluate the cost-effectiveness, patient-centered outcomes, and system-level impacts of GED implementation, thereby generating evidence that transcends regional contexts.

In conclusion, the experience from both the United States and Taiwan demonstrates that GEDs are a vital innovation at the intersection of emergency medicine and geriatric care. As societies continue to age, the question is not whether they can afford to implement GEDs, but whether they can afford not to. The time has come for policymakers, healthcare leaders, and clinicians worldwide to recognize GEDs as an essential pillar of resilient, age-friendly health systems.

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