Note of the editors: This is a BOWMAN-generated English translation of the officially indexed Spanish-language article, which should be cited as Emergencias 2026;38:161-162. In this translated version, the editors have supervised the process; however, it cannot be ruled out that some errors resulting from the artificial intelligence translation process may have gone unnoticed.

EDITORIAL

Design of emergency services oriented toward the geriatric population: an urgent necessity

Diseño de servicios de urgencias orientados a la población geriátrica: una necesidad inaplazable

Sira Aguiló

The transformation of the health care system through the adaptation of emergency services to older patients is unavoidable. Since change is always driven by an urgent need, we are currently in a favorable scenario. In hospital emergency departments (EDs), this need is no longer a future concern; it is demographic, clinical, and organizational. The progressive aging of the population has made older patients—and especially frail patients—one of the main users of emergency care. As demonstrated by the EDEN cohort,[1] more than one-third of older adults presenting to an ED have some degree of functional dependence. However, many EDs continue to be designed under care paradigms centered on the standard acute patient, rather than on the multidimensional complexity of older adults. Working in a high-pressure healthcare environment in which there is no concordance between actual demands and the organizational model explains, at least in part, healthcare professionals' burnout,[2] which is another challenge the current healthcare system must face.

Detecting frailty from the very first moment is essential; therefore, standardized dual triage should be implemented. In the future, it will probably be difficult to understand why this was not always performed systematically and why clinical judgment alone was used as a measure of frailty.[3] Traditional triage based solely on acute severity is insufficient to anticipate needs, risks, and clinical trajectories in the geriatric population. Structurally incorporating frailty assessment from the moment the patient arrives not only allows better prioritization, but also provides more appropriate guidance for diagnostic, therapeutic, and disposition decisions.

Assessment of the frail patient requires attention to the acute condition prompting consultation, but never outside the framework of their comorbidities, functional status, and social and cognitive condition. Structuring this assessment and determining the degree of frailty will allow more appropriate goals to be defined and will free clinical time for higher value-added interventions. Early identification of polypharmacy, social vulnerability, functional decline, delirium risk, and other factors associated with older adults presenting to an ED enables specific and early interventions that may modify the course of the episode and prevent avoidable complications.

Especially in high-pressure environments and complex situations, intelligent and objective standardization is an indispensable ally in guaranteeing equity and quality. In this regard, as shown in the article by García-Pérez et *al.*[4] published in this issue of EMERGENCIAS, the 3D/3D+ tool, designed by the GERIURG group and based on comprehensive geriatric assessment (CGA) adapted to the needs of EDs, helps structure clinical decisions and optimize healthcare resources without compromising patient safety. The 3D/3D+ model not only enables a structured assessment of frailty, but also systematically guides healthcare disposition following acute care. This promotes more appropriate admissions and greater use of alternatives to conventional hospitalization.

Although until recently conventional hospitalization was the default response for the management of acute episodes, in the geriatric population this strategy is not always associated with better health outcomes and may increase the risk of functional decline, delirium, or iatrogenesis. Intermediate care centers better adapted to the needs of these patients, short-stay units, or hospital-at-home programs constitute, in many cases, optimal options for this population.[5]

It is particularly coherent that in the article by Calvet-Pujol *et al.*,[6] also published in this issue of EMERGENCIAS, most patients admitted to a tertiary hospital appeared to have a low comorbidity burden based on the Elixhauser Index,[7] while profiles with greater comorbidity were preferentially referred to alternative care settings focused on intermediate-intensity care, rehabilitation, and social support. Although this convergence suggests that EDs are already moving—albeit heterogeneously and not always in a protocolized manner—toward differential management of frail patients, these results should be interpreted within the specific characteristics of the tertiary referral center included in the study, where a specialized unit for the care of older patients has existed for years.[8]

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Nevertheless, both studies provide complementary pieces of evidence and allow us to remain optimistic during this transition toward a new approach to frailty, which cannot and should not be limited to pharmacological treatment or conventional hospitalization. Frailty management is, by definition, interdisciplinary and requires the involvement of the entire healthcare team. Equally as important as pharmacological prescription may be deprescription, actions aimed at preventing loss of autonomy, ensuring adequate nutritional intake, or preventing geriatric syndromes associated with the hospitalization process per se. Similarly, avoiding unnecessary hospitalizations or providing resources to enable early discharge and ensure continuity of care are highly appropriate actions. These interventions, often considered "basic care," have a prognostic impact comparable to—and sometimes greater than—that of many pharmacological decisions. However, frailty must be measured systematically to generate solid evidence regarding these interventions, because only then will it be possible to align clinical decisions with real needs and propose safe, tailored interventions that truly provide value.

In conclusion, designing geriatric-competent EDs requires integrating early frailty detection, standardizing key processes, strengthening interdisciplinary work, and promoting a culture of value-based admission appropriateness. It also means accepting that excellence in 21st-century EDs will not be measured solely by diagnostic speed or technological complexity, but also by the ability to provide proportional, safe, and person-centered responses for older adults. Perhaps today, more than at any other moment in history, we must remember what William Osler told us: "The good physician treats the disease, but the great physician treats the patient who has the disease."

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